108TH CONGRESS
2D SESSION

S. 2217

To improve the health of health disparity populations.

IN THE SENATE OF THE UNITED STATES

MARCH 12, 2004

Mr. FRIST introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To improve the health of health disparity populations.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Closing the Health Care Gap Act of 2004''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The overall health of Americans has dramatically improved over the last century, and Americans are justifiably proud of the great strides that have been made in the health and medical sciences.

(2) As medical science and technology have advanced at a rapid pace, however, the health care delivery system has not been able to provide consistently high quality care to all Americans.

(3) In particular, people of lower socioeconomic status, racial and ethnic minorities, and medically

underserved populations have experienced poor health and challenges in accessing high quality health care.

(4) Recent studies have raised significant questions regarding differences in clinical care provided to racial and ethnic minorities and other health disparity populations. These differences are often grouped together under the broad heading of ''health disparities''.

(5) Studies indicate that a gap exists between ideal health care and the actual health care that some Americans receive.

(6) Data collection, analysis, and reporting by race, ethnicity, and primary language across federally supported health programs are essential for identifying, understanding the causes of, monitoring, and eventually eliminating health disparities.

(7) Current health related data collection and reporting activities largely reflect the efforts of the Department of Health and Human Services. Despite considerable efforts by the Department, data collection efforts governing racial, ethnic, and health disparity populations remain inconsistent and inadequate. They often quantify disparities but shed little light on their causes.

(8) Many Americans, and particularly racial and ethnic minorities and other health disparity populations, miss opportunities for preventive medical care. Similarly, management of chronic illnesses in these populations presents unique challenges to the nation's health care system.

(9) The largest numbers of the medically underserved are white individuals, and many of them have the same health care access problems as do members of minority groups. Nearly 22,000,000 white individuals live below the poverty line with many living in nonmetropolitan, rural areas such as Appalachia, where the high percentage of countries designated as health professional shortage areas (47 percent) and the high rate of poverty contribute to disparity outcomes. However, there is a higher proportion of racial and ethnic minorities in the United States represented among the medically underserved.

(10) While much research examines the question of racial and ethnic differences in health care, less is known about the magnitude and extent of differences in the quality of health care related to non-socioeconomic factors. Only recently have scientists and quality improvement experts begun to address the issue of how best to measure, track, and improve

quality of health care in diverse populations. Additional research in order to understand the causes of disparities and develop effective approaches to eliminate these gaps in health care quality will be necessary.

(11) There is a need to ensure appropriate representation of racial and ethnic minorities, and other health disparity populations, in the health care professions and in the fields of biomedical, clinical, behavioral, and health services research.

(12) Preventable disparities in access to and quality of health care are unacceptable. Health care delivered in the United States should be care that is as safe, effective, patient-centered, timely, efficient and equitable as possible.

TITLE I—IMPROVED HEALTH CARE QUALITY AND EFFECTIVE DATA COLLECTION AND ANALYSIS

SEC. 101. STANDARDIZED MEASURES OF QUALITY HEALTH CARE.

(a) IN GENERAL.—

(1) COLLABORATION.—The Secretary of Health and Human Services, the Secretary of Defense, the Secretary of Veterans Affairs, the Director of the

Indian Health Service, and the Director of the Office of Personnel Management (referred to in this section as the ''Secretaries'') shall work collaboratively to establish uniform, standardized health care quality measures across all Federal Government health programs. Such measures shall be designed to assess quality improvement efforts with regard to the safety, timeliness, effectiveness, patient-centeredness, and efficiency of health care delivered across all federally supported health care delivery programs including those in which health care services are delivered to health disparity populations.

(2) DEVELOPMENT OF MEASURES.—Relying on earlier work by the Secretary of Health and Human Services or others (including work such as the Healthy People 2010 or the IOM Quality Chasm reports) and with an emphasis on health conditions disproportionately affecting health disparity populations and taking into account health literacy and primary language and cultural factors, the Secretaries shall develop standardized sets of quality measures for—

(A) 5 common health conditions by not later than January 1, 2006; and

(B) an additional 10 common health conditions by not later than January 1, 2007.

(3) PILOT TESTING.—Each federally administered health care program may conduct a pilot test of the quality measures developed under paragraph (2) that shall include a collection of patient-level data and a public release of comparative performance reports.

(b) PUBLIC REPORTING REQUIREMENTS.—The Secretaries shall work collaboratively to establish standardized public reporting requirements for clinicians, institutional providers, and health plans in each of the health programs described in subsection (a).

(c) FULL IMPLEMENTATION.—The Secretaries shall work collaboratively to prepare for the full implementation of all standardized sets of quality measures and reporting systems developed under subsections (a) and (b) by not later than January 1, 2009.

(d) PROGRESS REPORT.—The Secretary of Health and Human Services shall prepare an annual progress report that details the collaborative efforts carried out under subsection (a).

(e) COMPARATIVE QUALITY REPORTS.—Beginning on January 1, 2008, in order to make comparative quality information available to health care consumers, including

members of health disparity populations, health professionals, public health officials, researchers, and other appropriate individuals and entities, the Secretaries shall provide for the pooling and analysis of quality measures collected under this section. Nothing in this section shall be construed as modifying the privacy standards under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191).

(f) ONGOING EVALUATION OF USE.—The Secretary of Health and Human Services shall ensure the ongoing evaluation of the use of the health care quality measures established under this section.

(g) EXISTING ACTIVITIES.—Notwithstanding any other provision of law, the standardized measures and reporting activities described in this section shall replace, to the extent practicable and appropriate, any existing measurement and reporting activities currently utilized by federally supported health care delivery programs.

(h) EVALUATION.—

(1) INSTITUTE OF MEDICINE.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall request the Institute of Medicine to conduct an evaluation of the collaborative efforts of the Secretaries to establish uniform, standardized health care

quality measures and reporting requirements for federally supported health care delivery programs as required under this section.

(B) REPORT.—Not later than 2 years after the date of enactment of this Act, the Institute of Medicine shall submit a report concerning the results of the evaluation under subparagraph (A) to the Secretary.

(2) REGULATIONS.—

(A) PROPOSED.—Not later than 18 months after the date on which the report is submitted under paragraph (1)(B), the Secretary shall publish proposed regulations regarding the uniform, standardized health care quality measures and reporting requirements described in this section.

(B) FINAL REGULATIONS.—Not later than 3 years after the date on which the report is submitted under paragraph (1)(B), the Secretary shall publish final regulations regarding the uniform, standardized health care quality measures and reporting requirements described in this section.

SEC. 102. DATA COLLECTION.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall—

(1) ensure that data collected under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) are accurate by race, ethnicity, and primary language and available for inclusion in the National Health Disparities Report;

(2) enforce State data collection and reporting by race, ethnicity, and primary language for enrollees in the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and the State Children's Health Insurance Program under title XXI of such Act (42 U.S.C. 1397aa et seq.) and ensure that such data are available for inclusion in the National Health Disparities Report;

(3) ensure that ongoing and any new program initiatives—

(A) collect and report data by race, ethnicity, and primary language and provide technical assistance to promote compliance;

(B) address technological difficulties;

(C) ensure privacy and confidentiality of data collected; and

(D) implement effective educational strategies;

(4) expand educational programs to inform insurers, providers, agencies and the public of the importance of data collection by race, ethnicity, and primary language to improving health care access and quality;

(5) raise awareness that these data are critical for achieving Healthy People 2010 goals and essential to the nondiscrimination requirements of title VI of the Civil Rights Act (42 U.S.C. 2000d et seq.); and

(6) support research on existing best practices for data collection.

(b) GRANTS FOR DATA COLLECTION BY HEALTH PLANS, HEALTH CENTERS, AND HOSPITALS.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, may support or conduct not to exceed 20 demonstration programs to enhance the collection, analysis, and reporting of the data required under this section.

(2) ELIGIBILITY.—To be eligible to receive a grant under this section an entity shall—

(A) be a health plan, federally qualified health center or health center network, or hospital; and

(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such as information as the Secretary may require.

(3) USE OF FUNDS.—A grantee shall use amounts received under a grant under this subsection to—

(A) collect, analyze, and report data by race, ethnicity, or other health disparity category for patients served by the grantee, including—

(i) in the case of a hospital, emergency room patients and patients served on an inpatient or outpatient basis;

(ii) in the case of a health plan, data for enrollees; and

(iii) in the case of a federally qualified health center or health center network, primary care, specialty care, and referrals;

(B) provide analyses of racial, ethnic and other disparities in health and health care, in-

cluding specific disease conditions, diagnostic and therapeutic procedures, or outcomes;

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

(D) develop mechanisms for sharing collected data, subject to applicable privacy and confidentiality regulations;

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

(F) ensure the evaluation of activities conducted under this section.

TITLE II—EXPANDED ACCESS TO QUALITY HEALTH CARE

Subtitle A—Access, Awareness, and Outreach

SEC. 201. ACCESS AND AWARENESS GRANTS.

(a) DEMONSTRATION PROJECTS.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') may award contracts or competitive grants to eligible entities to support demonstration projects designed to improve the health and health care of health disparity populations through improved access to health care, health care navigation assistance, and health literacy education.

(b) ELIGIBLE ENTITY DEFINED.—In this section the term ''eligible entity'' means—

(1) a hospital;

(2) an academic institution;

(3) a State health agency;

(4) an Indian Health Service hospital or clinic, Indian tribal health facility, or urban Indian facility;

(5) a nonprofit organization including a faith-based organization or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of section 1955 of the Public

Health Service Act (42 U.S.C. 300x–65) relating to grant award to nongovernmental entities;

(6) a primary care practice-based research network as defined by the Director of the Agency for Healthcare Research and Quality;

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

(8) any other entity determined to be appropriate by the Secretary.

(c) APPLICATION.—An eligible entity seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including assurances that the eligible entity will—

(1) target patient populations that are members of racial and ethnic minority groups or health disparity populations through specific outreach activities;

(2) coordinate with appropriate community organizations and include appropriate community participation in planning and implementation of activities;

(3) coordinate culturally competent and appropriate care;

(4) include a plan to ensure that the entity will become self-sustaining when funding under the grant terminates; and

(5) include quality and outcomes performance measures to evaluate the effectiveness of activities funded under this section to ensure that the activities are meeting their goals, and disseminate findings from such evaluations.

(d) PRIORITIES.—In awarding contracts and grants under this section, the Secretary shall give priority to applicants that intend to use amounts received under this section to carry out all programs specified under subsection (e).

(e) USE OF FUNDS.—An eligible entity shall use amounts received under this section to carry out programs that involve at least 2 of the following:

(1) Providing resources and guidance to individuals regarding sources of health insurance coverage, as well as information on how to obtain health coverage in the private insurance market, through Federal and State programs, and through other available coverage options.

(2) Providing patient navigator services to help individuals better utilize their health coverage by

working through the health system to obtain appropriate quality care, including programs in which—

(A) trained individuals (such as representatives from the community, nurses, social workers, physicians, or patient advocates) are assigned to act as contacts—

(i) within the community; or

(ii) within the health care system, to facilitate access to health care services;

(B) partnerships are created with community organizations (which may include hospitals, federally qualified health centers or health center networks, faith-based organizations, primary care providers, home care, nonprofit organizations, health plans, or other health providers determined appropriate by the Secretary) to help facilitate access or to improve the quality of care;

(C) activities are conducted to coordinate care and preventive services and referrals;

(D) services are provided for translation, interpretation, and other such linguistic services for patients with limited English proficiency; or

(E) an entity receiving a grant under this section negotiates on behalf of the patient with

relevant entities, or provides referrals and guides the patient through the mediation or arbitration process, to resolve issues that impede access to care.

(3) Promoting broad health awareness and prevention efforts, including patient education and health literacy programs to help increase a patient's knowledge of how to best participate in such patient's and such patient's children's treatment decisions.

(4) Enhancing preventive services and coordinated, multidisciplinary disease management of chronic conditions, such as diabetes mellitus, HIV/AIDS, asthma, cancer, cardiovascular disease, and obesity.

(f) REPORT.—Not later than 3 years after the date an entity receives a grant under this section and annually thereafter, the entity shall provide to the Secretary a report containing the results of any evaluation conducted pursuant to subsection (c)(5).

(g) 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 2005 through 2009.

SEC. 202. INNOVATIVE OUTREACH PROGRAMS.

(a) GRANTS TO PROMOTE INNOVATIVE OUTREACH AND ENROLLMENT UNDER MEDICAID AND SCHIP.—Section 2104(e) of the Social Security Act (42 U.S.C. 1397dd(e)) is amended—

(1) by striking ''Amounts allotted'' and inserting the following:

''(1) IN GENERAL.—Subject to paragraph (2), amounts allotted''; and

(2) by adding at the end the following:

''(2) GRANTS TO PROMOTE INNOVATIVE OUTREACH AND ENROLLMENT EFFORTS.—

''(A) IN GENERAL.—Prior to September 30 of each fiscal year, beginning with fiscal year 2004, the Secretary shall reserve from any unexpended allotments made to States under subsection (b) or (c) (including any portion of such allotments that were redistributed under subsection (f) or (g)) for a fiscal year that would revert to the Treasury on October 1 of the succeeding fiscal year but for the application of this paragraph, the lesser of $50,000,000 or the total amount of such unexpended allotments for purposes of awarding grants under this paragraph for such succeeding fiscal year to States or national, local, and community-based public

or nonprofit private organizations to conduct innovative outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children under this title and title XIX.

''(B) PRIORITY FOR GRANTS IN CERTAIN AREAS.—In making grants under subparagraph (A)(ii), the Secretary shall give priority to grant applicants that propose to target geographic areas—

''(i) with high rates of eligible but unenrolled children, including such children who reside in rural areas;

''(ii) with high rates of families for whom English is not their primary language; or

''(iii) with high rates of racial and ethnic minorities and health disparity populations.

''(C) APPLICATION.—An organization that desires to receive a grant under this paragraph shall submit an application to the Secretary in such form and manner, and containing such information, as the Secretary may decide. Such application shall include quality and outcomes

performance measures to evaluate the effectiveness of activities funded by a grant under this paragraph to ensure that the activities are meeting their goals, and disseminate findings from such evaluations.''.

(b) DEMONSTRATIONS TO REDUCE HEALTH DISPARITIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall, through contracts or grants to public and private entities, support demonstration programs for the purpose of conducting interventions among health disparity populations to—

(A) target, identify, and reduce or prevent behavioral risk factors that contribute to health disparities;

(B) promote translation, interpretation, and other such linguistic services for patients with limited English speaking proficiency;

(C) promote preventive services; or

(D) enhance coordinated, multidisciplinary disease management of chronic conditions, such as diabetes mellitus, HIV/AIDS, asthma, cancer, and obesity.

(2) APPLICATION.—An entity desiring a contract or grant under paragraph (1) shall submit an

application to the Secretary of Health and Human Services in such form and manner, and containing such information, as the Secretary may require.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection such sums as may be necessary for each of fiscal years 2005 through 2009.

Subtitle B—Refundable Health Insurance Credit

SEC. 211. REFUNDABLE HEALTH INSURANCE COSTS CREDIT.

(a) ALLOWANCE OF CREDIT.—

(1) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable personal credits) is amended by redesignating section 36 as section 37 and by inserting after section 35 the following new section:

"SEC. 36. HEALTH INSURANCE COSTS FOR UNINSURED INDIVIDUALS.

''(a) ALLOWANCE OF CREDIT.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the amount paid by the taxpayer during such tax-

able year for qualified health insurance for the taxpayer and the taxpayer's spouse and dependents.

''(b) LIMITATIONS.—

''(1) IN GENERAL.—The amount allowed as a credit under subsection (a) to the taxpayer for the taxable year shall not exceed the lesser of—

''(A) the sum of the monthly limitations for coverage months during such taxable year for the individuals referred to in subsection (a) for whom the taxpayer paid during the taxable year any amount for coverage under qualified health insurance, or

''(B) 90 percent of the sum of the amounts paid by the taxpayer for qualified health insurance for each such individual for coverage months of the individual during the taxable year.

''(2) MONTHLY LIMITATION.—

''(A) IN GENERAL.—The monthly limitation for an individual for each coverage month of such individual during the taxable year is the amount equal to 1/12 of—

''(i) $1,000 if such individual is the taxpayer,

''(ii) $1,000 if—

''(I) such individual is the spouse of the taxpayer,

''(II) the taxpayer and such spouse are married as of the first day of such month, and

''(III) the taxpayer files a joint return for the taxable year, and

''(iii) $500 if such individual is an individual for whom a deduction under section 151(c) is allowable to the taxpayer for such taxable year.

''(B) LIMITATION TO 2 DEPENDENTS.—Not more than 2 individuals may be taken into account by the taxpayer under subparagraph (A)(iii).

''(C) SPECIAL RULE FOR MARRIED INDIVIDUALS.—In the case of a taxpayer—

''(i) who is married (within the meaning of section 7703) as of the close of the taxable year but does not file a joint return for such year, and

''(ii) who does not live apart from such taxpayer's spouse at all times during the taxable year,

the dollar limitation imposed under subparagraph (A)(iii) shall be divided equally between the taxpayer and the taxpayer's spouse unless they agree on a different division.

"(3) INCOME PHASEOUT OF CREDIT PERCENTAGE.—

"(A) PHASEOUT FOR SINGLE COVERAGE.—If a taxpayer with self-only coverage has modified adjusted gross income in excess of $15,000 for a taxable year, the 90 percent under paragraph (1)(B) shall be reduced (but not below zero) by—

"(i) 2 percentage points for each $250 of such income in excess of $15,000 but not in excess of $20,000, and

"(ii) 1.25 percentage points for each $250 of such income in excess of $20,000.

"(B) AMOUNT OF REDUCTION FOR FAMILY COVERAGE.—If a taxpayer with family coverage has modified adjusted gross income in excess of $25,000 for a taxable year, the 90 percent under paragraph (1)(B) shall be reduced (but not below zero) by—

"(i) in the case of family coverage covering only 1 adult, 1.5 percentage points for each $250 of such excess, and

"(ii) in the case of family coverage covering more than 1 adult, 0.643 percentage points for each $250 of such excess.

Any percentage resulting from a reduction under clause (ii) shall be rounded to the nearest one-tenth of a percent.

"(C) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income determined—

"(i) without regard to this section and sections 911, 931, and 933, and

"(ii) after application of sections 86, 135, 137, 219, 221, and 469.

"(c) COVERAGE MONTH.—For purposes of this section—

"(1) IN GENERAL.—The term 'coverage month' means, with respect to an individual, any month if—

"(A) as of the first day of such month such individual is covered by qualified health insurance, and

"(B) the premium for coverage under such insurance for such month is paid by the taxpayer.

"(2) EMPLOYER-SUBSIDIZED COVERAGE.—

"(A) IN GENERAL.—The term 'coverage month' shall not include any month for which such individual is eligible to participate in any subsidized health plan (within the meaning of section 162(l)(2)) maintained by any employer of the taxpayer or of the spouse of the taxpayer. A subsidized health plan shall not include a plan substantially all of the coverage of which is of excepted benefits described in section 9832(c).

"(B) PREMIUMS TO NONSUBSIDIZED PLANS.—If an employer of the taxpayer or the spouse of the taxpayer maintains a health plan which is not a subsidized health plan (as so defined) and which constitutes qualified health insurance, employee contributions to the plan shall be treated as amounts paid for qualified health insurance.

"(3) CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT BENEFICIARIES.—The term 'coverage month' shall not include any month during a taxable

year if any amount is not includible in the gross income of the taxpayer for such year under section 106 with respect to—

"(A) a benefit chosen under a cafeteria plan (as defined in section 125(d)), or

"(B) a benefit provided under a flexible spending or similar arrangement.

"(4) MEDICARE, MEDICAID, AND SCHIP.—The term 'coverage month' shall not include any month with respect to an individual if, as of the first day of such month, such individual—

"(A) is entitled to any benefits under part A of title XVIII of the Social Security Act or is enrolled under part B of such title, or

"(B) is enrolled in the program under title XIX or XXI of such Act (other than under section 1928 of such Act).

"(5) CERTAIN OTHER COVERAGE.—The term 'coverage month' shall not include any month during a taxable year with respect to an individual if, at any time during such year, any benefit is provided to such individual under—

"(A) chapter 89 of title 5, United States Code,

"(B) chapter 55 of title 10, United States Code,

"(C) chapter 17 of title 38, United States Code, or

"(D) any medical care program under the Indian Health Care Improvement Act.

"(6) PRISONERS.—The term 'coverage month' shall not include any month with respect to an individual if, as of the first day of such month, such individual is imprisoned under Federal, State, or local authority.

"(7) INSUFFICIENT PRESENCE IN UNITED STATES.—The term 'coverage month' shall not include any month during a taxable year with respect to an individual if such individual is present in the United States on fewer than 183 days during such year (determined in accordance with section 7701(b)(7)).

"(d) QUALIFIED HEALTH INSURANCE.—For purposes of this section—

"(1) IN GENERAL.—The term 'qualified health insurance' means health insurance coverage (as defined in section 9832(b)(1)) which—

"(A) is coverage described in paragraph (2), and

''(B) meets the requirements of paragraph (3).

''(2) ELIGIBLE COVERAGE.—Coverage described in this paragraph is the following:

''(A) Coverage under individual health insurance.

''(B) Coverage under a group health plan (as defined in section 5000 without regard to subsection (d)).

''(C) Coverage through a private sector health care coverage purchasing pool.

''(D) Coverage under a State high risk pool described in subparagraph (C) of section 35(e)(1).

''(E) Continuation coverage described in subparagraph (A) or (B) of section 35(a)(1).

''(F) Coverage under an eligible State buyin program.

''(3) REQUIREMENTS.—The requirements of this paragraph are as follows:

''(A) COST LIMITS.—Under the coverage, the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid (other than premiums) for covered benefits does not exceed—

"(i) $5,000 for self-only coverage, and

"(ii) twice the dollar amount in clause (i) for family coverage, or

"(B) MAXIMUM BENEFITS.—Under the coverage, the annual and lifetime maximum benefits are not less than $700,000.

"(4) ELIGIBLE STATE BUYIN PROGRAM.—For purposes of paragraph (2)(F)—

"(A) IN GENERAL.—The term 'eligible State buyin program' means a State program under which an individual not otherwise eligible for assistance under the State medicaid program under title XIX of the Social Security Act or the State children's health insurance program under title XXI of such Act is able to buy health insurance coverage through a purchasing arrangement entered into between the State and a private sector health care purchasing group or health plan for purposes of providing health insurance coverage to recipients of assistance under such program or for purposes of providing such coverage to State employees.

"(B) REQUIREMENTS.—Subparagraph (A) shall only apply to a State program if—

''(i) the program uses private sector health care purchasing groups or health plans, and

''(ii) the State maintains separate risk pools for participants under the State program.

''(e) ARCHER MSA CONTRIBUTIONS; HSA CONTRIBUTIONS.—If a deduction would be allowed under section 220 to the taxpayer for a payment for the taxable year to the Archer MSA of an individual or under section 223 to the taxpayer for a payment for the taxable year to the Health Savings Account of such individual, subsection (a) shall not apply to the taxpayer for any month during such taxable year for which the taxpayer, spouse, or dependent is an eligible individual for purposes of either such section.

''(f) INFLATION ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any taxable year beginning after 2004, each dollar amount referred to in subsections (b)(2)(A) and (d)(3) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 213(d)(10)(B)(ii) for the calendar year in which the taxable year begins,

except that '2003' shall be substituted for '1996' in subclause (II) thereof.

''(2) ROUNDING.—If any amount as adjusted under paragraph (1) is not a multiple of $10, such amount shall be rounded to the next lowest multiple of $10.

''(g) SPECIAL RULES.—

''(1) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—The amount which would (but for this paragraph) be taken into account by the taxpayer under section 213 for the taxable year shall be reduced by the credit (if any) allowed by this section to the taxpayer for such year.

''(2) COORDINATION WITH DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—In the case of a taxpayer who is eligible to deduct any amount under section 162(l) for the taxable year, this section shall apply only if the taxpayer elects not to claim any amount as a deduction under such section for such year.

''(3) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a tax-

able year beginning in the calendar year in which such individual's taxable year begins.

''(4) COORDINATION WITH ADVANCE PAYMENT.—Rules similar to the rules of section 35(g)(1) shall apply to any credit to which this section applies.

''(5) COORDINATION WITH SECTION 35.—If a taxpayer is eligible for the credit allowed under this section and section 35 for any taxable year, the taxpayer shall elect which credit is to be allowed.

''(h) EXPENSES MUST BE SUBSTANTIATED.—A payment for insurance to which subsection (a) applies may be taken into account under this section only if the taxpayer substantiates such payment in such form as the Secretary may prescribe.

''(i) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''.

(b) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 (relating to information concerning transactions with other persons) is amended by inserting after section 6050T the following:

"SEC. 6050U. RETURNS RELATING TO PAYMENTS FOR QUALIFIED HEALTH INSURANCE.

"(a) IN GENERAL.—Any person who, in connection with a trade or business conducted by such person, receives payments during any calendar year from any individual for coverage of such individual or any other individual under creditable health insurance, shall make the return described in subsection (b) (at such time as the Secretary may by regulations prescribe) with respect to each individual from whom such payments were received.

"(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

"(1) is in such form as the Secretary may prescribe, and

"(2) contains—

"(A) the name, address, and TIN of the individual from whom payments described in subsection (a) were received,

"(B) the name, address, and TIN of each individual who was provided by such person with coverage under creditable health insurance by reason of such payments and the period of such coverage,

"(C) the aggregate amount of payments described in subsection (a), and

''(D) such other information as the Secretary may reasonably prescribe.

''(c) CREDITABLE HEALTH INSURANCE.—For purposes of this section, the term 'creditable health insurance' means qualified health insurance (as defined in section 36(d)).

''(d) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required under subsection (b)(2)(A) to be set forth in such return a written statement showing—

''(1) the name and address of the person required to make such return and the phone number of the information contact for such person,

''(2) the aggregate amount of payments described in subsection (a) received by the person required to make such return from the individual to whom the statement is required to be furnished, and

''(3) the information required under subsection (b)(2)(B) with respect to such payments.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

''(e) RETURNS WHICH WOULD BE REQUIRED TO BE MADE BY 2 OR MORE PERSONS.—Except to the extent provided in regulations prescribed by the Secretary, in the case of any amount received by any person on behalf of another person, only the person first receiving such amount shall be required to make the return under subsection (a).''.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by redesignating clauses (xii) through (xviii) as clauses (xiii) through (xix), respectively, and by inserting after clause (xi) the following:

''(xii) section 6050U (relating to returns relating to payments for qualified health insurance),''.

(B) Paragraph (2) of section 6724(d) of such Code is amended by striking ''or'' at the end of subparagraph (AA), by striking the period at the end of the subparagraph (BB) and inserting '', or'', and by adding at the end the following:

''(CC) section 6050U(d) (relating to returns relating to payments for qualified health insurance).''.

(3) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to section 6050T the following:

''Sec. 6050U. Returns relating to payments for qualified health insurance.''.

(c) CRIMINAL PENALTY FOR FRAUD.—Subchapter B of chapter 75 of the Internal Revenue Code of 1986 (relating to other offenses) is amended by adding at the end the following:

''SEC. 7276. PENALTIES FOR OFFENSES RELATING TO HEALTH INSURANCE TAX CREDIT.

''Any person who knowingly misuses Department of the Treasury names, symbols, titles, or initials to convey the false impression of association with, or approval or endorsement by, the Department of the Treasury of any insurance products or group health coverage in connection with the credit for health insurance costs under section 36 shall on conviction thereof be fined not more than $10,000, or imprisoned not more than 1 year, or both.''.

(d) CONFORMING AMENDMENTS.—

(1) Section 162(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(6) ELECTION TO HAVE SUBSECTION APPLY.—No deduction shall be allowed under paragraph (1) for a taxable year unless the taxpayer elects to have this subsection apply for such year.''.

(2) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period '', or from section 36 of such Code''.

(3) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the last item and inserting the following:

''Sec. 36. Health insurance costs for uninsured individuals.
''Sec. 37. Overpayments of tax.''

(4) The table of sections for subchapter B of chapter 75 of such Code is amended by adding at the end the following:

''Sec. 7276. Penalties for offenses relating to health insurance tax credit.''

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 2003, without regard to whether final regu-

lations to carry out such amendments have been promulgated by such date.

(2) PENALTIES.—The amendments made by subsections (c) and (d)(4) shall take effect on the date of the enactment of this Act.

SEC. 212. ADVANCE PAYMENT OF CREDIT TO ISSUERS OF QUALIFIED HEALTH INSURANCE.

(a) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following:

"SEC. 7529. ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS.

''(a) GENERAL RULE.—Not later than January 1, 2005, the Secretary shall establish a program for making payments on behalf of certified individuals to providers of qualified health insurance (as defined in section 36(d)) for such individuals.

''(b) PROGRAM OPTIONS.—The program under subsection (a) may—

''(1) provide that payments may be made on the basis of modified adjusted gross income of certified individuals for the preceding taxable year, and

''(2) provide that, in lieu of payments to providers, the following amounts may be offset:

"(A) Amounts required to be deposited by the provider as estimated income tax under section 6654 or 6655.

"(B) Amounts required to be deducted and withheld under section 3401 (relating to wage withholding).

"(C) Taxes imposed under section 3111(a) or 50 percent of taxes imposed under section 1401(a) (relating to FICA employer taxes).

"(D) Amounts required to be deducted under section 3102 with respect to taxes imposed under section 3101(a) or 50 percent of taxes imposed under section 1401(a) (relating to FICA employee taxes).

"(c) CERTIFIED INDIVIDUAL.—For purposes of this section, the term 'certified individual' means any individual for whom a qualified health insurance credit eligibility certificate is in effect.

"(d) QUALIFIED HEALTH INSURANCE CREDIT ELIGIBILITY CERTIFICATE.—For purposes of this section, a qualified health insurance credit eligibility certificate is a statement furnished by an individual to a provider of qualified health insurance which—

''(1) certifies that the individual will be eligible to receive the credit provided by section 36 for the taxable year,

''(2) estimates the amount of such credit for such taxable year, and

''(3) provides such other information as the Secretary may require for purposes of this section.''

(b) CLERICAL AMENDMENT.—The table of sections for chapter 77 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''Sec. 7529. Advance payment of health insurance credit for purchasers of qualified health insurance.''

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on July 1, 2005, without regard to whether final regulations to carry out such amendments have been promulgated by such date.

TITLE III—STRONG NATIONAL LEADERSHIP, COOPERATION, AND COORDINATION

SEC. 301. OFFICE OF MINORITY HEALTH AND HEALTH DISPARITIES.

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

(1) by striking the section heading and inserting the following:

''OFFICE OF MINORITY HEALTH AND HEALTH DISPARITIES''; and

(2) in subsection (a)—

(A) by striking ''Office of Minority Health'' each place that such appears and inserting ''Office of Minority Health and Health Disparities''; and

(B) by striking ''for Minority Health'' and inserting ''for Minority Health and Health Disparities''.

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

(1) in the matter preceding paragraph (1)—

(A) by inserting ''and health disparity populations'' after ''groups'' and

(B) by striking ''for Minority Health'' and inserting ''for Minority Health and Health Disparities'';

(2) in paragraph (1)—

(A) by striking ''Establish'' and all that follows through ''coordinate'' and inserting ''Coordinate''; and

(B) by striking ''such individuals'' and inserting ''health disparities'';

(4) in paragraph (1)

(3) in paragraph (5), by inserting ''or health disparity populations'' after ''minority groups'';

(4) in paragraph (6), by inserting ''or health disparity population'' after ''minority group'';

(5) by striking paragraphs (7) and (9);

(6) by redesignating paragraphs (1), (2), (3), (4), (5), (6), (8), and (10) as paragraphs (3), (4), (6), (7), (9), (10), (11), and (12), respectively;

(7) by inserting before paragraph (3) (as so redesignated) the following:

''(1) Establish specific short- and long-term goals and objectives for analyzing the causes of health disparities and addressing them, with a particular focus on the areas of health promotion, disease prevention, chronic care and research.

''(2) Work with agencies within the Department of Health and Human Services and with the Surgeon General to establish a strategic plan to analyze and address the causes of health disparities. The plan shall include recommendations to improve the collection, analysis, and reporting of data at the Federal, State, territorial, Tribal, and local levels, including how to—

''(A) implement data collection while minimizing the cost and administrative burdens of data collection and reporting;

''(B) expand awareness of the importance of such data collection to improving health care quality; and

''(C) provide researchers with greater access to racial, ethnic, and other health disparity data.'';

(8) by inserting after paragraph (4) (as so redesignated), the following:

''(5) Increase awareness of disparities in health care among health care providers, health plans, and the public.'';

(9) in paragraph (6) (as so redesignated)—

(A) by striking ''Support'' and inserting ''In cooperation with the appropriate agencies, support'';

(B) by inserting before the period the following: ''for—

''(A) expanding health care access;

''(B) improving health care quality; and

''(C) increasing health care educational opportunity.'';

(10) by inserting after paragraph (7) (as so redesignated), the following:

''(8) Consistent with section 102 of the Closing the Health Care Gap Act of 2004, coordinate the classification and collection of health care data to allow for the ongoing analysis of the causes of disparities and monitoring of progress toward the elimination of disparities.''; and

(11) by inserting after paragraph (12), as so redesignated, the following:

''(13) Work with Federal agencies and departments outside of the Department of Health and Human Services to maximize program resources available to understand why disparities exist, and effective ways to reduce and eliminate disparities.

''(14) Support a center for linguistic and cultural competence to carry out the following:

''(A) With respect to individuals who lack proficiency in speaking the English language, enter into contracts with public and nonprofit private providers of primary health services for the purpose of increasing the access of such individuals to such services by developing and carrying out programs to provide bilingual or interpretive services.

''(B) Carry out programs to improve access to health care services for individuals with limited proficiency in speaking the English language. Activities under this subparagraph shall include developing and evaluating model projects.''.

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

(1) in paragraph (1), by inserting ''and Health Disparities'' after ''Minority Health'';

(2) in paragraph (2), by inserting ''and health disparity populations'' after ''minority group''; and

(3) in paragraph (4)(B)—

(A) by inserting ''and health disparities'' after ''minority health''; and

(B) by inserting ''and health disparity populations'' after ''minority groups''.

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

(1) in paragraph (1)(A), by striking ''(b)(9)'' and inserting ''(b)(14);

(2) in paragraph (1)(B), by striking ''(b)(10)'' and inserting ''(b)(13)''; and

(3) in paragraph (3), insert ''take into account the unique cultural or linguistic issues facing such populations and'' after ''subsection (b)''.

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

(1) in paragraph (1)—

(A) by striking the subsection heading and inserting ''REPORT ON ACTIVITIES.—'';

(B) by striking ''1999'' and inserting ''2006'';

(C) by striking ''Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate'' and inserting ''appropriate committees of Congress''; and

(D) by inserting ''and health disparity populations'' after ''racial and ethnic minority groups'';

(2) in paragraph (2)—

(A) by striking ''1999'' and inserting ''2005''; and

(B) by inserting ''and health disparity'' after ''minority health'';

(3) by redesignating paragraph (1) and (2) as paragraphs (2) and (3), respectively; and

(4) by inserting after the subsection heading, the following:

''(1) IN GENERAL.—Not later than 1 year after the date of enactment of the Closing the Health Care Gap Act of 2004, the Secretary shall submit to the appropriate committees of Congress, a report on the plan developed under subsection (b)(2).''.

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

(1) by striking ''FUNDING.—'' and all that follows through the paragraph designation in paragraph (1); and

(2) by striking ''$30,000,000'' and all that follows through the period and inserting ''$50,000,000 for fiscal year 2005, such sums as may be necessary for each of fiscal years 2006 through 2009.''.

TITLE IV—PROFESSIONAL EDUCATION, AWARENESS, AND TRAINING

SEC. 401. WORKFORCE DIVERSITY AND TRAINING.

(a) PURPOSE.—Part B of title VII of the Public Health Service Act (42 U.S.C. 293 et seq.) is amended by inserting before section 736 the following:

''SEC. 736A. PURPOSE OF PROGRAM.

''It is the purpose of this part to improve health care quality and access in medically underserved communities, to improve the cultural competence of health care providers by increasing minority representation in the health professions, and to strengthen the research and education programs of designated health professions schools that disproportionately serve health disparity populations.''.

(b) CENTERS OF EXCELLENCE.—Section 736 of the Public Health Service Act (42 U.S.C. 293) is amended—

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

''(a) IN GENERAL.—The Secretary shall make grants to, and enter into contracts with, public and nonprofit private health or educational entities, including designated health professions schools described in subsection (c), for the purpose of assisting the schools in supporting programs of excellence in health professions education for racial or ethnic minority or health disparity populations.'';

(2) in subsection (b)—

(A) in paragraph (2), by striking ''underrepresented minority'' and inserting ''racial or ethnic minority'';

(B) in paragraph (3), by striking ''underrepresented minority'' and inserting ''racial or ethnic minority'';

(C) in paragraph (4), by striking ''minority health'' and inserting ''health disparity'';

(D) in paragraph (5), by striking ''under-represented minority groups'' and inserting ''racial or ethnic minorities and health disparity populations'';

(E) in paragraph (6)—

(i) in the matter preceding subparagraph (A), by striking ''under-represented minority'' and inserting ''individuals from racial or ethnic minorities or health disparity populations''; and

(ii) by striking ''and'' at the end;

(F) in paragraph (7), by striking the period and inserting ''; and''; and

(G) by adding at the end the following:

''(8) to conduct accountability and other reporting activities, as required by the Secretary.'';

(3) in subsection (c)—

(A) in paragraph (1)(B)—

(i) in clause (i), by striking ''under-represented minority'' and inserting ''individuals from racial or ethnic minorities or health disparity populations'';

(ii) in clause (ii), by striking ''under-represented minority'' and inserting ''such'';

(iii) in clause (iii)—

(I) by striking ''under-represented minority individuals'' the first place that such appears and inserting ''such students'';

(II) by striking ''such individuals'' and inserting ''such students''; and

(III) by striking ''under-represented minority'' the second place that such appears and inserting ''such''; and

(iv) in clause (iv), by striking ''under-represented minority individuals'' and inserting ''individuals from racial or ethnic minorities or health disparity populations''; and

(B) in paragraph (2)(B)—

(i) in clause (i), by striking ''under-represented'' and inserting ''racial or''; and

(C) in paragraph (5)(B)—

(i) by striking ''under-represented'' and inserting ''racial or''; and

(ii) by inserting ''or a health disparity population'' after ''minorities'';

(4) in subsection (d)(1), by striking ''Under-Represented Minority Health'' and inserting ''Minority Health and Health Disparity'';

(5) in subsection (h)—

(A) in paragraph (1), by striking ''$26,000,000'' and all that follows and inserting ''$50,000,000 for fiscal year 2005, and such sums as may be necessary for each of fiscal years 2006 through 2009''; and

(B) in paragraph (2)—

(i) in subparagraph (C)—

(I) in the matter preceding clause (i), by striking ''are $30,000,000 or more'' and inserting ''exceed $30,000,000 but are less than $40,000,000''; and

(II) in clause (iv), by striking ''any remaining funds'' and inserting ''any remaining excess amount''; and

(ii) by adding at the end the following:

"(D) FUNDING IN EXCESS OF $40,000,000.—If amounts appropriated under paragraph (1) for a fiscal year are $40,000,000 or more, the Secretary shall make available—

"(i) not less than $16,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A);

"(ii) not less than $16,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e));

"(iii) not less than $8,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5); and

"(iv) after grants are made with funds under clauses (i) through (iii), any remaining funds for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (2)(A), (3), (4), or (5) of subsection (c)."; and

(6) by adding at the end the following:

''(i) EVALUATION.—

''(1) IN GENERAL.—Not later than 1 year after the date of enactment of the Closing the Health Care Gap Act of 2004, the Secretary shall request that the Institute of Medicine evaluate the effectiveness of the programs under this section in meeting the purpose of this part. The Institute of Medicine shall submit a report on the evaluation to the Secretary.

''(2) WORKING GROUP.—Upon submission of the report under paragraph (1), the Secretary shall convene a working group composed of stakeholders, including designated health professions schools described in subsection (c), to define quality performance measures and reporting requirements of grant recipients that shall be tied to the purpose of this part.

''(3) REGULATIONS.—Not later than 18 months after the date the Institute of Medicine submits the report under paragraph (1), the Secretary shall publish proposed regulations regarding the quality performance measures and reporting requirements described in paragraph (2). Not later than 3 years after the date the Institute of Medicine submits the

report under paragraph (1), the Secretary shall publish final regulations regarding the quality performance measures and reporting requirements described in paragraph (2).''.

(c) SCHOLARSHIPS FOR DISADVANTAGED STUDENTS.—Section 737 of the Public Health Service Act (42 U.S.C. 293a) is amended—

(1) in subsection (c), by striking ''under-represented minority'' and inserting ''minority and health disparity''; and

(2) in subsection (d)(1)(B), by inserting ''or health disparity'' after ''minority''.

(d) LOAN REPAYMENTS AND FELLOWSHIPS REGARDING FACULTY POSITIONS.—Section 738(b) of the Public Health Service Act (42 U.S.C. 293b(b)) is amended—

(1) in paragraph (1), by striking ''underrepresented'';

(2) in paragraph (3)(A), by striking ''underrepresented minority individuals'' and inserting ''individuals from racial or ethnic minorities or health disparity populations''; and

(3) by striking paragraph (5).

(e) NATIONAL HEALTH SERVICE CORPS.—

(1) ASSIGNMENT.—Section 333(a)(3) of the Public Health Service Act (42 U.S.C. 254f(a)(3)) is amended—

(A) in the second sentence—

(i) by striking ''shall give preference'' and inserting the following: ''shall—

''(A) give preference''; and

(ii) by striking the period and inserting ''; and''; and

(B) by adding at the end the following:

''(B) give preference to applications from entities described in subparagraph (A) that serve individuals a majority of whom are members of a racial or ethnic minority or other health disparity population with annual incomes at or below twice those set forth in the most recent poverty guidelines issued by the Secretary pursuant to section 402(2) of the Community Services Block Grant Act.''.

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

(A) by redesignating paragraphs (1) through (3) as paragraphs (2) through (4), respectively; and

(B) by inserting before paragraph (2) (as so redesignated), the following:

''(1) give preference to applications as described in section 333(a)(3);''.

(e) AUTHORIZATION OF APPROPRIATIONS.—Section 740 of the Public Health Service Act (42 U.S.C. 293d) is amended—

(1) in subsection (a), by striking ''2002'' and inserting ''2009'';

(2) in subsection (b), by striking ''2002'' and inserting ''2009'';

(3) in subsection (c), by striking ''2002'' and inserting ''2009''; and

(4) by striking subsection (d).

(f) GRANTS FOR HEALTH PROFESSIONS EDUCATION.—Section 741 of the Public Health Service Act (42 U.S.C. 293e) is amended—

(1) in subsection (a)(2), in the first sentence by striking ''Unless'' and all that follows through ''the Secretary'' and inserting ''The Secretary''; and

(2) in subsection (b), by striking ''$3,500,000'' and all that follows through the period and inserting ''such sums as may be necessary for each of fiscal years 2005 through 2009.''.

(g) HEALTH CAREERS OPPORTUNITY PROGRAM.—Subpart 2 of part E of title VII of the Public Health Service Act (42 U.S.C. 295 et seq.) is amended—

(1) in section 770 by inserting ''(other than section 771)'' after ''this subpart'';

(2) by redesignating section 770 as section 771; and

(3) by inserting after section 769 the following:

''SEC. 770. HEALTH CAREERS OPPORTUNITY PROGRAM.

''(a) IN GENERAL.—The Secretary may make grants and enter into cooperative agreements and contracts with eligible entities for any of the following purposes:

''(1) Identifying and recruiting students who—

''(A) are from disadvantaged backgrounds or health disparity populations; and

''(B) are interested in a career in the health professions.

''(2) Providing counseling or other services designed to assist such individuals in entering a health professions school and successfully completing their education at such a school.

''(3) Providing, for a period prior to the entry of such individuals into the regular course of education of such a school, preliminary education designed to assist the individuals in successfully com-

pleting such regular course of education at such a school, or referring such individuals to institutions providing such preliminary education.

''(b) RECEIPT OF AWARD.—

''(1) ELIGIBLE ENTITIES; REQUIREMENT OF CONSORTIUM.—The Secretary may make an award under subsection (a) only if an eligible entity meets the following conditions:

''(A) The eligible entity is a public or private entity, and such entity has established a consortium consisting of private community-based organizations and health professions schools.

''(B) The health professions schools in the consortium are schools of medicine or osteopathic medicine, public health, nursing, dentistry, optometry, pharmacy, allied health, or podiatric medicine, or graduate programs in mental health practice (including programs in clinical psychology).

''(C)(i) Except as provided in clause (ii), the membership of the consortium includes not less than 1 nonprofit private community-based organization and not less than 3 health professions schools.

''(ii) In the case of an eligible entity whose exclusive activity under the award will be carrying out 1 or more programs described in subsection (a)(5), the membership of the consortium includes not less than 1 nonprofit private community-based organization and not less than 1 health professions school.

''(D) The members of the consortium have entered into an agreement specifying—

''(i) that each of the members will comply with the conditions upon which the award is made; and

''(ii) whether and to what extent the award will be allocated among the members.

''(2) REQUIREMENT OF COMPETITIVE AWARDS.—Awards under subsection (a) shall be made on a competitive basis.

''(c) REQUIREMENTS.—The Secretary may make an award under subsection (a) only if the Secretary determines that, in the case of activities carried out under the award that prove to be effective toward achieving the purposes of the activities—

''(1) the members of the consortium involved have or will have the financial capacity to continue

the activities, regardless of whether financial assistance under subsection (a) continues to be available; and

''(2) the members of the consortium demonstrate to the satisfaction of the Secretary a commitment to continue such activities, regardless of whether such assistance continues to be available.

''(d) OBJECTIVES UNDER AWARDS.—Before making a first award to an eligible entity under subsection (a), the Secretary shall establish objectives regarding the activities to be carried out under the award, which objectives are applicable until the next fiscal year for which such award is made after a competitive process of review. In making an award after such a review, the Secretary shall establish additional objectives for the applicant.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated, such sums as may be necessary for each of fiscal years 2005 through 2009.''.

SEC. 402. HIGHER EDUCATION TECHNICAL AMENDMENTS.

Section 326(c) of the Higher Education Act of 1965 (20 U.S.C. 1063b(c)) is amended—

(1) in paragraph (2), by inserting before the semicolon, the following: '', and for the acquisition

and development of real property that is adjacent to the campus to improve the academic environment'';

(2) in paragraph (6), by striking ''and'' at the end;

(3) in paragraph (7), by striking the period and inserting a semicolon; and

(4) by adding at the end the following:

''(8) Support of faculty exchanges, development, and fellowship to enable attainment of advanced degrees in their field of instruction; and

''(9) Tutoring, counseling, and student service programs designed to improve academic success.''.

SEC. 403. MODEL CULTURAL COMPETENCY CURRICULUM DEVELOPMENT.

(a) CURRICULA DEVELOPMENT AND MODEL CURRICULA.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') may award grants to eligible entities for curricula development for the training of health care providers and health professions students regarding cultural competency, and for demonstration projects to test new innovations for cultural competence education model curricula for and identify additional barriers to culturally appropriate care.

(b) APPLICATION.—Each eligible entity desiring a grant under subsection (a) shall submit an application to

the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(c) 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 2005 through 2009.

SEC. 404. INTERNET CULTURAL COMPETENCY CLEARINGHOUSE.

(a) DEVELOPMENT.—The Director of the Office of Minority Health and Health Disparities, with assistance from the Administrator of the Agency for Healthcare Research and Quality, shall develop and maintain an Internet clearinghouse to improve health care quality for individuals with specific cultural needs or with limited English proficiency or low functional health literacy and to reduce or eliminate the duplication of effort to translate materials.

(b) TEMPLATES.—In developing the clearinghouse under subsection (a), the Director of the Office of Minority Health and Health Disparities shall develop, test, and make available templates for standard documents that are necessary for patients and consumers to access and make educated decisions about their health care, including—

(1) administrative and legal documents;

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

(3) patient education and outreach materials such as immunization notices, health warnings, or screening notices.

(c) ONLINE LIBRARY OR DATABASE.—The Director of the Office of Minority Health and Health Disparities shall develop a readily accessible online library or database with searchable clinically relevant cultural information that is important for health care providers to have on hand in the direct provision of medical care to individuals from specific minority, ethnic, or other health disparity groups.

TITLE V—ENHANCED RESEARCH

SEC. 501. AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.

Part B of title IX of the Public Health Service Act (42 U.S.C. 299b) is amended by adding at the end the following:

"SEC. 918. ENHANCED RESEARCH WITH RESPECT TO HEALTH DISPARITIES.

''(a) ACCELERATING THE ELIMINATION OF DISPARITIES.—

''(1) IN GENERAL.—The Secretary, acting through the Director, may award grants or contracts to eligible entities (as defined in paragraph (4)) for short-term research to analyze the causes of disparities and identify or develop and evaluate effective strategies in closing the health care gap between minority and health disparity populations and non-minority populations or non-health disparity populations.

''(2) PROMPT USE OF RESEARCH.—To ensure that research described in paragraph (1) is effective and is disseminated and applied promptly, the Director shall—

''(A) expand practice-based research networks (primary care and larger delivery systems) to include networks of delivery sites serving large numbers of minority and health disparity populations including—

''(i) public hospitals;

''(ii) health centers; and

''(iii) other sites as determined appropriate by the Director;

''(B) work with health care providers to identify and develop those interventions for minority and health disparity populations for

which effective implementation strategies are not clear; and

''(C) develop a broad virtual network of continuous learning among health care providers (including institutions that did not receive a grant or contract under paragraph (1)) so that those participating in research can share findings and experience throughout the duration of such research and to facilitate interest in and prompt adoption of such findings and experience.

''(3) TECHNICAL ASSISTANCE.—The Director of the Agency for Healthcare Research and Quality shall provide technical assistance to assist in the implementation of strategies of evidence-based practices that will reduce health care disparities.

''(4) ELIGIBLE ENTITIES.—In paragraph (1), the term 'eligible entities' means institutions with researchers who have experience in conducting research relating to minority health and health disparity populations.

''(5) PUBLIC HOSPITALS.—In this subsection, the term 'public hospitals' means a hospital (as defined in section 1886(d)(1)(B) of the Social Security Act) that—

"(A) is owned or operated by a unit of State or local government, is a public or private non-profit corporation which is formally granted governmental powers by a unit of State or local government, or is a private non-profit hospital that has a contract with a State or local government to provide health care services to low income individuals who are not entitled to benefits under title XVIII of the Social Security Act or eligible for assistance under the State plan under title XIX of the Social Security Act; and

"(B) for the most recent cost reporting period that ended before the calendar quarter involved, had a disproportionate share adjustment percentage (as determined under section 1886(d)(5)(F) of the Social Security Act) greater than 11.75 percent or was described in section 1886(d)(5)F)(i)(II) of such Act.

"(b) REALIZING THE POTENTIAL OF DISEASE MANAGEMENT.—

"(1) PUBLIC-PRIVATE SECTOR PARTNERSHIP TO ASSESS EFFECTIVENESS OF EXISTING DATA MANAGEMENT STRATEGIES.—The Director shall establish a public-private partnership to assess the effectiveness of disease management strategies and iden-

tify effective interventions and support strategies with respect to minority and health disparity populations.

''(2) EFFECTIVE MANAGEMENT OF PATIENTS WITH MULTIPLE CHRONIC DISEASES.—

''(A) INITIATIVE FOR DISEASE MANAGEMENT STRATEGIES.—The Director shall coordinate an initiative to identify those chronic conditions for which disease-specific disease management strategies pose conflicts in preferred clinical interventions.

''(B) RESEARCH.—The Director, with support from other agencies within the Department of Health and Human Services shall conduct a program of research based in community and primary-care settings to test and evaluate the implications for patient outcomes of alternative approaches for reconciling conflicts from disease-specific disease management initiatives.

''(c) DEVELOPMENT OF EFFECTIVE MEASUREMENT OF DISPARITIES.—

''(1) IN GENERAL.—The Director shall conduct a demonstration project to—

"(A) assess alternative strategies for identifying population subgroups at highest risk of poor quality and poor health;

"(B) improve data collection for health care priority populations (as described in section 901(c)(1)(B));

"(C) improve the ability to identify the causes of disparities; and

"(D) track progress in reducing health care disparities with a focus on—

"(i) the minimum data set necessary to track such progress; and

"(ii) the identification of measures for which data currently being collected are insufficient.

"(2) REPORT.—Not later than 3 years after the date the demonstration project described in paragraph (1) receives funding, the Director shall submit to the appropriate committees of Congress a report containing the findings of the demonstration project together with any policy recommendations.

"(d) ANALYSIS OF RACIAL, ETHNIC, AND OTHER HEALTH DISPARITY DATA.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, and in coordination with the Adminis-

trator of the Centers for Medicare & Medicaid Services and the Director of the Centers for Disease Control and Prevention, shall provide technical assistance to agencies of the Department of Health and Human Services in meeting Federal standards for race, ethnicity, and other health disparity data collection and analysis of racial, ethnic, and other disparities in health and health care in Federally-administered programs by—

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

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

''(3) developing new quality measures relating to racial, ethnic, or other health disparities;

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

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

SEC. 502. NATIONAL INSTITUTES OF HEALTH.

The Director of the National Institutes of Health, in consultation with the Director of the National Center on Minority Health and Health Disparities, shall expand and intensify research at the National Institutes of Health relating to the sources of health and health care disparities, and increase efforts to recruit minority scientists and re-

search professionals into the field of health disparity research.

TITLE VI—MISCELLANEOUS PROVISIONS

SEC. 601. DEFINITIONS.

(a) IN GENERAL.—In this Act, including the amendments made by this Act:

(1) CULTURALLY COMPETENT.—

(A) IN GENERAL.—The term ''culturally competent'', with respect to the manner in which health-related services, education, and training are provided, means providing the services, education, and training in the language and cultural context that is most appropriate for the individuals for whom the services, education, and training are intended, including as necessary the provision of bilingual services.

(B) MODIFICATION.—The definition established in subparagraph (A) may be modified as needed at the discretion of the Secretary after providing a 30-day notice to Congress.

(2) MINORITY HEALTH CONDITIONS.—The term ''minority health conditions'', with respect to individuals who are members of minority groups, means all

diseases, disorders, and conditions (including with respect to mental health and substance abuse)—

(A) unique to, more serious, or more prevalent in such groups;

(B) for which the factors of medical risk or types of medical intervention may be different for such groups, or for which it is unknown whether such factors or types are different for such individuals; or

(C) with respect to which there has been insufficient research involving such individual members of such groups as subjects or insufficient data on such individuals.

(3) MINORITY HEALTH DISPARITIES RESEARCH.—The term ''minority health disparities research'' means basic, clinical, behavioral and health services research on minority health conditions (as defined in paragraph (2)), including research to prevent, diagnose, and treat such conditions.

(4) MINORITY.—The terms ''minority'' and ''minorities'' refer to individuals from a minority group.

(5) MINORITY GROUP.—The term ''minority group'' has the meaning given the term ''racial and

ethnic minority group'' in section 1707 of the Public Health Service Act (42 U.S.C. 300u–6).

(b) HEALTH DISPARITY POPULATIONS.—In this Act, including the amendments made by this Act:

(1) HEALTH DISPARITY POPULATION.—The term ''health disparity population'' has the meaning given such term in section 903(d)(1) of the Public Health Service Act (42 U.S.C. 299a–1(d)(1)).

(2) HEALTH DISPARITIES RESEARCH.—The term ''health disparities research'' shall include basic, clinical, behavioral, and health services research on health disparity populations (including individual members and communities of such populations) that relates to health disparities as defined under paragraph (1), including the causes of such disparities and methods to prevent, diagnose, and treat such disparities.

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