

111TH CONGRESS
1ST SESSION

H. R. 3090

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

IN THE HOUSE OF REPRESENTATIVES

JUNE 26, 2009

Mrs. CHRISTENSEN (for herself, Mr. DAVIS of Illinois, Ms. BORDALLO, Ms. ROYBAL-ALLARD, Mr. CLYBURN, Mr. RANGEL, Ms. LEE of California, Mr. HONDA, Mr. CUMMINGS, Ms. JACKSON-LEE of Texas, Ms. CLARKE, Mr. WATT, Mr. CLAY, Mr. THOMPSON of Mississippi, Mr. MEEK of Florida, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. AL GREEN of Texas, Mr. JOHNSON of Georgia, Mr. CLEAVER, Mr. ELLISON, Ms. WATSON, Mr. JACKSON of Illinois, Mr. CARSON of Indiana, Mr. TOWNS, Ms. FUDGE, Ms. KILPATRICK of Michigan, Ms. RICHARDSON, Ms. BALDWIN, Mr. FATTAH, Mr. BISHOP of Georgia, Mr. SCOTT of Georgia, Mr. PAYNE, Mr. MEEKS of New York, Mr. GRIJALVA, Mr. SCOTT of Virginia, Mr. DAVIS of Alabama, Mr. GRAYSON, Ms. EDWARDS of Maryland, Ms. MOORE of Wisconsin, Ms. CORRINE BROWN of Florida, Ms. WATERS, Ms. HIRONO, Ms. DEGETTE, Mr. FALEOMAVAEGA, Ms. MATSUI, Mr. LEWIS of Georgia, Mr. GONZALEZ, Mr. SABLAN, Mr. PIERLUISI, Mr. REYES, Mr. ORTIZ, Ms. VELÁZQUEZ, Mr. LUJÁN, Mr. HASTINGS of Florida, and Mr. CUELLAR) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, the Judiciary, Natural Resources, Armed Services, Veterans' Affairs, and Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

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

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 2009”.

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

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

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Sec. 206. National Health Service Corps; recruitment and fellowships for indi-
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- Sec. 403. Accountability within the Department of Health and Human Services.
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- Sec. 405. Establishment of the Indian Health Service as an agency of the Public Health Service.
- Sec. 406. Establishment of individual offices of minority health within agencies of the Public Health Service.
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1 **TITLE I—CULTURALLY AND LIN-**
2 **GUISTICALLY APPROPRIATE**
3 **HEALTH CARE**

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

5 **ACT.**

6 (a) FINDINGS.—Congress finds the following:

7 (1) Effective communication is essential to
8 meaningful access to quality physical and mental
9 health care.

10 (2) Research establishes that the lack of lan-
11 guage services creates barriers to and diminishes the
12 quality of health care and health status for limited
13 English proficient individuals.

14 (3) The number of limited English speaking
15 residents in the United States who speak English
16 less than very well and, therefore, cannot effectively
17 communicate with health and social service providers
18 continues to increase significantly.

19 (4) The responsibility to fund language services
20 in the provision of health care and health care-re-
21 lated services to limited English proficient individ-

1 uals is a societal one that cannot fairly be visited
2 solely upon the health care, public health or social
3 services community.

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

8 (6) All members of the health care and health
9 care-related services community should continue to
10 educate their staff and constituents about limited
11 English proficient issues and help them identify re-
12 sources to improve access to quality care for limited
13 English proficient individuals.

14 (7) Access to English as a Second Language in-
15 struction is an important mechanism for ensuring
16 effective communication and eliminating the lan-
17 guage barriers that impede access to health care.

18 (8) Competent languages services in health care
19 settings should be available as a matter of course.

20 (b) AMENDMENT.—The Public Health Service Act
21 (42 U.S.C. 201 et seq.) is amended by adding at the end
22 the following:

1 **“TITLE XXXI—CULTURALLY AND**
2 **LINGUISTICALLY APPRO-**
3 **PRIATE HEALTH CARE**

4 **“SEC. 3100. DEFINITIONS.**

5 “In this title:

6 “(1) BILINGUAL.—The term ‘bilingual’ with re-
7 spect to an individual means a person who has suffi-
8 cient degree of proficiency in two languages.

9 “(2) COMPETENT INTERPRETER SERVICES.—
10 The term ‘competent interpreter services’ means a
11 trans-language rendition of a spoken message in
12 which the interpreter comprehends the source lan-
13 guage and can speak comprehensively in the target
14 language to convey the meaning intended in the
15 source language. The interpreter knows health and
16 health-related terminology and provides accurate in-
17 terpretations by choosing equivalent expressions that
18 convey the best matching and meaning to the source
19 language and captures, to the greatest possible ex-
20 tent, all nuances intended in the source message.

21 “(3) COMPETENT TRANSLATION SERVICES.—
22 The term ‘competent translation services’ means a
23 trans-language rendition of a written document in
24 which the translator comprehends the source lan-
25 guage and can write comprehensively in the target

1 language to convey the meaning intended in the
2 source language. The translator knows health and
3 health-related terminology and provides accurate
4 translations by choosing equivalent expressions that
5 convey the best matching and meaning to the source
6 language and captures, to the greatest possible ex-
7 tent, all nuances intended in the source document.

8 “(4) EFFECTIVE COMMUNICATION.—The term
9 ‘effective communication’ means an exchange of in-
10 formation between the provider of health care or
11 health care-related services and the limited English
12 proficient recipient of such services that enables lim-
13 ited English proficient individuals to access, under-
14 stand, and benefit from health care or health care-
15 related services.

16 “(5) GRIEVANCE RESOLUTION PROCESS.—The
17 term ‘grievance resolution process’ means all aspects
18 of dispute resolution including filing complaints,
19 grievance and appeal procedures and court action.

20 “(6) HEALTH CARE GROUP.—The term ‘health
21 care group’ means a group of physicians organized,
22 at least in part, for the purposes of providing physi-
23 cians’ services under the Medicaid, SCHIP, or Medi-
24 care programs and may include a hospital and any
25 other individual or entity furnishing services covered

1 under the Medicaid, SCHIP or Medicare programs
2 that is affiliated with the health care group.

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

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

11 “(9) INDIAN TRIBE.—The term ‘Indian tribe’
12 means any Indian tribe, band, nation, or other orga-
13 nized group or community, including any Alaska Na-
14 tive village or group or regional or village corpora-
15 tion as defined in or established pursuant to the
16 Alaska Native Claims Settlement Act (85 Stat. 688)
17 (43 U.S.C. 1601 et seq.), which is recognized as eli-
18 gible for the special programs and services provided
19 by the United States to Indians because of their sta-
20 tus as Indians.

21 “(10) INTEGRATED HEALTH CARE DELIVERY
22 SYSTEM.—The term ‘integrated health care delivery
23 system’ means a system comprised of more than one
24 type of health care provider for the purposes of pro-
25 viding a. The providers may include hospitals, clin-

1 ics, home health agencies, ambulatory surgery cen-
2 ters, skilled nursing facilities, rehabilitation facilities
3 and clinics, and employed, independent or contracted
4 physicians.

5 “(11) INTERPRETING/INTERPRETATION.—The
6 terms ‘interpreting’ and ‘interpretation’ mean the
7 transmission of a spoken message from one language
8 into another, faithfully, accurately, and objectively.

9 “(12) LANGUAGE ACCESS.—The term ‘language
10 access’ means the provision of language services to
11 an LEP individual designed to enhance that individ-
12 ual’s access to, understanding of or benefit from
13 health care or health care-related services.

14 “(13) LANGUAGE SERVICES.—The term ‘lan-
15 guage services’ means provision of healthcare serv-
16 ices directly in a non-English language, interpreta-
17 tion, translation and non-English signage.

18 “(14) LEP.—The term ‘LEP’ means limited
19 English proficient.

20 “(15) LEP RELATED DATA COLLECTION AC-
21 TIVITIES.—The term ‘LEP related data collection
22 activities’ includes identifying, collecting, storing,
23 tracking, and analyzing primary language data, and
24 information on the methods used to meet the lan-

1 guage access needs of limited English proficient in-
2 dividuals.

3 “(16) MEDICARE, MEDICAID, AND SCHIP.—The
4 terms ‘Medicare’, ‘Medicaid’, and ‘SCHIP’ means
5 the respective programs under titles XVIII, XIX,
6 and XXI of the Social Security Act.

7 “(17) MINORITY.—

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

11 “(B) POPULATIONS.—The term ‘minority’,
12 with respect to populations, refers to racial and
13 ethnic minority groups.

14 “(18) MINORITY GROUP.—The term ‘minority
15 group’ has the meaning given the term ‘racial and
16 ethnic minority group’.

17 “(19) RACIAL AND ETHNIC MINORITY GROUP.—
18 The term ‘racial and ethnic minority group’ means
19 American Indians and Alaska Natives, African
20 Americans (including Caribbean Blacks, Africans
21 and other Blacks), Asian Americans, Hispanics (in-
22 cluding Latinos), and Native Hawaiians and other
23 Pacific Islanders.

24 “(20) ON-SITE INTERPRETING/INTERPRETA-
25 TION.—The term ‘on-site interpreting/interpretation’

1 means a method of interpreting/interpretation for
2 which the interpreter is in the physical presence of
3 the provider of health care or health care-related
4 services and the limited English proficient recipient
5 of such services.

6 “(21) SECRETARY.—The term ‘Secretary’
7 means the Secretary of Health and Human Services.

8 “(22) SIGHT TRANSLATION.—The term ‘sight
9 translation’ means the transmission of a written
10 message in one language into a spoken message in
11 another language.

12 “(23) STATE.—The term ‘State’ means each of
13 the several states, the District of Columbia, the
14 Commonwealth of Puerto Rico, the Indian tribes,
15 the U.S. Virgin Islands, Guam, American Samoa,
16 and the Commonwealth of the Northern Mariana Is-
17 lands.

18 “(24) TELEPHONIC INTERPRETATION.—The
19 term ‘telephonic interpretation’ (also known as over
20 the phone interpretation or OPI) means a method of
21 interpreting/interpretation for which the interpreter
22 is not in the physical presence of the provider of
23 health care or related services and the limited
24 English proficient recipient of such services but is
25 connected via telephone.

1 “(25) TRANSLATION.—The term ‘translation’
2 means the transmission of a written message in one
3 language into a written message in another lan-
4 guage.

5 “(26) VIDEO INTERPRETATION.—The term
6 ‘video interpretation’ means a method of inter-
7 preting/interpretation for which the interpreter is
8 not in the physical presence of the provider of health
9 care or related services and the limited English pro-
10 ficient recipient of such services but is connected via
11 a video hook-up that includes both audio and video
12 transmission.

13 “(27) VITAL DOCUMENT.—The term ‘vital doc-
14 ument’ includes but is not limited to applications for
15 government programs that provide health care serv-
16 ices; medical or financial consent forms; financial as-
17 sistance documents, letters containing important in-
18 formation regarding patient instructions (e.g., pre-
19 scriptions, referrals to other providers, discharge
20 plans) and participation in a program (such as a
21 Medicaid managed care program); notices pertaining
22 to the reduction, denial or termination of services or
23 benefits; notices of the right to appeal such actions;
24 and notices advising limited English proficient indi-

1 viduals of the availability of free language services,
2 and other outreach materials.

3 **“SEC. 3101. IMPROVING ACCESS TO SERVICES FOR INDIVID-**
4 **UALS WITH LIMITED ENGLISH PROFICIENCY.**

5 “(a) PURPOSE.—As provided in Executive Order
6 13166, it is the purpose of this section—

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

11 “(2) to require each Federal agency to examine
12 the services it provides and develop and implement
13 a system by which limited English proficient individ-
14 uals can obtain meaningful access to those services
15 consistent with, and without substantially burdening,
16 the fundamental mission of the agency;

17 “(3) to require each Federal agency to ensure
18 that recipients of Federal financial assistance pro-
19 vide meaningful access to their limited English pro-
20 ficient applicants and beneficiaries;

21 “(4) to ensure that recipients of Federal finan-
22 cial assistance take reasonable steps, consistent with
23 the guidelines set forth in the Limited English Pro-
24 ficient Guidance of the Department of Justice (as
25 issued on June 12, 2002), to ensure meaningful ac-

1 cess to their programs and activities by limited
2 English proficient individuals; and

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

7 “(b) **FEDERALLY CONDUCTED PROGRAMS AND AC-**
8 **TIVITIES.—**

9 “(1) **IN GENERAL.**—Not later than 120 days
10 after the date of enactment of this title, each Fed-
11 eral agency that carries out health care-related ac-
12 tivities shall prepare a plan to improve access to the
13 federally conducted health care-related programs
14 and activities of the agency by limited English pro-
15 ficient individuals. Each Federal agency must ensure
16 that such plan is fully implemented not later than
17 one year after the date of enactment of this Act.

18 “(2) **PLAN REQUIREMENT.**—Each plan under
19 paragraph (1) shall include—

20 “(A) the steps the agency will take to en-
21 sure that limited English proficient individuals
22 have access to the agency’s federally conducted
23 health care and health care-related programs
24 and activities;

1 “(B) the policies and procedures for identi-
2 fying, assessing, and meeting the language
3 needs of its limited English proficient bene-
4 ficiaries served by federally conducted programs
5 and activities;

6 “(C) the steps the agency will take for its
7 federally conducted programs and activities to
8 provide a range of language assistance options,
9 notice to limited English proficient individuals
10 of the right to competent language services,
11 periodic training of staff, monitoring and qual-
12 ity assessment of the language services and, in
13 appropriate circumstances, the translation of
14 written materials;

15 “(D) the steps the agency will take to en-
16 sure that applications, forms, and other rel-
17 evant documents for its federally conducted pro-
18 grams and activities are competently translated
19 into the primary language of a limited English
20 proficient client where such materials are need-
21 ed to improve access to federally conducted and
22 federally assisted programs and activities for
23 such a limited English proficient individual; and

24 “(E) the resources the agency will provide
25 to assist recipients of Federal funds to improve

1 access to health care or health care related pro-
2 grams and activities for limited English pro-
3 ficient individuals.

4 Each agency shall send a copy of such plan to the
5 Department of Justice, which shall serve as the cen-
6 tral repository of the agencies' plans.

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

9 “(1) IN GENERAL.—Not later than 120 days
10 after the date of enactment of this title, each Fed-
11 eral agency providing health care-related Federal fi-
12 nancial assistance shall ensure that the guidance for
13 recipients of Federal financial assistance developed
14 by the agency to ensure compliance with title VI of
15 the Civil Rights Act of 1964 (42 U.S.C. 2000d et
16 seq.) is specifically tailored to the recipients of such
17 assistance. Each agency shall send a copy of such
18 guidance to the Department of Justice which shall
19 serve as the central repository of the agencies' plans.
20 After approval by the Department of Justice, each
21 agency shall publish its guidance document in the
22 Federal Register for public comment.

23 “(2) REQUIREMENTS.—The agency-specific
24 guidance developed under paragraph (1) shall take
25 into account the types of health care services pro-

1 vided by the recipients, the individuals served by the
2 recipients, and other factors set out in such stand-
3 ards.

4 “(3) EXISTING GUIDANCES.—A Federal agency
5 that has developed a guidance for purposes of title
6 VI of the Civil Rights Act of 1964 shall examine
7 such existing guidance, as well as the programs and
8 activities to which such guidance applies, to deter-
9 mine if modification of such guidance is necessary to
10 comply with this subsection.

11 “(4) CONSULTATION.—Each Federal agency
12 shall consult with the Department of Justice in es-
13 tablishing the guidances under this subsection.

14 “(d) CONSULTATIONS.—

15 “(1) IN GENERAL.—In carrying out this sec-
16 tion, each Federal agency that carries out health
17 care and health care-related activities shall ensure
18 that stakeholders, such as limited English proficient
19 individuals and their representative organizations,
20 recipients of Federal assistance, and other appro-
21 priate individuals or entities, have an adequate op-
22 portunity to provide input with respect to the actions
23 of the agency.

24 “(2) EVALUATION.—Each Federal agency de-
25 scribed in paragraph (1) shall evaluate the—

1 “(A) particular needs of the limited
2 English proficient individuals served by the
3 agency;

4 “(B) particular needs of the limited
5 English proficient individuals served by the
6 agency’s recipients of Federal financial assist-
7 ance; and

8 “(C) burdens of compliance with the agen-
9 cy guidance and this section for the agency and
10 its recipients.

11 **“SEC. 3102. NATIONAL STANDARDS FOR CULTURALLY AND**
12 **LINGUISTICALLY APPROPRIATE SERVICES IN**
13 **HEALTH CARE.**

14 “Recipients of Federal financial assistance from the
15 Secretary shall, to the extent reasonable and practicable
16 after applying the 4-factor analysis described in title V
17 of the Guidance to Federal Financial Assistance Recipi-
18 ents Regarding Title VI Prohibition Against National Ori-
19 gin Discrimination Affecting Limited-English Proficient
20 Persons (June 12, 2002)—

21 “(1) 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 provide culturally and linguistically appropriate

1 health care to patient populations of the service area
2 of the organization;

3 “(2) ensure that staff at all levels and across all
4 disciplines of the organization receive ongoing edu-
5 cation and training in culturally and linguistically
6 appropriate service delivery;

7 “(3) offer and provide language assistance serv-
8 ices, including trained bilingual staff and interpreter
9 services, at no cost to each patient with limited
10 English proficiency at all points of contact, in a
11 timely manner during all hours of operation;

12 “(4) notify patients of their right to receive lan-
13 guage assistance services in their primary language;

14 “(5) ensure the competence of language assist-
15 ance provided to limited English proficient patients
16 by interpreters and bilingual staff, and ensure that
17 family, particularly minor children, and friends are
18 not used to provide interpretation services—

19 “(A) except in case of emergency; or

20 “(B) except on request of the patient, who
21 has been informed in his or her preferred lan-
22 guage of the availability of free interpretation
23 services;

24 “(6) make available easily understood patient-
25 related materials, if such materials exist for non-lim-

1 ited English proficient patients, including informa-
2 tion or notices about termination of benefits and
3 post signage in the languages of the commonly en-
4 countered groups or groups represented in the serv-
5 ice area of the organization;

6 “(7) develop and implement clear goals, poli-
7 cies, operational plans, and management account-
8 ability and oversight mechanisms to provide cul-
9 turally and linguistically appropriate services;

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

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

22 “(A) data on the individual patient’s race,
23 ethnicity, and primary language are collected in
24 health records, integrated into the organiza-

1 tion’s management information systems, and
2 periodically updated; and

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

6 “(10) maintain a current demographic, cultural,
7 and epidemiological profile of the community as well
8 as a needs assessment to accurately plan for and im-
9 plement services that respond to the cultural and
10 linguistic characteristics of the service area of the
11 organization;

12 “(11) develop participatory, collaborative part-
13 nerships with communities and utilize a variety of
14 formal and informal mechanisms to facilitate com-
15 munity and patient involvement in designing and im-
16 plementing culturally and linguistically appropriate
17 services-related activities;

18 “(12) ensure that conflict and grievance resolu-
19 tion processes are culturally and linguistically sen-
20 sitive and capable of identifying, preventing, and re-
21 solving cross-cultural conflicts or complaints by pa-
22 tients;

23 “(13) regularly make available to the public in-
24 formation about their progress and successful inno-
25 vations in implementing the standards under this

1 section and provide public notice in their commu-
 2 nities about the availability of this information; and

3 “(14) if requested, regularly make available to
 4 the head of each Federal entity from which Federal
 5 funds are received, information about their progress
 6 and successful innovations in implementing the
 7 standards under this section as required by the head
 8 of such entity.

9 **“SEC. 3103. ROBERT T. MATSUI CENTER FOR CULTURAL**
 10 **AND LINGUISTIC COMPETENCE IN HEALTH**
 11 **CARE.**

12 “(a) ESTABLISHMENT.—The Secretary, acting
 13 through the Director of the Agency for Healthcare Re-
 14 search and Quality, shall establish and support a center
 15 to be known as the ‘Robert T. Matsui Center for Cultural
 16 and Linguistic Competence in Health Care’ (referred to
 17 in this section as the ‘Center’) to carry out the following
 18 activities:

19 “(1) INTERPRETATION SERVICES.—The Center
 20 shall provide resources via the Internet to identify
 21 and link health care providers to competent inter-
 22 preter and translation services.

23 “(2) TRANSLATION OF WRITTEN MATERIAL.—

24 “(A) The Center shall provide, directly or
 25 through contract, vital documents from com-

1 petent translation services for providers of
2 health care and health care-related services at
3 no cost to such providers. Materials may be
4 submitted for translation into non-English lan-
5 guages. Translation services shall be provided
6 in a timely and reasonable manner and in ac-
7 cordance with the guidelines and standards set
8 forth in subsection (c) when such standards be-
9 come available. The quality of such translation
10 services shall be monitored and reported pub-
11 licly.

12 “(B) For each form developed or revised
13 by the Secretary that will be used by LEP indi-
14 viduals in health care or health care-related set-
15 tings, the Center shall translate the form, at a
16 minimum, into the top 15 non-English lan-
17 guages in the United States according to the
18 most recent data from the American Commu-
19 nity Survey or its replacement. The translation
20 must be completed within 45 days of the Sec-
21 retary receiving final approval of the form from
22 the Office of Management and Budget.

23 “(3) TOLL-FREE CUSTOMER SERVICE TELE-
24 PHONE NUMBER.—The Center shall provide,

1 through a toll-free number, a customer service line
2 for LEP individuals—

3 “(A) to obtain information about federally
4 conducted or funded health programs, including
5 Medicare, Medicaid, and SCHIP;

6 “(B) to obtain assistance with applying for
7 or accessing these programs and understanding
8 Federal notices written in English; and

9 “(C) to learn how to access language serv-
10 ices.

11 “(4) HEALTH INFORMATION CLEARING-
12 HOUSE.—

13 “(A) IN GENERAL.—The Center shall de-
14 velop and maintain an information clearing-
15 house to facilitate the provision of language
16 services by providers of health care and health
17 care-related services to reduce medical errors,
18 improve medical outcomes, reduce health care
19 costs caused by miscommunication with individ-
20 uals with limited English proficiency, and re-
21 duce or eliminate the duplication of effort to
22 translate materials. The clearinghouse shall
23 make such information available on the Internet
24 and in print. Such information shall include the

1 information described in the succeeding provi-
2 sions of this paragraph.

3 “(B) DOCUMENT TEMPLATES.—The Cen-
4 ter shall collect and evaluate for accuracy, de-
5 velop, and make available templates for stand-
6 ard documents that are necessary for patients
7 and consumers to access and make educated de-
8 cisions about their health care, including the
9 following:

10 “(i) Administrative and legal docu-
11 ments, including—

12 “(I) intake forms;

13 “(II) Medicare, Medicaid, and
14 SCHIP forms, including eligibility in-
15 formation;

16 “(III) forms informing patient of
17 HIPAA compliance and consent; and

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

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

1 “(iii) Public health, patient education,
2 and outreach materials, such as immuniza-
3 tion notices, health warnings, or screening
4 notices.

5 “(iv) Additional health or health care-
6 related materials as determined appro-
7 priate by the Director of the Center.

8 “(C) STRUCTURE OF FORMS.—The oper-
9 ating the clearinghouse, the Center shall—

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

13 “(ii) allow public review of the docu-
14 ments before dissemination in order to en-
15 sure that the documents are understand-
16 able and culturally appropriate for the tar-
17 get populations;

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

20 “(iv) facilitate access to these docu-
21 ments;

22 “(v) provide technical assistance with
23 respect to the access and use of such infor-
24 mation; and

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

4 “(D) LANGUAGE ASSISTANCE PRO-
5 GRAMS.—The Center shall provide for the col-
6 lection and dissemination of information on cur-
7 rent examples of language assistance programs
8 and strategies to improve language services for
9 LEP individuals, including case studies using
10 de-identified patient information, program sum-
11 maries, and program evaluations.

12 “(E) CULTURAL AND LINGUISTIC COM-
13 PETENCE MATERIALS.—The Center shall pro-
14 vide information relating to culturally and lin-
15 guistically competent health care for minority
16 populations residing in the United States to all
17 health care providers and health care-related
18 services at no cost. Such information shall in-
19 clude—

20 “(i) tenets of culturally and linguis-
21 tically competent care;

22 “(ii) cultural and linguistic com-
23 petence self-assessment tools;

24 “(iii) cultural and linguistic com-
25 petence training tools;

1 “(iv) strategic plans to increase cul-
2 tural and linguistic competence in different
3 types of providers of health care and
4 health care-related services, including re-
5 gional collaborations among health care or-
6 ganizations; and

7 “(v) cultural and linguistic com-
8 petence information for educators, practi-
9 tioners, and researchers.

10 “(F) INFORMATION ABOUT PROGRESS.—
11 The Center shall regularly collect and make
12 publicly available information about the
13 progress of entities receiving grants under sec-
14 tion 3104 regarding successful innovations in
15 implementing the obligations under this sub-
16 section and provide public notice in the entities’
17 communities about the availability of this infor-
18 mation;

19 “(b) DIRECTOR.—The Center shall be headed by a
20 Director who shall be appointed by, and who shall report
21 to, the Director of the Agency for Healthcare Research
22 and Quality.

23 “(c) INTERPRETATION AND TRANSLATION GUIDE-
24 LINES AND STANDARDS.—The Center shall convene a
25 working group to develop and adopt interpretation and

1 translation quality guidelines and standards for use by the
2 Center. The guidelines and standards must be sufficient
3 to ensure that LEP individuals have the equal opportunity
4 to benefit from health care services to the same extent
5 as non-LEP individuals. The guidelines and standards
6 shall address the training, assessment and certification of
7 individuals to provide competent interpreter and trans-
8 lator services to work in health care and health care-re-
9 lated settings and of bilingual staff who provide services
10 directly in non-English languages. The working group may
11 develop different guidelines and standards for bilingual
12 staff, interpreters, and translators.

13 “(d) MEMBERSHIP.—

14 “(1) QUALIFICATIONS.—The Working Group
15 shall consist of 14 members as follows:

16 “(A) Four members from organizations
17 that advocate on behalf of LEP individuals.

18 “(B) One member who represents a profes-
19 sional interpreter association (that is not the
20 National Council on Interpreting in Health
21 Care) or translator association.

22 “(C) One member from a non-profit com-
23 munity based organization that provides lan-
24 guage services.

1 “(D) Three members recommended by the
2 National Council on Interpreting in Health
3 Care, including one individual who is a
4 professional interpreter.

5 “(E) Four members who are health care
6 providers or represent health care provider as-
7 sociations, including one individual who rep-
8 resents a health care practice of fewer than 5
9 clinicians.

10 “(F) One member who works in or has ex-
11 tensive knowledge of issues related to health
12 care risk management.

13 “(2) GEOGRAPHIC REPRESENTATION.—The
14 membership of the Working Group shall reflect a
15 broad geographic representation including both
16 urban and rural representatives, including represent-
17 atives of the United States territories.

18 “(3) PROHIBITED APPOINTMENTS.—Members
19 of the Working Group shall not include Members of
20 Congress or other elected Federal, State, or local
21 government officials.

22 “(4) VACANCIES.—Any vacancies in the Work-
23 ing Group shall not affect the power and duties of
24 the Working Group but shall be filled in the same
25 manner as the original appointment.

1 “(5) SUBCOMMITTEES.—The Working Group
2 may establish subcommittees if doing so increases
3 the efficiency of the Working Group in completing
4 its tasks, including subcommittees to develop dif-
5 ferent guidelines and standards for interpreters,
6 translators, and bilingual staff.

7 “(6) ADVISORY PANEL TO THE WORKING
8 GROUP.—The Working Group shall consult with the
9 Advisory Panel in the development of the guidelines
10 and standards. The Advisory Panel shall include—

11 “(A) representatives from the American
12 Translators Association, Association of Lan-
13 guage Companies, the National Center for
14 State Courts, and States which have developed
15 interpreter standards such as California, Mas-
16 sachusetts and Oregon who have experience in
17 the development or implementation of their or-
18 ganizations’ interpreter and translator certifi-
19 cation programs;

20 “(B) Federal agencies including the Office
21 for Civil Rights, the Office of Minority Health,
22 and the Centers for Medicare & Medicaid Serv-
23 ices and the National Center on Minority
24 Health and Health Disparities; and

1 “(C) other individuals or entities deter-
2 mined appropriate by the Secretary who have
3 specific expertise that will be useful to the
4 Working Group.

5 “(7) PUBLICATION.—

6 “(A) DRAFT STANDARDS.—Not later than
7 18 months after the date of enactment of this
8 title, the Working Group shall—

9 “(i) prepare and make available to the
10 public through the Internet, the Federal
11 Register, and other appropriate public
12 channels, a proposed set of interpretation
13 and translation guidelines and standards
14 for training, assessment, and certification;
15 and

16 “(ii) accept public comment on such
17 guidelines and standards for a period of
18 not less than 90 days.

19 “(B) FINAL STANDARDS.—Not later than
20 120 days after the expiration of the public com-
21 ment period described in subparagraph (A), the
22 Director of the Agency for Healthcare Research
23 and Quality shall publish, after consultation
24 with and the approval of the Working Group,

1 final guidelines and standards in the Federal
2 Register and on the Internet.

3 “(C) TESTING DEVELOPMENT.—Not later
4 than 120 days after the publication of the final
5 recommendations described in subparagraph
6 (B), the Director of the Agency for Healthcare
7 Research and Quality shall, if deemed necessary
8 by the Working Group, enter into a contract
9 with an entity experienced in the development
10 of designing certification tests in language re-
11 lated fields to develop such tests as may be nec-
12 essary to implement the guidelines and stand-
13 ards.

14 “(D) PILOT PROJECT.—

15 “(i) Not later than 120 days after
16 completion of the test development de-
17 scribed in subparagraph (C) or after publi-
18 cation of the final guidelines and stand-
19 ards, whichever is later, the Secretary shall
20 design, fund, and implement a pilot project
21 in up to 50 geographically and demo-
22 graphically diverse sites, two of which must
23 be in the U.S. territory, to test and evalu-
24 ate implementation of the recommenda-
25 tions.

1 “(ii) The Secretary shall consult with
2 the Working Group and the Advisory
3 Panel in development of the pilot project
4 and report progress to the Working Group
5 on an ongoing basis.

6 “(iii) The pilot project shall include
7 interpreters and translators working with
8 various provider types, including small
9 group practices, hospitals, and community
10 health clinics, and shall include broad geo-
11 graphic representation including both
12 urban and rural representatives.

13 “(iv) The pilot project shall operate
14 for not less than two nor more than four
15 years, as determined by the Secretary.

16 “(v) If the Working Group determines
17 that any revisions to guidelines and stand-
18 ards are necessary as a result of the pilot
19 project, it shall revise such guidelines and
20 standards and the Director of the Agency
21 for Healthcare Research and Quality shall
22 publish the revisions in the Federal Reg-
23 ister for notice and comment. Not later
24 than 120 days after the expiration of the
25 public comment period on such revisions,

1 the Director of the Agency for Healthcare
2 Research and Quality shall publish, after
3 consultation with and the approval of the
4 Working Group, final revisions to the
5 guidelines and standards in the Federal
6 Register and on the Internet.

7 “(8) ADMINISTRATION.—

8 “(A) CHAIRPERSON.—Not later than 15
9 days after the date on which all members of the
10 Working Group have been appointed under sub-
11 section (d), the Working Group shall designate
12 its chairperson.

13 “(B) COMPENSATION.—While serving on
14 the business of the Working Group (including
15 travel time), a member of the Working Group
16 or the Advisory Panel shall be entitled to com-
17 pensation at the per diem equivalent of the rate
18 provided for level IV of the Executive Schedule
19 under section 5315 of title 5, United States
20 Code, and while so serving away from home and
21 the member’s regular place of business, a mem-
22 ber may be allowed travel expenses, as author-
23 ized by the chairperson of the Working Group.
24 For purposes of pay and employment benefits,
25 rights, and privileges, all personnel of the

1 Working Group shall be treated as if they were
2 employees of the House of Representatives.

3 “(C) INFORMATION FROM FEDERAL AGEN-
4 CIES.—The Working Group may secure directly
5 from any Federal department or agency such
6 information as the Working Group considers
7 necessary to carry out this section. Upon re-
8 quest of the Working Group, the head of such
9 department or agency shall furnish such infor-
10 mation. Any information that contains individ-
11 ually identifiable information received by the
12 Working Group shall not be disseminated or
13 disclosed outside of the Working Group and
14 shall not be used except by the Working Group.

15 “(D) DETAIL.—Not more than 10 Federal
16 Government employees employed by the Depart-
17 ment of Health and Human Services may be
18 detailed to staff the Working Group under this
19 section without further reimbursement. Any de-
20 tail of an employee shall be without interruption
21 or loss of civil service status or privilege.

22 “(E) TEMPORARY AND INTERMITTENT
23 SERVICES.—The Working Group may procure
24 temporary and intermittent services under sec-
25 tion 3109(b) of title 5, United States Code, at

1 rates for individuals which do not exceed the
2 daily equivalent of the annual rate of basic pay
3 prescribed for level V of the Executive Schedule
4 under section 5316 of such title.

5 “(F) AUTHORIZATION OF APPROPRIA-
6 TIONS.—There are authorized to be appro-
7 priated to carry out this section such sums as
8 may be necessary for the activities of the Work-
9 ing Group and Advisory Panel for each of fiscal
10 years 2010 through 2014, and for the funding
11 of the pilot project.

12 “(9) DEEMED STATUS.—

13 “(A) CERTIFICATION BY PRIVATE ORGANI-
14 ZATION.—If a private accreditation organization
15 establishes training, assessment, or certification
16 standards for interpreters or translators in
17 health care which the Secretary determines are
18 at least equivalent to the training, assessment,
19 or certification standards promulgated by the
20 Secretary as described in subsection (c), the
21 Secretary shall find that all organizations or in-
22 dividuals accredited by such organization com-
23 ply also with the standard described in sub-
24 section (c) if—

1 “(i) such organization or individual
2 authorizes the organization to release to
3 the Secretary upon the Secretary’s request
4 (or such State agency as the Secretary
5 may designate) a copy of the most current
6 accreditation survey of such organization
7 or individual made by the organization, to-
8 gether with any other information directly
9 related to the survey as the Secretary may
10 require (including corrective action plans);
11 and

12 “(ii) such organization releases such a
13 copy and any such information to the Sec-
14 retary.

15 “(B) CERTIFICATION BY A STATE OR LO-
16 CALITY.—If a State or locality has or estab-
17 lishes training, assessment, or certification
18 standards for interpreters or translators in
19 health care which the Secretary determines are
20 at least equivalent to the training, assessment,
21 or certification standards promulgated by the
22 Secretary as described in subsection (c), the
23 Secretary shall find that all organizations or in-
24 dividuals accredited by such State or locality

1 comply also with the standard described in sub-
2 section (c) if—

3 “(i) such organization or individual
4 authorizes the State or locality to release
5 to the Secretary upon his request (or such
6 State agency as the Secretary may des-
7 ignate) a copy of the most current accredi-
8 tation survey of such organization or indi-
9 vidual made by such State or locality, to-
10 gether with any other information directly
11 related to the survey as the Secretary may
12 require (including corrective action plans);
13 and

14 “(ii) such State or locality releases
15 such a copy and any such information to
16 the Secretary.

17 “(C) TIMELY ACTION ON APPLICATION.—

18 The Secretary shall determine, within 210 days
19 after the date the Secretary receives an applica-
20 tion by a private accrediting organization,
21 State, or locality whether the process of the pri-
22 vate accrediting organization, State, or locality
23 meets the requirements with respect to training,
24 assessment, or certification standards for inter-
25 preters or translators with respect to which

standards the application is made. The Secretary may not deny an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, training, assessment, or certification standards for interpreters or translators.

“(D) DISCLOSURE OF ACCREDITATION SURVEY.—The Secretary may not disclose any accreditation survey made and released to him by the National Council on Interpreting in Health Care or any State or locality of an accredited organization or individual, except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.

“(E) DEFICIENCIES.—If the Secretary finds that an accredited organization or individual has significant deficiencies (as defined in regulations pertaining to the training, assessment, or certification standards), the organization or individual shall, after the date of notice of such finding to the organization and for such period as may be prescribed in regulations, be deemed not to meet the conditions or require-

1 ments the organization or individual has been
2 treated as meeting pursuant to subparagraph
3 (A).

4 “(e) AVAILABILITY OF LANGUAGE ACCESS.—The Di-
5 rector shall collaborate with the Administrator of the Of-
6 fice of Minority Health, the Administrator of the Centers
7 for Medicare & Medicaid Services, and the Administrator
8 of the Health Resources and Services Administration to
9 notify health care providers and health care organizations
10 about the availability of language access services by the
11 Center.

12 “(f) EDUCATION.—The Secretary, directly or through
13 contract, shall undertake a national education campaign
14 to inform providers, LEP individuals, and health profes-
15 sional and graduate schools about—

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

18 “(2) the value of using trained interpreters and
19 the risks associated with using family members,
20 friends, minors, and untrained bilingual staff;

21 “(3) funding sources for developing and imple-
22 menting language services; and

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

1 “(g) AUTHORIZATION OF APPROPRIATIONS.—In ad-
2 dition to the amounts authorized under subsection
3 (e)(8)(F), there are authorized to be appropriated to carry
4 out this section such sums as may be necessary for each
5 of fiscal years 2010 through 2014.

6 **“SEC. 3104. INNOVATIONS IN CULTURAL AND LINGUISTIC**
7 **COMPETENCE GRANTS.**

8 “(a) IN GENERAL.—The Secretary, acting through
9 the Director of the Agency for Healthcare Research and
10 Quality, shall award grants to eligible entities to enable
11 such entities to design, implement, and evaluate innova-
12 tive, cost-effective programs to improve language access
13 in health care for individuals with limited English pro-
14 ficiency. The Director of the Agency for Healthcare Re-
15 search and Quality shall coordinate with, and ensure the
16 participation of, other agencies including but not limited
17 to the Health Resources and Services Administration, the
18 Center on Minority Health and Health Disparities at the
19 National Institutes of Health, and the Office of Minority
20 Health, regarding the design and evaluation of the grants
21 program.

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

24 “(1) be—

1 “(A) a city, county, Indian tribe, State,
2 territory or subdivision thereof;

3 “(B) an organization described in section
4 501(c)(3) of the Internal Revenue Code of
5 1986;

6 “(C) a community health center or commu-
7 nity clinic;

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

9 “(E) an integrated health care delivery
10 system;

11 “(F) public hospital;

12 “(G) health care group, university, or col-
13 lege; or

14 “(H) other entity designated by the Sec-
15 retary; and

16 “(2) prepare and submit to the Secretary an
17 application, at such time, in such manner, and ac-
18 companied by such additional information as the
19 Secretary may require.

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

22 “(1) develop, implement, and evaluate models of
23 providing competence interpretation services through
24 on-site interpretation, telephonic interpretation, or
25 video interpretation;

1 “(2) implement strategies to recruit, retain, and
2 promote individuals at all levels of the organization
3 to maintain a diverse staff and leadership that can
4 promote and provide language services to patient
5 populations of the service area of the organization;

6 “(3) develop and maintain a needs assessment
7 that identifies the current demographic, cultural,
8 and epidemiological profile of the community to ac-
9 curately plan for and implement language services
10 needed in service area of the organization;

11 “(4) develop a strategic plan to implement lan-
12 guage services;

13 “(5) develop participatory, collaborative part-
14 nerships with communities encompassing the LEP
15 patient populations being served to gain input in de-
16 signing and implementing language services;

17 “(6) develop and implement grievance resolu-
18 tion processes that are culturally and linguistically
19 sensitive and capable of identifying, preventing, and
20 resolving complaints by LEP individuals; or

21 “(7) develop short-term medical interpretation
22 training courses and incentives for bilingual health
23 care staff who are asked to interpret in the work-
24 place;

1 “(8) develop formal training programs for indi-
2 viduals interested in becoming dedicated health care
3 interpreters and culturally competent providers;

4 “(9) provide staff language training instruction,
5 which shall include information on the practical limi-
6 tations of such instruction for non-native speakers;
7 and

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

10 “(11) ensure that, consistent with the privacy
11 protections provided for under the regulations pro-
12 mulgated under section 264(c) of the Health Insur-
13 ance Portability and Accountability Act of 1996 (42
14 U.S.C. 1320d–2 note), and any applicable State pri-
15 vacy laws, data on the individual patient or recipi-
16 ent’s race, ethnicity, and primary language are col-
17 lected (and periodically updated) in health records
18 and integrated into the organization’s information
19 management systems or any similar system used to
20 store and retrieve data;

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

1 “(e) EVALUATION.—

2 “(1) An entity that receives a grant under this
3 section shall submit to the Secretary an evaluation
4 that describes, in the manner and to the extent re-
5 quired by the Secretary, the activities carried out
6 with funds received under the grant, and how such
7 activities improved access to health and health care-
8 related services and the quality of health care for in-
9 dividuals with limited English proficiency. Such eval-
10 uation shall be collected and disseminated through
11 the Robert T. Matsui Center for Cultural and Lin-
12 guistic Competence in Health Care established under
13 section 3103. The Director of the Agency for
14 Healthcare Research and Quality shall notify grant-
15 ees of the availability of technical assistance for the
16 evaluation and provide such assistance upon request.

17 “(2) The Director of the Agency for Healthcare
18 Research and Quality shall evaluate or arrange with
19 other individuals or organizations to evaluate
20 projects funded under this section.

21 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
22 is authorized to be appropriated to carry out this section,
23 \$5,000,000 for each of fiscal years 2010 through 2014.

1 **“SEC. 3105. RESEARCH ON CULTURAL AND LANGUAGE COM-**
2 **PETENCE.**

3 “(a) IN GENERAL.—The Secretary, acting through
4 the Director of the Agency for Healthcare Research and
5 Quality, shall expand research concerning language access
6 in the provision of health care.

7 “(b) ELIGIBILITY.—The Director of the Agency for
8 Healthcare Research and Quality may conduct the re-
9 search described in subsection (a) or enter into contracts
10 with other individuals or organizations to do so.

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

13 “(1) To identify the barriers to mental and be-
14 havioral services that are faced by LEP individuals.

15 “(2) To identify health care providers’ and
16 health administrators’ attitudes, knowledge, and
17 awareness of the barriers to quality health care serv-
18 ices that are faced by LEP individuals.

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

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

23 “(A) the collection by providers of health
24 care and health care-related services of data on
25 the race, ethnicity, and primary language of re-
26 cipients of such services, taking into account ex-

1 isting research conducted by the Government or
2 private sector;

3 “(B) the development and implementation
4 of data collection and reporting systems; and

5 “(C) effective privacy safeguards for col-
6 lected data.

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

9 “(6) To evaluate the most effective ways in
10 which the Department can create or coordinate, and
11 then subsidize or otherwise fund telephonic interpre-
12 tation providers for health care providers, taking
13 into consideration, among other factors, the flexi-
14 bility necessary for such a system to accommodate
15 variations in—

16 “(A) provider type;

17 “(B) languages needed and their frequency
18 of use;

19 “(C) type of encounter;

20 “(D) time of encounter, including regular
21 business hours and after hours; and

22 “(E) location of encounter.

23 “(d) 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 2010 through 2014.”.

3 **SEC. 102. FEDERAL REIMBURSEMENT FOR CULTURALLY**
 4 **AND LINGUISTICALLY APPROPRIATE SERV-**
 5 **ICES UNDER THE MEDICARE, MEDICAID AND**
 6 **THE STATE CHILDREN’S HEALTH INSURANCE**
 7 **PROGRAM.**

8 (a) MEDICARE.—Title XVIII of the Social Security
 9 Act is amended by adding at the end the following new
 10 section:

11 “MEDICARE SUPPORT FOR LANGUAGE SERVICES

12 “SEC. 1899.

13 “(a) ENSURING APPROPRIATE PAYMENT FOR THE
 14 FURNISHING OF LINGUISTICALLY APPROPRIATE LAN-
 15 GUAGE SERVICES TO ALL MEDICARE BENEFICIARIES.—

16 “(b) TEMPORARY COST-BASED PAYMENTS FOR LAN-
 17 GUAGE SERVICES TO HOSPITALS.—

18 “(1) IN GENERAL.—Not later than 90 days
 19 after enactment of this section, the Secretary shall
 20 initiate quarterly payments to all hospitals that are
 21 certified as Medicare providers (including short-term
 22 acute inpatient hospitals, long-term care hospitals,
 23 inpatient rehabilitation facilities, children’s, cancer,
 24 psychiatric, and critical access hospitals) to pay for
 25 the costs of providing language services to limited
 26 English proficient Medicare beneficiaries. These pay-

1 ments shall cover the provision of language services
2 by hospitals in inpatient and outpatient settings.
3 These payments shall continue until the Secretary
4 develops and implements reimbursement standards
5 for language services pursuant to the process set
6 forth in subsection (b).

7 “(2) DETERMINATION OF TEMPORARY PAY-
8 MENTS.—Payments under paragraph (1) shall be
9 calculated based on the estimated numbers of LEP
10 Medicare beneficiaries in a hospital’s service area
11 utilizing—

12 “(A) data on the numbers of LEP individ-
13 uals (defined for purposes of this paragraph as
14 individuals who speak English less than ‘very
15 well’) from the most recently available data
16 from the Bureau of the Census; or

17 “(B) the hospital’s own data if—

18 “(i) the hospital routinely collects
19 data on patients’ primary language or need
20 for an interpreter in both in- and out-pa-
21 tient settings;

22 “(ii) the data collection system used
23 by the hospital is, as determined by the
24 Secretary, likely to yield accurate data re-

1 garding the number of LEP individuals
2 served by the hospital, and,

3 “(iii) the hospital’s data documents
4 greater numbers of LEP individuals than
5 does the data described in clause (i).

6 “(C) DISTRIBUTION OF FUNDS.—On a
7 quarterly basis, the Secretary shall pay
8 amounts directly to eligible hospitals to pay for
9 the costs of providing language services to LEP
10 Medicare beneficiaries.

11 “(D) METHODOLOGIES.—In establishing a
12 methodology for temporary payments, the Sec-
13 retary may establish one or more payment
14 methodologies for inpatient and outpatient set-
15 tings.

16 “(3) REPORTING REQUIREMENTS.—Hospitals
17 receiving payment under paragraph (1) shall provide
18 the Secretary with two reports on—

19 “(A) the number of Medicare beneficiaries
20 to whom language services are provided;

21 “(B) the languages of those Medicare
22 beneficiaries;

23 “(C) the types of language services pro-
24 vided (such as provision of services directly in

1 non-English language by a health care provider
2 or use of an interpreter);

3 “(D) type of interpretation (such as in-per-
4 son, telephonic, or video interpretation);

5 “(E) the methods of providing language
6 services (staff, contract with external inde-
7 pendent contractors, or agencies);

8 “(F) the length of time for each interpre-
9 tation encounter; and

10 “(G) the costs of providing language serv-
11 ices (whether actual or estimated, as deter-
12 mined by the Secretary).

13 “(4) NO COST-SHARING.—There shall be no
14 cost-sharing for language services provided as tem-
15 porary payments to hospitals.

16 “(5) AUTHORIZATION OF APPROPRIATIONS.—
17 There is authorized to be appropriated to carry out
18 this subsection such sums as may be necessary for
19 each of fiscal years 2010 through 2014.

20 “(c) DEVELOPMENT OF PAYMENT AMOUNTS FOR
21 LANGUAGE SERVICES.—

22 “(1) IN GENERAL.—Not later than 6 months
23 after enactment of this section, the Secretary shall
24 convene a Working Group to advise the Secretary on
25 the development of payment amounts that are based

1 on hospital-reported costs for language services pro-
2 vided to LEP Medicare beneficiaries. Reimburse-
3 ment shall apply to all Medicare-covered services
4 furnished by certified providers to eligible bene-
5 ficiaries, whether covered under parts A and B or
6 under the Medicare Advantage program under
7 part C.

8 “(2) VARIATIONS.—The Secretary, in consulta-
9 tion with the Working Group, may establish vari-
10 ations within the reimbursement system based upon
11 available delivery methods and costs for providing
12 language services including such factors as—

13 “(A) the type of language services provided
14 (such as provision of services directly in a non-
15 English language by a health care provider or
16 use of an interpreter);

17 “(B) type of interpretation services pro-
18 vided (such as in-person, telephonic, or video in-
19 terpretation);

20 “(C) the methods and costs of providing
21 language services (including the costs of pro-
22 viding language services with internal staff or
23 through contract with external independent con-
24 tractors or agencies);

1 “(D) providing services for languages not
2 frequently encountered in the United States;
3 and

4 “(E) providing services in rural areas.

5 “(3) NO COST-SHARING.—There shall be no
6 cost-sharing for language services provided as pay-
7 ments to hospitals under this subsection.

8 “(4) LIMITATIONS.—

9 “(A) IN GENERAL.—Reimbursement shall
10 only be provided to hospitals under this sub-
11 section that report their costs of providing lan-
12 guage services, including information on the
13 factors described in paragraph (1) that are uti-
14 lized in establishing the reimbursement rates
15 and any other information specified by the Sec-
16 retary.

17 “(B) USE OF INTERPRETER OR TRANS-
18 LATION SERVICES.—

19 “(i) IN GENERAL.—Reimbursement
20 shall be provided under this subsection
21 only to hospitals that utilize interpreter or
22 translation services.

23 “(ii) INTERPRETER SERVICES DE-
24 FINED.—In this paragraph the term ‘inter-
25 preter services’ means services designed to

1 provide a competent trans-language ren-
2 dition of a spoken message in which an in-
3 terpreter comprehends the source language
4 and can speak comprehensively in the tar-
5 get language to convey the meaning in-
6 tended in the source language. Such inter-
7 preter shall know health and health-related
8 terminology and provide accurate interpre-
9 tations by choosing equivalent expressions
10 that convey the best matching and mean-
11 ing to the source language and captures, to
12 the greatest possible extent, all nuances in-
13 tended in the source message.

14 “(iii) INTERPRETER DEFINED.—In
15 this paragraph, the he term ‘interpreter’
16 means an individual who transmits a spo-
17 ken message from one language into an-
18 other, faithfully, accurately, and objec-
19 tively. Such term includes an individual
20 who provide in-person, telephonic, and
21 video interpretation and also includes an
22 individual who is employed or contracted
23 by those who provide benefits under sec-
24 tion 1832.

1 “(iv) TRANSLATION.—In this para-
2 graph, the term ‘translation’ means the
3 competent transmission of a written mes-
4 sage in one language into a written mes-
5 sage in another language.

6 “(v) EXEMPTIONS.—The require-
7 ments of clauses (i) and (ii) shall not
8 apply—

9 “(I) when a individual (who has
10 been informed in the individual’s pri-
11 mary language of the availability of
12 free interpreter and translation serv-
13 ices) requests the use of family,
14 friends or other persons untrained in
15 interpretation or translation; and

16 “(II) when a medical emergency
17 exists and the delay directly associ-
18 ated with obtaining a competent inter-
19 preter or translation services would
20 jeopardize the health of the individual.

21 Nothing in this clause shall exempt emer-
22 gency rooms or similar entities that regu-
23 larly provide health care services in med-
24 ical emergencies from having in place sys-

1 tems to provide competent interpreter and
2 translation services without undue delay.

3 “(5) WORKING GROUP.—The Secretary shall es-
4 tablish a Working Group (in this subsection referred
5 to as the ‘Working Group’) to develop the payment
6 amounts under this paragraph. Such Working Group
7 include representatives from the American Hospital
8 Association, National Association of Public Hos-
9 pitals and Health Systems, Association of Language
10 Companies, the National Council of Interpreting in
11 Health Care, organizations that advocate on behalf
12 of limited English proficient individuals, and other
13 individuals or entities determined appropriate by the
14 Secretary, including those who have specific exper-
15 tise in either developing cost-based reimbursement
16 or provision of language services, that will be useful.

17 “(6) PUBLICATION.—

18 “(A) PROPOSED REIMBURSEMENT STAND-
19 ARDS.—Not later than 18 months after the
20 date of enactment of this section, the Secretary
21 shall, contingent upon consultation with and ap-
22 proval of the Working Group—

23 “(i) prepare and make available to the
24 public through the Internet, the Federal
25 Register, and other appropriate public

1 channels, proposed payment amounts
2 under this subsection based on hospital-re-
3 ported costs; and

4 “(ii) accept public comment on such
5 reimbursement standards for a period of
6 not less than 90 days.

7 “(B) FINAL REIMBURSEMENT STAND-
8 ARDS.—

9 “(i) IN GENERAL.—Not later than
10 120 days after the expiration of the public
11 comment period described in subparagraph
12 (A), the Secretary shall publish, after con-
13 sultation with and the approval of the
14 Working Group, final reimbursement
15 standards in the Federal Register and on
16 the Internet. The final reimbursement
17 standards shall go into effect within six
18 months of the date of such publication.

19 “(ii) TRAINING.—Between such publi-
20 cation and effective dates, the Secretary
21 shall provide training and technical assist-
22 ance to hospitals on the final reimburse-
23 ment standards. As necessary, the Sec-
24 retary shall continue to provide training

1 and technical assistance after the reim-
2 bursement standards becomes effective.

3 “(iii) PHASE-OUT.—When the final
4 reimbursement standards go into effect,
5 the temporary adjustments described in
6 subsection (a) shall be phased out over a
7 one-year period as hospitals implement the
8 new reimbursement rates. Final reimburse-
9 ment rates shall not be constrained at the
10 level of total temporary adjustments. Re-
11 imbursement shall be set at the level of the
12 costs of language services at eligible hos-
13 pitals.

14 “(d) OTHER MEDICARE PAYMENT SYSTEMS.—

15 “(1) PAYMENT SYSTEMS.—

16 “(A) IN GENERAL.—Not later than two
17 years after enactment of this Act, and using the
18 guidelines described in subsection (b), the Sec-
19 retary shall make recommendations to include
20 payments or adjustments for language services
21 provided to limited English proficient Medicare
22 beneficiaries for all of the remaining payment
23 systems under this title, except the physician
24 fee schedule under such 1848, including psy-
25 chiatric hospitals, skilled nursing facilities,

1 home health agencies, rehabilitation facilities,
2 and long-term care hospitals, as well as the
3 TEFRA per discharge limit for children's and
4 cancer hospitals excluded from the inpatient
5 hospital prospective payment system under sec-
6 tion 1886(d), the ambulance fee schedule, and
7 payments to critical access hospitals. Program
8 costs for language services in critical access
9 hospitals shall be considered allowable costs
10 under this title and shall be calculated in the
11 same manner as other Medicare costs on the
12 cost report. These costs should be incorporated
13 into interim payments.

14 “(B) IMPLEMENTATION.—The Secretary
15 shall implement these payments within three
16 years.

17 “(C) NO COST-SHARING.—There shall be
18 no cost-sharing for such language services.

19 “(2) MEDICARE REIMBURSEMENT FOR LAN-
20 GUAGE SERVICES PROVIDED IN SUPPORT OF PHYSI-
21 CIAN OFFICE SERVICES.—

22 “(A) STUDY.—The Medicare Payment Ad-
23 visory Commission shall conduct a study that
24 examines ways that Medicare can pay for lan-
25 guage services (including foreign language and

1 sign language) provided in support of physician
2 office services and other services paid for
3 through the physician fee schedule under sec-
4 tion 1848. The report on such study shall in-
5 clude the following:

6 “(i) Recommendations and effective
7 methods for adopting a payment method-
8 ology for on-site interpreters, pursuant to
9 which such interpreters and agencies could
10 directly bill Medicare for language services
11 provided in support of benefits paid for
12 under section 1832 for a limited English
13 proficient Medicare patient. For purposes
14 of this subparagraph, the term ‘on-site in-
15 terpreters’ include interpreters who work
16 as independent contractors, for agencies
17 that provide on-site interpretation, and
18 who are employed by those who provide
19 benefits provided under section 1832.

20 “(ii) Recommendations and effective
21 methods for Medicare contracting directly
22 with agencies that provide off-site interpre-
23 tation, including telephonic and video in-
24 terpretation, pursuant to which such con-
25 tractors could directly bill Medicare for the

1 services provided in support of benefits
2 provided under section 1832 for a limited
3 English proficient Medicare patient.

4 “(iii) Recommendations for modifying
5 the existing Medicare resource-based rel-
6 ative value scale (RBRVS) by adding new
7 procedure codes in the Health Care Com-
8 mon Procedure Coding System.

9 “(B) REPORT.—Not later than 1 year
10 after the date of the enactment of this section,
11 the Commission shall submit to Congress and
12 the Centers for Medicare & Medicaid Services a
13 report on the study conducted under subpara-
14 graph (A), together with recommendations re-
15 garding the appropriateness of directly reim-
16 bursing interpreters versus physicians for lan-
17 guage services provided in support of benefits
18 provided under section 1832.

19 “(C) IMPLEMENTATION.—

20 “(i) IN GENERAL.—Not later than 1
21 year after the submission of the report des-
22 ignated in subparagraph (B), the Secretary
23 shall publish, after consultation with and
24 the approval of the Medicare Payment Ad-
25 visory Commission, final reimbursement

1 standards for language services provided in
2 support of benefits provided under section
3 1832. These standards shall be published
4 in the Federal Register and on the Inter-
5 net and shall go into effect within six
6 months of the date of such publication.
7 The final standards must ensure that—

8 “(I) for the first three years of
9 implementation, the payments for lan-
10 guage services do not diminish other
11 fees provided in support of benefits
12 provided under section 1832; and

13 “(II) enrollees do not have to pay
14 any co-pays or cost-sharing for lan-
15 guage services provided in support of
16 benefits provided under section 1832.

17 “(ii) TRAINING.—Between such date
18 of publication and the effective date, the
19 Secretary shall provide training and tech-
20 nical assistance to providers covered by the
21 physician fee schedule under section 1848
22 on the final reimbursement standards. As
23 necessary, the Secretary shall continue to
24 provide training and technical assistance

4 (1) TECHNICAL AMENDMENTS.—

8 “Language Services; Interpreter Services; Interpreter;
9 Translation; LEP

“(2) For the purposes of this subsection, the term ‘interpreter services’ means services designed to provide a competent trans-language rendition of a spoken message in which an interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language and interpreter knows health and health-related terminology and provides accurate interpretations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest

1 possible extent, all nuances intended in the source mes-
 2 sage.

3 “(3) The term ‘interpreter’ means an individual who
 4 transmits a spoken message from one language into an-
 5 other, faithfully, accurately, and objectively. Such term in-
 6 cludes individuals who provide in-person, telephonic, and
 7 video interpretation and such term ‘interpreter’ individ-
 8 uals who are employed or contracted by those who provide
 9 benefits provided under section 1832.

10 “(4) The term ‘translation’ means the competent
 11 transmission of a written message in one language into
 12 a written message in another language.

13 “(5) The terms ‘limited English proficient’ and
 14 ‘LEP’, with respect to an individual, means an individual
 15 who speaks a primary language other than English.”.

16 (B) Subsection (aa)(1)(B) of such section
 17 is amended by inserting “, language services as
 18 defined in subsection (hhh),” after “clinical so-
 19 cial worker (as defined in subsection (hh)(1)),”.

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

22 (i) by redesignating paragraph (9) as
 23 paragraph (10); and

24 (ii) by inserting after paragraph (8)
 25 the following new paragraph:

1 “(9) in the case of language services described
2 in section 1861(hhh), 100 percent of the reasonable
3 charges for such services.”.

4 (D) Section 1832(a)(2) of such Act (42
5 U.S.C. 1395k(a)(2)) is amended—

6 (i) by striking “and” at the end of
7 subparagraph (I);

8 (ii) by striking the period at the end
9 of subparagraph (K) and inserting “and”;
10 and

11 (iii) by adding at the end of subpara-
12 graph (K) the following:

13 “(L) language services (as defined in sec-
14 tion 1861(hhh) furnished by a interpreter or
15 translator, whether contracted or employed by
16 the entity providing benefits under this sec-
17 tion.”

18 (E) WAIVER OF BUDGET NEUTRALITY.—

19 For the first 3 years after the effective date of
20 this section, the budget neutrality provision of
21 section 1848(c)(2)(B)(ii) of the Social Security
22 Act (42 U.S.C. 1395w-4(c)(2)(B)(ii)) shall not
23 apply to language services.

24 (F) EFFECTIVE DATE.—These amend-
25 ments made by this subsection are effective

1 upon publication of the final reimbursement
2 standards described in section 1899(b) of the
3 Social Security Act, as added by subsection (a).

4 (2) MEDICARE PART C AND PART D.—The Sec-
5 retary of Health and Human Services shall ensure
6 Medicare Advantage plans participating in Medicare
7 part C and prescription drug plans participating in
8 Medicare part D effectively provide language serv-
9 ices to their enrollees. The Secretary shall require
10 annual reporting for such plans that includes infor-
11 mation on internal policies and procedures related to
12 cultural appropriateness in each of the following
13 contexts:

14 (A) Collection of data regarding the en-
15 rollee population.

16 (B) Education of plan staff and contrac-
17 tors who have routine contact with enrollees re-
18 garding the diverse needs of the enrollee popu-
19 lation.

20 (C) Recruitment and retention efforts that
21 encourage workforce diversity.

22 (D) Evaluation of the health plan's lan-
23 guage services programs and services with re-
24 spect to the plan's enrollee population, using

1 processes such as an analysis of complaints and
 2 satisfaction survey results.

3 (E) Methods by which the plan provides in-
 4 formation regarding the ethnic diversity of the
 5 plan’s enrollee population.

6 (F) The periodic provision of educational
 7 information to plan enrollee on the plan’s lan-
 8 guage services and programs. Plans may use
 9 existing means of communications.

10 (c) IMPROVING LANGUAGE SERVICES IN MEDICAID
 11 AND SCHIP.—

12 (1) Section 1903(a)(2)(E) of the Social Secu-
 13 rity Act (42 U.S.C. 1396b(a)(2)(E)) is amended
 14 by—

15 (A) striking “translation or interpretation
 16 services” and inserting “language services”;
 17 and

18 (B) striking “children of families” and in-
 19 serting “individuals”.

20 (2) Section 1902(a)(10)(A) of the Social Secu-
 21 rity Act (42 U.S.C. 1396a(a)(10)(A)) is amended by
 22 striking “and (21)” and inserting “(21), and (28)”.

23 (3) Section 1905(a) of the Social Security Act
 24 (42 U.S.C. 1396d(a)) is amended by—

1 (A) in paragraph (27), by striking “and”
2 at the end;

3 (B) by redesignating paragraph (28) as
4 paragraph (29); and

5 (C) by inserting after paragraph (27) the
6 following new paragraph:

7 “(27) language services (including the provision
8 of health care services directly in a non-English lan-
9 guage, interpretation, translation, and non-English
10 signage), provided in a timely manner to limited
11 English proficient individuals who need language
12 services in connection with administrative and cov-
13 ered services; and”.

14 (4) Section 1916(a)(2) of the Social Security
15 Act (42 U.S.C. 1396o(2)) is amended by—

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

18 (B) by striking “and” at the end of sub-
19 paragraph (E) and inserting “or”; and

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

22 “(F) language services described in section
23 1905(a)(27); and”.

24 (5) Section 2103 of the Social Security Act (42
25 U.S.C. 1397cc) is amended—

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

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

6 “(9) LANGUAGE SERVICES.—The child health
7 assistance provided to a targeted low-income child
8 shall include coverage of language services (including
9 the provision of health care services directly in a
10 non-English language, interpretation, translation
11 and non-English signage) provided in a timely man-
12 ner to limited English proficient individuals who
13 need them, in connection with administrative and
14 covered services.”; and

15 (C) in subsection (e)(2)—

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

18 (ii) by inserting “or subsection (c)(9)”
19 after “subsection (c)(1)(C)”.

20 (6) Section 2110(a)(27) of the Social Security
21 Act (42 U.S.C. 1397jj) is amended by striking
22 “translation” and inserting “language services as
23 described in section 2103(c)(7)”.

24 (7) Pursuant to the reporting requirement de-
25 scribed in section 2107(b)(1) of the Social Security

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

4 (A) primary language of those assisted;
 5 and

6 (B) for individuals who are minors or inca-
 7 pacitated, the primary language of the individ-
 8 ual's parent or guardian.

9 (8) Section 2105(c)(2)(A) of the Social Security
 10 Act (42 U.S.C. 1397ee(c)) is amended by inserting
 11 before the period “, except that expenditures pursu-
 12 ant to section 2105(a)(1)(D)(iv) shall not count to-
 13 wards this total”.

14 (d) FUNDING LANGUAGE SERVICES FURNISHED BY
 15 PROVIDERS OF HEALTH CARE AND HEALTH CARE-RE-
 16 LATED SERVICES THAT SERVE HIGH RATES OF UNIN-
 17 SURED LEP INDIVIDUALS.—

18 (1) PAYMENT OF COSTS.—

19 (A) IN GENERAL.—Subject to subpara-
 20 graph (B), the Secretary of Health and Human
 21 Services shall make payments (on a quarterly
 22 basis) directly to eligible entities to support the
 23 provision of language services to limited English
 24 proficient individuals in an amount equal to an

1 entity’s eligible costs for such services for the
2 quarter.

3 (B) LIMITATION.—If the amount of funds
4 appropriated under subparagraph (C) to carry
5 out this subsection for a fiscal year is insuffi-
6 cient to ensure that each eligible entity can re-
7 ceive full payment under subparagraph (A), the
8 Secretary shall reduce in a pro rata manner the
9 amount of such payment to each such entity.

10 (C) FUNDING.—Out of any funds in the
11 Treasury not otherwise appropriated, there are
12 appropriated to the Secretary of Health and
13 Human Services such sums as may be nec-
14 essary for each of fiscal years 2010 through
15 2014.

16 (D) LANGUAGE SERVICES.—In this sub-
17 section, the term “language services” has the
18 meaning given such term in section 3100 of the
19 Public Health Service Act.

20 (2) ELIGIBLE COSTS DEFINED.—

21 (A) IN GENERAL.—In this subsection, the
22 term “eligible costs” means, with respect to an
23 eligible entity that provides language services to
24 LEP individuals, the product of—

1 (i) the average per person cost of lan-
2 guage services, determined according to
3 the methodology devised under subpara-
4 graph (B), and

5 (ii) the number of limited English
6 proficient individuals who are provided lan-
7 guage services by the entity and for whom
8 no reimbursement is available for such
9 services under the amendments made by
10 subsections (a), (b), or (c) or by private
11 health insurance.

12 (B) METHODOLOGY.—The Secretary shall
13 devise a methodology to determine the average
14 per person cost of language services. In estab-
15 lishing a payment methodology, the Secretary
16 may establish different methodologies for dif-
17 ferent types of eligible entities. The Secretary
18 shall not require eligible entities to provide indi-
19 vidual claims for language services for each in-
20 dividual patient to be provided payment under
21 this subsection.

22 (3) ELIGIBLE ENTITY.—In order to receive
23 grants under this paragraph, an entity must—

24 (A) be—

25 (i) an individual provider;

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

6 (iii) a Federally-qualified health cen-
7 ter (as defined in section 1905(l)(2)(B) of
8 the Social Security Act (42 U.S.C.
9 1396d(l)(2)(B)));

10 (B) provide language services to at least 8
11 percent of the entity's total number of patients;
12 and

13 (C) prepare and submit an application to
14 the Secretary, at such time, in such manner,
15 and accompanied by such information as the
16 Secretary may require to ascertain the entities'
17 eligibility for funding under this subsection.

18 (4) RELATION TO MEDICAID DSH.—Payments
19 under this subsection shall not offset or reduce pay-
20 ments under section 1923 of the Social Security Act,
21 nor shall payments under such section be considered
22 when determining uncompensated costs associated
23 with the provision of language services.

24 (5) REPORTING REQUIREMENTS.—Entities re-
25 ceiving payment under this subsection shall provide

1 the Secretary with a quarterly report on such pay-
2 ments. Such report shall contain aggregate (and not
3 individualized) data and shall otherwise be in a form
4 and manner determined by the Secretary. 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 are provided.

11 (6) GUIDANCE.—

12 (A) ESTABLISHMENT.—Not later than 6
13 months after the date of enactment of this Act,
14 the Secretary of Health and Human Services
15 shall establish guidelines concerning the imple-
16 mentation of this subsection.

17 (B) REPORT.—Not later than 2 years after
18 the date of enactment of this Act, and every 2
19 years thereafter, the Secretary shall submit a
20 report to Congress concerning the implementa-
21 tion of such guidelines.

22 (e) EFFECTIVE DATE.—The amendments made by
23 this section take effect on October 1, 2009.

1 **SEC. 103. INCREASING UNDERSTANDING OF AND IMPROV-**
2 **ING HEALTH LITERACY.**

3 (a) IN GENERAL.—The Secretary, acting through the
4 Director of the Agency for Healthcare Research and Qual-
5 ity and the Administrator of the Health Resources and
6 Services Administration, in consultation with the National
7 Center on Minority Health and Health Disparities and the
8 Office of Minority Health, shall award grants to eligible
9 entities to improve health care for patient populations that
10 have low functional health literacy.

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

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

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

20 (c) USE OF FUNDS.—

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

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

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

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

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

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

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

16 (B) the tailoring of existing disease man-
17 agement programs addressing mental, physical,
18 oral, and behavioral health conditions for pa-
19 tients with low health literacy;

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

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

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

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

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

11 (e) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated to carry out this section,
13 such sums as may be necessary for each of fiscal years
14 2010 through 2014.

15 **SEC. 104. ASSURANCES FOR RECEIVING FEDERAL FUNDS.**

16 (a) IN GENERAL.—Entities that receive Federal
17 funds under sections 101 or 102 (including under the
18 amendments made by such section), in order to ensure the
19 right of LEP individuals to receive access to quality health
20 care, shall—

21 (1) ensure that appropriate clinical and support
22 staff receive ongoing education and training in lin-
23 guistically appropriate service delivery;

24 (2) offer and provide appropriate language serv-
25 ices at no additional charge to each patient with lim-

1 ited English proficiency at all points of contact, in
2 a timely manner 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 competent interpreter or trans-
6 lation services which—

7 (A) until adoption of the Interpreter and
8 Translator Guidelines and Standards described
9 in section 3103(c) of the Public Health Service
10 Act, are defined in section 3100 of the Public
11 Health Service Act; and

12 (B) after adoption of the Interpreter and
13 Translator Guidelines and Standards described
14 in section 3103(c) of the Public Health Service
15 Act, meet those guidelines and standards;

16 (b) EXEMPTIONS.—The requirements of subsection
17 (a)(4) shall not apply as follows:

18 (1) When a patient (who has been informed in
19 his or her primary language of the availability of
20 free interpreter and translation services) requests
21 the use of family, friends or other persons untrained
22 in interpretation or translation if the following con-
23 ditions are met:

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

1 (B) The recipient informs the patient that
2 he or she has the option of having the recipient
3 provide an interpreter for him/her without
4 charge, or of using his/her own interpreter.

5 (C) The recipient informs the patient that
6 the recipient may not require an LEP person to
7 use a family member or friend as an inter-
8 preter.

9 (D) The recipient evaluates whether the
10 person the patient wishes to use as an inter-
11 preter is competent. If the recipient has reason
12 to believe that the interpreter is not competent,
13 the recipient provides its own interpreter to
14 protect the recipient from liability if the pa-
15 tient's interpreter is later found not competent.

16 (E) If the recipient has reason to believe
17 that there is a conflict of interest between the
18 interpreter and patient, the recipient may not
19 use the patient's interpreter.

20 (F) The recipient has the patient sign a
21 waiver, witnessed by at least one individual not
22 related to the patient, that includes the infor-
23 mation stated in subparagraphs (A) through
24 (E) and is translated into the patient's lan-
25 guage.

1 (2) When a medical emergency exists and the
2 delay directly associated with obtaining competent
3 interpreter or translation services would jeopardize
4 the health of the patient but only until a competent
5 interpreter or translation service is available; how-
6 ever, nothing in this subsection shall exempt emer-
7 gency rooms or similar entities that regularly pro-
8 vide health care services in medical emergencies
9 from having in place systems to provide competent
10 interpreter and translation services without undue
11 delay.

12 **SEC. 105. REPORT ON FEDERAL EFFORTS TO PROVIDE CUL-**
13 **TURALLY AND LINGUISTICALLY APPRO-**
14 **PRIATE HEALTH CARE SERVICES.**

15 (a) REPORT.—Not later than 1 year after the date
16 of enactment of this Act and annually thereafter, the Sec-
17 retary of Health and Human Services shall enter into a
18 contract with the Institute of Medicine for the preparation
19 and publication of a report that describes Federal efforts
20 to ensure that all individuals with limited English pro-
21 ficiency have meaningful access to health care and health
22 care-related services. Such report shall include—

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

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

5 (3) recommendations on the development and
6 implementation of policies and practices by providers
7 of health care and health care-related services for
8 limited English proficient individuals;

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

12 (5) 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 2010 through 2014.

18 **SEC. 106. ENGLISH FOR SPEAKERS OF OTHER LANGUAGES.**

19 (a) GRANTS AUTHORIZED.—The Secretary of Edu-
20 cation is authorized to provide grants to States for the
21 provision of English as a second language (hereafter re-
22 ferred to as “ESL”) instruction and shall determine, after
23 consultation with appropriate stakeholders, the mecha-
24 nism for administering and distributing such grants.

1 (b) APPLICATION.—A State may apply for a grant
2 under this section by submitting such information as the
3 Secretary may require and in such form and manner as
4 the Secretary may require.

5 (c) USE OF GRANT.—As a condition of receiving a
6 grant under this section, a State shall—

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

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

18 (3) maintain current ESL instruction efforts by
19 using the additional funds to supplement rather
20 than supplant any funds expended for ESL instruc-
21 tion in the State as of January 1, 2006.

22 (d) ADDITIONAL DUTIES OF THE SECRETARY.—The
23 Secretary of Education shall—

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

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

8 (A) the extent of waiting lists including
9 how many programs maintain waiting lists and,
10 for programs that do not have waiting lists, the
11 reasons why not;

12 (B) the availability of programs to geo-
13 graphically isolated communities;

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

17 (D) the number individuals in the State
18 and each participating locality;

19 (E) the effectiveness of the instruction in
20 meeting the needs of individuals receiving in-
21 struction and those needing instruction;

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

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

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

6 (4) within 1 year of the date of enactment of
7 this Act, issue a report to Congress that assesses the
8 information collected in subparagraphs (1), (2), and
9 (3) and makes recommendations on steps that
10 should be taken to progressively realize the goal of
11 making ESL instruction available to all English lan-
12 guage learners seeking instruction.

13 (e) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated to the Secretary of Edu-
15 cation for each of fiscal years 2010 through 2013
16 \$250,000,000 to carry out this section.

17 **SEC. 107. DEFINITION.**

18 In this title, the definitions contained in section 3100
19 of the Public Health Service Act, as added by section 101,
20 shall apply.

21 **SEC. 108. TREATMENT OF THE MEDICARE PART B PRO-**
22 **GRAM UNDER TITLE VI OF THE CIVIL RIGHTS**
23 **ACT OF 1964.**

24 A payment to a provider of services, physician, or
25 other supplier under part B, C, or D of title XVIII of

1 the Social Security Act shall be deemed a grant, and not
2 a contract of insurance or guaranty, for the purposes of
3 title VI of the Civil Rights Act of 1964.

4 **SEC. 109. IMPLEMENTATION.**

5 (a) GENERAL PROVISIONS.—

6 (1) A State shall not be immune under the
7 Eleventh Amendment of the Constitution of the
8 United States from suit in Federal court for failing
9 to provide the language access funded pursuant to
10 this Act.

11 (2) In a suit against a State for a violation of
12 this Act, remedies (including remedies at both at law
13 and in equity) are available for such a violation to
14 the same extent as such remedies are available for
15 such a violation in the suit against any public or pri-
16 vate entity other than a State.

17 (b) RULE OF CONSTRUCTION.—Nothing in this Act
18 shall 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. 2000(d) et
21 seq.) or any other statute.

1 **TITLE II—HEALTH WORKFORCE**
2 **DIVERSITY**

3 **SEC. 201. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
4 **ACT.**

5 Title XXXI of the Public Health Service Act, as
6 added by section 201, is amended by adding at the end
7 the following:

8 **“Subtitle A—Diversifying the**
9 **Healthcare Workplace**

10 **“SEC. 3111. REPORT ON WORKFORCE DIVERSITY.**

11 “(a) IN GENERAL.—Not later than July 1, 2010, and
12 biannually thereafter, the Secretary, acting through the
13 director of each entity within the Department of Health
14 and Human Services, shall prepare and submit to the
15 Committee on Health, Education, Labor, and Pensions of
16 the Senate and the Committee on Energy and Commerce
17 of the House of Representatives a report on health work-
18 force diversity.

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

21 “(1) A description of any grant support that is
22 provided by each entity for workforce diversity ini-
23 tiatives with the following information—

24 “(A) the number of grants made;

25 “(B) the purpose of the grants;

1 “(C) the populations served through the
2 grants;

3 “(D) the organizations and institutions re-
4 ceiving the grants; and

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

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

10 “(A) the number of underrepresented mi-
11 nority health professionals that will be needed
12 in various disciplines over the next 10 years to
13 achieve population parity;

14 “(B) the level of funding needed to fully
15 expand and adequately support health profes-
16 sions pipeline programs;

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

20 “(D) the management strategy necessary
21 to effectively administer and institutionalize
22 health profession pipeline programs; and

23 “(E) the impact that the Government Per-
24 formance and Results Act (GPRA) has had on
25 evaluating the performance of grantees and

1 whether the GPRA is the best assessment tool
2 for programs under titles VII and VIII.

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

5 “(c) PUBLIC AVAILABILITY.—The report under sub-
6 section (a) shall be made available for public review and
7 comment.

8 **“SEC. 3112. NATIONAL WORKING GROUP ON WORKFORCE**
9 **DIVERSITY.**

10 “(a) IN GENERAL.—The Secretary, acting through
11 the Bureau of Health Professions within the Health Re-
12 sources and Services Administration, shall award a grant
13 to an entity determined appropriate by the Secretary for
14 the establishment of a national working group on work-
15 force diversity.

16 “(b) REPRESENTATION.—In establishing the national
17 working group under subsection (a), the grantee shall en-
18 sure that the group has representation from the following
19 entities:

20 “(1) The Health Resources and Services Ad-
21 ministration.

22 “(2) The Department of Health and Human
23 Services Data Council.

24 “(3) The Office of Minority Health.

1 “(4) The Bureau of Labor Statistics of the De-
2 partment of Labor.

3 “(5) The Public Health Practice Program Of-
4 fice—Office of Workforce Policy and Planning.

5 “(6) The National Center on Minority Health
6 and Health Disparities.

7 “(7) The Agency for Healthcare Research and
8 Quality.

9 “(8) The Institute of Medicine Study Com-
10 mittee for the 2004 workforce diversity report.

11 “(9) The Indian Health Service.

12 “(10) Academic institutions.

13 “(11) Consumer organizations.

14 “(12) Health professional associations, includ-
15 ing those that represent underrepresented minority
16 populations.

17 “(13) Researchers in the area of health work-
18 force.

19 “(14) Health workforce accreditation entities.

20 “(15) Private foundations that have sponsored
21 workforce diversity initiatives.

22 “(16) Not less than 5 health professions stu-
23 dents representing various health profession fields
24 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 current public and private health
5 workforce 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 curriculum guidelines for diversity
22 training.

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

1 “(9) Other activities determined appropriate by
2 the Secretary.

3 “(d) ANNUAL REPORT.—Not later than 1 year after
4 the establishment of the working group under subsection
5 (a), and annually thereafter, the working group shall pre-
6 pare and make available to the general public for com-
7 ment, an annual report on the activities of the working
8 group. Such report shall include the recommendations of
9 the working group for improving health workforce diver-
10 sity.

11 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
12 is authorized to be appropriated to carry out this section,
13 such sums as may be necessary for each of fiscal years
14 2010 through 2015.

15 **“SEC. 3113. TECHNICAL CLEARINGHOUSE FOR HEALTH**
16 **WORKFORCE DIVERSITY.**

17 “(a) IN GENERAL.—The Secretary, acting through
18 the Office of Minority Health, and in collaboration with
19 the Bureau of Health Professions within the Health Re-
20 sources and Services Administration, the National Center
21 on Minority Health and Health Disparities, shall establish
22 a technical clearinghouse on health workforce diversity
23 within the Office of Minority Health and coordinate cur-
24 rent and future clearinghouses.

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

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

6 “(2) Statistical information relating to under-
7 represented minority representation in health and al-
8 lied health professions and occupations.

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

11 “(4) Admissions policies that promote health
12 workforce diversity and are in compliance with Fed-
13 eral and State laws.

14 “(5) Lists of scholarship, loan repayment, and
15 loan cancellation grants as well as fellowship infor-
16 mation for underserved populations for health pro-
17 fessions schools.

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

20 “(c) CONSULTATION.—In carrying out this section,
21 the Secretary shall consult with non-Federal entities which
22 may include minority health professional associations to
23 ensure the adequacy and accuracy of information.

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

1 such sums as may be necessary for each of fiscal years
2 2010 through 2015.

3 **“SEC. 3114. EVALUATION OF WORKFORCE DIVERSITY INI-**
4 **TIATIVES.**

5 “(a) IN GENERAL.—The Secretary, acting through
6 the Bureau of Health Professions within the Health Re-
7 sources and Services Administration, shall award grants
8 to eligible entities for the conduct of an evaluation of cur-
9 rent health workforce diversity initiatives funded by the
10 Department of Health and Human Services.

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

13 “(1) be a city, county, Indian tribe, State, terri-
14 tory, community-based nonprofit organization,
15 health center, university, college, or other entity de-
16 termined appropriate by the Secretary;

17 “(2) with respect to an entity that is not an
18 academic medical center, university, or private re-
19 search institution, carry out activities under the
20 grant in partnership with an academic medical cen-
21 ter, university, or private research institution; and

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

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

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

6 “(2) The short- and long-term tracking of par-
7 ticipants in health workforce diversity pipeline pro-
8 grams funded by the Department of Health and
9 Human Services.

10 “(3) Assessments of partnerships formed
11 through activities to increase health workforce diver-
12 sity.

13 “(4) Assessments of barriers to health work-
14 force diversity.

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

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

19 “(7) Other activities determined appropriate by
20 the Secretary and the Working Group established
21 under section 3112.

22 “(d) REPORT.—Not later than 1 year after the date
23 of enactment of this title, the Bureau of Health Profes-
24 sions within the Health Resources and Services Adminis-
25 tration shall prepare and make available for public com-

1 ment a report that summarizes the findings made by enti-
 2 ties under grants under this section.

3 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
 4 is authorized to be appropriated to carry out this section,
 5 such sums as may be necessary for each of fiscal years
 6 2010 through 2015.

7 **“SEC. 3115. DATA COLLECTION AND REPORTING BY**
 8 **HEALTH PROFESSIONAL SCHOOLS.**

9 “(a) IN GENERAL.—The Secretary, acting through
 10 the Bureau of Health Professions of the Health Resources
 11 and Services Administration and the Office of Minority
 12 Health, shall establish an aggregated database on health
 13 professional students.

14 “(b) REQUIREMENT TO COLLECT DATA.—Each
 15 health professional school (including medical, dental, and
 16 nursing schools) and allied health profession school and
 17 program that receives Federal funds shall collect race, eth-
 18 nicity, and language proficiency data concerning those stu-
 19 dents enrolled at such schools or in such programs. In col-
 20 lecting such data, a school or program shall—

21 “(1) at a minimum, use the categories for race
 22 and ethnicity described in the 1997 Office of Man-
 23 agement and Budget Standards for Maintaining,
 24 Collecting, and Presenting Federal Data on Race
 25 and Ethnicity and available language standards; and

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

4 “(c) USE OF DATA.—Data on race, ethnicity, pri-
5 mary language, gender, and sexual orientation collected
6 under this section shall be reported to the database estab-
7 lished under subsection (a) on an annual basis. Such data
8 shall be available for public use.

9 “(d) PRIVACY.—The Secretary shall ensure that all
10 data collected under this section is protected from inap-
11 propriate internal and external use by any entity that col-
12 lects, stores, or receives the data and that such data is
13 collected without personally identifiable information.

14 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
15 is authorized to be appropriated to carry out this section,
16 such sums as may be necessary for each of fiscal years
17 2010 through 2015.

18 **“SEC. 3116. SUPPORT FOR INSTITUTIONS COMMITTED TO**
19 **WORKFORCE DIVERSITY.**

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

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

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

5 “(A) Historically Black Colleges and Uni-
6 versities;

7 “(B) Hispanic-Serving Health Professions
8 Schools;

9 “(C) Hispanic-Serving Institutions;

10 “(D) Tribal Colleges and Universities;

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

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

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

21 “(H) institutions—

22 “(i) located in communities with pre-
23 dominantly underrepresented minority pop-
24 ulations;

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

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

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

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

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

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

23 “(3) post-baccalaureate programs;

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

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

6 “(6) mentoring programs;

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

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

12 “(9) leadership training.

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

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

21 “(1) that are eligible institutions under section
22 312(b) of the Higher Education Act of 1965; and

23 “(2) that, at the time of their application, have
24 an enrollment of undergraduate students that is

1 made up of at least 10 percent Asian American and
2 Pacific Islander students.

3 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
4 is authorized to be appropriated to carry out this section,
5 such sums as may be necessary for each of fiscal years
6 2010 through 2015.

7 **“SEC. 3117. CAREER DEVELOPMENT FOR SCIENTISTS AND**
8 **RESEARCHERS.**

9 “(a) IN GENERAL.—The Secretary, acting through
10 the Director of the National Institutes of Health, the Di-
11 rector of the Centers for Disease Control and Prevention,
12 the Commissioner of Food and Drugs, and the Director
13 of the Agency for Healthcare Research and Quality, shall
14 award grants that expand existing opportunities for sci-
15 entists and researchers and promote the inclusion of
16 underrepresented minorities in the health professions.

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

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

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

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

1 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
2 is authorized to be appropriated to carry out this section,
3 such sums as may be necessary for each of fiscal years
4 2010 through 2015.

5 **“SEC. 3118. CAREER SUPPORT FOR NON-RESEARCH**
6 **HEALTH PROFESSIONALS.**

7 “(a) IN GENERAL.—The Secretary, acting through
8 the Director of the Centers for Disease Control and Pre-
9 vention, the Administrator of the Substance Abuse and
10 Mental Health Services Administration, the Administrator
11 of the Health Resources and Services Administration, and
12 the Administrator of the Centers for Medicare and Med-
13 icaid Services shall establish a program to award grants
14 to eligible individuals for career support in non-research-
15 related healthcare.

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

18 “(1) be a student in a health professions school,
19 a graduate of such a school who is working in a
20 health profession, or a faculty member of such a
21 school; and

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

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

3 “(1) support the individual’s health activities or
4 projects that involve underserved communities, in-
5 cluding racial and ethnic minority communities;

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

8 “(3) to pay, or as reimbursement for payments
9 of, student loans for individuals who are health pro-
10 fessionals and are focused on health issues affecting
11 underserved communities, including racial and eth-
12 nic minority communities.

13 “(d) DEFINITION.—In this section, the term ‘career
14 in non-research-related healthcare’ means employment or
15 intended employment in the field of public health, health
16 policy, health management, health administration, medi-
17 cine, nursing, pharmacy, allied health, community health,
18 or other fields determined appropriate by the Secretary,
19 other than in a position that involves research.

20 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
21 is authorized to be appropriated to carry out this section,
22 such sums as may be necessary for each of fiscal years
23 2010 through 2015.

1 **“SEC. 3119. RESEARCH ON THE EFFECT OF WORKFORCE DI-**
2 **VERSITY ON QUALITY.**

3 “(a) IN GENERAL.—The Director of the Agency for
4 Healthcare Research and Quality, in collaboration with
5 the Director of the Office of Minority Health and the Di-
6 rector of the National Center on Minority Health and
7 Health Disparities, shall award grants to eligible entities
8 to expand research on the link between health workforce
9 diversity and quality healthcare.

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

12 “(1) be a clinical, public health, or health serv-
13 ices research entity or other entity determined ap-
14 propriate by the Director; and

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

18 “(c) USE OF FUNDS.—Amounts received under a
19 grant awarded under subsection (a) shall be used to sup-
20 port research that investigates the effect of health work-
21 force diversity on—

22 “(1) language access;

23 “(2) cultural competence;

24 “(3) patient satisfaction;

25 “(4) timeliness of care;

26 “(5) safety of care;

1 “(6) effectiveness of care;
 2 “(7) efficiency of care;
 3 “(8) patient outcomes;
 4 “(9) community engagement;
 5 “(10) resource allocation;
 6 “(11) organizational structure;
 7 “(12) other topics determined appropriate by
 8 the Director; or
 9 “(13) compliance of care.

10 “(d) PRIORITY.—In awarding grants under sub-
 11 section (a), the Director shall give individualized consider-
 12 ation to all relevant aspects of the applicant’s background.
 13 Consideration of prior research experience involving the
 14 health of underserved communities shall be such a factor.
 15 “(e) 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 2010 through 2015.

19 **“SEC. 3120. HEALTH DISPARITIES EDUCATION PROGRAM.**

20 “(a) ESTABLISHMENT.—The Secretary, acting
 21 through the National Center on Minority Health and
 22 Health Disparities and in collaboration with the Office of
 23 Minority Health, the Office for Civil Rights, the Centers
 24 for Disease Control and Prevention, the Centers for Medi-
 25 care and Medicaid Services, the Health Resources and

1 Services Administration, and other appropriate public and
2 private entities, shall establish and coordinate a health and
3 healthcare disparities education program to support, de-
4 velop, and implement educational initiatives and outreach
5 strategies that inform healthcare professionals and the
6 public about the existence of and methods to reduce racial
7 and ethnic disparities in health and healthcare.

8 “(b) ACTIVITIES.—The Secretary, through the edu-
9 cation program established under subsection (a) shall,
10 through the use of public awareness and outreach cam-
11 paigns targeting the general public and the medical com-
12 munity at large—

13 “(1) disseminate scientific evidence for the ex-
14 istence and extent of racial and ethnic disparities in
15 healthcare, including disparities that are not other-
16 wise attributable to known factors such as access to
17 care, patient preferences, or appropriateness of
18 intervention, as described in the 2002 Institute of
19 Medicine Report, Unequal Treatment;

20 “(2) disseminate new research findings to
21 healthcare providers and patients to assist them in
22 understanding, reducing, and eliminating health and
23 healthcare disparities;

24 “(3) disseminate information about the impact
25 of linguistic and cultural barriers on healthcare qual-

1 ity and the obligation of health providers who receive
2 Federal financial assistance to ensure that people
3 with limited English proficiency have access to lan-
4 guage access services;

5 “(4) disseminate information about the impor-
6 tance and legality of racial, ethnic, and primary lan-
7 guage data collection, analysis, and reporting;

8 “(5) design and implement specific educational
9 initiatives to health care providers relating to health
10 and health care disparities; and

11 “(6) assess the impact of the programs estab-
12 lished under this section in raising awareness of
13 health and healthcare disparities and providing in-
14 formation on available resources.

15 “(c) 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 2010 through 2015.

19 **“SEC. 3120A. CULTURAL COMPETENCE TRAINING FOR**
20 **HEALTHCARE PROFESSIONALS.**

21 “(a) IN GENERAL.—The Secretary, acting through
22 the Administrator of the Health Resources and Services
23 Administration, the Director of the Office of Minority
24 Health, and the Director of the National Center for Mi-
25 nority Health and Health Disparities, shall award grants

1 to eligible entities to test, implement, and evaluate models
2 of cultural competence training, including continuing edu-
3 cation, for healthcare providers in coordination with the
4 initiative under section 3120(a).

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

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

11 “(2) partner with a minority serving institution,
12 minority professional association, or community-
13 based organization representing minority popu-
14 lations, in addition to a research institution to carry
15 out activities under this grant; and

16 “(3) prepare and submit to the Secretary an
17 application at such time, in such manner, and con-
18 taining such information as the Secretary may re-
19 quire.

20 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
21 is authorized to be appropriated to carry out this section,
22 such sums as may be necessary for each of fiscal years
23 2010 through 2015.”.

1 **SEC. 202. HEALTH CAREERS OPPORTUNITY PROGRAM.**

2 (a) PURPOSE.—It is the purpose of this section to
3 diversify the healthcare workforce by increasing the num-
4 ber of individuals from disadvantaged backgrounds in the
5 health and allied health professions by enhancing the aca-
6 demic skills of students from disadvantaged backgrounds
7 and supporting them in successfully competing, entering,
8 and graduating from health professions training pro-
9 grams.

10 (b) AUTHORIZATION OF APPROPRIATIONS.—Section
11 740(c) of the Public Health Service Act (42 U.S.C.
12 293d(c)) is amended by striking “\$29,400,000” and all
13 that follows through “2002” and inserting “\$50,000,000
14 for fiscal year 2010, and such sums as may be necessary
15 for each of fiscal years 2011 through 2015”.

16 **SEC. 203. PROGRAM OF EXCELLENCE IN HEALTH PROFES-**
17 **SIONS EDUCATION FOR UNDERREP-**
18 **RESENTED MINORITIES.**

19 (a) PURPOSE.—It is the purpose of this section to
20 diversify the healthcare workforce by supporting programs
21 of excellence in designated health professions schools that
22 demonstrate a commitment to underrepresented minority
23 populations with a focus on minority health issues, cul-
24 tural and linguistic competence, and eliminating health
25 disparities.

1 (b) AUTHORIZATION OF APPROPRIATION.—Section
2 736(h)(1) of the Public Health Service Act (42 U.S.C.
3 293(h)(1)) is amended to read as follows:

4 “(1) AUTHORIZATION OF APPROPRIATIONS.—
5 For the purpose of making grants under subsection
6 (a), there are authorized to be appropriated
7 \$50,000,000 for fiscal year 2010, and such sums as
8 may be necessary for each of the fiscal years 2011
9 through 2015.”.

10 **SEC. 204. HISPANIC-SERVING HEALTH PROFESSIONS**
11 **SCHOOLS.**

12 Part B of title VII of the Public Health Service Act
13 (42 U.S.C. 293 et seq.) is amended by adding at the end
14 the following:

15 **“SEC. 742. HISPANIC-SERVING HEALTH PROFESSIONS**
16 **SCHOOLS.**

17 “(a) IN GENERAL.—The Secretary, acting through
18 the Administrator of the Health Resources and Services
19 Administration, shall award grants to Hispanic-serving
20 health professions schools for the purpose of carrying out
21 programs to recruit Hispanic individuals to enroll in and
22 graduate from such schools, which may include providing
23 scholarships and other financial assistance as appropriate.

1 “(b) ELIGIBILITY.—In subsection (a), the term ‘His-
 2 panic-serving health professions school’ means an entity
 3 that—

4 “(1) is a school or program under section
 5 799B;

6 “(2) has an enrollment of full-time equivalent
 7 students that is made up of at least 9 percent His-
 8 panic students;

9 “(3) has been effective in carrying out pro-
 10 grams to recruit Hispanic individuals to enroll in
 11 and graduate from the school;

12 “(4) has been effective in recruiting and retain-
 13 ing Hispanic faculty members; and

14 “(5) has a significant number of graduates who
 15 are providing health services to medically under-
 16 served populations or to individuals in health profes-
 17 sional shortage areas.”.

18 **SEC. 205. HEALTH PROFESSIONS STUDENT LOAN FUND; AU-**
 19 **THORIZATIONS OF APPROPRIATIONS RE-**
 20 **GARDING STUDENTS FROM DISADVANTAGED**
 21 **BACKGROUNDS.**

22 Section 724(f)(1) of the Public Health Service Act
 23 (42 U.S.C. 292t(f)(1)) is amended by striking
 24 “\$8,000,000” and all that follows and inserting
 25 “\$35,000,000 for fiscal year 2010, and such sums as may

1 be necessary for each of the fiscal years 2011 through
2 2015.”.

3 **SEC. 206. NATIONAL HEALTH SERVICE CORPS; RECRUIT-**
4 **MENT AND FELLOWSHIPS FOR INDIVIDUALS**
5 **FROM DISADVANTAGED BACKGROUNDS.**

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

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

15 (b) ASSIGNMENT OF CORPS PERSONNEL.—Section
16 333(a) of the Public Health Service Act (42 U.S.C.
17 254f(a)) is amended by adding at the end the following:

18 “(4) In assigning Corps personnel under this section,
19 the Secretary shall give preference to applicants who re-
20 quest assignment to a Federally-qualified health center (as
21 defined in section 1905(l)(2)(B) of the Social Security
22 Act) or to a provider organization that has a majority of
23 patients who are minorities or individuals from low-income
24 families (families with a family income that is less than
25 200 percent of the Official Poverty Line).”.

1 **SEC. 207. LOAN REPAYMENT PROGRAM OF CENTERS FOR**
2 **DISEASE CONTROL AND PREVENTION.**

3 Section 317F(c) of the Public Health Service Act (42
4 U.S.C. 247b–7(c)) is amended—

5 (1) by striking “and” after “1994,”; and

6 (2) by inserting before the period the following:

7 “\$750,000 for fiscal year 2010, and such sums as
8 may be necessary for each of the fiscal years 2011
9 through 2015.”.

10 **SEC. 208. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
11 **GREE PROGRAMS AT SCHOOLS OF PUBLIC**
12 **HEALTH AND SCHOOLS OF ALLIED HEALTH.**

13 Part B of title VII of the Public Health Service Act
14 (42 U.S.C. 293 et seq.), as amended by section 204, is
15 further amended by adding at the end the following:

16 **“SEC. 743. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
17 **GREE PROGRAMS.**

18 “(a) COOPERATIVE AGREEMENTS.—The Secretary,
19 acting through the Administrator of the Health Resources
20 and Services Administration, in consultation with the Di-
21 rector of the Centers for Disease Control and Prevention,
22 the Director of the Agency for Healthcare Research and
23 Quality, and the Director of the Office of Minority Health,
24 shall award cooperative agreements to schools of public
25 health and schools of allied health to design and imple-
26 ment online degree programs.

1 “(b) PRIORITY.—In awarding cooperative agreements
2 under this section, the Secretary shall give priority to any
3 school of public health or school of allied health that has
4 an established track record of serving medically under-
5 served communities.

6 “(c) REQUIREMENTS.—Awardees must design and
7 implement an online degree program, that meet the fol-
8 lowing restrictions:

9 “(1) Enrollment of individuals who have ob-
10 tained a secondary school diploma or its recognized
11 equivalent.

12 “(2) Maintaining a significant enrollment of
13 underrepresented minority or disadvantaged stu-
14 dents.

15 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated to carry out this section,
17 such sums as may be necessary for each of fiscal years
18 2010 through 2015.”.

19 **SEC. 209. MID-CAREER HEALTH PROFESSIONS SCHOLAR-**
20 **SHIP PROGRAM.**

21 Part B of title VII of the Public Health Service Act
22 (as amended by section 208) is further amended by adding
23 at the end the following:

1 **“SEC. 744. MID-CAREER HEALTH PROFESSIONS SCHOLAR-**
2 **SHIP PROGRAM.**

3 “(a) IN GENERAL.—The Secretary may make grants
4 to eligible schools for awarding scholarships to eligible in-
5 dividuals to attend the school involved, for the purpose of
6 enabling the individuals to make a career change from a
7 non-health profession to a health profession.

8 “(b) EXPENSES.—Amounts awarded as a scholarship
9 under this section—

10 “(1) subject to paragraph (2), may be expended
11 only for tuition expenses, other reasonable edu-
12 cational expenses, and reasonable living expenses in-
13 curred in the attendance of the school involved; and

14 “(2) may be expended for stipends to eligible
15 individuals for the enrolled period at eligible schools,
16 except that such a stipend may not be provided to
17 an individual for more than 4 years, and such a sti-
18 pend may not exceed \$35,000 per year (notwith-
19 standing any other provision of law regarding the
20 amount of stipends).

21 “(c) DEFINITIONS.—In this section:

22 “(1) ELIGIBLE SCHOOL.—The term ‘eligible
23 school’ means a school of medicine, osteopathic med-
24 icine, dentistry, nursing (as defined in section 801),
25 pharmacy, podiatric medicine, optometry, veterinary
26 medicine, public health, chiropractic, or allied health,

1 a school offering a graduate program in mental and
2 behavioral health practice, or an entity providing
3 programs for the training of physician assistants
4 and nurse midwives.

5 “(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible
6 individual’ means an individual who has obtained a
7 secondary school diploma or its recognized equiva-
8 lent.

9 “(d) PRIORITY.—In providing scholarships to eligible
10 individuals, eligible schools shall give to individuals from
11 disadvantaged backgrounds.

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 2010 through 2015.”.

16 **SEC. 210. NATIONAL REPORT ON THE PREPAREDNESS OF**
17 **HEALTH PROFESSIONALS TO CARE FOR DI-**
18 **VERSE POPULATIONS.**

19 The Secretary of Health and Human Services, in col-
20 laboration with the Bureau of Health Professions, the Of-
21 fice of Minority Health and the National Center on Minor-
22 ity Health and Health Disparities, shall prepare and dis-
23 seminate a report that details and assesses the prepared-
24 ness of health professionals to care for racially and eth-
25 nically diverse populations. Such information, which shall

1 be collected by the Bureau of Health Professions, shall
2 include—

3 (1) with respect to health professions education,
4 the number and percentage of hours of classroom
5 discussion relating to minority health issues, includ-
6 ing cultural competence;

7 (2) a description of the coursework involved in
8 such education;

9 (3) a description of the results of an evaluation
10 of the preparedness of students in such education;

11 (4) a description of the types of exposure that
12 students have during their education to minority pa-
13 tient populations; and

14 (5) a description of model programs and prac-
15 tices.

16 **SEC. 211. SCHOLARSHIP AND FELLOWSHIP PROGRAMS.**

17 Subtitle A of title XXXI of the Public Health Service
18 Act, as amended by section 201, is further amended by
19 adding at the end the following:

20 **“SEC. 3120B. DAVID SATCHER PUBLIC HEALTH AND**
21 **HEALTH SERVICES CORPS.**

22 “(a) IN GENERAL.—The Administrator of the Health
23 Resources and Services Administration and Director of
24 the Centers for Disease Control and Prevention, in col-
25 laboration with the Director of the Office of Minority

1 Health, shall award grants to eligible entities to increase
2 awareness among post-primary and post-secondary stu-
3 dents of career opportunities in the health professions.

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

6 “(1) be a clinical, public health or health serv-
7 ices organization, community-based or non-profit en-
8 tity, or other entity determined appropriate by the
9 Director of the Centers for Disease Control and Pre-
10 vention;

11 “(2) serve a health professional shortage area,
12 as determined by the Secretary;

13 “(3) work with students, including those from
14 racial and ethnic minority backgrounds, that have
15 expressed an interest in the health professions; and

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

19 “(c) USE OF FUNDS.—Grant awards under sub-
20 section (a) shall be used to support internships that will
21 increase awareness among students of non-research based
22 and career opportunities in the following health profes-
23 sions:

24 “(1) Medicine.

25 “(2) Nursing.

1 “(3) Public Health.

2 “(4) Pharmacy.

3 “(5) Health Administration and Management.

4 “(6) Health Policy.

5 “(7) Psychology.

6 “(8) Dentistry.

7 “(9) International Health.

8 “(10) Social Work.

9 “(11) Allied Health.

10 “(12) Psychiatry.

11 “(13) Hospice care.

12 “(14) Other professions deemed appropriate by
13 the Director of the Centers for Disease Control and
14 Prevention.

15 “(d) PRIORITY.—In awarding grants under sub-
16 section (a), the Director of the Centers for Disease Con-
17 trol and Prevention shall give priority to those entities
18 that—

19 “(1) serve a high proportion of individuals from
20 disadvantaged backgrounds;

21 “(2) have experience in health disparity elimi-
22 nation programs;

23 “(3) facilitate the entry of disadvantaged indi-
24 viduals into institutions of higher education; and

13 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
14 is authorized to be appropriated to carry out this section,
15 such sums as may be necessary for each of fiscal years
16 2010 through 2015.

19 “(a) IN GENERAL.—The Director of the Centers for
20 Disease Control and Prevention, in collaboration with the
21 Director of the Office of Minority Health, shall award
22 scholarships to postsecondary students who seek a career
23 in public health.

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1 “(1) have experience in public health research
2 or public health practice, or other health professions
3 as determined appropriate by the Director of the
4 Centers for Disease Control and Prevention;

5 “(2) reside in a health professional shortage
6 area as determined by the Secretary;

7 “(3) have expressed an interest in public health;

8 “(4) demonstrate promise for becoming a leader
9 in public health;

10 “(5) secure admission to a 4-year institution of
11 higher education;

12 “(6) comply with subsection (f); and

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

16 “(c) USE OF FUNDS.—Amounts received under an
17 award under subsection (a) shall be used to support oppor-
18 tunities for students to become public health professionals.

19 “(d) PRIORITY.—In awarding grants under sub-
20 section (a), the Director shall give priority to those stu-
21 dents that—

22 “(1) are from disadvantaged backgrounds;

23 “(2) have secured admissions to a minority
24 serving institution; and

13 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
14 is authorized to be appropriated to carry out this section,
15 such sums as may be necessary for each of fiscal years
16 2010 through 2015.

“(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Director of the Office of Minority Health, the Administrator of the Substance Abuse and Mental Health Services Administration, and the Director of the Indian Health Services, shall award research fellowships to post-baccalaureate students to conduct research that will examine

1 gender and health disparities and to pursue a career in
2 the health professions.

3 “(b) ELIGIBILITY.—To be eligible to receive a fellow-
4 ship under subsection (a) an individual shall—

5 “(1) have experience in health research or pub-
6 lic health practice;

7 “(2) reside in a health professional shortage
8 area as determined by the Secretary;

9 “(3) have expressed an interest in the health
10 professions;

11 “(4) demonstrate promise for becoming a leader
12 in the field of women’s health;

13 “(5) secure admission to a health professions
14 school or graduate program with an emphasis in
15 gender studies;

16 “(6) comply with subsection (f); and

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

20 “(c) USE OF FUNDS.—Amounts received under an
21 award under subsection (a) shall be used to support oppor-
22 tunities for students to become researchers and advance
23 the research base on the intersection between gender and
24 health.

1 “(d) PRIORITY.—In awarding grants under sub-
2 section (a), the Director of the Centers for Disease Con-
3 trol and Prevention shall give priority to those applicants
4 that—

5 “(1) are from disadvantaged backgrounds; and

6 “(2) have identified a mentor and academic ad-
7 visor who will assist in the completion of their grad-
8 uate or professional degree and have secured a re-
9 search assistant position with a researcher working
10 in the area of gender and health.

11 “(e) FELLOWSHIPS.—The Director of the Centers for
12 Disease Control and Prevention may approve fellowships
13 for individuals under this section for any period of edu-
14 cation in the student’s graduate or health profession ten-
15 ure, except that such a fellowship may not be provided
16 to an individual for more than 3 years, and such a fellow-
17 ship may not exceed \$18,000 per academic year (notwith-
18 standing any other provision of law regarding the amount
19 of fellowship).

20 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
21 is authorized to be appropriated to carry out this section,
22 such sums as may be necessary for each of fiscal years
23 2010 through 2015.

1 **“SEC. 3120E. PAUL DAVID WELLSTONE INTERNATIONAL**
2 **HEALTH FELLOWSHIP PROGRAM.**

3 “(a) IN GENERAL.—The Director of the Agency for
4 Healthcare Research and Quality, in collaboration with
5 the Director of the Office of Minority Health, shall award
6 research fellowships to college students or recent grad-
7 uates to advance their understanding of international
8 health.

9 “(b) ELIGIBILITY.—To be eligible to receive a fellow-
10 ship under subsection (a) an individual shall—

11 “(1) have educational experience in the field of
12 international health;

13 “(2) reside in a health professional shortage
14 area as determined by the Secretary;

15 “(3) demonstrate promise for becoming a leader
16 in the field of international health;

17 “(4) be a college senior or recent graduate of
18 a four year higher education institution;

19 “(5) comply with subsection (f); and

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

23 “(c) USE OF FUNDS.—Amounts received under an
24 award under subsection (a) shall be used to support oppor-
25 tunities for students to become health professionals and

1 to advance their knowledge about international issues re-
2 lating to healthcare access and quality.

3 “(d) PRIORITY.—In awarding grants under sub-
4 section (a), the Director shall give priority to those appli-
5 cants that—

6 “(1) are from a disadvantaged background; and

7 “(2) have identified a mentor at a health pro-
8 fessions school or institution, an academic advisor to
9 assist in the completion of their graduate or profes-
10 sional degree, and an advisor from an international
11 health Non-Governmental Organization, Private Vol-
12 unteer Organization, or other international institu-
13 tion or program that focuses on increasing
14 healthcare access and quality for residents in devel-
15 oping countries.

16 “(e) FELLOWSHIPS.—The Secretary shall approve
17 fellowships for college seniors or recent graduates, except
18 that such a fellowship may not be provided to an indi-
19 vidual for more than 6 months, may not be awarded to
20 a graduate that has not been enrolled in school for more
21 than 1 year, and may not exceed \$4,000 per academic year
22 (notwithstanding any other provision of law regarding the
23 amount of fellowship).

24 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
25 is authorized to be appropriated to carry out this section,

1 such sums as may be necessary for each of fiscal years
2 2010 through 2015.

3 **“SEC. 3120F. EDWARD R. ROYBAL HEALTHCARE SCHOLAR**
4 **PROGRAM.**

5 “(a) IN GENERAL.—The Director of the Agency for
6 Healthcare Research and Quality, the Director of the Cen-
7 ters for Medicaid and Medicare, and the Administrator for
8 Health Resources and Services Administration, in collabo-
9 ration with the Director of the Office of Minority Health,
10 shall award grants to eligible entities to expose entering
11 graduate students to the health professions.

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

14 “(1) be a clinical, public health or health serv-
15 ices organization, community-based or non-profit en-
16 tity, or other entity determined appropriate by the
17 Director of the Agency for Healthcare Research and
18 Quality;

19 “(2) serve in a health professional shortage
20 area as determined by the Secretary;

21 “(3) work with students obtaining a degree in
22 the health professions; and

23 “(4) 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 opportunities that expose students to non-research
4 based health professions, including—

5 “(1) public health policy;

6 “(2) healthcare and pharmaceutical policy;

7 “(3) healthcare administration and manage-
8 ment;

9 “(4) health economics; and

10 “(5) other professions determined appropriate
11 by the Director of the Agency for Healthcare Re-
12 search and Quality.

13 “(d) PRIORITY.—In awarding grants under sub-
14 section (a), the Director of the Agency for Healthcare Re-
15 search and Quality shall give priority to those entities
16 that—

17 “(1) have experience with health disparity elimi-
18 nation programs;

19 “(2) facilitate training in the fields described in
20 subsection (c); and

21 “(3) provide counseling or other services de-
22 signed to assist such individuals in successfully com-
23 pleting their education at the post-secondary level.

24 “(e) STIPENDS.—The Secretary may approve the
25 payment of stipends for individuals under this section for

1 any period of education in student-enhancement programs
2 (other than regular courses) at health professions schools
3 or entities, except that such a stipend may not be provided
4 to an individual for more than 2 months, and such a sti-
5 pend may not exceed \$100 per day (notwithstanding any
6 other provision of law regarding the amount of stipends).

7 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
8 is authorized to be appropriated to carry out this section
9 such sums as may be necessary for each of fiscal years
10 2010 through 2015.”.

11 **SEC. 212. ADVISORY COMMITTEE ON HEALTH PROFES-**
12 **SIONS TRAINING FOR DIVERSITY.**

13 (a) ESTABLISHMENT.—The Secretary of Health and
14 Human Services (referred to in this section as the “Sec-
15 retary”) shall establish an advisory committee to be known
16 as the Advisory Committee on Health Professions Train-
17 ing for Diversity (in this section referred to as the “Advi-
18 sory Committee”).

19 (b) COMPOSITION.—

20 (1) IN GENERAL.—The Secretary shall deter-
21 mine the appropriate number of individuals to serve
22 on the Advisory Committee. Such individuals shall
23 not be officers or employees of the Federal Govern-
24 ment.

1 (2) APPOINTMENT.—Not later than 60 days
2 after the date of enactment of this section, the Sec-
3 retary shall appoint the members of the Advisory
4 Committee from among individuals who are health
5 professionals. In making such appointments, the
6 Secretary shall ensure a fair balance between the
7 health professions, that at least 75 percent of the
8 members of the Advisory Committee are health pro-
9 fessionals, a broad geographic representation of
10 members and a balance between urban and rural
11 members. Members shall be appointed based on their
12 competence, interest, and knowledge of the mission
13 of the profession involved.

14 (3) MINORITY REPRESENTATION.—In appoint-
15 ing the members of the Advisory Committee under
16 paragraph (2), the Secretary shall ensure the ade-
17 quate representation of women and minorities.

18 (c) TERMS.—

19 (1) IN GENERAL.—A member of the Advisory
20 Committee shall be appointed for a term of 3 years,
21 except that of the members first appointed—

22 (A) $\frac{1}{3}$ of such members shall serve for a
23 term of 1 year;

24 (B) $\frac{1}{3}$ of such members shall serve for a
25 term of 2 years; and

1 (C) $\frac{1}{3}$ of such members shall serve for a
2 term of 3 years.

3 (2) VACANCIES.—

4 (A) IN GENERAL.—A vacancy on the Advi-
5 sory Committee shall be filled in the manner in
6 which the original appointment was made and
7 shall be subject to any conditions which applied
8 with respect to the original appointment.

9 (B) FILLING UNEXPIRED TERM.—An indi-
10 vidual chosen to fill a vacancy shall be ap-
11 pointed for the unexpired term of the member
12 replaced.

13 (d) DUTIES.—

14 (1) IN GENERAL.—The Advisory Committee
15 shall—

16 (A) provide advice and recommendations to
17 the Secretary concerning policy and program
18 development and other matters of significance
19 concerning activities under this part; and

20 (B) not later than 2 years after the date
21 of enactment of this section, and annually
22 thereafter, prepare and submit to the Secretary,
23 and the Committee on Health, Education,
24 Labor and Pensions of the Senate, and the
25 Committee on Energy and Commerce of the

1 House of Representatives, a report describing
2 the activities of the Committee.

3 (2) CONSULTATION WITH STUDENTS.—In car-
4 rying out duties under paragraph (1), the Advisory
5 Committee shall consult with individuals who are at-
6 tending health professions schools with which this
7 part is concerned.

8 (e) MEETINGS AND DOCUMENTS.—

9 (1) MEETINGS.—The Advisory Committee shall
10 meet not less than 2 times each year. Such meetings
11 shall be held jointly with other related entities estab-
12 lished under this title where appropriate.

13 (2) DOCUMENTS.—Not later than 14 days prior
14 to the convening of a meeting under paragraph (1),
15 the Advisory Committee shall prepare and make
16 available an agenda of the matters to be considered
17 by the Advisory Committee at such meeting. At any
18 such meeting, the Advisory Committee shall dis-
19 tribute materials with respect to the issues to be ad-
20 dressed at the meeting. Not later than 30 days after
21 the adjourning of such a meeting, the Advisory Com-
22 mittee shall prepare and make available a summary
23 of the meeting and any actions taken by the Com-
24 mittee based upon the meeting.

25 (f) COMPENSATION AND EXPENSES.—

1 (1) COMPENSATION.—Each member of the Ad-
2 visory Committee shall be compensated at a rate
3 equal to the daily equivalent of the annual rate of
4 basic pay prescribed for level IV of the Executive
5 Schedule under section 5315 of title 5, United
6 States Code, for each day (including travel time)
7 during which such member is engaged in the per-
8 formance of the duties of the Committee.

9 (2) EXPENSES.—The members of the Advisory
10 Committee shall be allowed travel expenses, includ-
11 ing per diem in lieu of subsistence, at rates author-
12 ized for employees of agencies under subchapter I of
13 chapter 57 of title 5, United States Code, while
14 away from their homes or regular places of business
15 in the performance of services for the Committee.

16 (g) FACA.—The Federal Advisory Committee Act
17 shall apply to the Advisory Committee under this section
18 only to the extent that the provisions of such Act do not
19 conflict with the requirements of this section.

20 **SEC. 213. MCNAIR POSTBACCALAUREATE ACHIEVEMENT**
21 **PROGRAM.**

22 Section 402E of the Higher Education Act of 1965
23 (20 U.S.C. 1070a–15) is amended by striking subsection
24 (g) and inserting the following:

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

11 “(h) FUNDING.—From amounts appropriated pursu-
 12 ant to the authority of section 402A(g), the Secretary
 13 shall, to the extent practicable, allocate funds for projects
 14 authorized by this section in an amount which is not less
 15 than \$31,000,000 for each of the fiscal years 2010
 16 through 2016.”.

17 **TITLE III—DATA COLLECTION** 18 **AND REPORTING**

19 **SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE** 20 **ACT.**

21 (a) PURPOSE.—It is the purpose of this section to
 22 promote data collection, analysis, and reporting by race,
 23 ethnicity, and primary language among federally sup-
 24 ported health programs.

1 (b) AMENDMENT.—Title XXXI of the Public Health
2 Service Act, as amended by title II of this Act, is further
3 amended by adding at the end the following:

4 **“Subtitle B—Strengthening Data**
5 **Collection, Improving Data**
6 **Analysis, and Expanding Data**
7 **Reporting**

8 **“SEC. 3131. DATA ON RACE, ETHNICITY, AND PRIMARY LAN-**
9 **GUAGE.**

10 **“(a) REQUIREMENTS.—**

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

16 **“(A) require the collection, by the agency**
17 **or program involved, of data on the race, eth-**
18 **nicity, primary language, and sexual orientation**
19 **of each applicant for and recipient of health-re-**
20 **lated assistance under such program—**

21 **“(i) using, at a minimum, the cat-**
22 **egories for race and ethnicity described in**
23 **the 1997 Office of Management and Budg-**
24 **et Standards for Maintaining, Collecting,**

1 and Presenting Federal Data on Race and
2 Ethnicity;

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

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

10 “(iv) where practicable, through self-
11 report;

12 “(B) with respect to the collection of the
13 data described in subparagraph (A) for appli-
14 cants and recipients who are minors or other-
15 wise legally incapacitated, require that—

16 “(i) such data be collected from the
17 parent or legal guardian of such an appli-
18 cant or recipient; and

19 “(ii) the preferred language of the
20 parent or legal guardian of such an appli-
21 cant or recipient be collected;

22 “(C) systematically analyze such data
23 using the smallest appropriate units of analysis
24 feasible to detect racial and ethnic disparities as
25 well as disparities along lines of sexual orienta-

tion in health and health care and when appropriate, for men and women separately, and report the results of such analysis to the Secretary, the Director of the Office for Civil Rights, the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives;

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

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

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

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

1 “(B) require health care providers to col-
2 lect data.

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

7 “(1) under the same privacy protections as the
8 Secretary applies to other health data under the reg-
9 ulations promulgated under section 264(c) of the
10 Health Insurance Portability and Accountability Act
11 of 1996 (Public Law 104–191; 110 Stat. 2033) re-
12 lating to the privacy of individually identifiable
13 health information and other protections; and

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

20 “(c) NATIONAL PLAN OF THE DATA COUNCIL.—The
21 Secretary shall develop and implement a national plan to
22 ensure the collection of data in a culturally appropriate
23 and competent manner, and to improve the collection,
24 analysis, and reporting of racial, ethnic, and primary lan-
25 guage data at the Federal, State, territorial, Tribal, and

1 local levels, including data to be collected under subsection
2 (a). The Data Council of the Department of Health and
3 Human Services, in consultation with the National Com-
4 mittee on Vital Health Statistics, the Office of Minority
5 Health, and other appropriate public and private entities,
6 shall make recommendations to the Secretary concerning
7 the development, implementation, and revision of the na-
8 tional plan. Such plan shall include recommendations on
9 how to—

10 “(1) implement subsection (a) while minimizing
11 the cost and administrative burdens of data collec-
12 tion and reporting;

13 “(2) expand awareness among Federal agencies,
14 States, territories, Indian tribes, health providers,
15 health plans, health insurance issuers, and the gen-
16 eral public that data collection, analysis, and report-
17 ing by race, ethnicity, and primary language is legal
18 and necessary to assure equity and non-discrimina-
19 tion in the quality of health care services;

20 “(3) ensure that future patient record systems
21 have data code sets for racial, ethnic, primary lan-
22 guage, and sexual orientation identifiers and that
23 such identifiers can be retrieved from clinical
24 records, including records transmitted electronically;

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

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

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

13 “(d) COMPLIANCE WITH STANDARDS.—Data col-
14 lected under subsection (a) shall be obtained, maintained,
15 and presented (including for reporting purposes) in ac-
16 cordance with the 1997 Office of Management and Budget
17 Standards for Maintaining, Collecting, and Presenting
18 Federal Data on Race and Ethnicity (at a minimum).

19 “(e) LANGUAGE COLLECTION STANDARDS.—Not
20 later than 1 year after the date of enactment of this title,
21 the Deputy Assistant Secretary for Minority Health, in
22 consultation with the Office for Civil Rights of the Depart-
23 ment of Health and Human Services, shall develop and
24 disseminate Standards for the Classification of Federal
25 Data on Preferred Written and Spoken Language.

1 “(f) TECHNICAL ASSISTANCE FOR THE COLLECTION
2 AND REPORTING OF DATA.—

3 “(1) IN GENERAL.—The Secretary may, either
4 directly or through grant or contract, provide tech-
5 nical assistance to enable a health care program or
6 an entity operating under such program to comply
7 with the requirements of this section.

8 “(2) TYPES OF ASSISTANCE.—Assistance pro-
9 vided under this subsection may include assistance
10 to—

11 “(A) enhance or upgrade computer tech-
12 nology that will facilitate racial, ethnic, and pri-
13 mary language data collection and analysis;

14 “(B) improve methods for health data col-
15 lection and analysis including additional popu-
16 lation groups beyond the Office of Management
17 and Budget categories if such groups can be
18 aggregated into the minimum race and ethnicity
19 categories;

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

23 “(D) develop educational programs to in-
24 form health insurance issuers, health plans,
25 health providers, health-related agencies, and

1 the general public that data collection and re-
2 porting by race, ethnicity, and preferred lan-
3 guage are legal and essential for eliminating
4 health and health care disparities.

5 “(g) ANALYSIS OF RACIAL AND ETHNIC DATA.—The
6 Secretary, acting through the Director of the Agency for
7 Healthcare Research and Quality and in coordination with
8 the Administrator of the Centers for Medicare & Medicaid
9 Services, shall provide technical assistance to agencies of
10 the Department of Health and Human Services in meeting
11 Federal standards for race, ethnicity, and primary lan-
12 guage data collection and analysis of racial and ethnic dis-
13 parities in health and health care in public programs by—

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

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

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

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

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

1 “(h) REPORT.—Not later than 2 years after the date
2 of enactment of this title, and biennially thereafter, the
3 Secretary shall submit to the appropriate committees of
4 Congress a report on the effectiveness of data collection,
5 analysis, and reporting on race, ethnicity, and primary
6 language under the programs and activities of the Depart-
7 ment of Health and Human Services and under other Fed-
8 eral data collection systems with which the Department
9 interacts to collect relevant data on race and ethnicity.
10 The report shall evaluate the progress made in the De-
11 partment with respect to the national plan under sub-
12 section (c) or subsequent revisions thereto.

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

15 “(1) under the Social Security Act (42 U.S.C.
16 301 et seq.) that pay for health care and services;
17 and

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

22 “(j) 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 2010 through 2015.

1 **“SEC. 3132. PROVISIONS RELATING TO NATIVE AMERICANS.**

2 “(a) ESTABLISHMENT OF EPIDEMIOLOGY CEN-
3 TERS.—The Secretary shall establish an epidemiology cen-
4 ter in each service area to carry out the functions de-
5 scribed in subsection (b). Any new center established after
6 the date of the enactment of the Health Equity and Ac-
7 countability Act of 2009 may be operated under a grant
8 authorized by subsection (d), but funding under such a
9 grant shall not be divisible.

10 “(b) FUNCTIONS OF CENTERS.—In consultation with
11 and upon the request of Indian Tribes, Tribal Organiza-
12 tions, and Urban Indian Organizations, each service area
13 epidemiology center established under this subsection
14 shall, with respect to such service area—

15 “(1) collect data relating to, and monitor
16 progress made toward meeting, each of the health
17 status objectives of the Service, the Indian Tribes,
18 Tribal Organizations, and Urban Indian Organiza-
19 tions in the service area;

20 “(2) evaluate existing delivery systems, data
21 systems, and other systems that impact the improve-
22 ment of Indian health;

23 “(3) assist Indian Tribes, Tribal Organizations,
24 and Urban Indian Organizations in identifying their
25 highest priority health status objectives and the

1 services needed to achieve such objectives, based on
2 epidemiological data;

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

5 “(5) make recommendations to improve health
6 care delivery systems for Indians and Urban Indi-
7 ans;

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

14 “(7) provide disease surveillance and assist In-
15 dian Tribes, Tribal Organizations, and Urban Indian
16 Organizations to promote public health.

17 “(c) TECHNICAL ASSISTANCE.—The Director of the
18 Centers for Disease Control and Prevention shall provide
19 technical assistance to the centers in carrying out the re-
20 quirements of this subsection.

21 “(d) GRANTS FOR STUDIES.—

22 “(1) IN GENERAL.—The Secretary may make
23 grants to Indian Tribes, Tribal Organizations,
24 Urban Indian Organizations, and eligible intertribal

1 consortia to conduct epidemiological studies of In-
2 dian communities.

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

6 “(A) the intertribal consortium is incor-
7 porated for the primary purpose of improving
8 Indian health; and

9 “(B) the intertribal consortium is rep-
10 resentative of the Indian Tribes or urban In-
11 dian communities in which the intertribal con-
12 sortium is located.

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

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

19 “(A) demonstrate the technical, adminis-
20 trative, and financial expertise necessary to
21 carry out the functions described in paragraph
22 (5);

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

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

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

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

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

12 “(C) in collaboration with Indian Tribes,
13 Tribal Organizations, and urban Indian com-
14 munities, to provide the Service with informa-
15 tion regarding ways to improve the health sta-
16 tus of Indians.

17 “(e) ACCESS TO INFORMATION.—An epidemiology
18 center operated by a grantee pursuant to a grant awarded
19 under subsection (d) shall be treated as a public health
20 authority for purposes of the Health Insurance Portability
21 and Accountability Act of 1996 (Public Law 104–191; 110
22 Stat. 2033), as such entities are defined in part 164.501
23 of title 45, Code of Federal Regulations (or a successor
24 regulation). The Secretary shall grant such grantees ac-
25 cess to and use of data, data sets, monitoring systems,

1 delivery systems, and other protected health information
2 in the possession of the Secretary.”.

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

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

8 **“SEC. 1150A. COLLECTION OF RACE AND ETHNICITY DATA**
9 **BY THE SOCIAL SECURITY ADMINISTRATION.**

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

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

21 “(A) using, at a minimum, the categories
22 for race and ethnicity described in the 1997 Of-
23 fice of Management and Budget Standards for
24 Maintaining, Collecting, and Presenting Federal

1 Data on Race and Ethnicity and available lan-
2 guage standards; and

3 “(B) where practicable, collecting data for
4 additional population groups if such groups can
5 be aggregated into the minimum race and eth-
6 nicity categories;

7 “(2) with respect to the collection of the data
8 described in paragraph (1) for applicants who are
9 under 18 years of age or otherwise legally incapac-
10 itated, require that—

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

13 “(B) the primary language of the parent
14 or legal guardian of such an applicant or recipi-
15 ent be used;

16 “(3) require that such data be uniformly ana-
17 lyzed and reported at least annually to the Commis-
18 sioner of Social Security;

19 “(4) be responsible for storing the data re-
20 ported under paragraph (3);

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

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

1 “(7) ensure that the provision of assistance to
2 an applicant is not denied or otherwise adversely af-
3 fected because of the failure of the applicant to pro-
4 vide race, ethnicity, and primary language data.

5 “(b) PROTECTION OF DATA.—The Commissioner of
6 Social Security shall ensure (through the promulgation of
7 regulations or otherwise) that all data collected pursuant
8 subsection (a) is protected—

9 “(1) under the same privacy protections as the
10 Secretary applies to health data under the regula-
11 tions promulgated under section 264(c) of the
12 Health Insurance Portability and Accountability Act
13 of 1996 (Public Law 104–191; 110 Stat. 2033) re-
14 lating to the privacy of individually identifiable
15 health information and other protections; and

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

22 “(c) RULE OF CONSTRUCTION.—Nothing in this sec-
23 tion shall be construed to permit the use of information
24 collected under this section in a manner that would ad-

1 versely affect any individual providing any such informa-
2 tion.

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

7 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated to carry out this section,
9 such sums as may be necessary for each of fiscal years
10 2010 through 2015.”.

11 **SEC. 303. REVISION OF HIPAA CLAIMS STANDARDS.**

12 (a) IN GENERAL.—Not later than 1 year after the
13 date of enactment of this Act, the Secretary of Health and
14 Human Services shall revise the regulations promulgated
15 under part C of title XI of the Social Security Act (42
16 U.S.C. 1320d et seq.), as added by the Health Insurance
17 Portability and Accountability Act of 1996 (Public Law
18 104–191), relating to the collection of data on race, eth-
19 nicity, and primary language in a health-related trans-
20 action to require—

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

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

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

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

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

17 **SEC. 304. NATIONAL CENTER FOR HEALTH STATISTICS.**

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

20 (1) in paragraph (1), by striking “2003” and
21 inserting “2014”;

22 (2) in paragraph (2), in the first sentence, by
23 striking “2003” and inserting “2014”; and

24 (3) in paragraph (3), by striking “2002” and
25 inserting “2014”.

1 **SEC. 305. GEO-ACCESS STUDY.**

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

4 (1) conduct a study to—

5 (A) determine which geographic areas of
6 the United States have shortages of specialty
7 mental health providers; and

8 (B) assess the preparedness of speciality
9 mental health providers to deliver culturally and
10 linguistically appropriate services; and

11 (2) submit a report to the Congress on the re-
12 sults of such study.

13 **SEC. 306. RACIAL, ETHNIC, AND LINGUISTIC DATA COL-**
14 **LECTED BY THE FEDERAL GOVERNMENT.**

15 (a) COLLECTION; SUBMISSION.—Not later than 90
16 days after the date of the enactment of this Act, and Jan-
17 uary 31st of each year thereafter, each department, agen-
18 cy, and office of the Federal Government that has col-
19 lected racial, ethnic, or linguistic data during the pre-
20 ceding calendar year shall submit such data to the Sec-
21 retary of Health and Human Services.

22 (b) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—
23 Not later than April 30, 2010, and each April 30th there-
24 after, the Secretary of Health and Human Services, acting
25 through the Director of the National Center on Minority

1 Health and Health Disparities and the Deputy Assistant
2 Secretary for Minority Health, shall—

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

6 (2) make publicly available such data and the
7 results of such analysis; and

8 (3) submit a report to the Congress on such
9 data and analysis.

10 **SEC. 307. HEALTH INFORMATION TECHNOLOGY GRANTS.**

11 (a) **AUTHORITY.**—The Deputy Assistant Secretary
12 for Minority Health, in coordination with the Office of the
13 National Coordinator for Health Information Technology,
14 the Health Resources and Services Administration, the
15 Substance Abuse and Mental Health Services Administra-
16 tion, and the National Center on Minority Health and
17 Health Disparities, may award grants to appropriate enti-
18 ties for the purpose of ensuring appropriate and best prac-
19 tices to collect appropriate data and documents on the re-
20 duction of health disparities.

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

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

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

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

9 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
10 out this section, there are authorized to be appropriated
11 \$20,000,000 for each of fiscal years 2010 through 2015.

12 **SEC. 308. STUDY OF HEALTH INFORMATION TECHNOLOGY**
13 **IN MEDICALLY UNDERSERVED COMMU-**
14 **NITIES.**

15 (a) STUDY.—The National Coordinator for Health
16 Information Technology shall conduct a study on the de-
17 velopment and implementation of health information tech-
18 nology in medically underserved communities. The study
19 shall—

20 (1) identify barriers to successful implementa-
21 tion of health information technology in these com-
22 munities;

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

1 (3) examine urban and rural community health
2 systems and determine the impact that health infor-
3 mation technology may have on the capacity of pri-
4 mary health providers; and

5 (4) assess the feasibility and the costs of associ-
6 ated with the use of health information technology
7 in these communities.

8 (b) REPORT.—Not later than 18 months after the
9 date of the enactment of this Act, the National Coordi-
10 nator for Health Information Technology shall submit to
11 the Congress a report on the study conducted under sub-
12 section (a) and shall include in such report such rec-
13 ommendations for legislation or administrative action as
14 the Coordinator determines appropriate.

15 **SEC. 309. HEALTH INFORMATION TECHNOLOGY IN MEDI-**
16 **CALLY UNDERSERVED COMMUNITIES.**

17 The National Coordinator for Health Information
18 Technology shall—

19 (1) identify sources of funds that will be made
20 available to promote and support the planning and
21 adoption of health information technology in medi-
22 cally underserved communities (as defined in section
23 799B of the Public Health Service Act (42 U.S.C.
24 295p)), including in urban and rural areas, either
25 through grants or technical assistance;

1 (2) coordinate with the funding sources to help
2 such communities connect to identified funding; and
3 (3) collaborate with the Agency for Healthcare
4 Research and Quality, the Health Resources and
5 Services Administration, and other Federal agencies
6 to support technical assistance, knowledge dissemi-
7 nation, and resource development, to such commu-
8 nities seeking to plan for and adopt technology and
9 establish electronic health information networks
10 across providers.

11 **SEC. 310. DATA COLLECTION AND ANALYSIS GRANTS TO MI-**
12 **NORITY-SERVING INSTITUTIONS.**

13 (a) **AUTHORITY.**—The Secretary of Health and
14 Human Services, acting through the Center on Minority
15 Health and Health Disparities and the Office of Minority
16 Health, may award grants to access and analyze racial and
17 ethnic, and where possible, primary language data to mon-
18 itor and report on progress to reduce and eliminate racial
19 and ethnic disparities in health and health care.

20 (b) **ELIGIBLE ENTITY.**—In this section, the term “el-
21 igible entity” means a historically Black college or univer-
22 sity, an Hispanic-serving institution, a tribal college or
23 university, or an Asian American and Pacific Islander-
24 serving institution with an accredited public health, health
25 policy, or health services research program.

1 **SEC. 311. HEALTH INFORMATION TECHNOLOGY GRANTS**
2 **FOR RURAL HEALTH CARE PROVIDERS.**

3 Title II of the Public Health Service Act is amended
4 by adding at the end the following new part:

5 **“PART D—HEALTH INFORMATION TECHNOLOGY**
6 **GRANTS**

7 **“SEC. 271. GRANTS TO FACILITATE THE WIDESPREAD**
8 **ADOPTION OF INTEROPERABLE HEALTH IN-**
9 **FORMATION TECHNOLOGY IN RURAL AREAS.**

10 **“(a) COMPETITIVE GRANTS TO ELIGIBLE ENTITIES**
11 **IN RURAL AREAS.—**

12 **“(1) IN GENERAL.—**The Secretary may award
13 competitive grants to eligible entities in rural areas
14 to facilitate the purchase and enhance the utilization
15 of qualified health information technology systems to
16 improve the quality and efficiency of health care.

17 **“(2) ELIGIBILITY.—**To be eligible to receive a
18 grant under paragraph (1) an entity shall—

19 **“(A)** submit to the Secretary an applica-
20 tion at such time, in such manner, and con-
21 taining such information as the Secretary may
22 require;

23 **“(B)** submit to the Secretary a strategic
24 plan for the implementation of data sharing
25 and interoperability measures;

26 **“(C)** be a rural health care provider;

1 “(D) adopt any applicable core interoper-
2 ability guidelines (endorsed under other provi-
3 sions of law);

4 “(E) agree to notify patients if their indi-
5 vidually identifiable health information is
6 wrongfully disclosed;

7 “(F) demonstrate significant financial
8 need; and

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

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

16 “(4) MATCHING REQUIREMENT.—To be eligible
17 for a grant under this subsection an entity shall con-
18 tribute non-Federal contributions to the costs of car-
19 rying out the activities for which the grant is award-
20 ed in an amount equal to \$1 for each \$3 of Federal
21 funds provided under the grant.

22 “(5) LIMIT ON GRANT AMOUNT.—In no case
23 shall the payment amount under this subsection with
24 respect to the purchase or enhanced utilization of
25 qualified health information technology for a rural

1 health care provider, in addition to the amount of
2 any loan made to the provider from a grant to a
3 State under subsection (b) for such purpose, exceed
4 100 percent of the provider's costs for such purchase
5 or enhanced utilization (taking into account costs for
6 training, implementation, and maintenance).

7 “(6) PREFERENCE IN AWARDING GRANTS.—In
8 awarding grants to eligible entities under this sub-
9 section, the Secretary shall give preference to each
10 of the following types of applicants:

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

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

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

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

23 “(b) AUTHORIZATION OF APPROPRIATIONS.—

24 “(1) IN GENERAL.—For the purpose of car-
25 rying out this section, there are authorized to be ap-

1 appropriated \$20,000,000 for fiscal year 2010,
2 \$30,000,000 for fiscal year 2011, and such sums as
3 may be necessary, but not to exceed \$30,000,000 for
4 each of fiscal years 2012 through 2014.

5 “(2) AVAILABILITY.—Amounts appropriated
6 under paragraph (1) shall remain available through
7 fiscal year 2013.

8 “(c) DEFINITIONS.—In this section:

9 “(1) FEDERALLY QUALIFIED HEALTH CEN-
10 TER.—The term ‘Federally qualified health center’
11 has the meaning given that term in section
12 1861(aa)(4) of the Social Security Act (42 U.S.C.
13 1395x(aa)(4)).

14 “(2) GROUP PRACTICE.—The term ‘group prac-
15 tice’ has the meaning given that term in section
16 1877(h)(4) of the Social Security Act (42 U.S.C.
17 1395nn(h)(4)).

18 “(3) HEALTH CARE PROVIDER.—The term
19 ‘health care provider’ means a hospital, skilled nurs-
20 ing facility, home health agency (as defined in sub-
21 section (o) of section 1861 of the Social Security
22 Act, 42 U.S.C. 1395x), health care clinic, rural
23 health clinic, Federally qualified health center, group
24 practice, a pharmacist, a pharmacy, a laboratory, a
25 physician (as defined in subsection (r) of such sec-

tion), a practitioner (as defined in section 1842(b)(18)(CC) of such Act, 42 U.S.C. 1395u(b)(18)(CC)), a health facility operated by or pursuant to a contract with the Indian Health Service, and any other category of facility or clinician determined appropriate by the Secretary.

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

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

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

“(7) QUALIFIED HEALTH INFORMATION TECHNOLOGY.—The term ‘qualified health information technology’ means a system or components of health information technology that meet any applicable core interoperability guidelines (endorsed under applicable provisions of law) when in use or that use inter-

1 face software that allows for interoperability in ac-
2 cordance with such guidelines.

3 “(8) RURAL AREA.—The term ‘rural area’ has
4 the meaning given such term for purposes of section
5 1886(d)(2)(D) of the Social Security Act (42 U.S.C.
6 1395ww(d)(2)(D)).

7 “(9) RURAL HEALTH CARE PROVIDER.—The
8 term ‘rural health care provider’ means a health
9 care provider that is located in a rural area.”.

10 **SEC. 312. SURVEY QUESTIONS ON SEXUAL ORIENTATION**
11 **AND GENDER IDENTITY.**

12 The Secretary of Health and Human Services, acting
13 through the Director of the Centers for Disease Control
14 and Prevention, shall include in the National Health Inter-
15 view Survey (or any successor survey) questions to identify
16 the sexual orientation and gender identity of individuals
17 participating in the survey.

18 **SEC. 313. DISAGGREGATION OF COMPARATIVE EFFECTIVE-**
19 **NESS RESEARCH DATA.**

20 The Secretary of Health and Human Services may
21 not make available any Federal funds for comparative ef-
22 fectiveness health care research, unless the recipient of the
23 funds agrees to ensure that the research data will be
24 disaggregated by race, ethnicity, and gender to detect and
25 measure differences among subpopulations.

**TITLE IV—ACCOUNTABILITY
AND EVALUATION**

Subtitle A—General Provisions

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

(a) IN GENERAL.—Not later than September 1, 2010, each Federal health agency shall develop and implement a national strategic action plan to eliminate disparities on the basis of race, ethnicity, and primary language and improve the health and health care of minority populations, through programs relevant to the mission of the agency.

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

(1) be publicly reported in draft form for public review and comment;

(2) include a response to the review and comment described in paragraph (1) in the final plan;

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

(4) respond to data and analyses presented in the National Healthcare Disparities Report and the

1 National Healthcare Quality Report published annu-
2 ally by the Agency for Healthcare Research and
3 Quality;

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

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

8 **SEC. 402. PROHIBITION ON DISCRIMINATION IN FEDERAL**
9 **ASSISTED HEALTH CARE SERVICES AND RE-**
10 **SEARCH PROGRAMS ON THE BASIS OF SEX,**
11 **RACE, COLOR, NATIONAL ORIGIN, SEXUAL**
12 **ORIENTATION, GENDER IDENTITY, OR DIS-**
13 **ABILITY STATUS.**

14 No person in the United States shall, on the basis
15 of sex, race, color, national origin, sexual orientation, gen-
16 der identity, or disability status, be excluded from partici-
17 pation in, be denied the benefits of, or be subjected to dis-
18 crimination under any health care service or research pro-
19 gram or activity receiving Federal financial assistance.

20 **SEC. 403. ACCOUNTABILITY WITHIN THE DEPARTMENT OF**
21 **HEALTH AND HUMAN SERVICES.**

22 Title XXXI of the Public Health Service Act, as
23 amended by titles II and III of this Act, is further amend-
24 ed by adding at the end the following:

“Subtitle C—Strengthening Accountability

“SEC. 3141. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.

“(a) IN GENERAL.—The Secretary shall establish within the Office for Civil Rights an Office of Health Disparities, which shall be headed by a director to be appointed by the Secretary.

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

“(1) The development and implementation of an action plan to address racial and ethnic health care disparities, which shall address concerns relating to the Office for Civil Rights as released by the United States Commission on Civil Rights in the report entitled ‘Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equity’ (September, 1999) in conjunction with the reports by the Institute of Medicine entitled ‘Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care’, ‘Crossing the Quality

1 Chasm: A New Health System for the 21st Cen-
2 tury’, and ‘In the Nation’s Compelling Interest: En-
3 suring Diversity in the Health Care Workforce’ and
4 other related reports by the Institute of Medicine.
5 This plan shall be publicly disclosed for review and
6 comment and the final plan shall address any com-
7 ments or concerns that are received by the Office.

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

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

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

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

21 “(6) Coordination and oversight of activities of
22 the civil rights compliance offices established under
23 section 3142.

24 “(7) Ensuring compliance with the 1997 Office
25 of Management and Budget Standards for Maintain-

1 ing, Collecting, and Presenting Federal Data on
2 Race, Ethnicity and the available language stand-
3 ards.

4 “(c) FUNDING AND STAFF.—The Secretary shall en-
5 sure the effectiveness of the Office of Health Disparities
6 by ensuring that the Office is provided with—

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

9 “(2) staff with expertise in—

10 “(A) epidemiology;

11 “(B) statistics;

12 “(C) health quality assurance;

13 “(D) minority health and health dispari-
14 ties;

15 “(E) cultural and linguistic competency;

16 and

17 “(F) civil rights.

18 “(d) REPORT.—Not later than December 31, 2010,
19 and annually thereafter, the Secretary, in collaboration
20 with the Director of the Office for Civil Rights and the
21 Director of the Office of Minority Health, shall submit a
22 report to the Committee on Health, Education, Labor, and
23 Pensions of the Senate and the Committee on Energy and
24 Commerce of the House of Representatives that in-
25 cludes—

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

3 “(2) the number of cases investigated and
4 closed by the office;

5 “(3) the outcomes of cases investigated;

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

8 “(5) the number of other lingering and emerg-
9 ing cases in which civil rights inequities can be dem-
10 onstrated; and

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

13 “(e) 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 2010 through 2015.

17 **“SEC. 3142. ESTABLISHMENT OF HEALTH PROGRAM OF-**
18 **FICES FOR CIVIL RIGHTS WITHIN FEDERAL**
19 **HEALTH AND HUMAN SERVICES AGENCIES.**

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 their programs, services, and activities in a
3 manner that—

4 “(1) does not discriminate, either intentionally
5 or in effect, on the basis of race, national origin, lan-
6 guage, ethnicity, sex, age, or disability; and

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

11 “(c) POWERS AND DUTIES.—The offices established
12 in subsection (a) shall have the following powers and du-
13 ties:

14 “(1) The establishment of compliance and pro-
15 gram participation standards for recipients of Fed-
16 eral financial assistance under each program admin-
17 istered by an agency within the Department of
18 Health and Human Services including the establish-
19 ment of disparity reduction standards to encompass
20 disparities in health and health care related to race,
21 national origin, language, ethnicity, sex, age, and
22 disability.

23 “(2) The development and implementation of
24 program-specific guidelines that interpret and apply
25 Department of Health and Human Services guid-

1 ance under title VI of the Civil Rights Act of 1964
2 to each Federal health program administered by the
3 agency.

4 “(3) The development of a disparity-reduction
5 impact analysis methodology that shall be applied to
6 every rule issued by the agency and published as
7 part of the formal rulemaking process under sections
8 555, 556, and 557 of title 5, United States Code.

9 “(4) Oversight of data collection, analysis, and
10 publication requirements for all recipients of Federal
11 financial assistance under each Federal health pro-
12 gram administered by the agency, and compliance
13 with the 1997 Office of Management and Budget
14 Standards for Maintaining, Collecting, and Pre-
15 senting Federal Data on Race and Ethnicity and the
16 available language standards.

17 “(5) The conduct of publicly available studies
18 regarding discrimination within Federal health pro-
19 grams administered by the agency as well as dis-
20 parity reduction initiatives by recipients of Federal
21 financial assistance under Federal health programs.

22 “(6) Annual reports to the Committee on
23 Health, Education, Labor, and Pensions and the
24 Committee on Finance of the Senate and the Com-
25 mittee on Energy and Commerce and the Committee

1 on Ways and Means of the House of Representatives
2 on the progress in reducing disparities in health and
3 health care through the Federal programs adminis-
4 tered by the agency.

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

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

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

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

22 “(1) under the Social Security Act (42 U.S.C.
23 301 et seq.) that pay for health care and services;
24 and

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

5 **SEC. 404. OFFICE OF MINORITY HEALTH.**

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

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

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

15 “(1) Establish, implement, monitor, and evalu-
16 ate short-range and long-range goals and objectives
17 and oversee all other activities within the Public
18 Health Service that relate to disease prevention,
19 health promotion, service delivery, and research con-
20 cerning minority groups. The heads of each of the
21 agencies of the Service shall consult with the Deputy
22 Assistant Secretary to ensure the coordination of
23 such activities.

24 “(2) Oversee all activities within the Depart-
25 ment of Health and Human Services that relate to

1 reducing or eliminating disparities in health and
2 health care in racial and ethnic minority populations
3 and in rural and underserved communities, including
4 coordinating—

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

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

9 “(C) research efforts;

10 “(D) the training of health providers; and

11 “(E) information and education programs
12 and campaigns.

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

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

24 “(5) Provide technical assistance to States,
25 local agencies, territories, Indian tribes, and entities

1 for activities relating to the elimination of racial and
2 ethnic disparities in health and health care.

3 “(6) Support a national minority health re-
4 source center to carry out the following:

5 “(A) Facilitate the exchange of informa-
6 tion regarding matters relating to health infor-
7 mation, health promotion and wellness, preven-
8 tive health services, clinical trials, health infor-
9 mation technology, and education in the appro-
10 priate use of health services.

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

13 “(C) Assist in the analysis of such infor-
14 mation.

15 “(D) Provide technical assistance with re-
16 spect to the exchange of such information (in-
17 cluding facilitating the development of materials
18 for such technical assistance).

19 “(7) Carry out programs to improve access to
20 health care services for individuals with limited
21 English proficiency, including developing and car-
22 rying out programs to provide bilingual or interpre-
23 tive services through the development and support of
24 the Robert T. Matsui Center for Cultural and Lin-

1 guistic Competence in Health Care as provided for
2 in section 3103.

3 “(8) Carry out programs to improve access to
4 health care services and to improve the quality of
5 health care services for individuals with low func-
6 tional health literacy. As used in the preceding sen-
7 tence, the term ‘functional health literacy’ means the
8 ability to obtain, process, and understand basic
9 health information and services needed to make ap-
10 propriate health decisions.

11 “(9) Advise in matters related to the develop-
12 ment, implementation, and evaluation of health pro-
13 fessions education on decreasing disparities in health
14 care outcomes, with focus on cultural competency as
15 a method of eliminating disparities in health and
16 health care in racial and ethnic minority popu-
17 lations.

18 “(10) Assist health care professionals, commu-
19 nity and advocacy organizations, academic centers
20 and public health departments in the design and im-
21 plementation of programs that will improve the qual-
22 ity of health outcomes by strengthening the pro-
23 vider-patient relationship.”;

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

1 (3) by inserting after subsection (d) the fol-
 2 lowing:

3 “(f) PREPARATION OF HEALTH PROFESSIONALS TO
 4 PROVIDE HEALTH CARE TO MINORITY POPULATIONS.—
 5 The Secretary, in collaboration with the Director of the
 6 Bureau of Health Professions and the Deputy Assistant
 7 Secretary for Minority Health, shall require that health
 8 professional schools that receive Federal funds train fu-
 9 ture health professionals to provide culturally and linguis-
 10 tically appropriate health care to diverse populations.”;
 11 and

12 (4) by striking subsection (i) (as so redesign-
 13 nated) and inserting the following:

14 “(i) AUTHORIZATION OF APPROPRIATIONS.—For the
 15 purpose of carrying out this section, there are authorized
 16 to be appropriated \$100,000,000 for fiscal year 2010, and
 17 such sums as may be necessary for each of fiscal years
 18 2011 through 2015.”.

19 **SEC. 405. ESTABLISHMENT OF THE INDIAN HEALTH SERV-**
 20 **ICE AS AN AGENCY OF THE PUBLIC HEALTH**
 21 **SERVICE.**

22 (a) ESTABLISHMENT.—

23 (1) IN GENERAL.—In order to more effectively
 24 and efficiently carry out the responsibilities, authori-
 25 ties, and functions of the United States to provide

1 health care services to Indians and Indian tribes, as
2 are or may be hereafter provided by Federal statute
3 or treaties, there is established within the Public
4 Health Service of the Department of Health and
5 Human Services the Indian Health Service.

6 (2) ASSISTANT SECRETARY OF INDIAN
7 HEALTH.—The Service shall be administered by an
8 Assistant Secretary of Indian Health, who shall be
9 appointed by the President, by and with the advice
10 and consent of the Senate. The Assistant Secretary
11 shall report to the Secretary. Effective with respect
12 to an individual appointed by the President, by and
13 with the advice and consent of the Senate the term
14 of service of the Assistant Secretary shall be 4 years.
15 An Assistant Secretary may serve more than 1 term.

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

20 (c) FUNCTIONS AND DUTIES.—The Secretary shall
21 carry out through the Assistant Secretary of the Service—

22 (1) all functions which were, on the day before
23 the date of enactment of the Indian Health Care
24 Amendments of 1988, carried out by or under the

1 direction of the individual serving as Director of the
2 Service on such day;

3 (2) all functions of the Secretary relating to the
4 maintenance and operation of hospital and health fa-
5 cilities for Indians and the planning for, and provi-
6 sion and utilization of, health services for Indians;

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

11 (A) the Indian Health Care Improvement
12 Act;

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

15 (C) the Act of August 5, 1954 (42 U.S.C.
16 2001 et seq.);

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

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

21 (F) title XXXI of the Public Health Serv-
22 ice Act, as added by this Act; and

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

1 (d) AUTHORITY.—

2 (1) IN GENERAL.—The Secretary, acting
3 through the Assistant Secretary, shall have the au-
4 thority—

5 (A) except to the extent provided for in
6 paragraph (2), to appoint and compensate em-
7 ployees for the Service in accordance with title
8 5, United States Code;

9 (B) to enter into contracts for the procure-
10 ment of goods and services to carry out the
11 functions of the Service; and

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

14 (2) PERSONNEL ACTIONS.—Notwithstanding
15 any other provision of law, the provisions of section
16 12 of the Act of June 18, 1934 (48 Stat. 986; 25
17 U.S.C. 472), shall apply to all personnel actions
18 taken with respect to new positions created within
19 the Service as a result of its establishment under
20 subsection (a).

21 (e) RATE OF PAY.—

22 (1) POSITIONS AT LEVEL IV.—Section 5315 of
23 title 5, United States Code, is amended by striking
24 the following: “Assistant Secretaries of Health and

1 Human Services (6).” and inserting “Assistant Sec-
2 retaries of Health and Human Services (7).”.

3 (2) POSITIONS AT LEVEL V.—Section 5316 of
4 such title is amended by striking the following: “Di-
5 rector, Indian Health Service, Department of Health
6 and Human Services.”.

7 (f) DUTIES OF ASSISTANT SECRETARY FOR INDIAN
8 HEALTH.—Section 601 of the Indian Health Care Im-
9 provement Act (25 U.S.C. 1661) is amended in subsection
10 (a)—

11 (1) by inserting “(1)” after “(a)”;

12 (2) in the second sentence of paragraph (1), as
13 so designated, by striking “a Director,” and insert-
14 ing “the Assistant Secretary for Indian Health,”;

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

21 (4) by adding after paragraph (1) the following:

22 “(2) The Assistant Secretary for Indian Health
23 shall—

1 “(A) report directly to the secretary con-
2 cerning all policy and budget-related matters
3 affecting Indian health;

4 “(B) collaborate with the Assistant Sec-
5 retary for Health concerning appropriate mat-
6 ters of Indian health that affect the agencies of
7 the Public Health Service;

8 “(C) advise each Assistant Secretary of the
9 Department of Health and Human Services
10 concerning matters of Indian health with re-
11 spect to which that Assistant Secretary has au-
12 thority and responsibility;

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

18 “(E) coordinate the activities of the De-
19 partment of Health and Human Services con-
20 cerning matters of Indian health.”.

21 (g) CONTINUED SERVICE BY INCUMBENT.—The indi-
22 vidual serving in the position of Director of the Indian
23 Health Service on the date preceding the date of enact-
24 ment of this Act may serve as Assistant Secretary for In-

1 dian Health, at the pleasure of the President after the
2 date of enactment of this Act.

3 (h) CONFORMING AMENDMENTS.—

4 (1) AMENDMENTS TO INDIAN HEALTH CARE IM-
5 PROVEMENT ACT.—The Indian Health Care Im-
6 provement Act (25 U.S.C. 1601 et seq.) is amend-
7 ed—

8 (A) in section 601—

9 (i) in subsection (c), by striking “Di-
10 rector of the Indian Health Service” both
11 places it appears and inserting “Assistant
12 Secretary for Indian Health”; and

13 (ii) in subsection (d), by striking “Di-
14 rector of the Indian Health Service” and
15 inserting “Assistant Secretary for Indian
16 Health”; and

17 (B) in section 816(c)(1), by striking “Di-
18 rector of the Indian Health Service” and insert-
19 ing “Assistant Secretary for Indian Health”.

20 (2) AMENDMENTS TO OTHER PROVISIONS OF
21 LAW.—The following provisions are each amended
22 by striking “Director of the Indian Health Service”
23 each place it appears and inserting “Assistant Sec-
24 retary for Indian Health”:

1 (A) Section 203(a)(1) of the Rehabilitation
2 Act of 1973 (29 U.S.C. 763(a)(1)).

3 (B) Subsections (b) and (e) of section 518
4 of the Federal Water Pollution Control Act (33
5 U.S.C. 1377 (b) and (e)).

6 (C) Section 803B(d)(1) of the Native
7 American Programs Act of 1974 (42 U.S.C.
8 2991b-2(d)(1)).

9 (i) REFERENCES.—Reference in any other Federal
10 law, Executive order, rule, regulation, or delegation of au-
11 thority, or any document of or relating to the Director
12 of the Indian Health Service shall be deemed to refer to
13 the Assistant Secretary for Indian Health.

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

17 **SEC. 406. ESTABLISHMENT OF INDIVIDUAL OFFICES OF MI-**
18 **NORITY HEALTH WITHIN AGENCIES OF THE**
19 **PUBLIC HEALTH SERVICE.**

20 Title XVII of the Public Health Service Act (42
21 U.S.C. 300u et seq.) is amended by inserting after section
22 1707 the following section:

23 “INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN
24 PUBLIC HEALTH SERVICE

25 “SEC. 1707A.

1 “(a) IN GENERAL.—The head of each agency speci-
2 fied in subsection (b)(1) shall establish within the agency
3 an office to be known as the Office of Minority Health.
4 Each such Office shall be headed by a director, who shall
5 be appointed by the head of the agency within which the
6 Office is established, and who shall report directly to the
7 head of the agency. The head of such agency shall carry
8 out this section (as this section relates to the agency) act-
9 ing through such Director.

10 “(b) SPECIFIED AGENCIES.—

11 “(1) IN GENERAL.—The agencies referred to in
12 subsection (a) are the following:

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

15 “(B) The Health Resources and Services
16 Administration.

17 “(C) The Substance Abuse and Mental
18 Health Services Administration.

19 “(D) The Administration on Aging.

20 “(c) COMPOSITION.—The head of each specified
21 agency shall ensure that the officers and employees of the
22 minority health office of the agency are, collectively, expe-
23 rienced in carrying out community-based health programs
24 for each of the various racial and ethnic minority groups

1 that are present in significant numbers in the United
2 States.

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

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

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

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

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

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

1 “(C) the programs utilize racial and ethnic
2 minority community-based organizations to de-
3 liver services.

4 “(e) BIENNIAL REPORTS TO SECRETARY.—The head
5 of each specified agency shall submit to the Secretary for
6 inclusion in each biennial report describing—

7 “(1) the extent to which the minority health of-
8 fice of the agency employs individuals who are mem-
9 bers of racial and ethnic minority groups, including
10 a specification by minority group of the number of
11 such individuals employed by such office.

12 “(f) FUNDING.—

13 “(1) ALLOCATIONS.—Of the amounts appro-
14 priated for a specified agency for a fiscal year, the
15 Secretary must designate an appropriate amount of
16 funds for the purpose of carrying out activities
17 under this section through the minority health office
18 of the agency. In reserving an amount under the
19 preceding sentence for a minority health office for a
20 fiscal year, the Secretary shall reduce, by substan-
21 tially the same percentage, the amount that other-
22 wise would be available for each of the programs of
23 the designated agency involved.

24 “(2) AVAILABILITY OF FUNDS FOR STAFF-
25 ING.—The purposes for which amounts made avail-

1 able under paragraph may be expended by a minor-
2 ity health office include the costs of employing staff
3 for such office.”.

4 **SEC. 407. OFFICE OF MINORITY HEALTH AT THE CENTERS**
5 **FOR MEDICARE & MEDICAID SERVICES.**

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

11 (b) DUTIES.—The Office shall be responsible for the
12 coordination and facilitation of activities of the Centers
13 for Medicare & Medicaid Services to improve minority
14 health and health care and to reduce racial and ethnic dis-
15 parities in health and health care, which shall include—

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

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

1 (3) assisting health plans, hospitals, and other
2 health entities in providing culturally and linguis-
3 tically appropriate health care services;

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

8 (5) developing grant programs and demonstra-
9 tion projects to identify, implement and evaluate in-
10 novative approaches to improving the health and
11 health care of minority beneficiaries in the Medicare,
12 Medicaid, and SCHIP programs;

13 (6) considering incentive programs relating to
14 reimbursement that would reward health entities for
15 providing quality health care for minority popu-
16 lations using established benchmarks for quality of
17 care;

18 (7) collaborating with the compliance office to
19 ensure compliance with the anti-discrimination provi-
20 sions under title VI of the Civil Rights Act of 1964;

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

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

4 (10) publishing an annual report about the ac-
5 tivities of the Centers for Medicare & Medicaid Serv-
6 ices relating to minority health improvement; and

7 (11) other activities determined appropriate by
8 the Secretary of Health and Human Services.

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

10 (1) one or more individuals with expertise in
11 minority health and racial and ethnic health dispari-
12 ties; and

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

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

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

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

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

1 (e) AUTHORIZATION OF APPROPRIATIONS.—For the
2 purpose of carrying out this section, there are authorized
3 to be appropriated \$10,000,000 for fiscal year 2010, and
4 such sums may be necessary for each of fiscal years 2011
5 through 2016.

6 **SEC. 408. OFFICE OF MINORITY AFFAIRS AT THE FOOD AND**
7 **DRUG ADMINISTRATION.**

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

11 **“SEC. 911. OFFICE OF MINORITY AFFAIRS.**

12 “(a) IN GENERAL.—Not later than 60 days after the
13 date of enactment of this section, the Secretary shall es-
14 tablish within the Office of the Commissioner of Food and
15 Drugs an Office of Minority Affairs (referred to in this
16 section as the ‘Office’).

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

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

1 “(2) encouraging appropriate data collection,
2 analysis, and dissemination of racial and ethnic dif-
3 ferences using, at a minimum, the categories de-
4 scribed in the 1997 Office of Management and
5 Budget standards, in response to different therapies
6 in both adult and pediatric populations;

7 “(3) providing, in coordination with other ap-
8 propriate government agencies, education, training,
9 and support to increase participation of minority pa-
10 tients and physicians in clinical trials;

11 “(4) collecting and analyzing data using, at a
12 minimum, the categories described in the 1997 Of-
13 fice of Management and Budget standards, on the
14 number of participants from minority racial and eth-
15 nic backgrounds in clinical trials used to support
16 medical product approvals;

17 “(5) the identification of methods to reduce lan-
18 guage and literacy barriers; and

19 “(6) publishing an annual report about the ac-
20 tivities of the Food and Drug Administration per-
21 taining to minority health.

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

23 “(1) one or more individuals with expertise in
24 the design and conduct of clinical trials of drugs, bi-
25 ological products, and medical devices; and

1 “(2) one or more individuals with expertise in
2 therapeutic classes or disease states for which med-
3 ical evidence suggests a difference based on race or
4 ethnicity.

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

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

9 “(2) the National Institute for Minority Health
10 and Health Disparities in the National Institutes of
11 Health; and

12 “(3) the Office of Minority Health in the Cen-
13 ters for Disease Control and Prevention.

14 “(e) AUTHORIZATION OF APPROPRIATIONS.—For the
15 purpose of carrying out this section, there are authorized
16 to be appropriated such sums as may be necessary for
17 each of the fiscal years 2010 through 2015.”.

18 **SEC. 409. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
19 **RESPECT TO RACIAL AND ETHNIC BACK-**
20 **GROUND.**

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

1 **“SEC. 505E. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
2 **RESPECT TO RACIAL AND ETHNIC BACK-**
3 **GROUND.**

4 “(a) PRE-APPROVAL STUDIES.—If there is evidence
5 that there may be a disparity on the basis of racial or
6 ethnic background as to the safety or effectiveness of a
7 drug, then—

8 “(1)(A) the investigations required under sec-
9 tion 505(b)(1)(A) shall include adequate and well-
10 controlled investigations of the disparity; or

11 “(B) the evidence required under section 351(a)
12 of the Public Health Service Act for approval of a
13 biologics license application for the drug shall in-
14 clude adequate and well-controlled investigations of
15 the disparity; and

16 “(2) if the investigations confirm that there is
17 a disparity, the labeling of the drug shall include ap-
18 propriate information about the disparity.

19 “(b) POST-MARKET STUDIES.—

20 “(1) IN GENERAL.—If there is evidence that
21 there may be a disparity on the basis of racial or
22 ethnic background as to the safety or effectiveness
23 of a drug for which there is an approved application
24 under section 505 or a license under section 351 of
25 the Public Health Service Act, the Secretary may by
26 order require the holder of the approved application

1 or license to conduct, by a date specified by the Sec-
2 retary, post-marketing studies to investigate the dis-
3 parity.

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

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

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

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

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

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

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

8 “(3) other evidence as the Secretary may deter-
9 mine.

10 “(d) APPLICATIONS UNDER SECTION 505(b)(2) AND
11 505(j).—

12 “(1) IN GENERAL.—A drug for which an appli-
13 cation has been submitted or approved under section
14 505(j) shall not be considered ineligible for approval
15 under that section or misbranded under section 502
16 on the basis that the labeling of the drug omits in-
17 formation relating to a disparity on the basis of ra-
18 cial or ethnic background as to the safety or effec-
19 tiveness of the drug, whether derived from investiga-
20 tions or studies required under this section or de-
21 rived from other sources, when the omitted informa-
22 tion is protected by patent or by exclusivity under
23 clause (iii) or (iv) of section 505(j)(5)(B).

24 “(2) LABELING.—Notwithstanding clauses (iii)
25 and (iv) of section 505(j)(5)(B), the Secretary may

1 require that the labeling of a drug approved under
2 section 505(j) that omits information relating to a
3 disparity on the basis of racial or ethnic background
4 as to the safety or effectiveness of the drug include
5 a statement of any appropriate contraindications,
6 warnings, or precautions related to the disparity
7 that the Secretary considers necessary.”.

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

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

16 (c) DRUG FEES.—Section 736(a)(1)(A)(ii) of the
17 Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379h)
18 is amended by adding after “are required” the following:
19 “, including supplements required under section 505E”.

20 **SEC. 410. UNITED STATES COMMISSION ON CIVIL RIGHTS.**

21 (a) COORDINATION WITHIN DEPARTMENT OF JUSTICE OF
22 ACTIVITIES REGARDING HEALTH DISPARITIES.—Section 3 of the Civil Rights Commission Act of
23 1983 (42 U.S.C. 1975a) is amended—
24

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

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

6 (3) by adding at the end the following:

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

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

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

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

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

23 (b) AUTHORIZATION OF APPROPRIATIONS.—Section
24 5 of the Civil Rights Commission Act of 1983 (42 U.S.C.
25 1975c) is amended by striking the first sentence and in-

1 setting the following: “For the purpose of carrying out
2 this Act, there are authorized to be appropriated
3 \$30,000,000 for fiscal year 2010, and such sums as may
4 be necessary for each of the fiscal years 2011 through
5 2015.”.

6 **SEC. 411. SENSE OF CONGRESS CONCERNING FULL FUND-**
7 **ING OF ACTIVITIES TO ELIMINATE RACIAL**
8 **AND ETHNIC HEALTH DISPARITIES.**

9 (a) FINDINGS.—Congress makes the following find-
10 ings:

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

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

19 (3) Efforts to improve minority health have
20 been limited by inadequate resources (funding, staff-
21 ing, and stewardship) and accountability.

22 (b) SENSE OF CONGRESS.—It is the sense of Con-
23 gress that—

24 (1) funding should be doubled by fiscal year
25 2010 for the National Institute for Minority Health

1 Disparities, the Office of Civil Rights in the Depart-
2 ment of Health and Human Services, the National
3 Institute of Nursing Research, and the Office of Mi-
4 nority Health;

5 (2) adequate funding by fiscal year 2010, and
6 subsequent funding increases, should be provided for
7 health professions training programs, the Racial and
8 Ethnic Approaches to Community Health (REACH)
9 at the Center for Disease Control and Prevention,
10 the Minority HIV/AIDS Initiative, and the Excel-
11 lence Centers to Eliminate Ethnic/Racial Disparities
12 (EXCEED) Program at the Agency for Healthcare
13 Research and Quality;

14 (3) current and newly created health disparity
15 elimination incentives, programs, agencies, and de-
16 partments under this Act (and the amendments
17 made by this Act) should receive adequate staffing
18 and funding by fiscal year 2010; and

19 (4) stewardship and accountability should be
20 provided to Congress and the President for measur-
21 able and sustainable progress toward health dis-
22 parity elimination.

1 **SEC. 412. GUIDELINES FOR DISEASE SCREENING FOR MI-**
2 **NORITY PATIENTS.**

3 (a) IN GENERAL.—The Secretary, acting through the
4 Director of the Agency for Healthcare Research and Qual-
5 ity, shall convene a series of meetings to develop guidelines
6 for disease screening for minority patient populations
7 which have a higher than average risk for many chronic
8 diseases and cancers.

9 (b) PARTICIPANTS.—In convening meetings under
10 subsection (a), the Secretary shall ensure that meeting
11 participants include representatives of—

- 12 (1) professional societies and associations;
- 13 (2) minority health organizations;
- 14 (3) health care researchers and providers, in-
15 cluding those with expertise in minority health;
- 16 (4) Federal health agencies, including the Of-
17 fice of Minority Health, the National Center on Mi-
18 nority Health and Health Disparities, and the Na-
19 tional Institutes of Health; and
- 20 (5) other experts determined appropriate by the
21 Secretary.

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

- 24 (1) hypertension;
- 25 (2) hypercholesterolemia;
- 26 (3) diabetes;

- 1 (4) cardiovascular disease;
- 2 (5) cancers, including breast, prostate, colon,
- 3 cervical, and lung cancer;
- 4 (6) asthma;
- 5 (7) diabetes;
- 6 (8) kidney diseases;
- 7 (9) eye diseases and disorders, including glau-
- 8 coma;
- 9 (10) HIV/AIDS and sexually transmitted dis-
- 10 eases;
- 11 (11) uterine fibroids;
- 12 (12) autoimmune disease;
- 13 (13) mental health conditions;
- 14 (14) dental health conditions and oral diseases;
- 15 (15) environmental and related health illnesses
- 16 and conditions;
- 17 (16) Sickle cell disease;
- 18 (17) violence and injury prevention and control;
- 19 (18) genetic and related conditions;
- 20 (19) heart disease and stroke;
- 21 (20) tuberculosis;
- 22 (21) chronic obstructive pulmonary disease; and
- 23 (22) other diseases determined appropriate by
- 24 the Secretary.

1 (d) DISSEMINATION.—Not later than 24 months
 2 after the date of enactment of this title, the Secretary
 3 shall publish and disseminate to health care provider orga-
 4 nizations the guidelines developed under subsection (a).

5 (e) AUTHORIZATION OF APPROPRIATIONS.—There
 6 are authorized to be appropriated to carry out this section,
 7 sums as may be necessary for each of fiscal years 2010
 8 through 2015.

9 **SEC. 413. NATIONAL INSTITUTE FOR MINORITY HEALTH**
 10 **AND HEALTH DISPARITIES.**

11 (a) REDESIGNATION.—

12 (1) IN GENERAL.—Title IV of the Public
 13 Health Service Act (42 U.S.C. 281 et seq.) is
 14 amended—

15 (A) in section 401(b)(24), by striking “Na-
 16 tional Center on Minority Health and Health
 17 Disparities” and inserting “National Institute
 18 for Minority Health and Health Disparities”;
 19 and

20 (B) in subpart 6 of part E—

21 (i) in the subpart heading, by striking
 22 “Center” and inserting “Institute”;

23 (ii) in the headings of sections 485E
 24 and 485H, by striking “**CENTER**” and in-
 25 serting “**INSTITUTE**”; and

1 (iii) by striking (other than in section
2 485E(i)(1)) the term “Center” each place
3 it appears and inserting “Institute”.

4 (2) REFERENCES.—Any reference in any law,
5 map, regulation, document, paper, or other record of
6 the United States to the National Center on Minor-
7 ity Health and Health Disparities shall be deemed to
8 be a reference to the National Institute for Minority
9 Health and Health Disparities.

10 (b) DUTIES; AUTHORITIES; FUNDING.—Section
11 485E of the Public Health Service Act (42 U.S.C. 287c–
12 31) is amended—

13 (1) by amending subsection (e) to read as fol-
14 lows:

15 “(e) DUTIES OF THE DIRECTOR.—

16 “(1) INTERAGENCY COORDINATION OF MINOR-
17 ITY HEALTH AND HEALTH DISPARITY ACTIVITIES.—

18 With respect to minority health and health dispari-
19 ties, the Director of the Institute shall plan, coordi-
20 nate, and evaluate research and other activities con-
21 ducted or supported by the institutes and centers of
22 the National Institutes of Health. In carrying out
23 the preceding sentence, the Director of the Institute
24 shall evaluate the minority health and health dis-
25 parity activities of each of such institutes and cen-

1 ters and shall provide for the periodic reevaluation
2 of such activities. Such institutes and centers shall
3 be responsible for providing information to the Insti-
4 tute, including data on clinical trials funded or con-
5 ducted by these institutes and centers.

6 “(2) CONSULTATIONS.—The Director of the In-
7 stitute shall carry out this subpart (including devel-
8 oping and revising the plan and budget required by
9 subsection (f) in consultation with the heads of the
10 institutes and centers of the National Institutes of
11 Health, the advisory councils of such institutes and
12 centers, and the advisory council established pursu-
13 ant to subsection (j).

14 “(3) COORDINATION OF ACTIVITIES.—The Di-
15 rector of the Institute—

16 “(A) shall act as the primary Federal offi-
17 cial with responsibility for coordinating all re-
18 search and activities conducted or supported by
19 the National Institutes of Health on minority or
20 other health disparities;

21 “(B) shall represent the health disparities
22 research program of the National Institutes of
23 Health, including the minority health and other
24 health disparities research program, at all rel-

1 evant executive branch task forces, committees,
2 and planning activities; and

3 “(C) shall maintain communications with
4 all relevant agencies of the Public Health Serv-
5 ice, including the Indian Health Service, and
6 various other departments and agencies of the
7 Federal Government to ensure the timely trans-
8 mission of information concerning advances in
9 minority health disparities research and other
10 health disparities research among these various
11 agencies for dissemination to affected commu-
12 nities and health care providers.”;

13 (2) by amending subsection (f) to read as fol-
14 lows:

15 “(f) STRATEGIC PLAN.—

16 “(1) IN GENERAL.—Subject to the provisions of
17 this section and other applicable law, the Director of
18 the Institute, in consultation with the Director of
19 NIH, the Directors of the other institutes and cen-
20 ters of the National Institutes of Health, and the
21 advisory council established pursuant to subsection
22 (j), shall—

23 “(A) annually review and revise a strategic
24 plan (referred to in this section as ‘the plan’)
25 and budget for the conduct and support of all

1 minority health disparity research and other
2 health disparity research activities of the insti-
3 tutes and centers of the National Institutes of
4 Health that include time-based targeted objec-
5 tives with measurable outcomes and assure that
6 the annual review and revision of the plan uses
7 an established trans-National Institutes of
8 Health process subject to timely review, ap-
9 proval, and dissemination;

10 “(B) ensure that the plan and budget es-
11 tablish priorities among the health disparities
12 research activities that such agencies are au-
13 thorized to carry out;

14 “(C) ensure that the plan and budget es-
15 tablish objectives regarding such activities, de-
16 scribe the means for achieving the objectives,
17 and designate the date by which the objectives
18 are expected to be achieved;

19 “(D) ensure that all amounts appropriated
20 for such activities are expended in accordance
21 with the plan and budget;

22 “(E) annually submit to Congress a report
23 on the progress made with respect to the plan;
24 and

1 “(F) create and implement a plan for the
2 systemic review of research activities supported
3 by the National Institutes of Health that are
4 within the mission of both the Institute and
5 other institutes and centers of the National In-
6 stitutes of Health, including by establishing
7 mechanisms for—

8 “(i) tracking minority health and
9 health disparity research conducted within
10 the institutes and centers assessing the ap-
11 propriateness of this research with regard
12 to the overall goals and objectives of the
13 plan;

14 “(ii) the early identification of appli-
15 cations and proposals for grants, contracts,
16 and cooperative agreements supporting ex-
17 tramural training, research, and develop-
18 ment, that are submitted to the institutes
19 and centers that are within the mission of
20 the Institute;

21 “(iii) providing the Institute with the
22 written descriptions and scientific peer re-
23 view results of such applications and pro-
24 posals;

1 “(iv) enabling the institutes and cen-
2 ters to consult with the Director of the In-
3 stitute prior to final approval of such ap-
4 plications and proposals; and

5 “(v) reporting to the Director of the
6 Institute all such applications and pro-
7 posals that are approved for funding by
8 the institutes and centers.

9 “(2) CERTAIN COMPONENTS OF PLAN AND
10 BUDGET.—With respect to health disparities re-
11 search activities of the agencies of the National In-
12 stitutes of Health, the Director of the Institute shall
13 ensure that the plan and budget under paragraph
14 (1) provide for—

15 “(A) basic research and applied research,
16 including research and development with re-
17 spect to products;

18 “(B) research that is conducted by the
19 agencies;

20 “(C) research that is supported by the
21 agencies;

22 “(D) proposals developed pursuant to so-
23 licitations by the agencies and for proposals de-
24 veloped independently of such solicitations; and

1 “(E) behavioral research and social
2 sciences research, which may include cultural
3 and linguistic research in each of the agencies.

4 “(3) MINORITY HEALTH DISPARITIES RE-
5 SEARCH.—The plan and budget under paragraph (1)
6 shall include a separate statement of the plan and
7 budget for minority health disparities research.”;

8 (3) by amending subsection (h) to read as fol-
9 lows:

10 “(h) RESEARCH ENDOWMENTS.—

11 “(1) IN GENERAL.—The Director of the Insti-
12 tute shall carry out a program to facilitate minority
13 health and health disparities research and other
14 health disparities research by providing research en-
15 dowments at—

16 “(A) centers of excellence under section
17 736; and

18 “(B) centers of excellence under section
19 485F.

20 “(2) ELIGIBILITY.—The Director of the Insti-
21 tute shall provide for a research endowment under
22 paragraph (1) only if the institution involved meets
23 the following conditions:

24 “(A) The institution does not have an en-
25 dowment that is worth in excess of an amount

1 equal to 50 percent of the national average of
2 endowment funds at institutions that conduct
3 similar biomedical research or training of health
4 professionals.

5 “(B) The application of the institution
6 under paragraph (1) regarding a research en-
7 dowment has been recommended pursuant to
8 technical and scientific peer review and has
9 been approved by the advisory council estab-
10 lished pursuant to subsection (j).

11 “(C) The institution at any time was
12 deemed to be eligible to receive a grant under
13 section 736 and at any time received a research
14 endowment under paragraph (1).”; and
15 (4) by adding at the end the following:

16 “(k) FUNDING.—

17 “(1) FULL FUNDING BUDGET.—

18 “(A) IN GENERAL.—With respect to a fis-
19 cal year, the Director of the Institute shall pre-
20 pare and submit directly to the President, for
21 review and transmittal to Congress, a budget
22 estimate for carrying out the plan for the fiscal
23 year, after reasonable opportunity for comment
24 (but without change) by the Secretary, the Di-
25 rector of the National Institutes of Health, the

1 directors of the other institutes and centers of
2 the National Institutes of Health, and the advi-
3 sory council established pursuant to subsection
4 (j). The budget estimate shall include an esti-
5 mate of the number and type of personnel
6 needs for the Institute.

7 “(B) AMOUNTS NECESSARY.—The budget
8 estimate submitted under subparagraph (A)
9 shall estimate the amounts necessary for the in-
10 stitutes and centers of the National Institutes
11 of Health to carry out all minority health and
12 health disparities activities determined by the
13 Director of the Institute to be appropriate,
14 without regard to the probability that such
15 amounts will be appropriated.

16 “(2) ALTERNATE BUDGETS.—

17 “(A) IN GENERAL.—With respect to a fis-
18 cal year, the Director of the Institute shall pre-
19 pare and submit to the Secretary and the Di-
20 rector of the National Institutes of Health the
21 budget estimates described in subparagraph (B)
22 for carrying out the plan for the fiscal year.
23 The Secretary and such Director shall consider
24 each of such estimates in making recommenda-

1 tions to the President regarding a budget for
2 the plan for such year.

3 “(B) DESCRIPTION.—With respect to the
4 fiscal year involved, the budget estimates re-
5 ferred to in subparagraph (A) for the plan are
6 as follows:

7 “(i) The budget estimate submitted
8 under paragraph (1).

9 “(ii) A budget estimate developed on
10 the assumption that the amounts appro-
11 priated will be sufficient only for—

12 “(I) continuing the conduct by
13 the institutes and centers of the Na-
14 tional Institutes of Health of existing
15 minority health and health disparity
16 activities (if approved for continu-
17 ation), and continuing the support of
18 such activities by the institutes and
19 centers in the case of projects or pro-
20 grams for which the institutes or cen-
21 ters have made a commitment of con-
22 tinued support; and

23 “(II) carrying out activities that
24 are in addition to activities specified
25 in subclause (I), only for which the

1 Director determines there is the most
2 substantial need.

3 “(iii) Such other budget estimates as
4 the Director of the Institute determines to
5 be appropriate.”.

6 **SEC. 414. IOM REPORT ON LGBT HEALTH DISPARITIES.**

7 The Secretary of Health and Human Services shall
8 enter into an agreement with the Institute of Medicine to
9 prepare and submit to the Congress a report on—

10 (1) health and health care disparities experi-
11 enced by the lesbian, gay, bisexual, and transgender
12 communities; and

13 (2) the unique health and health care chal-
14 lenges experienced by such communities.

15 **Subtitle B—Improving**
16 **Environmental Justice**

17 **SEC. 421. CODIFICATION OF EXECUTIVE ORDER 12898.**

18 (a) IN GENERAL.—The President of the United
19 States is authorized and directed to execute, administer,
20 and enforce as a matter of Federal law the provisions of
21 Executive Order 12898, dated February 11, 1994 (“Fed-
22 eral Actions To Address Environmental Justice In Minor-
23 ity Populations and Low-Income Populations”), with such
24 modifications as are provided in this section.

1 (b) DEFINITION OF ENVIRONMENTAL JUSTICE.—For
2 purposes of carrying out the provisions of Executive Order
3 12898, the following definitions shall apply:

4 (1) The term “environmental justice” means
5 the fair treatment and meaningful involvement of all
6 people regardless of race, color, national origin, edu-
7 cational level, or income with respect to the develop-
8 ment, implementation, and enforcement of environ-
9 mental laws and regulations in order to ensure
10 that—

11 (A) minority and low-income communities
12 have access to public information relating to
13 human health and environmental planning, reg-
14 ulations, and enforcement; and

15 (B) no minority or low-income population
16 is forced to shoulder a disproportionate burden
17 of the negative human health and environ-
18 mental impacts of pollution or other environ-
19 mental hazard.

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

1 (c) JUDICIAL REVIEW AND RIGHTS OF ACTION.—

2 The provisions of section 6–609 of Executive Order 12898

3 shall not apply for purposes of this Act.

4 **SEC. 422. IMPLEMENTATION OF RECOMMENDATIONS BY**
5 **ENVIRONMENTAL PROTECTION AGENCY.**

6 (a) INSPECTOR GENERAL RECOMMENDATIONS.—The

7 Administrator of the Environmental Protection Agency

8 shall, as promptly as practicable, carry out each of the

9 following recommendations of the Inspector General of the

10 agency as set forth in Report No. 2006–P–00034 entitled

11 “EPA needs to conduct environmental justice reviews of

12 its programs, policies and activities”:

13 (1) The recommendation that the Agency’s pro-

14 gram and regional offices identify which programs,

15 policies, and activities need environmental justice re-

16 views and require these offices to establish a plan to

17 complete the necessary reviews.

18 (2) The recommendation that the Administrator

19 of the Agency ensure that these reviews determine

20 whether the programs, policies, and activities may

21 have a disproportionately high and adverse health or

22 environmental impact on minority and low-income

23 populations.

24 (3) The recommendation that each program

25 and regional office develop specific environmental

1 justice review guidance for conducting environmental
2 justice reviews.

3 (4) The recommendation that the Administrator
4 designate a responsible office to compile results of
5 environmental justice reviews and recommend appro-
6 priate actions.

7 (b) GAO RECOMMENDATIONS.—In developing rules
8 under laws administered by the Environmental Protection
9 Agency, the Administrator of the Agency shall, as prompt-
10 ly as practicable, carry out each of the following rec-
11 ommendations of the Comptroller General of the United
12 States as set forth in GAO Report numbered GAO–05–
13 289 entitled “EPA Should Devote More Attention to En-
14 vironmental Justice when Developing Clean Air Rules”:

15 (1) The recommendation that the Administrator
16 ensure that workgroups involved in developing a rule
17 devote attention to environmental justice while draft-
18 ing and finalizing the rule.

19 (2) The recommendation that the Administrator
20 enhance the ability of such workgroups to identify
21 potential environmental justice issues through such
22 steps as providing workgroup members with guid-
23 ance and training to helping them identify potential
24 environmental justice problems and involving envi-

1 ronmental justice coordinators in the workgroups
2 when appropriate.

3 (3) The recommendation that the Administrator
4 improve assessments of potential environmental jus-
5 tice impacts in economic reviews by identifying the
6 data and developing the modeling techniques needed
7 to assess such impacts.

8 (4) The recommendation that the Administrator
9 direct appropriate Agency officers and employees to
10 respond fully when feasible to public comments on
11 environmental justice, including improving the Agen-
12 cy's explanation of the basis for its conclusions, to-
13 gether with supporting data.

14 (c) 2004 INSPECTOR GENERAL REPORT.—The Ad-
15 ministrator of the Environmental Protection Agency shall,
16 as promptly as practicable, carry out each of the following
17 recommendations of the Inspector General of the Agency
18 as set forth in the report entitled “EPA Needs to Consist-
19 ently Implement the Intent of the Executive Order on En-
20 vironmental Justice” (Report No. 2004–P–00007):

21 (1) The recommendation that the Agency clear-
22 ly define the mission of the Office of Environmental
23 Justice (OEJ) and provide Agency staff with an un-
24 derstanding of the roles and responsibilities of the
25 Office.

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

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

18 (d) REPORT.—The Administrator shall submit an ini-
19 tial report to Congress within 6 months after the enact-
20 ment of this Act regarding the Administrator’s strategy
21 for implementing the recommendations referred to in sub-
22 sections (a), (b), and (c). Thereafter, the Administrator
23 shall provide semi-annual reports to Congress regarding
24 the Administrator’s progress in implementing such rec-
25 ommendations and modifying the Administrator’s emer-

1 gency management procedures to incorporate environ-
2 mental justice in the Agency’s Incident Command Struc-
3 ture (in accordance with the December 18, 2006, letter
4 from the Deputy Administrator to the Acting Inspector
5 General of the agency).

6 **SEC. 423. GRANT PROGRAM.**

7 (a) DEFINITIONS.—In this section:

8 (1) DIRECTOR.—The term “Director” means
9 the Director of the Centers for Disease Control and
10 Prevention, acting in collaboration with the Adminis-
11 trator of the Environmental Protection Agency and
12 the Director of the National Institute of Environ-
13 mental Health Sciences.

14 (2) ELIGIBLE ENTITY.—The term “eligible enti-
15 ty” means a State or local community that—

16 (A) bears a disproportionate burden of ex-
17 posure to environmental health hazards;

18 (B) has established a coalition—

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

21 (ii) with not less than 1—

22 (I) public health entity;

23 (II) health care provider organi-
24 zation; or

1 (III) academic institution, includ-
2 ing any minority-serving institution
3 (including an Hispanic-serving institu-
4 tion, a historically Black college or
5 university, and a tribal college or uni-
6 versity);

7 (C) ensures planned activities and funding
8 streams are coordinated to improve community
9 health; and

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

12 (b) ESTABLISHMENT.—The Director shall establish a
13 grant program under which eligible entities shall receive
14 grants to conduct environmental health improvement ac-
15 tivities.

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

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

22 (1) to promote environmental health; and

23 (2) to address environmental health disparities.

24 (e) AMOUNT OF COOPERATIVE AGREEMENT.—

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

4 (2) LEVEL 1 COOPERATIVE AGREEMENTS.—

5 (A) IN GENERAL.—An eligible entity
6 awarded a grant under this paragraph shall use
7 the funds to identify environmental health prob-
8 lems and solutions by—

9 (i) establishing a planning and
10 prioritizing council in accordance with sub-
11 paragraph (B); and

12 (ii) conducting an environmental
13 health assessment in accordance with sub-
14 paragraph (C).

15 (B) PLANNING AND PRIORITIZING COUN-
16 CIL.—

17 (i) IN GENERAL.—A prioritizing and
18 planning council established under sub-
19 paragraph (A)(i) (referred to in this para-
20 graph as a “PPC”) shall assist the envi-
21 ronmental health assessment process and
22 environmental health promotion activities
23 of the eligible entity.

24 (ii) MEMBERSHIP.—Membership of a
25 PPC shall consist of representatives from

1 various organizations within public health,
2 planning, development, and environmental
3 services and shall include stakeholders
4 from vulnerable groups such as children,
5 the elderly, disabled, and minority ethnic
6 groups that are often not actively involved
7 in democratic or decision-making proc-
8 esses.

9 (iii) DUTIES.—A PPC shall—

10 (I) identify key stakeholders and
11 engage and coordinate potential part-
12 ners in the planning process;

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

16 (III) conduct an in-depth review
17 of the nature and extent of the need
18 for an environmental health assess-
19 ment, including a local epidemiological
20 profile, an evaluation of the service
21 provider capacity of the community,
22 and a profile of any target popu-
23 lations; and

24 (IV) define the components of
25 care and form essential programmatic

1 linkages with related providers in the
2 community.

3 (C) ENVIRONMENTAL HEALTH ASSESS-
4 MENT.—

5 (i) IN GENERAL.—A PPC shall carry
6 out an environmental health assessment to
7 identify environmental health concerns.

8 (ii) ASSESSMENT PROCESS.—The
9 PPC shall—

10 (I) define the goals of the assess-
11 ment;

12 (II) generate the environmental
13 health issue list;

14 (III) analyze issues with a sys-
15 tems framework;

16 (IV) develop appropriate commu-
17 nity environmental health indicators;

18 (V) rank the environmental
19 health issues;

20 (VI) set priorities for action;

21 (VII) develop an action plan;

22 (VIII) implement the plan; and

23 (IX) evaluate progress and plan-
24 ning for the future.

1 (D) EVALUATION.—Each eligible entity
2 that receives a grant under this paragraph shall
3 evaluate, report, and disseminate program find-
4 ings and outcomes.

5 (E) TECHNICAL ASSISTANCE.—The Direc-
6 tor may provide such technical and other non-
7 financial assistance to eligible entities as the
8 Director determines to be necessary.

9 (3) LEVEL 2 COOPERATIVE AGREEMENTS.—

10 (A) ELIGIBILITY.—

11 (i) IN GENERAL.—The Director shall
12 award grants under this paragraph to eli-
13 gible entities that have already—

14 (I) established broad-based col-
15 laborative partnerships; and

16 (II) completed environmental as-
17 sessments.

18 (ii) NO LEVEL 1 REQUIREMENT.—To
19 be eligible to receive a grant under this
20 paragraph, an eligible entity is not re-
21 quired to have successfully completed a
22 Level 1 Cooperative Agreement (as de-
23 scribed in paragraph (2)).

24 (B) USE OF GRANT FUNDS.—An eligible
25 entity awarded a grant under this paragraph

1 shall use the funds to further activities to carry
2 out environmental health improvement activi-
3 ties, including—

4 (i) addressing community environ-
5 mental health priorities in accordance with
6 paragraph (2)(C)(ii), including—

7 (I) air quality;

8 (II) water quality;

9 (III) solid waste;

10 (IV) land use;

11 (V) housing;

12 (VI) food safety;

13 (VII) crime;

14 (VIII) injuries; and

15 (IX) healthcare services;

16 (ii) building partnerships between
17 planning, public health, and other sectors,
18 to address how the built environment im-
19 pacts food availability and access and
20 physical activity to promote healthy behav-
21 iors and lifestyles and reduce overweight
22 and obesity, asthma, respiratory condi-
23 tions, dental, oral and mental health condi-
24 tions, and 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 those conditions influ-
8 ence the concerns and needs of people
9 who have impaired mobility and use
10 assistance devices, including wheel-
11 chairs and lower limb prostheses; and

12 (iv) convening intervention programs
13 that examine the role of the social environ-
14 ment in connection with the physical and
15 chemical environment in—

16 (I) determining access to nutri-
17 tional food; and

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

21 (f) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this sec-
23 tion—

24 (1) \$25,000,000 for fiscal year 2010; and

1 (2) such sums as may be necessary for fiscal
2 years 2011 through 2014.

3 **SEC. 424. ADDITIONAL RESEARCH ON THE RELATIONSHIP**
4 **BETWEEN THE BUILT ENVIRONMENT AND**
5 **THE HEALTH OF COMMUNITY RESIDENTS.**

6 (a) DEFINITION OF ELIGIBLE INSTITUTION.—In this
7 section, the term “eligible institution” means a public or
8 private nonprofit institution that submits to the Secretary
9 of Health and Human Services (in this section referred
10 to as the “Secretary”) and the Administrator of the Envi-
11 ronmental Protection Agency (in this section referred to
12 as the “Administrator”) an application for a grant under
13 the grant program authorized under subsection (b)(2) at
14 such time, in such manner, and containing such agree-
15 ments, assurances, and information as the Secretary and
16 Administrator may require.

17 (b) RESEARCH GRANT PROGRAM.—

18 (1) DEFINITION OF HEALTH.—In this section,
19 the term “health” includes—

20 (A) levels of physical activity;

21 (B) consumption of nutritional foods;

22 (C) rates of crime;

23 (D) air, water, and soil quality;

24 (E) risk of injury;

25 (F) accessibility to healthcare services; and

1 (G) other indicators as determined appro-
2 priate by the Secretary.

3 (2) GRANTS.—The Secretary, in collaboration
4 with the Administrator, shall provide grants to eligi-
5 ble institutions to conduct and coordinate research
6 on the built environment and its influence on indi-
7 vidual and population-based health.

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

10 (A) investigates and defines the causal
11 links between all aspects of the built environ-
12 ment and the health of residents;

13 (B) examines—

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

18 (ii) the variance in the health of resi-
19 dents by—

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

23 (II) population subgroup (such as
24 children, the elderly, the disadvan-
25 tagged); or

1 (iii) the importance of the built envi-
2 ronment to the total health of residents,
3 which is the primary variable of interest
4 from a public health perspective;

5 (C) is used to develop—

6 (i) measures to address health and the
7 connection of health to the built environ-
8 ment; and

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

11 (D) distinguishes carefully between per-
12 sonal attitudes and choices and external influ-
13 ences on observed behavior to determine how
14 much an observed association between the built
15 environment and the health of residents, versus
16 the lifestyle preferences of the people that
17 choose to live in the neighborhood, reflects the
18 physical characteristics of the neighborhood;
19 and

20 (E)(i) identifies or develops effective inter-
21 vention strategies to promote better health
22 among residents with a focus on behavioral
23 interventions and enhancements of the built en-
24 vironment that promote increased use by resi-
25 dents; and

1 (ii) in developing the intervention strate-
 2 gies under clause (i), ensures that the interven-
 3 tion strategies will reach out to high-risk popu-
 4 lations, including racial and ethnic minorities
 5 and low-income urban and rural communities.

6 (4) PRIORITY.—In providing assistance under
 7 the grant program authorized under paragraph (2),
 8 the Secretary and the Administrator shall give pri-
 9 ority to research that incorporates—

10 (A) minority-serving institutions as grant-
 11 ees;

12 (B) interdisciplinary approaches; or

13 (C) the expertise of the public health,
 14 physical activity, urban planning, and transpor-
 15 tation research communities in the United
 16 States and abroad.

17 **TITLE V—IMPROVEMENT OF**
 18 **HEALTH CARE SERVICES**
 19 **Subtitle A—Health Empowerment**
 20 **Zones**

21 **SEC. 501. SHORT TITLE.**

22 This subtitle may be cited as the “Health Empower-
 23 ment Zone Act of 2009”.

24 **SEC. 502. FINDINGS.**

25 The Congress finds the following:

1 (1) Numerous studies and reports, including
2 the National Healthcare Disparities Report and Un-
3 equal Treatment, the 2002 Institute of Medicine Re-
4 port, document the extensiveness to which health
5 disparities exist across the country.

6 (2) These studies have found that, on average,
7 racial and ethnic minorities are disproportionately
8 afflicted with chronic and acute conditions—such as
9 cancer, diabetes, and hypertension—and suffer
10 worse health outcomes, worse health status, and
11 higher mortality rates than their White counter-
12 parts.

13 (3) Several recent studies also show that health
14 disparities are a function of not only access to health
15 care, but also the social determinants of health—in-
16 cluding the environment, the physical structure of
17 communities, nutrition and food options, educational
18 attainment, employment, race, ethnicity, geography,
19 and language preference—that directly and indi-
20 rectly affect the health, health care, and wellness of
21 individuals and communities.

22 (4) Integrally involving and fully supporting the
23 communities most affected by health inequities in
24 the assessment, planning, launch, and evaluation of
25 health disparity elimination efforts is among the

1 leading recommendations made to adequately ad-
2 dress and ultimately reduce health disparities.

3 (5) Recommendations also include supporting
4 the efforts of community stakeholders from a broad
5 cross-section—including, but not limited to local
6 businesses, local departments of commerce, edu-
7 cation, labor, urban planning, and transportation,
8 and community-based and other nonprofit organiza-
9 tions—to find areas of common ground around
10 health disparity elimination and collaborate to im-
11 prove the overall health and wellness of a community
12 and its residents.

13 **SEC. 503. DESIGNATION OF HEALTH EMPOWERMENT**
14 **ZONES.**

15 (a) IN GENERAL.—At the request of an eligible com-
16 munity partnership, the Secretary may designate an eligi-
17 ble area as a health empowerment zone.

18 (b) ELIGIBILITY CRITERIA.—

19 (1) ELIGIBLE COMMUNITY PARTNERSHIP.—A
20 community partnership is eligible to submit a re-
21 quest under this section if the partnership—

22 (A) demonstrates widespread public sup-
23 port from key individuals and entities in the eli-
24 gible area, including State and local govern-
25 ments, nonprofit organizations, and community

1 and industry leaders, for designation of the eli-
2 gible area as a health empowerment zone; and

3 (B) includes representatives of—

4 (i) a broad cross section of stake-
5 holders and residents from communities in
6 the eligible area experiencing dispropor-
7 tionate disparities in health status and
8 health care; and

9 (ii) organizations, facilities, and insti-
10 tutions that have a history of working
11 within and serving such communities.

12 (2) ELIGIBLE AREA.—An area is eligible to be
13 designated as a health empowerment zone under this
14 section if one or more communities in the area expe-
15 rience disproportionate disparities in health status
16 and health care. In determining whether a commu-
17 nity experiences such disparities, the Secretary shall
18 consider the data collected by the Department of
19 Health and Human Services focusing on the fol-
20 lowing areas:

21 (A) Access to high-quality health services.

22 (B) Arthritis, osteoporosis, and chronic
23 back conditions.

24 (C) Cancer.

25 (D) Chronic kidney disease.

- 1 (E) Diabetes.
- 2 (F) Injury and violence prevention.
- 3 (G) Maternal, infant, and child health.
- 4 (H) Medical product safety.
- 5 (I) Mental health and mental disorders.
- 6 (J) Nutrition and overweight.
- 7 (K) Disability and secondary conditions.
- 8 (L) Educational and community-based
- 9 health programs.
- 10 (M) Environmental health.
- 11 (N) Family planning.
- 12 (O) Food safety.
- 13 (P) Health communication.
- 14 (Q) Health disease and stroke.
- 15 (R) HIV/AIDS.
- 16 (S) Immunization and infectious diseases.
- 17 (T) Occupational safety and health.
- 18 (U) Oral health.
- 19 (V) Physical activity and fitness.
- 20 (W) Public health infrastructure.
- 21 (X) Respiratory diseases.
- 22 (Y) Sexually transmitted diseases.
- 23 (Z) Substance abuse.
- 24 (AA) Tobacco use.
- 25 (BB) Vision and hearing.

1 (c) PROCEDURE.—

2 (1) REQUEST.—A request under subsection (a)
3 shall—

4 (A) describe the bounds of the area to be
5 designated as a health empowerment zone and
6 the process used to select those bounds;

7 (B) demonstrate that the partnership sub-
8 mitting the request is an eligible community
9 partnership described in subsection (b)(1);

10 (C) demonstrate that the area is an eligible
11 area described in subsection (b)(2);

12 (D) include a comprehensive assessment of
13 disparities in health status and health care ex-
14 perience by one or more communities in the
15 area;

16 (E) set forth—

17 (i) a vision and a set of values for the
18 area; and

19 (ii) a comprehensive and holistic set of
20 goals to be achieved in the area through
21 designation as a health empowerment zone;
22 and

23 (F) include a strategic plan for achieving
24 the goals described in subparagraph (E)(ii).

1 (2) APPROVAL.—Not later than 60 days after
2 the receipt of a request for designation of an area
3 as a health empowerment zone under this section,
4 the Secretary shall approve or disapprove the re-
5 quest.

6 (d) MINIMUM NUMBER.—The Secretary—

7 (1) shall designate not more than 110 health
8 empowerment zones under this section; and

9 (2) shall designate at least one health empower-
10 ment zone in each of the several States, the District
11 of Columbia, and each territory or possession of the
12 United States.

13 **SEC. 504. ASSISTANCE TO THOSE SEEKING DESIGNATION.**

14 At the request of any organization or entity seeking
15 to submit a request under section 503(a), the Secretary
16 shall provide technical assistance, and may award a grant,
17 to assist such organization or entity—

18 (1) to form an eligible community partnership
19 described in section 503(b)(1);

20 (2) to complete a health assessment, including
21 an assessment of health disparities under section
22 503(c)(1)(D); or

23 (3) to prepare and submit a request, including
24 a strategic plan, in accordance with section 503.

1 **SEC. 505. BENEFITS OF DESIGNATION.**

2 (a) PRIORITY.—In awarding any competitive grant,
3 a Federal official shall give priority to any applicant
4 that—

5 (1) meets the eligibility criteria for the grant;

6 (2) proposes to use the grant for activities in a
7 health empowerment zone; and

8 (3) demonstrates that such activities will di-
9 rectly and significantly further the goals of the stra-
10 tegic plan approved for such zone under section 503.

11 (b) GRANTS FOR INITIAL IMPLEMENTATION OF
12 STRATEGIC PLAN.—

13 (1) IN GENERAL.—Upon designating an eligible
14 area as a health empowerment zone at the request
15 of an eligible community partnership, the Secretary
16 shall, subject to the availability of appropriations,
17 make a grant to the community partnership for im-
18 plementation of the strategic plan for such zone.

19 (2) GRANT PERIOD.—A grant under paragraph
20 (1) for a health empowerment zone shall be for a pe-
21 riod of 2 years and may be renewed, except that the
22 total period of grants under paragraph (1) for such
23 zone may not exceed 10 years.

24 (3) LIMITATION.—In awarding grants under
25 this subsection, the Secretary shall not give less pri-
26 ority to an applicant or reduce the amount of a

1 grant because the Secretary rendered technical as-
2 sistance or made a grant to the same applicant
3 under section 504.

4 (4) REPORTING.—The Secretary shall require
5 each recipient of a grant under this subsection to re-
6 port to the Secretary not less than every 6 months
7 on the progress in implementing the strategic plan
8 for the health empowerment zone.

9 **SEC. 506. DEFINITION.**

10 In this subtitle, the term “Secretary” means the Sec-
11 retary of Health and Human Services, acting through the
12 Administrator of the Health Resources and Services Ad-
13 ministration and the Director of the Office of Minority
14 Health, and in cooperation with the Director of the Office
15 of Community Services and the Director of the National
16 Institute for Minority Health and Health Disparities.

17 **SEC. 507. AUTHORIZATION OF APPROPRIATIONS.**

18 To carry out this subtitle, there is authorized to be
19 appropriated \$100,000,000 for fiscal year 2010.

1 **Subtitle B—Other Improvements of**
2 **Health Care Services**

3 **CHAPTER 1—IN GENERAL**

4 **SEC. 511. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
5 **ACT.**

6 Title XXXI of the Public Health Service Act, as
7 amended by titles II, III, and IV of this Act, is further
8 amended by adding at the end the following:

9 **“Subtitle D—Reconstruction and**
10 **Improvement Grants for Public**
11 **Health Care Facilities Serving**
12 **Pacific Islanders and the Insu-**
13 **lar Areas**

14 **“SEC. 3151. GRANT SUPPORT FOR QUALITY IMPROVEMENT**
15 **INITIATIVES.**

16 “(a) IN GENERAL.—The Secretary, in collaboration
17 with the Administrator of the Health Resources and Serv-
18 ices Administration, the Director of the Agency for
19 Healthcare Research and Quality, and the Administrator
20 of the Centers for Medicare & Medicaid Services, shall
21 award grants to eligible entities for the conduct of dem-
22 onstration projects to improve the quality of and access
23 to health care.

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

1 “(1) be a health center, hospital, health plan,
2 health system, community clinic. or other health en-
3 tity determined appropriate by the Secretary—

4 “(A) that, by legal mandate or explicitly
5 adopted mission, provides patients with access
6 to services regardless of their ability to pay;

7 “(B) that provides care or treatment for a
8 substantial number of patients who are unin-
9 sured, are receiving assistance under a State
10 program under title XIX of the Social Security
11 Act, or are members of vulnerable populations,
12 as determined by the Secretary; and

13 “(C)(i) with respect to which, not less than
14 50 percent of the entity’s patient population is
15 made up of racial and ethnic minorities; or

16 “(ii) that—

17 “(I) serves a disproportionate percent-
18 age of local, minority racial and ethnic pa-
19 tients, or that has a patient population, at
20 least 50 percent of which is limited English
21 proficient; and

22 “(II) provides an assurance that
23 amounts received under the grant will be
24 used only to support quality improvement

1 activities in the racial and ethnic popu-
2 lation served; and

3 “(2) prepare and submit to the Secretary an
4 application at such time, in such manner, and con-
5 taining such information as the Secretary may re-
6 quire.

7 “(c) PRIORITY.—In awarding grants under sub-
8 section (a), the Secretary shall give priority to applicants
9 under subsection (b)(2) that—

10 “(1) demonstrate an intent to operate as part
11 of a health care partnership, network, collaborative,
12 coalition, or alliance where each member entity con-
13 tributes to the design, implementation, and evalua-
14 tion of the proposed intervention; or

15 “(2) intend to use funds to carry out system-
16 wide changes with respect to health care quality im-
17 provement, including—

18 “(A) improved systems for data collection
19 and reporting;

20 “(B) innovative collaborative or similar
21 processes;

22 “(C) group programs with behavioral or
23 self-management interventions;

24 “(D) case management services;

1 “(E) physician or patient reminder sys-
2 tems;

3 “(F) educational interventions; or

4 “(G) other activities determined appro-
5 priate by the Secretary.

6 “(d) USE OF FUNDS.—An entity shall use amounts
7 received under a grant under subsection (a) to support
8 the implementation and evaluation of health care quality
9 improvement activities or minority health and health care
10 disparity reduction activities that include—

11 “(1) with respect to health care systems, activi-
12 ties relating to improving—

13 “(A) patient safety;

14 “(B) timeliness of care;

15 “(C) effectiveness of care;

16 “(D) efficiency of care;

17 “(E) patient centeredness; and

18 “(F) health information technology; and

19 “(2) with respect to patients, activities relating
20 to—

21 “(A) staying healthy;

22 “(B) getting well;

23 “(C) living with illness or disability; and

24 “(D) coping with end of life issues.

1 “(e) COMMON DATA SYSTEMS.—The Secretary shall
2 provide financial and other technical assistance to grant-
3 ees under this section for the development of common data
4 systems.

5 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated to carry out this section,
7 such sums as may be necessary for each of fiscal years
8 2010 through 2015.

9 **“SEC. 3152. CENTERS OF EXCELLENCE.**

10 “(a) IN GENERAL.—The Secretary, acting through
11 the Administrator of the Health Resources and Services
12 Administration, shall designate centers of excellence at
13 public hospitals, and other health systems serving large
14 numbers of minority patients, that—

15 “(1) meet the requirements of section
16 3151(b)(1);

17 “(2) demonstrate excellence in providing care to
18 minority populations; and

19 “(3) demonstrate excellence in reducing dispari-
20 ties in health and health care.

21 “(b) REQUIREMENTS.—A hospital or health system
22 that serves as a Center of Excellence under subsection (a)
23 shall—

24 “(1) design, implement, and evaluate programs
25 and policies relating to the delivery of care in ra-

1 cially, ethnically, and linguistically diverse popu-
2 lations;

3 “(2) provide training and technical assistance
4 to other hospitals and health systems relating to the
5 provision of quality health care to minority popu-
6 lations; and

7 “(3) develop activities for graduate or con-
8 tinuing medical education that institutionalize a
9 focus on cultural competence training for health care
10 providers.

11 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated to carry out this section,
13 such sums as may be necessary for each of fiscal years
14 2010 through 2015.

15 **“SEC. 3153. RECONSTRUCTION AND IMPROVEMENT GRANTS**
16 **FOR PUBLIC HEALTH CARE FACILITIES SERV-**
17 **ING PACIFIC ISLANDERS AND THE INSULAR**
18 **AREAS.**

19 “(a) IN GENERAL.—The Secretary shall provide di-
20 rect financial assistance to designated health care pro-
21 viders and community health centers in American Samoa,
22 Guam, the Commonwealth of the Northern Mariana Is-
23 lands, the United States Virgin Islands, Puerto Rico, and
24 Hawaii for the purposes of reconstructing and improving
25 health care facilities and services.

1 “(b) ELIGIBILITY.—To be eligible to receive direct fi-
2 nancial assistance under subsection (a), an entity shall be
3 a public health facility or community health center located
4 in American Samoa, Guam, or the Commonwealth of the
5 Northern Mariana Islands, the United States Virgin Is-
6 lands, Puerto Rico, and Hawaii that—

7 “(1) is owned or operated by—

8 “(A) the government of American Samoa,
9 Guam, or the Commonwealth of the Northern
10 Mariana Islands, the United States Virgin Is-
11 lands, Puerto Rico, and Hawaii or a unit of
12 local government; or

13 “(B) a nonprofit organization; and

14 “(2)(A) provides care or treatment for a sub-
15 stantial number of patients who are uninsured, re-
16 ceiving assistance under a State program under a
17 title XVIII of the Social Security Act, or a State
18 program under title XIX of such Act, or who are
19 members of a vulnerable population, as determined
20 by the Secretary; or

21 “(B) serves a disproportionate percentage of
22 local, minority racial and ethnic patients.

23 “(c) REPORT.—Not later than 180 days after the
24 date of enactment of this title and annually thereafter, the
25 Secretary shall submit to the Congress and the President

1 a report that includes an assessment of health resources
2 and facilities serving populations in American Samoa,
3 Guam, and the Commonwealth of the Northern Mariana
4 Islands, the United States Virgin Islands, Puerto Rico,
5 and Hawaii. In preparing such report, the Secretary
6 shall—

7 “(1) consult with and obtain information on all
8 health care facilities needs from the entities de-
9 scribed in subsection (b);

10 “(2) include all amounts of Federal assistance
11 received by each entity in the preceding fiscal year;

12 “(3) review the total unmet needs of each juris-
13 diction for health care facilities, including needs for
14 renovation and expansion of existing facilities; and

15 “(4) include a strategic plan for addressing the
16 needs of each jurisdiction identified in the report.

17 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated such sums as necessary
19 to carry out this section.”.

20 **SEC. 512. MEDICAID PAYMENT FOR CERTAIN ALIENS.**

21 (a) MEDICAID.—Section 1903(v) of the Social Secu-
22 rity Act (42 U.S.C. 1396b(v)) is amended by striking
23 paragraph (4) and inserting the following:

24 “(4)(A) Notwithstanding sections 401(a), 402(b),
25 403, and 421 of Public Law 104–193, payment shall be

1 made under this section for care and services that are fur-
2 nished to individuals, if they who otherwise meet the eligi-
3 bility requirements for medical assistance under the State
4 plan approved under this title (other than the requirement
5 of the receipt of aid or assistance under title IV, supple-
6 mental security income benefits under title XVI, or a State
7 supplementary payment), and are—

8 “(i) lawfully present in the United States;

9 “(ii) children under age 21, including optional
10 targeted low-income children described in section
11 1905(u)(2)(B); or

12 “(iii) pregnant women during pregnancy (and
13 during the 60-day period beginning on the last day
14 of the pregnancy).

15 “(B) No debt shall accrue under an affidavit of sup-
16 port against any sponsor of such individual on the basis
17 of provision of medical assistance and the cost of such as-
18 sistance shall not be considered as an unreimbursed
19 cost.”.

20 (b) SCHIP.—Section 2107(e)(1) of the Social Secu-
21 rity Act (42 U.S.C. 1397gg(e)(1)) is amended by striking
22 subparagraph (H) and inserting the following:

23 “(H) Paragraph (4) of section 1903(v) (re-
24 lating to individuals who, but for sections
25 401(a), 403, and 421 of Public Law 104–193

1 would be eligible for medical assistance under
2 title XXI).”.

3 (c) CONFORMING AMENDMENT.—Section 1137(f) of
4 such Act (42 U.S.C. 1320b–7(f)) is amended by inserting
5 “and for medical assistance provided to children and preg-
6 nant women” before the period at the end.

7 **SEC. 513. MEDICAID PAYMENT PARITY FOR THE TERRI-**
8 **TORIES.**

9 (a) ELIMINATION OF FUNDING LIMITATIONS FOR
10 PUERTO RICO, THE VIRGIN ISLANDS, GUAM, THE NORTH-
11 ERN MARIANA ISLANDS, AND AMERICAN SAMOA.—

12 (1) IN GENERAL.—Section 1108 of the Social
13 Security Act (42 U.S.C. 1308) is amended—

14 (A) in subsection (f), in the matter before
15 paragraph (1), by striking “subsection (g)” and
16 inserting “subsections (g) and (h)”;

17 (B) in subsection (g)(2), in the matter be-
18 fore subparagraph (A), by inserting “and sub-
19 section (h)” after “paragraph (3)”; and

20 (C) by adding at the end the following new
21 subsection:

22 “(h) SUNSET OF FUNDING LIMITATIONS FOR PUER-
23 TO RICO, THE VIRGIN ISLANDS, GUAM, THE NORTHERN
24 MARIANA ISLANDS, AND AMERICAN SAMOA.—Subsections
25 (f) and (g) shall not apply to Puerto Rico, the Virgin Is-

1 lands, Guam, the Northern Mariana Islands, and Amer-
2 ican Samoa for any fiscal year after fiscal year 2009.”.

3 (2) CONFORMING AMENDMENT.—Section
4 1903(u) of such Act (42 U.S.C. 1396c(u)) is amend-
5 ed by striking paragraph (4).

6 (3) EFFECTIVE DATE.—The amendments made
7 by this subsection shall apply beginning with fiscal
8 year 2010.

9 (b) PARITY IN FMAP.—

10 (1) IN GENERAL.—Section 1905(b)(2) of such
11 Act (42 U.S.C. 1396d(b)(2)) is amended by insert-
12 ing after “50 per centum” the following: “(except
13 that, beginning with fiscal year 2012, the Federal
14 medical assistance percentage for Puerto Rico, the
15 Virgin Islands, Guam, the Northern Mariana Is-
16 lands, and American Samoa shall be the Federal
17 medical assistance percentage determined by the
18 Secretary in consultation (for the Virgin Islands,
19 Guam, the Northern Mariana Islands, and American
20 Samoa) with the Secretary of the Interior)”.

21 (2) 2-FISCAL-YEAR TRANSITION.—Notwith-
22 standing any other provision of law, during fiscal
23 years 2010 and 2011, the Federal medical assist-
24 ance percentage established under section 1905(b) of
25 the Social Security Act (42 U.S.C. 1396d(b)) for

1 Puerto Rico, the Virgin Islands, Guam, the North-
2 ern Mariana Islands, and American Samoa shall be
3 the highest such Federal medical assistance percent-
4 age applicable to any of the 50 States or the District
5 of Columbia for the fiscal year involved, taking into
6 account the application of subsections (a) and (b)(1)
7 of 5001 of division B of the American Recovery and
8 Reinvestment Act of 2009 (Public Law 111–5) to
9 such States and District for calendar quarters dur-
10 ing such fiscal years for which such subsections
11 apply respectively.

12 (3) PER CAPITA INCOME DATA.—

13 (A) REPORT TO CONGRESS.—Not later
14 than October 1, 2010, the Secretary of Health
15 and Human Services shall submit to Congress
16 a report that describes the per capita income
17 data used to promulgate the Federal medical
18 assistance percentage in the territories and how
19 such data differ from the per capita income
20 data used to promulgate Federal medical assist-
21 ance percentages for the 50 States and the Dis-
22 trict of Columbia. The report should include
23 recommendations on how the Federal medical
24 assistance percentages can be calculated for the

1 territories to ensure parity with the 50 States
2 and the District of Columbia.

3 (B) APPLICATION.—Section 1101(a)(8)(B)
4 of the Social Security Act (42 U.S.C.
5 1308(a)(8)(B)) is amended—

6 (i) by striking “(other than Puerto
7 Rico, the Virgin Islands, and Guam)” and
8 inserting “(including Puerto Rico, the Vir-
9 gin Islands, Guam, the Northern Mariana
10 Islands, and American Samoa)”; and

11 (ii) by inserting “(or, if such satisfac-
12 tory data are not available in the case of
13 the Virgin Islands, Guam, the Northern
14 Mariana Islands, or American Samoa, sat-
15 isfactory data available from the Depart-
16 ment of the Interior for the same period,
17 or if such satisfactory data are not avail-
18 able in the case of Puerto Rico, satisfac-
19 tory data available from the government of
20 the Commonwealth of Puerto Rico for the
21 same period)” after “Department of Com-
22 merce”.

23 (4) RELATION TO AMERICAN RECOVERY AND
24 REINVESTMENT ACT OF 2009.—For any period and
25 territory in which the provisions of this subsection

1 apply to a territory, the provisions of section
2 5001(b)(2) of division B of the American Recovery
3 and Reinvestment Act of 2009 (Public Law 111–5)
4 shall not apply (except as otherwise specifically pro-
5 vided in paragraph (2)).

6 **SEC. 514. EXTENSION OF MEDICARE SECONDARY PAYER.**

7 (a) IN GENERAL.—Section 1862(b)(1)(C) of the So-
8 cial Security Act (42 U.S.C. 1395y(b)(1)(C)) is amend-
9 ed—

10 (1) in the last sentence, by inserting “, and be-
11 fore January 1, 2010” after “prior to such date”;
12 and

13 (2) by adding at the end the following new sen-
14 tence: “Effective for items and services furnished on
15 or after January 1, 2010 (with respect to periods
16 beginning on or after the date that is 42 months
17 prior to such date), clauses (i) and (ii) shall be ap-
18 plied by substituting ‘42-month’ for ‘12-month’ each
19 place it appears in the first sentence.”.

20 (b) EFFECTIVE DATE.—The amendments made by
21 this subsection shall take effect on the date of enactment
22 of this Act. For purposes of determining an individual’s
23 status under section 1862(b)(1)(C) of the Social Security
24 Act (42 U.S.C. 1395y(b)(1)(C)), as amended by para-
25 graph (1), an individual who is within the coordinating

1 period as of the date of enactment of this Act shall have
2 that period extended to the full 42 months described in
3 the last sentence of such section, as added by the amend-
4 ment made by paragraph (1)(B).

5 **SEC. 515. BORDER HEALTH GRANTS.**

6 (a) ELIGIBLE ENTITY DEFINED.—In this section,
7 the term “eligible entity” means a State, public institution
8 of higher education, local government, tribal government,
9 nonprofit health organization, community health center, or
10 community clinic receiving assistance under section 330
11 of the Public Health Service Act (42 U.S.C. 254b), that
12 is located in the border area.

13 (b) AUTHORIZATION.—From funds appropriated
14 under subsection (f), the Secretary of Health and Human
15 Services (in this section referred to as the “Secretary”),
16 acting through the United States members of the United
17 States-Mexico Border Health Commission, shall award
18 grants to eligible entities to address priorities and rec-
19 ommendations to improve the health of border area resi-
20 dents that are established by—

- 21 (1) the United States members of the United
22 States-Mexico Border Health Commission;
23 (2) the State border health offices; and
24 (3) the Secretary.

1 (c) APPLICATION.—An eligible entity that desires a
2 grant under subsection (b) shall submit an application to
3 the Secretary at such time, in such manner, and con-
4 taining such information as the Secretary may require.

5 (d) USE OF FUNDS.—An eligible entity that receives
6 a grant under subsection (b) shall use the grant funds
7 for—

8 (1) programs relating to—

9 (A) maternal and child health;

10 (B) primary care and preventative health;

11 (C) public health and public health infra-
12 structure;

13 (D) health education and promotion;

14 (E) oral health;

15 (F) mental and behavioral health;

16 (G) substance abuse;

17 (H) health conditions that have a high
18 prevalence in the border area;

19 (I) medical and health services research;

20 (J) workforce training and development;

21 (K) community health workers or
22 promotoras;

23 (L) health care infrastructure problems in
24 the border area (including planning and con-
25 struction grants);

1 (M) health disparities in the border area;

2 (N) environmental health; and

3 (O) outreach and enrollment services with

4 respect to Federal programs (including pro-

5 grams authorized under titles XIX and XXI of

6 the Social Security Act (42 U.S.C. 1396 and

7 1397aa)); and

8 (2) other programs determined appropriate by

9 the Secretary.

10 (e) SUPPLEMENT, NOT SUPPLANT.—Amounts pro-

11 vided to an eligible entity awarded a grant under sub-

12 section (b) shall be used to supplement and not supplant

13 other funds available to the eligible entity to carry out the

14 activities described in subsection (d).

15 (f) AUTHORIZATION OF APPROPRIATIONS.—There

16 are authorized to be appropriated to carry out this section,

17 \$200,000,000 for fiscal year 2010, and such sums as may

18 be necessary for each succeeding fiscal year.

19 **SEC. 516. CANCER PREVENTION AND TREATMENT DEM-**

20 **ONSTRATION FOR ETHNIC AND RACIAL MI-**

21 **NORITIES.**

22 (a) DEMONSTRATION.—

23 (1) IN GENERAL.—The Secretary of Health and

24 Human Services (in this section referred to as the

25 “Secretary”) shall conduct demonstration projects

(in this section referred to as “demonstration projects”) for the purpose of developing models and evaluating methods that—

(A) improve the quality of items and services provided to target individuals in order to facilitate reduced disparities in early detection and treatment of cancer;

(B) improve clinical outcomes, satisfaction, quality of life, and appropriate use of Medicare-covered services and referral patterns among those target individuals with cancer;

(C) eliminate disparities in the rate of preventive cancer screening measures, such as pap smears, prostate cancer screenings, and CT scans for lung cancer among target individuals; and

(D) promote collaboration with community-based organizations to ensure cultural competency of health care professionals and linguistic access for persons with limited English proficiency.

(2) TARGET INDIVIDUAL DEFINED.—In this section, the term “target individual” means an individual of a racial and ethnic minority group, as defined by section 1707 of the Public Health Service

1 Act (42 U.S.C. 300u–6) who is entitled to benefits
2 under part A, and enrolled under part B, of title
3 XVIII of the Social Security Act.

4 (b) PROGRAM DESIGN.—

5 (1) INITIAL DESIGN.—Not later than 1 year
6 after the date of the enactment of this Act, the Sec-
7 retary shall evaluate best practices in the private
8 sector, community programs, and academic research
9 of methods that reduce disparities among individuals
10 of racial and ethnic minority groups in the preven-
11 tion and treatment of cancer and shall design the
12 demonstration projects based on such evaluation.

13 (2) NUMBER AND PROJECT AREAS.—Not later
14 than 2 years after the date of the enactment of this
15 Act, the Secretary shall implement at least nine
16 demonstration projects, including the following:

17 (A) Two projects for each of the four fol-
18 lowing major racial and ethnic minority groups:

19 (i) American Indians and Alaska Na-
20 tives, Eskimos and Aleuts.

21 (ii) Asian Americans.

22 (iii) Blacks/African Americans.

23 (iv) Hispanic/Latino Americans.

24 (v) Native Hawaiians and other Pa-
25 cific Islanders.

1 The two projects must target different ethnic
2 subpopulations.

3 (B) One project within the Pacific Islands
4 or United States insular areas.

5 (C) At least one project each in a rural
6 area and inner-city area.

7 (3) EXPANSION OF PROJECTS; IMPLEMENTA-
8 TION OF DEMONSTRATION PROJECT RESULTS.—If
9 the initial report under subsection (c) contains an
10 evaluation that demonstration projects—

11 (A) reduce expenditures under the Medi-
12 care program under title XVIII of the Social
13 Security Act; or

14 (B) do not increase expenditures under the
15 Medicare program and reduce racial and ethnic
16 health disparities in the quality of health care
17 services provided to target individuals and in-
18 crease satisfaction of beneficiaries and health
19 care providers;

20 the Secretary shall continue the existing demonstra-
21 tion projects and may expand the number of dem-
22 onstration projects.

23 (c) REPORT TO CONGRESS.—

24 (1) IN GENERAL.—Not later than 2 years after
25 the date the Secretary implements the initial dem-

1 onstration projects, and biannually thereafter, the
2 Secretary shall submit to Congress a report regard-
3 ing the demonstration projects.

4 (2) CONTENTS OF REPORT.—Each report under
5 paragraph (1) shall include the following:

6 (A) A description of the demonstration
7 projects.

8 (B) An evaluation of—

9 (i) the cost-effectiveness of the dem-
10 onstration projects;

11 (ii) the quality of the health care serv-
12 ices provided to target individuals under
13 the demonstration projects; and

14 (iii) beneficiary and health care pro-
15 vider satisfaction under the demonstration
16 projects.

17 (C) Any other information regarding the
18 demonstration projects that the Secretary de-
19 termines to be appropriate.

20 (d) WAIVER AUTHORITY.—The Secretary shall waive
21 compliance with the requirements of title XVIII of the So-
22 cial Security Act to such extent and for such period as
23 the Secretary determines is necessary to conduct dem-
24 onstration projects.

1 **SEC. 517. GRANTS TO PROMOTE POSITIVE HEALTH BEHAV-**
2 **IORS IN WOMEN AND CHILDREN.**

3 Part P of title III of the Public Health Service Act
4 (42 U.S.C. 280g et seq.) is amended—

5 (1) by redesignating the second and third sec-
6 tions 399R (added by Public Laws 110–373 and
7 110–374) as sections 399S and 399T, respectively;
8 and

9 (2) by adding at the end the following:

10 **“SEC. 399U. GRANTS TO PROMOTE POSITIVE HEALTH BE-**
11 **HAVIORS IN WOMEN AND CHILDREN.**

12 “(a) GRANTS AUTHORIZED.—The Secretary, in col-
13 laboration with the Director of the Centers for Disease
14 Control and Prevention and other Federal officials deter-
15 mined appropriate by the Secretary, is authorized to
16 award grants to eligible entities to promote positive health
17 behaviors for women and children in target populations,
18 especially racial and ethnic minority women and children
19 in medically underserved communities.

20 “(b) USE OF FUNDS.—Grants awarded pursuant to
21 subsection (a) may be used to support community health
22 workers—

23 “(1) to educate and provide outreach regarding
24 enrollment in health insurance including the State
25 Children’s Health Insurance Program under title
26 XXI of the Social Security Act, Medicare under title

1 XVIII of such Act, and Medicaid under title XIX of
2 such Act;

3 “(2) to educate, guide, and provide outreach in
4 a community setting regarding health problems prev-
5 alent among women and children and especially
6 among racial and ethnic minority women and chil-
7 dren;

8 “(3) to educate, guide, and provide experiential
9 learning opportunities that target behavioral risk
10 factors including—

11 “(A) poor nutrition;

12 “(B) physical inactivity;

13 “(C) being overweight or obese;

14 “(D) tobacco use;

15 “(E) alcohol and substance use;

16 “(F) injury and violence;

17 “(G) risky sexual behavior;

18 “(H) mental health problems;

19 “(I) dental and oral health problems; and

20 “(J) understanding informed consent;

21 “(4) to educate and guide regarding effective
22 strategies to promote positive health behaviors with-
23 in the family;

24 “(5) to promote community wellness and aware-
25 ness; and

1 “(6) to educate and refer target populations to
2 appropriate health care agencies and community-
3 based programs and organizations in order to in-
4 crease access to quality health care services, includ-
5 ing preventive health services.

6 “(c) APPLICATION.—

7 “(1) IN GENERAL.—Each eligible entity that
8 desires to receive a grant under subsection (a) shall
9 submit an application to the Secretary, at such time,
10 in such manner, and accompanied by such additional
11 information as the Secretary may require.

12 “(2) CONTENTS.—Each application submitted
13 pursuant to paragraph (1) shall—

14 “(A) describe the activities for which as-
15 sistance under this section is sought;

16 “(B) contain an assurance that with re-
17 spect to each community health worker pro-
18 gram receiving funds under the grant awarded,
19 such program provides training and supervision
20 to community health workers to enable such
21 workers to provide authorized program services;

22 “(C) contain an assurance that the appli-
23 cant will evaluate the effectiveness of commu-
24 nity health worker programs receiving funds
25 under the grant;

1 “(D) contain an assurance that each com-
2 munity health worker program receiving funds
3 under the grant will provide services in the cul-
4 tural context most appropriate for the individ-
5 uals served by the program;

6 “(E) contain a plan to document and dis-
7 seminate project description and results to
8 other States and organizations as identified by
9 the Secretary; and

10 “(F) describe plans to enhance the capac-
11 ity of individuals to utilize health services and
12 health-related social services under Federal,
13 State, and local programs by—

14 “(i) assisting individuals in estab-
15 lishing eligibility under the programs and
16 in receiving the services or other benefits
17 of the programs; and

18 “(ii) providing other services as the
19 Secretary determines to be appropriate,
20 that may include transportation and trans-
21 lation services.

22 “(d) PRIORITY.—In awarding grants under sub-
23 section (a), the Secretary shall give priority to those appli-
24 cants—

25 “(1) who propose to target geographic areas—

1 “(A) with a high percentage of residents
2 who are eligible for health insurance but are
3 uninsured or underinsured; and

4 “(B) with a high percentage of families for
5 whom English is not their primary language.

6 “(2) with experience in providing health or
7 health-related social services to individuals who are
8 underserved with respect to such services; and

9 “(3) with documented community activity and
10 experience with community health workers.

11 “(e) COLLABORATION WITH ACADEMIC INSTITU-
12 TIONS.—The Secretary shall encourage community health
13 worker programs receiving funds under this section to col-
14 laborate with academic institutions, including minority-
15 serving institutions. Nothing in this section shall be con-
16 strued to require such collaboration.

17 “(f) QUALITY ASSURANCE AND COST-EFFECTIVE-
18 NESS.—The Secretary shall establish guidelines for assur-
19 ing the quality of the training and supervision of commu-
20 nity health workers under the programs funded under this
21 section and for assuring the cost-effectiveness of such pro-
22 grams.

23 “(g) MONITORING.—The Secretary shall monitor
24 community health worker programs identified in approved
25 applications and shall determine whether such programs

1 are in compliance with the guidelines established under
2 subsection (f).

3 “(h) TECHNICAL ASSISTANCE.—The Secretary may
4 provide technical assistance to community health worker
5 programs identified in approved applications with respect
6 to planning, developing, and operating programs under the
7 grant.

8 “(i) REPORT TO CONGRESS.—

9 “(1) IN GENERAL.—Not later than 4 years
10 after the date on which the Secretary first awards
11 grants under subsection (a), the Secretary shall sub-
12 mit to Congress a report regarding the grant
13 project.

14 “(2) CONTENTS.—The report required under
15 paragraph (1) shall include the following:

16 “(A) A description of the programs for
17 which grant funds were used.

18 “(B) The number of individuals served.

19 “(C) An evaluation of—

20 “(i) the effectiveness of these pro-
21 grams;

22 “(ii) the cost of these programs; and

23 “(iii) the impact of the project on the
24 health outcomes of the community resi-
25 dents.

1 “(D) Recommendations for sustaining the
2 community health worker programs developed
3 or assisted under this section.

4 “(E) Recommendations regarding training
5 to enhance career opportunities for community
6 health workers.

7 “(j) DEFINITIONS.—In this section:

8 “(1) COMMUNITY HEALTH WORKER.—The term
9 ‘community health worker’ means an individual who
10 promotes health or nutrition within the community
11 in which the individual resides—

12 “(A) by serving as a liaison between com-
13 munities and health care agencies;

14 “(B) by providing guidance and social as-
15 sistance to community residents;

16 “(C) by enhancing community residents’
17 ability to effectively communicate with health
18 care providers;

19 “(D) by providing culturally and linguis-
20 tically appropriate health or nutrition edu-
21 cation;

22 “(E) by advocating for individual and com-
23 munity health, including dental, oral, mental,
24 and environmental health, or nutrition needs;
25 and

1 “(F) by providing referral and followup
2 services.

3 “(2) COMMUNITY SETTING.—The term ‘commu-
4 nity setting’ means a home or a community organi-
5 zation located in the neighborhood in which a partic-
6 ipant resides.

7 “(3) ELIGIBLE ENTITY.—The term ‘eligible en-
8 tity’ means—

9 “(A) a unit of State, territorial, local, or
10 tribal government (including a federally recog-
11 nized tribe or Alaska native villages); or

12 “(B) a community-based organization.

13 “(4) MEDICALLY UNDERSERVED COMMUNITY.—
14 The term ‘medically underserved community’ means
15 a community—

16 “(A) that has a substantial number of in-
17 dividuals who are members of a medically un-
18 derserved population, as defined by section
19 330(b)(3); and

20 “(B) a significant portion of which is a
21 health professional shortage area as designated
22 under section 332.

23 “(5) SUPPORT.—The term ‘support’ means the
24 provision of training, supervision, and materials
25 needed to effectively deliver the services described in

1 subsection (b), reimbursement for services, and
2 other benefits.

3 “(6) TARGET POPULATION.—The term ‘target
4 population’ means women of reproductive age, re-
5 gardless of their current childbearing status and
6 children under 21 years of age.

7 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated to carry out this section
9 \$15,000,000 for each of fiscal years 2010, 2011, 2012,
10 2013, and 2014.”.

11 **SEC. 518. EXCEPTION FOR CITIZENS OF FREELY ASSOCI-**
12 **ATED STATES.**

13 (a) IN GENERAL.—Section 402(a)(2) of the Personal
14 Responsibility and Work Opportunity Reconciliation Act
15 of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at
16 the end the following:

17 “(N) EXCEPTION FOR CITIZENS OF FREE-
18 LY ASSOCIATED STATES.—With respect to eligi-
19 bility for benefits for the specified Federal pro-
20 grams described in paragraph (3), paragraph
21 (1) shall not apply to any individual who law-
22 fully resides in the United States (including ter-
23 ritories and possessions of the United States) in
24 accordance with—

1 “(i) section 141 of the Compact of
2 Free Association between the Government
3 of the United States and the Government
4 of the Federated States of Micronesia, ap-
5 proved by Congress in the Compact of
6 Free Association Amendments Act of
7 2003;

8 “(ii) section 141 of the Compact of
9 Free Association between the Government
10 of the United States and the Government
11 of the Republic of the Marshall Islands,
12 approved by Congress in the Compact of
13 Free Association Amendments Act of
14 2003; or

15 “(iii) section 141 of the Compact of
16 Free Association between the Government
17 of the United States and the Government
18 of Palau, approved by Congress in Public
19 Law 99–658 (100 Stat. 3672).”.

20 (b) MEDICAID EXCEPTION.—Section 402(b)(2) of the
21 Personal Responsibility and Work Opportunity Reconcili-
22 ation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by
23 adding at the end the following:

24 “(G) MEDICAID EXCEPTIONS FOR CITI-
25 ZENS OF FREELY ASSOCIATED STATES.—With

1 respect to eligibility for benefits for the pro-
2 grams defined in subparagraphs (A) and (C) of
3 paragraph (3) (relating to Medicaid), paragraph
4 (1) shall not apply to any individual who law-
5 fully resides in the United States (including ter-
6 ritories and possessions of the United States) in
7 accordance with a Compact of Free Association
8 referred to in subsection (a)(2)(N).”.

9 (c) QUALIFIED ALIEN.—Section 431(b) of the Per-
10 sonal Responsibility and Work Opportunity Reconciliation
11 Act of 1996 (8 U.S.C. 1641(b)) is amended—

12 (1) in paragraph (6), by striking “or” at the
13 end;

14 (2) in paragraph (7), by striking the period at
15 the end and inserting “; or”; and

16 (3) by adding at the end the following:

17 “(8) an individual who lawfully resides in the
18 United States (including territories and possessions
19 of the United States) in accordance with a Compact
20 of Free Association referred to in section
21 402(a)(2)(N).”.

22 (d) INCREASED FMAP.—The third sentence of sec-
23 tion 1905(b) of the Social Security Act (42 U.S.C.
24 1396d(b)) is amended by inserting before the period at
25 the end the following: “and for services furnished to indi-

1 viduals described in section 431(b)(8) of the Personal Re-
2 sponsibility and Work Opportunity Reconciliation Act of
3 1996”.

4 **SEC. 519. MEDICARE GRADUATE MEDICAL EDUCATION.**

5 (a) CLARIFICATION OF CONGRESSIONAL INTENT RE-
6 GARDING THE COUNTING OF RESIDENTS IN A NONHOS-
7 PITAL SETTING.—

8 (1) D–GME.—Section 1886(h)(4)(E) of the So-
9 cial Security Act (42 U.S.C. 1395ww(h)(4)(E)) is
10 amended by adding at the end the following new
11 sentences: “For purposes of the preceding sentence,
12 the term ‘all, or substantially all, of the costs for the
13 training program’ means the stipends and benefits
14 provided to the resident and other amounts, if any,
15 as determined by the hospital and the entity oper-
16 ating the nonhospital setting. The hospital is not re-
17 quired to pay the entity any amounts other than
18 those determined by the hospital and the entity in
19 order for the hospital to be considered to have in-
20 curred all, or substantially all, of the costs for the
21 training program in that setting.”.

22 (2) IME.—Section 1886(d)(5)(B)(iv) of the So-
23 cial Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is
24 amended by adding at the end the following new
25 sentences: “For purposes of the preceding sentence,

1 the term ‘all, or substantially all, of the costs for the
2 training program’ means the stipends and benefits
3 provided to the resident and other amounts, if any,
4 as determined by the hospital and the entity oper-
5 ating the nonhospital setting. The hospital is not re-
6 quired to pay the entity any amounts other than
7 those determined by the hospital and the entity in
8 order for the hospital to be considered to have in-
9 curred all, or substantially all, of the costs for the
10 training program in that setting.”.

11 (3) EFFECTIVE DATE.—The amendments made
12 by this subsection shall take effect on January 1,
13 2010.

14 (b) CLARIFICATION OF ELIGIBILITY OF A NONRURAL
15 HOSPITAL THAT HAS A TRAINING PROGRAM WITH AN
16 INTEGRATED RURAL TRACK.—

17 (1) IN GENERAL.—Section 1886(h)(4)(H) of
18 the Social Security Act (42 U.S.C.
19 1395ww(h)(4)(H)) is amended—

20 (A) in clause (iv), by inserting “(as defined
21 in clause (vi))” after “an integrated rural
22 track”; and

23 (B) by adding at the end the following new
24 clause:

1 “(vi) DEFINITION OF ACCREDITED
2 TRAINING PROGRAM WITH AN INTEGRATED
3 RURAL TRACK.—For purposes of clause
4 (iv), the term ‘accredited training program
5 with an integrated rural track’ means an
6 accredited medical residency training pro-
7 gram located in an urban area which offers
8 a curriculum for all residents in the pro-
9 gram that includes the following character-
10 istics:

11 “(I) A minimum of 3 block
12 months of rural rotations. During
13 such 3 block months, the resident is
14 in a rural area for 4 weeks or a
15 month.

16 “(II) A stated mission for train-
17 ing rural physicians.

18 “(III) A minimum of 3 months of
19 obstetrical training, or an equivalent
20 longitudinal experience.

21 “(IV) A minimum of 4 months of
22 pediatric training that includes neo-
23 natal, ambulatory, inpatient, and
24 emergency experiences through rota-

1 tions, or an equivalent longitudinal ex-
2 perience.

3 “(V) A minimum of 2 months of
4 emergency medicine rotations, or an
5 equivalent longitudinal experience.”.

6 (2) EFFECTIVE DATE.—The amendments made
7 by this subsection apply with respect to—

8 (A) payments to hospitals under section
9 1886(h) of the Social Security Act (42 U.S.C.
10 1395ww(h)) for cost reporting periods begin-
11 ning on or after January 1, 2010; and

12 (B) payments to hospitals under section
13 1886(d)(5)(B)(v) of such Act (42 U.S.C.
14 1395ww(d)(5)(B)(v)) for discharges occurring
15 on or after January 1, 2010.

16 **SEC. 520. HIV/AIDS REDUCTION IN RACIAL AND ETHNIC MI-**
17 **NORITY COMMUNITIES.**

18 (a) EXPANDED FUNDING.—The Secretary, in col-
19 laboration with the Director of the Office of Minority
20 Health, the Director of the Centers for Disease Control
21 and Prevention, the Administrator of the Health Re-
22 sources and Services Administration, and the Adminis-
23 trator of the Substance Abuse and Mental Health Services
24 Administration, shall provide funds and carry out activi-
25 ties to expand the Minority HIV/AIDS Initiative.

1 (b) USE OF FUNDS.—The additional funds made
2 available under this section may be used, through the Mi-
3 nority AIDS Initiative, to support the following activities:

4 (1) Providing technical assistance and infra-
5 structure support to reduce HIV/AIDS in minority
6 populations.

7 (2) Increasing minority populations' access to
8 HIV/AIDS prevention and care services.

9 (3) Building strong community programs and
10 partnerships to address HIV prevention and the
11 health care needs of specific racial and ethnic minor-
12 ity populations.

13 (c) PRIORITY INTERVENTIONS.—Within the racial
14 and ethnic minority populations referred to in subsection
15 (b), priority in conducting intervention services shall be
16 given to—

17 (1) women;

18 (2) youth;

19 (3) men who engage in homosexual activity;

20 (4) persons who engage in intravenous drug
21 abuse;

22 (5) homeless individuals; and

23 (6) individuals incarcerated or in the penal sys-
24 tem.

1 (d) AUTHORIZATION OF APPROPRIATIONS.—For car-
2 rying out this section, there are authorized to be appro-
3 priated \$610,000,000 for fiscal year 2010 and such sums
4 as may be necessary for each of fiscal years 2011 through
5 2014.

6 **SEC. 521. GRANTS FOR RACIAL AND ETHNIC APPROACHES**
7 **TO COMMUNITY HEALTH.**

8 (a) PURPOSE.—It is the purpose of this section to
9 provide for the awarding of grants to assist communities
10 in mobilizing and organizing resources in support of effec-
11 tive and sustainable programs that will reduce or eliminate
12 disparities in health and healthcare experienced by racial
13 and ethnic minority individuals.

14 (b) AUTHORITY TO AWARD GRANTS.—The Sec-
15 retary, acting through the Centers for Disease Control and
16 Prevention, shall award grants to eligible entities to assist
17 in designing, implementing, and evaluating culturally and
18 linguistically appropriate, science-based and community-
19 driven sustainable strategies to eliminate racial and ethnic
20 health and healthcare disparities.

21 (c) ELIGIBLE ENTITIES.—To be eligible to receive a
22 grant under this section, an entity shall—

23 (1) represent a coalition—

24 (A) whose principal purpose is to develop
25 and implement interventions to reduce or elimi-

1 nate a health or healthcare disparity in a tar-
2 geted racial or ethnic minority group in the
3 community served by the coalition; and

4 (B) that includes—

5 (i) members selected from among—

6 (I) public health departments;

7 (II) community-based organiza-
8 tions;

9 (III) university and research or-
10 ganizations;

11 (IV) American Indian tribal or-
12 ganizations, national American Indian
13 organizations, Indian Health Service,
14 or organizations serving Alaska Na-
15 tives; and

16 (V) interested public or private
17 healthcare providers or organizations
18 as deemed appropriate by the Sec-
19 retary; and

20 (ii) at least 1 member from a commu-
21 nity-based organization that represents the
22 targeted racial or ethnic minority group;
23 and

24 (2) submit to the Secretary an application at
25 such time, in such manner, and containing such in-

1 formation as the Secretary may require, which shall
2 include—

3 (A) a description of the targeted racial or
4 ethnic populations in the community to be
5 served under the grant;

6 (B) a description of at least 1 health dis-
7 parity that exists in the racial or ethnic tar-
8 geted populations, including health issues such
9 as infant mortality, breast and cervical cancer
10 screening and management, cardiovascular dis-
11 ease, diabetes, child and adult immunization
12 levels, or other health priority area(s) as des-
13 ignated by the Secretary; and

14 (C) a demonstration of a proven record of
15 accomplishment of the coalition members in
16 serving and working with the targeted commu-
17 nity.

18 (d) SUSTAINABILITY.—The Secretary shall give pri-
19 ority to an eligible entity under this section if the entity
20 agrees that, with respect to the costs to be incurred by
21 the entity in carrying out the activities for which the grant
22 was awarded, the entity (and each of the participating
23 partners in the coalition represented by the entity) will
24 maintain its expenditures of non-Federal funds for such
25 activities at a level that is not less than the level of such

1 expenditures during the fiscal year immediately preceding
2 the first fiscal year for which the grant is awarded.

3 (e) NONDUPLICATION.—Funds provided through this
4 grant program should supplement, not supplant, existing
5 Federal funding, and the funds should not be used to du-
6 plicate the activities of the other health disparity grant
7 programs in this Act.

8 (f) TECHNICAL ASSISTANCE.—The Secretary may,
9 either directly or by grant or contract, provide any entity
10 that receives a grant under this section with technical and
11 other nonfinancial assistance necessary to meet the re-
12 quirements of this section.

13 (g) DISSEMINATION.—The Secretary shall encourage
14 and enable grantees to share best practices, evaluation re-
15 sults, and reports with communities not affiliated with
16 grantees using the Internet, conferences, and other perti-
17 nent information regarding the projects funded by this
18 section, including the outreach efforts of the Office of Mi-
19 nority Health and Health Disparity Elimination and the
20 Centers for Disease Control and Prevention.

21 (h) ADMINISTRATIVE BURDENS.—The Secretary
22 shall make every effort to minimize duplicative or unneces-
23 sary administrative burdens on grantees.

1 (i) AUTHORIZATION OF APPROPRIATIONS.—There
 2 are authorized to be appropriated such sums as may be
 3 necessary to carry out the Public Health Service Act.

4 **SEC. 522. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.**

5 (a) ELIMINATION OF ISOLATION TEST FOR COST-
 6 BASED AMBULANCE REIMBURSEMENT.—

7 (1) IN GENERAL.—Section 1834(l)(8) of the
 8 Social Security Act (42 U.S.C. 1395m(l)(8)) is
 9 amended—

10 (A) in subparagraph (B)—

11 (i) by striking “owned and”; and

12 (ii) by inserting “(including when
 13 such services are provided by the entity
 14 under an arrangement with the hospital)”
 15 after “hospital”; and

16 (B) by striking the comma at the end of
 17 subparagraph (B) and all that follows and in-
 18 serting a period.

19 (2) EFFECTIVE DATE.—The amendments made
 20 by this subsection shall apply to services furnished
 21 on or after January 1, 2010.

22 (b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE
 23 TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT
 24 REQUIREMENT.—

1 (1) IN GENERAL.—Section 1820(c)(2) of the
2 Social Security Act (42 U.S.C. 1395i–4(c)(2)) is
3 amended—

4 (A) in subparagraph (B)(iii), by striking
5 “provides not more than” and inserting “sub-
6 ject to subparagraph (F), provides not more
7 than”; and

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

10 “(F) ALTERNATIVE TO 25 INPATIENT BED
11 LIMIT REQUIREMENT.—

12 “(i) IN GENERAL.—A State may elect
13 to treat a facility, with respect to the des-
14 ignation of the facility for a cost reporting
15 period, as satisfying the requirement of
16 subparagraph (B)(iii) relating to a max-
17 imum number of acute care inpatient beds
18 if the facility elects, in accordance with a
19 method specified by the Secretary and be-
20 fore the beginning of the cost reporting pe-
21 riod, to meet the requirement under clause
22 (ii).

23 “(ii) ALTERNATE REQUIREMENT.—
24 The requirement under this clause, with
25 respect to a facility and a cost reporting

1 period, is that the total number of inpa-
2 tient bed days described in subparagraph
3 (B)(iii) during such period will not exceed
4 7,300. For purposes of this subparagraph,
5 an individual who is an inpatient in a bed
6 in the facility for a single day shall be
7 counted as one inpatient bed day.

8 “(iii) WITHDRAWAL OF ELECTION.—
9 The option described in clause (i) shall not
10 apply to a facility for a cost reporting pe-
11 riod if the facility (for any two consecutive
12 cost reporting periods during the previous
13 5 cost reporting periods) was treated under
14 such option and had a total number of in-
15 patient bed days for each of such two cost
16 reporting periods that exceeded the num-
17 ber specified in such clause.”.

18 (2) EFFECTIVE DATE.—The amendments made
19 by paragraph (1) shall apply to cost reporting peri-
20 ods beginning on or after the date of the enactment
21 of this Act.

1 **SEC. 523. COVERAGE OF MARRIAGE AND FAMILY THERA-**
2 **PIST SERVICES AND MENTAL HEALTH COUN-**
3 **SELOR SERVICES UNDER PART B OF THE**
4 **MEDICARE PROGRAM.**

5 (a) COVERAGE OF SERVICES.—

6 (1) IN GENERAL.—Section 1861(s)(2) of the
7 Social Security Act (42 U.S.C. 1395x(s)(2)) is
8 amended—

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

11 (B) in subparagraph (EE), by inserting
12 “and” at the end; and

13 (C) by adding at the end the following new
14 subparagraph:

15 “(FF) marriage and family therapist services
16 (as defined in subsection (ccc)(1)) and mental health
17 counselor services (as defined in subsection
18 (hhh)(3));”.

19 (2) DEFINITIONS.—Section 1861 of such Act
20 (42 U.S.C. 1395x) is amended by adding at the end
21 the following new subsection:

22 “Marriage and Family Therapist Services; Marriage and
23 Family Therapist; Mental Health Counselor Serv-
24 ices; Mental Health Counselor

25 “(hhh)(1) The term ‘marriage and family therapist
26 services’ means services performed by a marriage and

1 family therapist (as defined in paragraph (2)) for the diag-
2 nosis and treatment of mental illnesses, which the mar-
3 riage and family therapist is legally authorized to perform
4 under State law (or the State regulatory mechanism pro-
5 vided by State law) of the State in which such services
6 are performed, as would otherwise be covered if furnished
7 by a physician or as an incident to a physician's profes-
8 sional service, but only if no facility or other provider
9 charges or is paid any amounts with respect to the fur-
10 nishing of such services.

11 “(2) The term ‘marriage and family therapist’ means
12 an individual who—

13 “(A) possesses a master’s or doctoral degree
14 which qualifies for licensure or certification as a
15 marriage and family therapist pursuant to State
16 law;

17 “(B) after obtaining such degree has performed
18 at least 2 years of clinical supervised experience in
19 marriage and family therapy; and

20 “(C) in the case of an individual performing
21 services in a State that provides for licensure or cer-
22 tification of marriage and family therapists, is li-
23 censed or certified as a marriage and family thera-
24 pist in such State.

1 “(3) The term ‘mental health counselor services’
2 means services performed by a mental health counselor (as
3 defined in paragraph (4)) for the diagnosis and treatment
4 of mental illnesses which the mental health counselor is
5 legally authorized to perform under State law (or the
6 State regulatory mechanism provided by the State law) of
7 the State in which such services are performed, as would
8 otherwise be covered if furnished by a physician or as inci-
9 dent to a physician’s professional service, but only if no
10 facility or other provider charges or is paid any amounts
11 with respect to the furnishing of such services.

12 “(4) The term ‘mental health counselor’ means an
13 individual who—

14 “(A) possesses a master’s or doctor’s degree in
15 mental health counseling or a related field;

16 “(B) after obtaining such a degree has per-
17 formed at least 2 years of supervised mental health
18 counselor practice; and

19 “(C) in the case of an individual performing
20 services in a State that provides for licensure or cer-
21 tification of mental health counselors or professional
22 counselors, is licensed or certified as a mental health
23 counselor or professional counselor in such State.”.

24 (3) PROVISION FOR PAYMENT UNDER PART
25 B.—Section 1832(a)(2)(B) of such Act (42 U.S.C.

1 1395k(a)(2)(B)) is amended by adding at the end
2 the following new clause:

3 “(v) marriage and family therapist
4 services and mental health counselor serv-
5 ices;”.

6 (4) AMOUNT OF PAYMENT.—Section 1833(a)(1)
7 of such Act (42 U.S.C. 1395l(a)(1)) is amended—

8 (A) by striking “and (W)” and inserting
9 “(W)”; and

10 (B) by inserting before the semicolon at
11 the end the following: “, and (X) with respect
12 to marriage and family therapist services and
13 mental health counselor services under section
14 1861(s)(2)(FF), the amounts paid shall be 80
15 percent of the lesser of the actual charge for
16 the services or 75 percent of the amount deter-
17 mined for payment of a psychologist under sub-
18 paragraph (L)”.

19 (5) EXCLUSION OF MARRIAGE AND FAMILY
20 THERAPIST SERVICES AND MENTAL HEALTH COUN-
21 SELOR SERVICES FROM SKILLED NURSING FACILITY
22 PROSPECTIVE PAYMENT SYSTEM.—Section
23 1888(e)(2)(A)(ii) of such Act (42 U.S.C.
24 1395yy(e)(2)(A)(ii)) is amended by inserting “mar-
25 riage and family therapist services (as defined in

1 section 1861(hhh)(1)), mental health counselor serv-
2 ices (as defined in section 1861(hhh)(3)),” after
3 “qualified psychologist services,”.

4 (6) INCLUSION OF MARRIAGE AND FAMILY
5 THERAPISTS AND MENTAL HEALTH COUNSELORS AS
6 PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Sec-
7 tion 1842(b)(18)(C) of such Act (42 U.S.C.
8 1395u(b)(18)(C)) is amended by adding at the end
9 the following new clauses:

10 “(vii) A marriage and family therapist (as de-
11 fined in section 1861(hhh)(2)).

12 “(viii) A mental health counselor (as defined in
13 section 1861(hhh)(4)).”.

14 (b) COVERAGE OF CERTAIN MENTAL HEALTH SERV-
15 ICES PROVIDED IN CERTAIN SETTINGS.—

16 (1) RURAL HEALTH CLINICS AND FEDERALLY
17 QUALIFIED HEALTH CENTERS.—Section
18 1861(aa)(1)(B) of the Social Security Act (42
19 U.S.C. 1395x(aa)(1)(B)) is amended by striking “or
20 by a clinical social worker (as defined in subsection
21 (hh)(1)),” and inserting “, by a clinical social worker
22 (as defined in subsection (hh)(1)), by a marriage
23 and family therapist (as defined in subsection
24 (hhh)(2)), or by a mental health counselor (as de-
25 fined in subsection (hhh)(4)),”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to services furnished on or after January 1, 2010.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 523, is amended by adding at the end of the following new subsection:

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1 “(A) is located in a rural area (as defined in
2 section 1886(d)(2)(D)) or treated as being so lo-
3 cated pursuant to section 1886(d)(8)(E);

4 “(B) subject to paragraph (2), has less than 51
5 acute care inpatient beds, as reported in its most re-
6 cent cost report;

7 “(C) makes available 24-hour emergency care
8 services;

9 “(D) subject to paragraph (3), has a provider
10 agreement in effect with the Secretary and is open
11 to the public as of January 1, 2010; and

12 “(E) applies to the Secretary for such designa-
13 tion.

14 “(2) For purposes of paragraph (1)(B), beds in a
15 psychiatric or rehabilitation unit of the hospital which is
16 a distinct part of the hospital shall not be counted.

17 “(3) Subparagraph (1)(D) shall not be construed to
18 prohibit any of the following from qualifying as a rural
19 community hospital:

20 “(A) A replacement facility (as defined by the
21 Secretary in regulations in effect on January 1,
22 2010) with the same service area (as defined by the
23 Secretary in regulations in effect on such date).

24 “(B) A facility obtaining a new provider num-
25 ber pursuant to a change of ownership.

1 “(C) A facility which has a binding written
2 agreement with an outside, unrelated party for the
3 construction, reconstruction, lease, rental, or financ-
4 ing of a building as of January 1, 2010.

5 “(4) Nothing in this subsection shall be construed as
6 prohibiting a critical access hospital from qualifying as a
7 rural community hospital if the critical access hospital
8 meets the conditions otherwise applicable to hospitals
9 under subsection (e) and section 1866.

10 “(5) Nothing in this subsection shall be construed as
11 prohibiting a rural community hospital participating in
12 the demonstration program under Section 410A of the
13 Medicare Prescription Drug, Improvement, and Mod-
14 ernization Act of 2003 (Public Law 108–173; 117 Stat.
15 2313) from qualifying as a rural community hospital if
16 the rural community hospital meets the conditions other-
17 wise applicable to hospitals under subsection (e) and sec-
18 tion 1866.”.

19 (b) PAYMENT.—

20 (1) INPATIENT HOSPITAL SERVICES.—Section
21 1814 of the Social Security Act (42 U.S.C. 1395f)
22 is amended by adding at the end the following new
23 subsection:

1 “Payment for Inpatient Services Furnished in Rural
2 Community Hospitals

3 “(m) The amount of payment under this part for in-
4 patient hospital services furnished in a rural community
5 hospital, other than such services furnished in a psy-
6 chiatric or rehabilitation unit of the hospital which is a
7 distinct part, is, at the election of the hospital in the appli-
8 cation referred to in section 1861(iii)(1)(E)—

9 “(1) 101 percent of the reasonable costs of pro-
10 viding such services, without regard to the amount
11 of the customary or other charge, or

12 “(2) the amount of payment provided for under
13 the prospective payment system for inpatient hos-
14 pital services under section 1886(d).”.

15 (2) OUTPATIENT SERVICES.—Section 1834 of
16 such Act (42 U.S.C. 1395m) is amended by adding
17 at the end the following new subsection:

18 “(n) PAYMENT FOR OUTPATIENT SERVICES FUR-
19 NISHED IN RURAL COMMUNITY HOSPITALS.—The
20 amount of payment under this part for outpatient services
21 furnished in a rural community hospital is, at the election
22 of the hospital in the application referred to in section
23 1861(iii)(1)(E)—

24 “(1) 101 percent of the reasonable costs of pro-
25 viding such services, without regard to the amount

1 of the customary or other charge and any limitation
2 under section 1861(v)(1)(U), or

3 “(2) the amount of payment provided for under
4 the prospective payment system for covered OPD
5 services under section 1833(t).”.

6 (3) EXEMPTION FROM 30-PERCENT REDUCTION
7 IN REIMBURSEMENT FOR BAD DEBT.—Section
8 1861(v)(1)(T) of such Act (42 U.S.C.
9 1395x(v)(1)(T)) is amended by inserting “(other
10 than for a rural community hospital)” after “In de-
11 termining such reasonable costs for hospitals”.

12 (c) BENEFICIARY COST-SHARING FOR OUTPATIENT
13 SERVICES.—Section 1834(n) of such Act (as added by
14 subsection (b)(2)) is amended—

15 (1) by redesignating paragraphs (1) and (2) as
16 subparagraphs (A) and (B), respectively;

17 (2) by inserting “(1)” after “(n)”; and

18 (3) by adding at the end the following:

19 “(2) The amounts of beneficiary cost-sharing for out-
20 patient services furnished in a rural community hospital
21 under this part shall be as follows:

22 “(A) For items and services that would have
23 been paid under section 1833(t) if provided by a
24 hospital, the amount of cost-sharing determined
25 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 or supplier, no cost-sharing shall apply.

4 “(C) For all other items and services, the
5 amount of cost-sharing that would apply to the item
6 or service under the methodology that would be used
7 to determine payment for such item or service if pro-
8 vided by a physician, provider, or supplier, as the
9 case may be.”.

10 (d) CONFORMING AMENDMENTS.—

11 (1) PART A PAYMENT.—Section 1814(b) of
12 such Act (42 U.S.C. 1395f(b)) is amended in the
13 matter preceding paragraph (1) by inserting “other
14 than inpatient hospital services furnished by a rural
15 community hospital,” after “critical access hospital
16 services,”.

17 (2) PART B PAYMENT.—Section 1833(a) of
18 such Act (42 U.S.C. 1395l(a)) is amended—

19 (A) in paragraph (2), in the matter before
20 subparagraph (A), by striking “and (I)” and in-
21 serting “(I), and (K)”;

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

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

1 (D) by adding at the end the following:

2 “(10) in the case of outpatient services fur-
3 nished by a rural community hospital, the amounts
4 described in section 1834(n).”.

5 (3) TECHNICAL AMENDMENTS.—

6 (A) CONSULTATION WITH STATE AGEN-
7 CIES.—Section 1863 of such Act (42 U.S.C.
8 1395z) is amended by striking “and (dd)(2)”
9 and inserting “(dd)(2), (mm)(1), and (iii)(1)”.

10 (B) PROVIDER AGREEMENTS.—Section
11 1866(a)(2)(A) of such Act (42 U.S.C.
12 1395cc(a)(2)(A)) is amended by inserting “sec-
13 tion 1834(n)(2),” after “section 1833(b),”.

14 (e) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to items and services furnished on
16 or after October 1, 2009.

17 **SEC. 525. MEDICARE REMOTE MONITORING PILOT**
18 **PROJECTS.**

19 (a) PILOT PROJECTS.—

20 (1) IN GENERAL.—Not later than 9 months
21 after the date of enactment of this Act, the Sec-
22 retary of Health and Human Services (in this sec-
23 tion referred to as the “Secretary”) shall conduct
24 pilot projects under title XVIII of the Social Secu-
25 rity Act for the purpose of providing incentives to

1 home health agencies to utilize home monitoring and
2 communications technologies that—

3 (A) enhance health outcomes for Medicare
4 beneficiaries; and

5 (B) reduce expenditures under such title.

6 (2) SITE REQUIREMENTS.—

7 (A) URBAN AND RURAL.—The Secretary
8 shall conduct the pilot projects under this sec-
9 tion in both urban and rural areas.

10 (B) SITE IN A SMALL STATE.—The Sec-
11 retary shall conduct at least 3 of the pilot
12 projects in a State with a population of less
13 than 1,000,000.

14 (3) DEFINITION OF HOME HEALTH AGENCY.—

15 In this section, the term “home health agency” has
16 the meaning given that term in section 1861(o) of
17 the Social Security Act (42 U.S.C. 1395x(o)).

18 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE
19 OF PROJECTS.—The Secretary shall specify the criteria
20 for identifying those Medicare beneficiaries who shall be
21 considered within the scope of the pilot projects under this
22 section for purposes of the application of subsection (c)
23 and for the assessment of the effectiveness of the home
24 health agency in achieving the objectives of this section.
25 Such criteria may provide for the inclusion in the projects

1 of Medicare beneficiaries who begin receiving home health
2 services under title XVIII of the Social Security Act after
3 the date of the implementation of the projects.

4 (c) INCENTIVES.—

5 (1) PERFORMANCE TARGETS.—The Secretary
6 shall establish for each home health agency partici-
7 pating in a pilot project under this section a per-
8 formance target using one of the following meth-
9 odologies, as determined appropriate by the Sec-
10 retary:

11 (A) ADJUSTED HISTORICAL PERFORMANCE
12 TARGET.—The Secretary shall establish for the
13 agency—

14 (i) a base expenditure amount equal
15 to the average total payments made to the
16 agency under parts A and B of title XVIII
17 of the Social Security Act for Medicare
18 beneficiaries determined to be within the
19 scope of the pilot project in a base period
20 determined by the Secretary; and

21 (ii) an annual per capita expenditure
22 target for such beneficiaries, reflecting the
23 base expenditure amount adjusted for risk
24 and adjusted growth rates.

1 (B) COMPARATIVE PERFORMANCE TAR-
2 GET.—The Secretary shall establish for the
3 agency a comparative performance target equal
4 to the average total payments under such parts
5 A and B during the pilot project for comparable
6 individuals in the same geographic area that
7 are not determined to be within the scope of the
8 pilot project.

9 (2) INCENTIVE.—Subject to paragraph (3), the
10 Secretary shall pay to each participating home care
11 agency an incentive payment for each year under the
12 pilot project equal to a portion of the Medicare sav-
13 ings realized for such year relative to the perform-
14 ance target under paragraph (1).

15 (3) LIMITATION ON EXPENDITURES.—The Sec-
16 retary shall limit incentive payments under this sec-
17 tion in order to ensure that the aggregate expendi-
18 tures under title XVIII of the Social Security Act
19 (including incentive payments under this subsection)
20 do not exceed the amount that the Secretary esti-
21 mates would have been expended if the pilot projects
22 under this section had not been implemented.

23 (d) WAIVER AUTHORITY.—The Secretary may waive
24 such provisions of titles XI and XVIII of the Social Secu-

1 rity Act as the Secretary determines to be appropriate for
2 the conduct of the pilot projects under this section.

3 (e) REPORT TO CONGRESS.—Not later than 5 years
4 after the date that the first pilot project under this section
5 is implemented, the Secretary shall submit to Congress a
6 report on the pilot projects. Such report shall contain a
7 detailed description of issues related to the expansion of
8 the projects under subsection (f) and recommendations for
9 such legislation and administrative actions as the Sec-
10 retary considers appropriate.

11 (f) EXPANSION.—If the Secretary determines that
12 any of the pilot projects under this section enhance health
13 outcomes for Medicare beneficiaries and reduce expendi-
14 tures under title XVIII of the Social Security Act, the Sec-
15 retary may initiate comparable projects in additional
16 areas.

17 (g) INCENTIVE PAYMENTS HAVE NO EFFECT ON
18 OTHER MEDICARE PAYMENTS TO AGENCIES.—An incen-
19 tive payment under this section—

20 (1) shall be in addition to the payments that a
21 home health agency would otherwise receive under
22 title XVIII of the Social Security Act for the provi-
23 sion of home health services; and

24 (2) shall have no effect on the amount of such
25 payments.

1 **SEC. 526. RURAL HEALTH QUALITY ADVISORY COMMISSION**
2 **AND DEMONSTRATION PROJECTS.**

3 (a) RURAL HEALTH QUALITY ADVISORY COMMISS-
4 SION.—

5 (1) ESTABLISHMENT.—Not later than 6
6 months after the date of the enactment of this sec-
7 tion, the Secretary of Health and Human Services
8 (in this section referred to as the “Secretary”) shall
9 establish a commission to be known as the Rural
10 Health Quality Advisory Commission (in this section
11 referred to as the “Commission”).

12 (2) DUTIES OF COMMISSION.—

13 (A) NATIONAL PLAN.—The Commission
14 shall develop, coordinate, and facilitate imple-
15 mentation of a national plan for rural health
16 quality improvement. The national plan shall—

17 (i) identify objectives for rural health
18 quality improvement;

19 (ii) identify strategies to eliminate
20 known gaps in rural health system capacity
21 and improve rural health quality; and

22 (iii) provide for Federal programs to
23 identify opportunities for strengthening
24 and aligning policies and programs to im-
25 prove rural health quality.

1 (B) DEMONSTRATION PROJECTS.—The
2 Commission shall design demonstration projects
3 to test alternative models for rural health qual-
4 ity improvement, including with respect to both
5 personal and population health.

6 (C) MONITORING.—The Commission shall
7 monitor progress toward the objectives identi-
8 fied pursuant to paragraph (1)(A).

9 (3) MEMBERSHIP.—

10 (A) NUMBER.—The Commission shall be
11 composed of 11 members appointed by the Sec-
12 retary.

13 (B) SELECTION.—The Secretary shall se-
14 lect the members of the Commission from
15 among individuals with significant rural health
16 care and health care quality expertise, including
17 expertise in clinical health care, health care
18 quality research, population or public health, or
19 purchaser organizations.

20 (4) CONTRACTING AUTHORITY.—Subject to the
21 availability of funds, the Commission may enter into
22 contracts and make other arrangements, as may be
23 necessary to carry out the duties described in para-
24 graph (2).

1 (5) STAFF.—Upon the request of the Commis-
2 sion, the Secretary may detail, on a reimbursable
3 basis, any of the personnel of the Office of Rural
4 Health Policy of the Health Resources and Services
5 Administration, the Agency for Health Care Quality
6 and Research, or the Centers for Medicare & Med-
7 icaid Services to the Commission to assist in car-
8 rying out this subsection.

9 (6) REPORTS TO CONGRESS.—Not later than 1
10 year after the establishment of the Commission, and
11 annually thereafter, the Commission shall submit a
12 report to the Congress on rural health quality. Each
13 such report shall include the following:

14 (A) An inventory of relevant programs and
15 recommendations for improved coordination and
16 integration of policy and programs.

17 (B) An assessment of achievement of the
18 objectives identified in the national plan devel-
19 oped under paragraph (2) and recommenda-
20 tions for realizing such objectives.

21 (C) Recommendations on Federal legisla-
22 tion, regulations, or administrative policies to
23 enhance rural health quality and outcomes.

24 (b) RURAL HEALTH QUALITY DEMONSTRATION
25 PROJECTS.—

1 (1) IN GENERAL.—Not later than 270 days
2 after the date of the enactment of this section, the
3 Secretary, in consultation with the Rural Health
4 Quality Advisory Commission, the Office of Rural
5 Health Policy of the Health Resources and Services
6 Administration, the Agency for Healthcare Research
7 and Quality, and the Centers for Medicare & Med-
8 icaid Services, shall make grants to eligible entities
9 for 5 demonstration projects to implement and
10 evaluate methods for improving the quality of health
11 care in rural communities. Each such demonstration
12 project shall include—

13 (A) alternative community models that—

14 (i) will achieve greater integration of
15 personal and population health services;
16 and

17 (ii) address safety, effectiveness,
18 patient- or community-centeredness, timeli-
19 ness, efficiency, and equity (the six aims
20 identified by the Institute of Medicine of
21 the National Academies in its report enti-
22 tled “Crossing the Quality Chasm: A New
23 Health System for the 21st Century” re-
24 leased on March 1, 2001);

1 (B) innovative approaches to the financing
2 and delivery of health services to achieve rural
3 health quality goals; and

4 (C) development of quality improvement
5 support structures to assist rural health sys-
6 tems and professionals (such as workforce sup-
7 port structures, quality monitoring and report-
8 ing, clinical care protocols, and information
9 technology applications).

10 (2) ELIGIBLE ENTITIES.—In this subsection,
11 the term “eligible entity” means a consortium
12 that—

13 (A) shall include—

14 (i) at least one health care provider or
15 health care delivery system located in a
16 rural area; and

17 (ii) at least one organization rep-
18 resenting multiple community stakeholders;
19 and

20 (B) may include other partners such as
21 rural research centers.

22 (3) CONSULTATION.—In developing the pro-
23 gram for awarding grants under this subsection, the
24 Secretary shall consult with the Administrator of the
25 Agency for Healthcare Research and Quality, rural

1 health care providers, rural health care researchers,
2 and private and non-profit groups (including na-
3 tional associations) which are undertaking similar
4 efforts.

5 (4) EXPEDITED WAIVERS.—The Secretary shall
6 expedite the processing of any waiver that—

7 (A) is authorized under title XVIII or XIX
8 of the Social Security Act (42 U.S.C. 1395 et
9 seq.); and

10 (B) is necessary to carry out a demonstra-
11 tion project under this subsection.

12 (5) DEMONSTRATION PROJECT SITES.—The
13 Secretary shall ensure that the 5 demonstration
14 projects funded under this subsection are conducted
15 at a variety of sites representing the diversity of
16 rural communities in the Nation.

17 (6) DURATION.—Each demonstration project
18 under this subsection shall be for a period of 4
19 years.

20 (7) INDEPENDENT EVALUATION.—The Sec-
21 retary shall enter into an arrangement with an enti-
22 ty that has experience working directly with rural
23 health systems for the conduct of an independent
24 evaluation of the program carried out under this
25 subsection.

1 (8) REPORT.—Not later than one year after the
2 conclusion of all of the demonstration projects fund-
3 ed under this subsection, the Secretary shall submit
4 a report to the Congress on the results of such
5 projects. The report shall include—

6 (A) an evaluation of patient access to care,
7 patient outcomes, and an analysis of the cost
8 effectiveness of each such project; and

9 (B) recommendations on Federal legisla-
10 tion, regulations, or administrative policies to
11 enhance rural health quality and outcomes.

12 (c) APPROPRIATION.—

13 (1) IN GENERAL.—Out of funds in the Treas-
14 ury not otherwise appropriated, there are appro-
15 priated to the Secretary to carry out this section
16 \$30,000,000 for the period of fiscal years 2010
17 through 2014.

18 (2) AVAILABILITY.—

19 (A) IN GENERAL.—Funds appropriated
20 under paragraph (1) shall remain available for
21 expenditure through fiscal year 2014.

22 (B) REPORT.—For purposes of carrying
23 out subsection (b)(8), funds appropriated under
24 paragraph (1) shall remain available for ex-
25 penditure through fiscal year 2015.

1 (3) RESERVATION.—Of the amount appro-
 2 priated under paragraph (1), the Secretary shall re-
 3 serve—

4 (A) \$5,000,000 to carry out subsection (a);

5 and

6 (B) \$25,000,000 to carry out subsection

7 (b), of which—

8 (i) 2 percent shall be for the provision

9 of technical assistance to grant recipients;

10 and

11 (ii) 5 percent shall be for independent

12 evaluation under subsection (b)(7).

13 **SEC. 527. RURAL HEALTH CARE SERVICES.**

14 Section 330A of the Public Health Service Act (42
 15 U.S.C. 254c) is amended to read as follows:

16 **“SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH,**

17 **RURAL HEALTH NETWORK DEVELOPMENT,**

18 **DELTA RURAL DISPARITIES AND HEALTH**

19 **SYSTEMS DEVELOPMENT, AND SMALL RURAL**

20 **HEALTH CARE PROVIDER QUALITY IMPROVE-**

21 **MENT GRANT PROGRAMS.**

22 “(a) PURPOSE.—The purpose of this section is to
 23 provide for grants—

24 “(1) under subsection (b), to promote rural

25 health care services outreach;

1 “(2) under subsection (c), to provide for the
2 planning and implementation of integrated health
3 care networks in rural areas;

4 “(3) under subsection (d), to assist rural com-
5 munities in the Delta Region to reduce health dis-
6 parities and to promote and enhance health system
7 development; and

8 “(4) under subsection (e), to provide for the
9 planning and implementation of small rural health
10 care provider quality improvement activities.

11 “(b) RURAL HEALTH CARE SERVICES OUTREACH
12 GRANTS.—

13 “(1) GRANTS.—The Director of the Office of
14 Rural Health Policy of the Health Resources and
15 Services Administration may award grants to eligible
16 entities to promote rural health care services out-
17 reach by expanding the delivery of health care serv-
18 ices to include new and enhanced services in rural
19 areas. The Director may award the grants for peri-
20 ods of not more than 3 years.

21 “(2) ELIGIBILITY.—To be eligible to receive a
22 grant under this subsection for a project, an enti-
23 ty—

24 “(A) shall be a rural public or rural non-
25 profit private entity, a facility that qualifies as

1 a rural health clinic under title XVIII of the
2 Social Security Act, a public or nonprofit entity
3 existing exclusively to provide services to mi-
4 grant and seasonal farm workers in rural areas,
5 or a tribal government whose grant-funded ac-
6 tivities will be conducted within federally recog-
7 nized tribal areas;

8 “(B) shall represent a consortium com-
9 posed of members—

10 “(i) that include 3 or more independ-
11 ently owned health care entities; and

12 “(ii) that may be nonprofit or for-
13 profit entities; and

14 “(C) shall not previously have received a
15 grant under this subsection for the same or a
16 similar project, unless the entity is proposing to
17 expand the scope of the project or the area that
18 will be served through the project.

19 “(3) APPLICATIONS.—To be eligible to receive a
20 grant under this subsection, an eligible entity shall
21 prepare and submit to the Director an application at
22 such time, in such manner, and containing such in-
23 formation as the Director may require, including—

1 “(A) a description of the project that the
2 eligible entity will carry out using the funds
3 provided under the grant;

4 “(B) a description of the manner in which
5 the project funded under the grant will meet
6 the health care needs of rural populations in
7 the local community or region to be served;

8 “(C) a plan for quantifying how health
9 care needs will be met through identification of
10 the target population and benchmarks of service
11 delivery or health status, such as—

12 “(i) quantifiable measurements of
13 health status improvement for projects fo-
14 cusing on health promotion; or

15 “(ii) benchmarks of increased access
16 to primary care, including tracking factors
17 such as the number and type of primary
18 care visits, identification of a medical
19 home, or other general measures of such
20 access;

21 “(D) a description of how the local com-
22 munity or region to be served will be involved
23 in the development and ongoing operations of
24 the project;

1 “(E) a plan for sustaining the project after
2 Federal support for the project has ended;

3 “(F) a description of how the project will
4 be evaluated;

5 “(G) the administrative capacity to submit
6 annual performance data electronically as speci-
7 fied by the Director; and

8 “(H) other such information as the Direc-
9 tor determines to be appropriate.

10 “(c) RURAL HEALTH NETWORK DEVELOPMENT
11 GRANTS.—

12 “(1) GRANTS.—

13 “(A) IN GENERAL.—The Director may
14 award rural health network development grants
15 to eligible entities to promote, through planning
16 and implementation, the development of inte-
17 grated health care networks that have combined
18 the functions of the entities participating in the
19 networks in order to—

20 “(i) achieve efficiencies and economies
21 of scale;

22 “(ii) expand access to, coordinate, and
23 improve the quality of the health care de-
24 livery system through development of orga-
25 nizational efficiencies;

1 “(iii) implement health information
2 technology to achieve efficiencies, reduce
3 medical errors, and improve quality;

4 “(iv) coordinate care and manage
5 chronic illness; and

6 “(v) strengthen the rural health care
7 system as a whole in such a manner as to
8 show a quantifiable return on investment
9 to the participants in the network.

10 “(B) GRANT PERIODS.—The Director may
11 award such a rural health network development
12 grant—

13 “(i) for a period of 3 years for imple-
14 mentation activities; or

15 “(ii) for a period of 1 year for plan-
16 ning activities to assist in the initial devel-
17 opment of an integrated health care net-
18 work, if the proposed participants in the
19 network do not have a history of collabo-
20 rative efforts and a 3-year grant would be
21 inappropriate.

22 “(2) ELIGIBILITY.—To be eligible to receive a
23 grant under this subsection, an entity—

24 “(A) shall be a rural public or rural non-
25 profit private entity, a facility that qualifies as

1 a rural health clinic under title XVIII of the
2 Social Security Act, a public or nonprofit entity
3 existing exclusively to provide services to mi-
4 grant and seasonal farm workers in rural areas,
5 or a tribal government whose grant-funded ac-
6 tivities will be conducted within federally recog-
7 nized tribal areas;

8 “(B) shall represent a network composed
9 of participants—

10 “(i) that include 3 or more independ-
11 ently owned health care entities; and

12 “(ii) that may be nonprofit or for-
13 profit entities; and

14 “(C) shall not previously have received a
15 grant under this subsection (other than a 1-
16 year grant for planning activities) for the same
17 or a similar project.

18 “(3) APPLICATIONS.—To be eligible to receive a
19 grant under this subsection, an eligible entity, in
20 consultation with the appropriate State office of
21 rural health or another appropriate State entity,
22 shall prepare and submit to the Director an applica-
23 tion at such time, in such manner, and containing
24 such information as the Director may require, in-
25 cluding—

1 “(A) a description of the project that the
2 eligible entity will carry out using the funds
3 provided under the grant;

4 “(B) an explanation of the reasons why
5 Federal assistance is required to carry out the
6 project;

7 “(C) a description of—

8 “(i) the history of collaborative activi-
9 ties carried out by the participants in the
10 network;

11 “(ii) the degree to which the partici-
12 pants are ready to integrate their func-
13 tions; and

14 “(iii) how the local community or re-
15 gion to be served will benefit from and be
16 involved in the activities carried out by the
17 network;

18 “(D) a description of how the local com-
19 munity or region to be served will experience in-
20 creased access to quality health care services
21 across the continuum of care as a result of the
22 integration activities carried out by the net-
23 work, including a description of—

24 “(i) return on investment for the com-
25 munity and the network members; and

1 “(ii) other quantifiable performance
2 measures that show the benefit of the net-
3 work activities;

4 “(E) a plan for sustaining the project after
5 Federal support for the project has ended;

6 “(F) a description of how the project will
7 be evaluated;

8 “(G) the administrative capacity to submit
9 annual performance data electronically as speci-
10 fied by the Director; and

11 “(H) other such information as the Direc-
12 tor determines to be appropriate.

13 “(d) DELTA RURAL DISPARITIES AND HEALTH SYS-
14 TEMS DEVELOPMENT GRANTS.—

15 “(1) GRANTS.—The Director may award grants
16 to eligible entities to support reduction of health dis-
17 parities, improve access to health care, and enhance
18 rural health system development in the Delta Re-
19 gion.

20 “(2) ELIGIBILITY.—To be eligible to receive a
21 grant under this subsection, an entity shall be a
22 rural public or rural nonprofit private entity, a facil-
23 ity that qualifies as a rural health clinic under title
24 XVIII of the Social Security Act, a public or non-
25 profit entity existing exclusively to provide services

1 to migrant and seasonal farm workers in rural
2 areas, or a tribal government whose grant-funded
3 activities will be conducted within federally recog-
4 nized tribal areas.

5 “(3) APPLICATIONS.—To be eligible to receive a
6 grant under this subsection, an eligible entity shall
7 prepare and submit to the Director an application at
8 such time, in such manner, and containing such in-
9 formation as the Director may require, including—

10 “(A) a description of the project that the
11 eligible entity will carry out using the funds
12 provided under the grant;

13 “(B) an explanation of the reasons why
14 Federal assistance is required to carry out the
15 project;

16 “(C) a description of the manner in which
17 the project funded under the grant will meet
18 the health care needs of the Delta Region;

19 “(D) a description of how the local com-
20 munity or region to be served will experience in-
21 creased access to quality health care services as
22 a result of the activities carried out by the enti-
23 ty;

1 “(E) a description of how health dispari-
2 ties will be reduced or the health system will be
3 improved;

4 “(F) a plan for sustaining the project after
5 Federal support for the project has ended;

6 “(G) a description of how the project will
7 be evaluated including process and outcome
8 measures related to the quality of care provided
9 or how the health care system improves its per-
10 formance;

11 “(H) a description of how the grantee will
12 develop an advisory group made up of rep-
13 resentatives of the communities to be served to
14 provide guidance to the grantee to best meet
15 community need; and

16 “(I) other such information as the Director
17 determines to be appropriate.

18 “(e) SMALL RURAL HEALTH CARE PROVIDER QUAL-
19 ITY IMPROVEMENT GRANTS.—

20 “(1) GRANTS.—The Director may award grants
21 to provide for the planning and implementation of
22 small rural health care provider quality improvement
23 activities. The Director may award the grants for
24 periods of 1 to 3 years.

1 “(2) ELIGIBILITY.—To be eligible for a grant
2 under this subsection, an entity—

3 “(A) shall be—

4 “(i) a rural public or rural nonprofit
5 private health care provider or provider of
6 health care services, such as a rural health
7 clinic; or

8 “(ii) another rural provider or net-
9 work of small rural providers identified by
10 the Director as a key source of local care;
11 and

12 “(B) shall not previously have received a
13 grant under this subsection for the same or a
14 similar project.

15 “(3) PREFERENCE.—In awarding grants under
16 this subsection, the Director shall give preference to
17 facilities that qualify as rural health clinics under
18 title XVIII of the Social Security Act.

19 “(4) APPLICATIONS.—To be eligible to receive a
20 grant under this subsection, an eligible entity shall
21 prepare and submit to the Director an application at
22 such time, in such manner, and containing such in-
23 formation as the Director may require, including—

1 “(A) a description of the project that the
2 eligible entity will carry out using the funds
3 provided under the grant;

4 “(B) an explanation of the reasons why
5 Federal assistance is required to carry out the
6 project;

7 “(C) a description of the manner in which
8 the project funded under the grant will assure
9 continuous quality improvement in the provision
10 of services by the entity;

11 “(D) a description of how the local com-
12 munity or region to be served will experience in-
13 creased access to quality health care services as
14 a result of the activities carried out by the enti-
15 ty;

16 “(E) a plan for sustaining the project after
17 Federal support for the project has ended;

18 “(F) a description of how the project will
19 be evaluated including process and outcome
20 measures related to the quality of care pro-
21 vided; and

22 “(G) other such information as the Direc-
23 tor determines to be appropriate.

24 “(f) GENERAL REQUIREMENTS.—

1 “(1) PROHIBITED USES OF FUNDS.—An entity
2 that receives a grant under this section may not use
3 funds provided through the grant—

4 “(A) to build or acquire real property; or
5 “(B) for construction.

6 “(2) COORDINATION WITH OTHER AGENCIES.—
7 The Director shall coordinate activities carried out
8 under grant programs described in this section, to
9 the extent practicable, with Federal and State agen-
10 cies and nonprofit organizations that are operating
11 similar grant programs, to maximize the effect of
12 public dollars in funding meritorious proposals.

13 “(g) REPORT.—Not later than September 30, 2012,
14 the Secretary shall prepare and submit to the appropriate
15 committees of Congress a report on the progress and ac-
16 complishments of the grant programs described in sub-
17 sections (b), (c), (d), and (e).

18 “(h) DEFINITIONS.—In this section:

19 “(1) The term ‘Delta Region’ has the meaning
20 given to the term ‘region’ in section 382A of the
21 Consolidated Farm and Rural Development Act (7
22 U.S.C. 2009aa).

23 “(2) The term ‘Director’ means the Director of
24 the Office of Rural Health Policy of the Health Re-
25 sources and Services Administration.

1 “(i) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 \$40,000,000 for fiscal year 2010, and such sums as may
4 be necessary for each of fiscal years 2011 through 2014.”.

5 **SEC. 528. COMMUNITY HEALTH CENTER COLLABORATIVE**
6 **ACCESS EXPANSION.**

7 Section 330 of the Public Health Service Act (42
8 U.S.C. 254b) is amended by adding at the end the fol-
9 lowing:

10 “(s) MISCELLANEOUS PROVISIONS.—

11 “(1) RULE OF CONSTRUCTION WITH RESPECT
12 TO RURAL HEALTH CLINICS.—

13 “(A) IN GENERAL.—Nothing in this sec-
14 tion shall be construed to prevent a community
15 health center from contracting with a federally
16 certified rural health clinic (as defined by sec-
17 tion 1861(aa)(2) of the Social Security Act) for
18 the delivery of primary health care services that
19 are available at the rural health clinic to indi-
20 viduals who would otherwise be eligible for free
21 or reduced cost care if that individual were able
22 to obtain that care at the community health
23 center. Such services may be limited in scope to
24 those primary health care services available in
25 that rural health clinic.

1 “(B) ASSURANCES.—In order for a rural
 2 health clinic to receive funds under this section
 3 through a contract with a community health
 4 center under paragraph (1), such rural health
 5 clinic shall establish policies to ensure—

6 “(i) nondiscrimination based upon the
 7 ability of a patient to pay; and

8 “(ii) the establishment of a sliding fee
 9 scale for low-income patients.”.

10 **SEC. 529. FACILITATING THE PROVISION OF TELEHEALTH**
 11 **SERVICES ACROSS STATE LINES.**

12 (a) IN GENERAL.—For purposes of expediting the
 13 provision of telehealth services, for which payment is made
 14 under the Medicare program, across State lines, the Sec-
 15 retary of Health and Human Services shall, in consulta-
 16 tion with representatives of States, physicians, health care
 17 practitioners, and patient advocates, encourage and facili-
 18 tate the adoption of provisions allowing for multistate
 19 practitioner practice across State lines.

20 (b) DEFINITIONS.—In subsection (a):

21 (1) TELEHEALTH SERVICE.—The term “tele-
 22 health service” has the meaning given that term in
 23 subparagraph (F) of section 1834(m)(4) of the So-
 24 cial Security Act (42 U.S.C. 1395m(m)(4)).

1 (2) PHYSICIAN, PRACTITIONER.—The terms
2 “physician” and “practitioner” have the meaning
3 given those terms in subparagraphs (D) and (E), re-
4 spectively, of such section.

5 (3) MEDICARE PROGRAM.—The term “Medicare
6 program” means the program of health insurance
7 administered by the Secretary of Health and Human
8 Services under title XVIII of the Social Security Act
9 (42 U.S.C. 1395 et seq.).

10 **SEC. 530. REMOVING BARRIERS TO HEALTH CARE AND NU-**
11 **TRITION ASSISTANCE HEALTH COVERAGE**
12 **FOR CHILDREN, PREGNANT WOMEN, AND**
13 **LAWFULLY RESIDING INDIVIDUALS.**

14 (a) MEDICAID.—Section 1903(v) of the Social Secu-
15 rity Act (42 U.S.C. 1396b(v)) is amended by striking
16 paragraph (4) and inserting the following new paragraph:

17 “(4)(A) Notwithstanding sections 401(a), 402(b),
18 403, and 421 of the Personal Responsibility and Work Op-
19 portunity Reconciliation Act of 1996, payment shall be
20 made under this section for care and services that are fur-
21 nished to individuals, including those described in para-
22 graph (1), if they otherwise meet the eligibility require-
23 ments for medical assistance under the State plan ap-
24 proved under this title (other than the requirement of the
25 receipt of aid or assistance under title IV, supplemental

1 security income benefits under title XVI, or a State sup-
2 plementary payment), and are—

3 “(i) lawfully present in the United States;

4 “(ii) children under age 21, including optional
5 targeted low-income children described in section
6 1905(u)(2)(B); or

7 “(iii) pregnant women during pregnancy (and
8 during the 60-day period beginning on the last day
9 of the pregnancy).

10 “(B) No debt shall accrue under an affidavit of sup-
11 port against any sponsor of such an alien on the basis
12 of provision of assistance to such category and the cost
13 of such assistance shall not be considered as an unreim-
14 bursed cost.”.

15 (b) SCHIP.—Section 2107(e)(1) of the Social Secu-
16 rity Act (42 U.S.C. 1397gg(e)(1)) is amended by striking
17 subparagraph (H) and inserting the following new sub-
18 paragraph:

19 “(H) Paragraph (4) of section 1903(v) (re-
20 lating to individuals who, but for sections
21 401(a), 403, and 421 of the Personal Responsi-
22 bility and Work Opportunity Reconciliation Act
23 of 1996, would be eligible for medical assistance
24 under title XXI).”.

25 (c) NUTRITION ASSISTANCE.—

1 (1) SUPPLEMENTAL NUTRITION ASSISTANCE.—
2 Notwithstanding sections 401(a), 402(a), and 403(a)
3 of the Personal Responsibility and Work Oppor-
4 tunity Reconciliation Act of 1996 (8 U.S.C. 1611(a);
5 1612(a), 1613(a)) and section 6(f) of the Food and
6 Nutrition Act of 2008 (7 U.S.C. 2015(f)), persons
7 who are lawfully present in the United States shall
8 be not be ineligible for benefits under the supple-
9 mental nutrition assistance program on the basis of
10 their immigration status or date of entry into the
11 United States.

12 (2) ELIGIBILITY FOR FAMILIES WITH CHIL-
13 DREN.—Section of the 421(d)(3) of the Personal Re-
14 sponsibility and Work Opportunity Reconciliation
15 Act of 1996 (8 U.S.C. 1631(d)(3)) is amended by
16 striking “to the extent that a qualified alien is eligi-
17 ble under section 402(a)(2)(J)” and inserting, “to
18 the extent that a child is a member of a household
19 under the supplemental nutrition assistance pro-
20 gram”.

21 (3) ENSURING PROPER SCREENING.—Section
22 11(e)(2)(B) of the Food and Nutrition Act of 2008
23 (7 U.S.C. 2020(e)(2)(B)) is amended—

24 (A) by redesignating clauses (vi) and (viii)
25 as clauses (vii) and (viii); and

1 (B) by inserting after clause (v) the fol-
2 lowing:

3 “(vi) shall provide a method for imple-
4 menting section 421 of the Personal Re-
5 sponsibility and Work Opportunity Rec-
6 onciliation Act of 1996 (8 U.S.C. 1631)
7 that does not require any unnecessary in-
8 formation from persons who may be ex-
9 empt from that provision;”.

10 **SEC. 531. REMOVING MEDICARE BARRIER TO HEALTH**
11 **CARE.**

12 Section 1818(a)(3) of the Social Security Act (42
13 U.S.C. 1395i–2(a)(3)) is amended by amending clause (B)
14 to read as follows: “(B) an individual who is lawfully
15 present in the United States”.

16 **CHAPTER 2—LUNG CANCER MORTALITY**
17 **REDUCTION**

18 **SEC. 541. SHORT TITLE.**

19 This chapter may be cited as the “Lung Cancer Mor-
20 tality Reduction Act of 2009”.

21 **SEC. 542. FINDINGS.**

22 Congress makes the following findings:

23 (1) Lung cancer is the leading cause of cancer
24 death for both men and women, accounting for 28
25 percent of all cancer deaths.

1 (2) Lung cancer kills more people annually
2 than breast cancer, prostate cancer, colon cancer,
3 liver cancer, melanoma, and kidney cancer combined.

4 (3) Since the National Cancer Act of 1971
5 (Public Law 92–218; 85 Stat. 778), coordinated and
6 comprehensive research has raised the 5-year sur-
7 vival rates for breast cancer to 88 percent, for pros-
8 tate cancer to 99 percent, and for colon cancer to
9 64 percent.

10 (4) However, the 5-year survival rate for lung
11 cancer is still only 15 percent and a similar coordi-
12 nated and comprehensive research effort is required
13 to achieve increases in lung cancer survivability
14 rates.

15 (5) Sixty percent of lung cancer cases are now
16 diagnosed as nonsmokers or former smokers.

17 (6) Two-thirds of nonsmokers diagnosed with
18 lung cancer are women.

19 (7) Certain minority populations, such as Afri-
20 can-American males, have disproportionately high
21 rates of lung cancer incidence and mortality, not-
22 withstanding their similar smoking rate.

23 (8) Members of the baby boomer generation are
24 entering their sixties, the most common age at which
25 people develop lung cancer.

1 (9) Tobacco addiction and exposure to other
2 lung cancer carcinogens such as Agent Orange and
3 other herbicides and battlefield emissions are serious
4 problems among military personnel and war vet-
5 erans.

6 (10) Significant and rapid improvements in
7 lung cancer mortality can be expected through great-
8 er use and access to lung cancer screening tests for
9 at-risk individuals.

10 (11) Additional strategies are necessary to fur-
11 ther enhance the existing tests and therapies avail-
12 able to diagnose and treat lung cancer in the future.

13 (12) The August 2001 Report of the Lung
14 Cancer Progress Review Group of the National Can-
15 cer Institute stated that funding for lung cancer re-
16 search was “far below the levels characterized for
17 other common malignancies and far out of propor-
18 tion to its massive health impact”.

19 (13) The Report of the Lung Cancer Progress
20 Review Group identified as its “highest priority” the
21 creation of integrated, multidisciplinary, multi-insti-
22 tutional research consortia organized around the
23 problem of lung cancer rather than around specific
24 research disciplines.

1 (14) The United States must enhance its re-
2 sponse to the issues raised in the Report of the
3 Lung Cancer Progress Review Group, and this can
4 be accomplished through the establishment of a co-
5 ordinated effort designed to reduce the lung cancer
6 mortality rate by 50 percent by 2015 and targeted
7 funding to support this coordinated effort.

8 **SEC. 543. SENSE OF CONGRESS CONCERNING INVESTMENT**
9 **IN LUNG CANCER RESEARCH.**

10 It is the sense of the Congress that—

11 (1) lung cancer mortality reduction should be
12 made a national public health priority; and

13 (2) a comprehensive mortality reduction pro-
14 gram coordinated by the Secretary of Health and
15 Human Services is justified and necessary to ade-
16 quately address and reduce lung cancer mortality.

17 **SEC. 544. LUNG CANCER MORTALITY REDUCTION PRO-**
18 **GRAM.**

19 (a) IN GENERAL.—Subpart 1 of part C of title IV
20 of the Public Health Service Act (42 U.S.C. 285 et seq.)
21 is amended by adding at the end the following:

22 **“SEC. 417G. LUNG CANCER MORTALITY REDUCTION PRO-**
23 **GRAM.**

24 “(a) IN GENERAL.—Not later than 6 months after
25 the date of the enactment of this section, the Secretary,

1 in consultation with the Secretary of Defense, the Sec-
2 retary of Veterans Affairs, the Director of the National
3 Institutes of Health, the Director of the Centers for Dis-
4 ease Control and Prevention, the Commissioner of Food
5 and Drugs, the Administrator of the Centers for Medicare
6 & Medicaid Services, the Director of the National Center
7 on Minority Health and Health Disparities, and other
8 members of the Lung Cancer Advisory Board established
9 under section 546 of the Lung Cancer Mortality Reduc-
10 tion Act of 2009, shall implement a comprehensive pro-
11 gram, to be known as the Lung Cancer Mortality Reduc-
12 tion Program, to achieve a reduction of at least 25 percent
13 in the mortality rate of lung cancer by 2015.

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 of the Lung Cancer
21 Mortality Reduction Program in reducing lung
22 cancer mortality;

23 “(B) the provision of funds to enable the
24 Airway Biology and Disease Branch of the Na-
25 tional Heart, Lung, and Blood Institute to ex-

1 pand its research programs to include pre-
2 dispositions to lung cancer, the interrelationship
3 between lung cancer and other pulmonary and
4 cardiac disease, and the diagnosis and treat-
5 ment of these interrelationships;

6 “(C) the provision of funds to enable the
7 National Institute of Biomedical Imaging and
8 Bioengineering to expedite the development of
9 computer assisted diagnostic, surgical, treat-
10 ment, and drug testing innovations to reduce
11 lung cancer mortality, such as through expan-
12 sion of the Institute’s Quantum Grant Program
13 and Image-Guided Interventions programs; and

14 “(D) the provision of funds to enable the
15 National Institute of Environmental Health
16 Sciences to implement research programs rel-
17 ative to the lung cancer incidence.

18 “(2) With respect to the Food and Drug Ad-
19 ministration—

20 “(A) activities under section 529 of the
21 Federal Food, Drug, and Cosmetic Act; and

22 “(B) activities under section 561 of the
23 Federal Food, Drug, and Cosmetic Act to ex-
24 pand access to investigational drugs and devices

1 for the diagnosis, monitoring, or treatment of
2 lung cancer.

3 “(3) With respect to the Centers for Disease
4 Control and Prevention, the establishment of an
5 early disease research and management program
6 under section 1511.

7 “(4) With respect to the Agency for Healthcare
8 Research and Quality, the conduct of a biannual re-
9 view of lung cancer screening, diagnostic, and treat-
10 ment protocols, and the issuance of updated guide-
11 lines.

12 “(5) The cooperation and coordination of all
13 minority and health disparity programs within the
14 Department of Health and Human Services to en-
15 sure that all aspects of the Lung Cancer Mortality
16 Reduction Program under this section adequately
17 address the burden of lung cancer on minority and
18 rural populations.

19 “(6) The cooperation and coordination of all to-
20 bacco control and cessation programs within agen-
21 cies of the Department of Health and Human Serv-
22 ices to achieve the goals of the Lung Cancer Mor-
23 tality Reduction Program under this section with
24 particular emphasis on the coordination of drug and

1 other cessation treatments with early detection pro-
2 tocols.”.

3 (b) FEDERAL FOOD, DRUG, AND COSMETIC ACT.—
4 Subchapter B of chapter V of the Federal Food, Drug,
5 and Cosmetic Act (21 U.S.C. 360aaa et seq.) is amended
6 by adding at the end the following:

7 “DRUGS RELATING TO LUNG CANCER

8 “SEC. 529. (a) IN GENERAL.—The provisions of this
9 subchapter shall apply to a drug described in subsection
10 (b) to the same extent and in the same manner as such
11 provisions apply to a drug for a rare disease or condition.

12 “(b) QUALIFIED DRUGS.—A drug described in this
13 subsection is—

14 “(1) a chemoprevention drug for precancerous
15 conditions of the lung;

16 “(2) a drug for a targeted therapeutic treat-
17 ments, including any vaccine for, lung cancer; and

18 “(3) a drug to curtail or prevent nicotine addic-
19 tion.

20 “(c) BOARD.—The Board established under section
21 546 of the Lung Cancer Mortality Reduction Act of 2009
22 shall monitor the program implemented under this sec-
23 tion.”.

24 (c) ACCESS TO UNAPPROVED THERAPIES.—Section
25 561(e) of the Federal Food, Drug, and Cosmetic Act (21
26 U.S.C. 360bbb(e)) is amended by inserting before the pe-

1 riod the following: “and shall include expanding access to
2 drugs under section 529, with substantial consideration
3 being given to whether the totality of information available
4 to the Secretary regarding the safety and effectiveness of
5 an investigational drug, as compared to the risk of mor-
6 bidity and death from the disease, indicates that a patient
7 may obtain more benefit than risk if treated with the
8 drug”.

9 (d) CDC.—Title XV of the Public Health Service Act
10 (42 U.S.C. 300k et seq.) is amended by adding at the end
11 the following:

12 **“SEC. 1511. EARLY DISEASE RESEARCH AND MANAGEMENT**
13 **PROGRAM.**

14 “The Secretary shall establish and implement an
15 early disease research and management program targeted
16 at the high incidence and mortality rates of lung cancer
17 among minority and low-income populations.”.

18 **SEC. 545. DEPARTMENT OF DEFENSE AND THE DEPART-**
19 **MENT OF VETERANS AFFAIRS.**

20 The Secretary of Defense and the Secretary of Vet-
21 erans Affairs shall coordinate with the Secretary of Health
22 and Human Services—

23 (1) in the development of the Lung Cancer
24 Mortality Reduction Program under section 417G;

1 (2) in the implementation within the Depart-
2 ment of Defense and the Department of Veterans
3 Affairs of an early detection and disease manage-
4 ment research program for military personnel and
5 veterans whose smoking history and exposure to car-
6 cinogens during active duty service has increased
7 their risk for lung cancer; and

8 (3) in the implementation of coordinated care
9 programs for military personnel and veterans diag-
10 nosed with lung cancer.

11 **SEC. 546. LUNG CANCER ADVISORY BOARD.**

12 (a) IN GENERAL.—The Secretary of Health and
13 Human Services shall convene a Lung Cancer Advisory
14 Board (referred to in this section as the “Board”)—

15 (1) to monitor the programs established under
16 this chapter (and the amendments made by this
17 chapter); and

18 (2) to provide annual reports to the Congress
19 concerning benchmarks, expenditures, lung cancer
20 statistics, and the public health impact of such pro-
21 grams.

22 (b) COMPOSITION.—The Board shall be composed
23 of—

24 (1) the Secretary of Health and Human Serv-
25 ices;

1 (2) the Secretary of Defense;

2 (3) the Secretary of Veterans Affairs; and

3 (4) two representatives each from the fields of
4 clinical medicine focused on lung cancer, lung cancer
5 research, imaging, drug development, and lung can-
6 cer advocacy, to be appointed by the Secretary of
7 Health and Human Services.

8 **SEC. 547. AUTHORIZATION OF APPROPRIATIONS.**

9 (a) IN GENERAL.—To carry out this chapter (and the
10 amendments made by this chapter), there are authorized
11 to be appropriated such sums as may be necessary for
12 each of fiscal years 2010 through 2014.

13 (b) LUNG CANCER MORTALITY REDUCTION PRO-
14 GRAM.—Of the amounts authorized to be appropriated by
15 subsection (a), there are authorized to be appropriated—

16 (1) \$25,000,000 for fiscal year 2010, and such
17 sums as may be necessary for each of fiscal years
18 2011 through 2014, for the activities described in
19 section 417G(b)(1)(B) of the Public Health Service
20 Act, as added by section 544(a);

21 (2) \$25,000,000 for fiscal year 2010, and such
22 sums as may be necessary for each of fiscal years
23 2011 through 2014, for the activities described in
24 section 417G(b)(1)(C) of such Act;

1 (3) \$10,000,000 for fiscal year 2010, and such
 2 sums as may be necessary for each of fiscal years
 3 2011 through 2014, for the activities described in
 4 section 417G(b)(1)(D) of such Act; and

5 (4) \$15,000,000 for fiscal year 2010, and such
 6 sums as may be necessary for each of fiscal years
 7 2011 through 2014, for the activities described in
 8 section 417G(b)(3) of such Act.

9 **TITLE VI—ELIMINATING DIS-**
 10 **PARITIES IN DIABETES PRE-**
 11 **VENTION ACCESS AND CARE**
 12 **ACT**

13 **Subtitle A—NATIONAL**
 14 **INSTITUTES OF HEALTH**

15 **SEC. 611. RESEARCH, TREATMENT, AND EDUCATION.**

16 (a) IN GENERAL.—Subpart 3 of part C of title IV
 17 of the Public Health Service Act (42 U.S.C. 285c et seq.)
 18 is amended by adding at the end the following new section:

19 **“SEC. 434B. DIABETES IN MINORITY POPULATIONS.**

20 “(a) IN GENERAL.—The Director of the National In-
 21 stitutes of Health shall expand, intensify, and support on-
 22 going research and other activities with respect to pre-dia-
 23 betes and diabetes, particularly type 2, in minority popu-
 24 lations, including research to identify clinical, socio-

1 economic, geographical, cultural, and organizational fac-
2 tors that contribute to type 2 diabetes in such populations.

3 “(b) CERTAIN ACTIVITIES.—Activities under sub-
4 section (a) regarding type 2 diabetes in minority popu-
5 lations shall include the following:

6 “(1) Continue research on behavior and obesity,
7 including research through the obesity research cen-
8 ter that is sponsored by the National Institutes of
9 Health.

10 “(2) Research on environmental factors that
11 may contribute to the increase in type 2 diabetes.

12 “(3) Support for new methods to identify envi-
13 ronmental triggers and genetic interactions that lead
14 to the development of type 2 diabetes in minority
15 newborns. Such research should follow the newborns
16 through puberty, an increasingly high-risk period for
17 developing type 2 diabetes.

18 “(4) Research to identify genes that predispose
19 individuals to the onset of developing type 1 and
20 type 2 diabetes and to the development of complica-
21 tions.

22 “(5) Research to prevent complications in indi-
23 viduals who have already developed diabetes, such as
24 research that attempts to identify the genes that

1 predispose individuals with diabetes to the develop-
2 ment of complications.

3 “(6) Research methods and alternative thera-
4 pies to control blood glucose.

5 “(7) Support of ongoing research efforts exam-
6 ining the level of glycemia at which adverse out-
7 comes develop during pregnancy and to address the
8 many clinical issues associated with minority moth-
9 ers and fetuses during diabetic and gestational dia-
10 betic pregnancies.

11 “(c) EDUCATION.—The Director of the National In-
12 stitutes of Health shall—

13 “(1) through the National Center on Minority
14 Health and Health Disparities and the National Di-
15 abetes Education Program—

16 “(A) make grants to programs funded
17 under section 485F (relating to centers of ex-
18 cellence) for the purpose of establishing a men-
19 toring program for health care professionals to
20 be more involved in weight counseling, obesity
21 research, and nutrition; and

22 “(B) provide for the participation of mi-
23 nority health professionals in diabetes-focused
24 research programs; and

1 “(2) make grants for programs to establish a
2 pipeline from high school to professional school that
3 will increase minority representation in diabetes-foc-
4 cused health fields by expanding Minority Access to
5 Research Careers (MARC) program internships and
6 mentoring opportunities for recruitment.

7 “(d) DEFINITION.—For purposes of this section, the
8 term ‘minority population’ means a racial and ethnic mi-
9 nority group, as defined in section 1707.

10 “(e) AUTHORIZATION OF APPROPRIATIONS.—For the
11 purpose of carrying out this section, there are authorized
12 to be appropriated such sums as are necessary for fiscal
13 year 2010 and each subsequent fiscal year.”.

14 (b) DIABETES MELLITUS INTERAGENCY COORDI-
15 NATING COMMITTEE.—Section 429 of the Public Health
16 Service Act (42 U.S.C. 285c–3) is amended by adding at
17 the end the following new subsection:

18 “(c)(1) In each annual report prepared by the Diabe-
19 tes Mellitus Interagency Coordinating Committee, the
20 Committee shall include an assessment of the Federal ac-
21 tivities and programs related to diabetes in minority popu-
22 lations. Such assessment shall—

23 “(A) compile the current activities of all
24 current Federal health programs to allow for
25 the assessment of their adequacy as a systemic

1 method of addressing the impact of diabetes
2 mellitus on minority populations;

3 “(B) develop strategic planning activities
4 to develop an effective and comprehensive Fed-
5 eral plan to address diabetes mellitus within mi-
6 nority populations which will involve all appro-
7 priate Federal health programs and shall—

8 “(i) include steps to address issues in-
9 cluding type 1 and type 2 diabetes in chil-
10 dren and the disproportionate impact of di-
11 abetes mellitus on minority populations;
12 and

13 “(ii) remain consistent with the pro-
14 grams and activities identified in section
15 3990, as well as remaining consistent with
16 the intent of the Eliminating Disparities in
17 Diabetes Prevention Access and Care Act
18 of 2009; and

19 “(C) assess the implementation of such a
20 plan throughout Federal health programs.

21 “(2) For the purposes of this subsection, the
22 term ‘minority population’ means a racial and ethnic
23 minority group, as defined in section 1707.

24 “(3) For the purpose of carrying out this sub-
25 section, there are authorized to be appropriated such

1 sums as are necessary for fiscal year 2010 and each
2 subsequent fiscal year.”.

3 **Subtitle B—CENTERS FOR DIS-**
4 **EASE CONTROL AND PREVEN-**
5 **TION**

6 **SEC. 621. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

7 Part B of title III of the Public Health Service Act
8 (42 U.S.C. 243 et seq.) is amended by inserting after sec-
9 tion 317T the following section:

10 **“SEC. 317U. DIABETES IN MINORITY POPULATIONS.**

11 “(a) RESEARCH AND OTHER ACTIVITIES.—

12 “(1) IN GENERAL.—The Secretary, acting
13 through the Director of the Centers for Disease
14 Control and Prevention, shall conduct and support
15 research and other activities with respect to diabetes
16 in minority populations.

17 “(2) CERTAIN ACTIVITIES.—Activities under
18 paragraph (1) regarding diabetes in minority popu-
19 lations shall include the following:

20 “(A) Expanding the National Diabetes
21 Laboratory capacity for translational research
22 and the identification of genetic and
23 immunological risk factors associated with dia-
24 betes.

1 “(B) Enhancing the National Health and
2 Nutrition Examination Survey to include risk
3 factors for type 2 diabetes and pre-diabetes
4 with emphasis on eating and dietary habits, and
5 focus, including cultural and socioeconomic fac-
6 tors, on Hispanic-American, African-American,
7 American Indian and Alaskan Native, and
8 Asian-American, Native Hawaiian and other
9 Pacific Islander communities.

10 “(C) Further enhancing the National
11 Health and Nutrition Examination Survey by
12 over-sampling Asian-American, Native Hawai-
13 ian, and Other Pacific Islanders in appropriate
14 geographic areas to better determine the preva-
15 lence of diabetes in such populations as well as
16 to improve the data collection of diabetes pene-
17 tration disaggregated into major ethnic groups
18 within such populations.

19 “(D) Within the Division of Diabetes
20 Translation, providing for prevention research
21 to better understand how to influence health
22 care systems changes to improve quality of care
23 being delivered to such populations, and within
24 the Division of Diabetes Translation, carrying
25 out model demonstration projects to design, im-

1 plement, and evaluate effective diabetes preven-
2 tion and control intervention for such popu-
3 lations.

4 “(E) Through the Division of Diabetes
5 Translation, carrying out culturally appropriate
6 community-based interventions designed to ad-
7 dress issues and problems experienced by such
8 populations.

9 “(F) Conducting applied research within
10 the Division of Diabetes Translation to reduce
11 health disparities within such populations with
12 diabetes.

13 “(G) Conducting applied research on pri-
14 mary prevention within the Division of Diabetes
15 Translation to specifically focus on such popu-
16 lations with pre-diabetes.

17 “(b) EDUCATION.—

18 “(1) IN GENERAL.—The Secretary, acting
19 through the Director of the Centers for Disease
20 Control and Prevention, shall direct the Division of
21 Diabetes Translation to conduct and support pro-
22 grams to educate the public on the causes and ef-
23 fects of diabetes in minority populations.

24 “(2) CERTAIN ACTIVITIES.—Programs under
25 paragraph (1) regarding education on diabetes in

1 minority populations shall include carrying out pub-
2 lic awareness campaigns directed toward such popu-
3 lations to aggressively emphasize the importance and
4 impact of physical activity and diet in regard to dia-
5 betes and diabetes-related complications through the
6 National Diabetes Education Program.

7 “(c) DIABETES; HEALTH PROMOTION, PREVENTION
8 ACTIVITIES, AND ACCESS.—

9 “(1) IN GENERAL.—The Secretary, acting
10 through the Director of the Centers for Disease
11 Control and Prevention, shall carry out culturally
12 appropriate diabetes health promotion and preven-
13 tion programs for minority populations.

14 “(2) CERTAIN ACTIVITIES.—Activities regard-
15 ing culturally appropriate diabetes health promotion
16 and prevention programs for minority populations
17 shall include the following:

18 “(A) Expanding the Diabetes Prevention
19 and Control Program (currently existing in all
20 the States and territories) and providing funds
21 for education and community outreach on dia-
22 betes.

23 “(B) Providing funds for an expansion of
24 the Diabetes Prevention Program Initiative that
25 focuses on physical inactivity and diet and its

1 relation to type 2 diabetes within such popu-
 2 lations.

3 “(C) Providing funds to strengthen exist-
 4 ing surveillance systems to improve the quality,
 5 accuracy, and timeliness of morbidity and mor-
 6 tality diabetes data for such populations.

7 “(d) DEFINITION.—For purposes of this section, the
 8 term ‘minority population’ means a racial and ethnic mi-
 9 nority group, as defined in section 1707.

10 “(e) AUTHORIZATION OF APPROPRIATIONS.—For the
 11 purpose of carrying out this section, there are authorized
 12 to be appropriated such sums as are necessary for fiscal
 13 year 2010 and each subsequent fiscal year.”.

14 **Subtitle C—HEALTH RESOURCES**
 15 **AND SERVICES ADMINISTRA-**
 16 **TION**

17 **SEC. 631. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

18 Part P of title III of the Public Health Service Act,
 19 as amended, is amended by adding at the end the following
 20 new section:

21 **“SEC. 399V. PROGRAMS TO EDUCATE HEALTH PROVIDERS**
 22 **ON THE CAUSES AND EFFECTS OF DIABETES**
 23 **IN MINORITY POPULATIONS.**

24 “(a) IN GENERAL.—The Secretary, acting through
 25 the Director of the Health Resources and Services Admin-

1 istration, shall conduct and support programs described
2 in subsection (b) to educate health professionals on the
3 causes and effects of diabetes in minority populations.

4 “(b) PROGRAMS.—Programs described in this sub-
5 section, with respect to education on diabetes in minority
6 populations, shall include the following:

7 “(1) Making grants for diabetes-focused edu-
8 cation classes or training programs on cultural sen-
9 sitivity and patient care within such populations for
10 health care providers.

11 “(2) Providing funds to community health cen-
12 ters for programs that provide diabetes services and
13 screenings.

14 “(3) Providing additional funds for the Health
15 Careers Opportunity Program, Centers for Excel-
16 lence, and the Minority Faculty Fellowship Program
17 to partner with the Office of Minority Health under
18 section 1707 and the National Institutes of Health
19 to strengthen programs for career opportunities
20 within minority populations focused on diabetes
21 treatment and care.

22 “(4) Developing a diabetes focus within, and
23 providing additional funds for, the National Health
24 Service Corps Scholarship program to place individ-
25 uals in areas that are disproportionately affected by

1 diabetes and to provide health care services to such
2 areas.

3 “(5) Establishing a diabetes ambassador pro-
4 gram for recruitment efforts to increase the number
5 of underrepresented minorities currently serving in
6 student, faculty, or administrative positions in insti-
7 tutions of higher learning, hospitals, and community
8 health centers.

9 “(6) Establishing a loan repayment program
10 that focuses on diabetes care and prevention in mi-
11 nority populations.”.

12 **Subtitle D—ADDITIONAL** 13 **PROGRAMS**

14 **SEC. 641. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

15 Part P of title III of the Public Health Service Act
16 (42 U.S.C. 280g et seq.), as amended, is further amended
17 by adding at the end the following section:

18 **“SEC. 399W. RESEARCH, EDUCATION, AND OTHER ACTIVI- 19 TIES REGARDING DIABETES IN MINORITY 20 POPULATIONS.**

21 **“(a) RESEARCH AND OTHER ACTIVITIES.—**

22 **“(1) IN GENERAL.—**In addition to activities
23 under sections 317U and 434B, the Secretary shall
24 conduct and support research and other activities
25 with respect to diabetes within minority populations.

1 “(2) CERTAIN ACTIVITIES.—Activities under
2 paragraph (1) regarding diabetes in minority popu-
3 lations shall include the following:

4 “(A) Through the National Center on Mi-
5 nority Health and Health Disparities, the Office
6 of Minority Health under section 1707, the
7 Health Resources and Services Administration,
8 the Centers for Disease Control and Prevention,
9 and the Indian Health Service, establishing
10 partnerships within minority populations to
11 conduct studies on cultural, familial, and social
12 factors that may influence health promotion, di-
13 abetes management, and prevention.

14 “(B) Through the Indian Health Service,
15 in collaboration with other appropriate Federal
16 agencies, coordinating the collection of data on
17 ethnic and culturally appropriate diabetes treat-
18 ment, care, prevention, and services by health
19 care professionals to the American Indian popu-
20 lation.

21 “(3) PROGRAMS RELATING TO CLINICAL RE-
22 SEARCH.—

23 “(A) EDUCATION REGARDING CLINICAL
24 TRIALS.—The Secretary shall carry out edu-
25 cation and awareness programs designed to in-

1 crease participation of minority populations in
2 clinical trials.

3 “(B) MINORITY RESEARCHERS.—The Sec-
4 retary shall carry out mentorship programs for
5 minority researchers who are conducting or in-
6 tend to conduct research on diabetes in minor-
7 ity populations.

8 “(C) SUPPLEMENTING CLINICAL RE-
9 SEARCH REGARDING CHILDREN.—The Sec-
10 retary shall make grants to supplement clinical
11 research programs to assist such programs in
12 obtaining the services of health professionals
13 and other resources to provide specialized care
14 for children with type 1 and type 2 diabetes.

15 “(4) ADDITIONAL PROGRAMS.—Activities under
16 paragraph (1) regarding education on diabetes in
17 minority populations shall include providing funds
18 for new and existing diabetes-focused education
19 grants and programs for present and future stu-
20 dents and clinicians in the medical field from minor-
21 ity populations, including for the following:

22 “(A) For Federal and State loan repay-
23 ment programs for health profession students
24 within communities of color.

1 “(B) For the Office of Minority Health
2 under section 1707 for training health profes-
3 sion students to focus on diabetes within such
4 populations.

5 “(C) For State and local entities to estab-
6 lish diabetes awareness week or day every
7 month in schools, nursing homes, and colleges
8 through partnerships with the Office of Minor-
9 ity Health under section 1707 and the Health
10 Resources and Services Administration.

11 “(b) DEFINITION.—For purposes of this section, the
12 term ‘minority population’ means a racial and ethnic mi-
13 nority group as defined in section 1707.

14 “(c) AUTHORIZATION OF APPROPRIATIONS.—For the
15 purpose of carrying out this section, there are authorized
16 to be appropriated such sums as are necessary for fiscal
17 year 2010 and each subsequent fiscal year.”.

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