113TH CONGRESS
2D SESSION

# S. 2841

To provide for a study by the Institute of Medicine on health disparities, to direct the Secretary of Health and Human Services to develop guidelines on reducing health disparities, and for other purposes.

---

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 17 (legislative day, SEPTEMBER 16), 2014

Mr. BOOKER introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

---

# A BILL

To provide for a study by the Institute of Medicine on health disparities, to direct the Secretary of Health and Human Services to develop guidelines on reducing health disparities, and for other purposes.

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Reducing Disparities Using Care Models and Education Act of 2014''.

**SEC. 2. FINDINGS.**

The Congress finds as follows:

(1) The infant death rate among African-Americans is more than double that of Whites.

(2) The death rate for all cancers is 30 percent higher for African-Americans than for Whites; for prostate cancer, it is more than double that for Whites.

(3) Black women have a higher death rate from breast cancer despite having a mammography screening rate that is nearly the same as the rate for White women.

(4) Diabetes incidence is highest among Native Americans, at 15.9 percent, followed by 13.2 percent for African-Americans, 12.8 percent for Hispanics, 9.0 percent for Asians, and 7.6 percent for Whites.

(5) New cases of hepatitis and tuberculosis are higher in Asians and Pacific Islanders living in the United States than in Whites.

(6) Individuals in same-sex couples were more likely than individuals in different-sex couples to report a delay in getting necessary prescriptions.

(7) Infants born to Black women are 1.5 to 3 times more likely to die than those born to women of other races or ethnicities, and American Indian and Alaska Native infants die from sudden infant

death syndrome (SIDS) at nearly 2.5 times the rate of White infants.

(8) Low-income children have higher rates of mortality (even with the same condition), have higher rates of disability, and are more likely to have multiple conditions.

(9) White children are half as likely as Black and Latino children not to be in excellent or very good health.

(10) As of 2012, 38.9 percent of United States adults were obese, with the highest rate among African-Americans at 47.9 percent, followed by Hispanics at 42.5 percent, Whites at 32.6 percent, and Asians at 10.8 percent.

(11) The risk of stroke is twice as high for African-Americans as for Whites, and African-Americans are more likely to die of stroke. Other ethnic minorities also have higher risk than Whites. Overall, strokes are most prevalent in the Southeast United States, and less so in the Northeast.

(12) African-Americans accounted for 44 percent of all those infected with HIV, despite being only 12 percent of the United States population.

(13) Black men who have sex with men (MSM) ages 13 to 24 had the most new infections among youth.

(14) One study found that among heterosexuals living in the same urban community, those below the poverty line were twice as likely to contract human immunodeficiency virus (HIV).

(15) Persons with less than a high school diploma (6.7 percent) and high school graduates (4.0 percent) were more likely to report major depression than those with at least some college education (2.5 percent).

(16) Only about 10 percent of physicians practice in rural America despite the fact that nearly one-fourth of the population lives in these areas.

(17) Rural residents are less likely to have employer-provided health care coverage or prescription drug coverage, and the rural poor are less likely to be covered by Medicaid benefits than their urban counterparts.

(18) Twenty percent of nonmetropolitan counties lack mental health services versus 5 percent of metropolitan counties.

(19) Fifteen percent of persons with disabilities report not seeing a doctor due to cost in comparison to 6 percent of the general population.

**SEC. 3. INSTITUTE OF MEDICINE STUDY.**

(a) IN GENERAL.—Not later than 60 days after the date of the enactment of this Act, the Secretary shall enter into an arrangement with the Institute of Medicine under which the Institute agrees to study—

(1) the extent of health disparities in the type and quality of preventive interventions, health services, and outcomes in the United States;

(2) the factors that may contribute to inequities in such disparities;

(3) existing programs and policies intended to reduce such disparities;

(4) best practices and successful strategies in programs that aim to reduce such disparities;

(5) priorities for successful intervention programs targeting such disparities; and

(6) potential opportunities for expanding or replicating such programs.

(b) REPORT.—The arrangement under subsection (a) shall provide for submission by the Institute of Medicine to the Secretary and Congress, not later than 20 months

after the date of enactment of this Act, of a report on the results of the study.

**SEC. 4. GUIDELINES FOR DEVELOPMENT AND IMPLEMENTATION OF HEALTH DISPARITIES REDUCTION PROGRAMS AND ACTIVITIES.**

(a) GUIDELINES.—Not later than 90 days after the submission of the report described in section 3(b), and taking such report into consideration, the Secretary shall develop guidelines for entities to develop and implement programs and activities to reduce health disparities.

(b) USE BY HHS.—The Secretary shall, where appropriate, incorporate the use of the guidelines developed under subsection (a) into the programs and activities of the Department of Health and Human Services.

(c) GRANTS FOR DISPARITIES REDUCTION ACTIVITIES.—

(1) IN GENERAL.—The Secretary may award grants to entities for the development and implementation of programs and activities to reduce health disparities in accordance with the guidelines described in subparagraph (a).

(2) APPLICATIONS.—To seek a grant under this subsection, an entity shall submit an application to the Secretary at such time, in such manner, and

containing such information as the Secretary may require.

(3) MINIMUM CONTENTS.—The Secretary shall require that an application for a grant under this subsection contains at a minimum—

(A) a description of the population and public health concern the program will target and an outreach plan to ensure that the most in need populations will benefit;

(B) a description of the strategies the entity will use—

(i) to develop and implement its programs and activities in accordance with the guidelines developed under subsection (a); and

(ii) to make the interventions sustainable; and

(C) an agreement by the entities to periodically provide data with respect to—

(i) the population served;

(ii) improvements in reducing health disparities; and

(iii) effectiveness of the interventions used.

(d) APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $5,000,000 for fiscal year 2016 and such sums as may be necessary for each of fiscal years 2017 through 2020.

**SEC. 5. TESTING ALTERNATIVE PAYMENT AND DELIVERY MODELS TO REDUCE HEALTH DISPARITIES.**

(a) IN GENERAL.—The Secretary acting through the Centers for Medicare and Medicaid Innovation under section 1115A of the Social Security Act (42 U.S.C. 1315a) shall provide for the testing of a payment and service delivery model that includes incentives for reducing health disparities consistent with the cost and quality criteria otherwise applicable to the testing of models under such section.

(b) DOCUMENTATION REQUIREMENT FOR MODEL TESTING.—In carrying out subsection (a), the Secretary shall require that an application to conduct such testing of such a model include at least—

(1) documentation of at least one health disparity targeted for reduction;

(2) a root-cause analysis of the health disparity targeted for reduction;

(3) identification and selection of performance targets for such reduction;

(4) a proposal to make payments in some way contingent on a reduction in health disparities; and

(5) a reliable method for monitoring progress in achieving such a reduction.

**SEC. 6. DEFINITIONS.**

In this Act:

(1) The term ''health disparity'' means significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in a population as compared to the health status of the general population.

(2) The term ''intervention'' means an activity taken by an entity on behalf of individuals or populations to reduce health disparities.

(3) The term ''Secretary'' means the Secretary of Health and Human Services.

○