

115TH CONGRESS
2D SESSION

H. R. 5942

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

IN THE HOUSE OF REPRESENTATIVES

MAY 23, 2018

Ms. LEE (for herself, Mr. AGUILAR, Ms. BARRAGÁN, Ms. BASS, Ms. BONAMICI, Ms. BORDALLO, Mr. BROWN of Maryland, Mr. CARBAJAL, Mr. CÁRDENAS, Mr. CARSON of Indiana, Mr. CASTRO of Texas, Ms. JUDY CHU of California, Ms. CLARKE of New York, Mr. CORREA, Mr. DANNY K. DAVIS of Illinois, Mr. ELLISON, Ms. ESHOO, Mr. ESPAILLAT, Ms. FUDGE, Mr. GALLEGO, Mr. GOMEZ, Mr. AL GREEN of Texas, Mr. GRIJALVA, Mr. GUTIÉRREZ, Ms. HANABUSA, Mr. HASTINGS, Ms. JAYAPAL, Ms. EDDIE BERNICE JOHNSON of Texas, Ms. KELLY of Illinois, Mr. KHANNA, Mr. LEWIS of Georgia, Mr. TED LIEU of California, Ms. LOFGREN, Mr. LOWENTHAL, Ms. MICHELLE LUJAN GRISHAM of New Mexico, Ms. MATSUI, Mr. MEEKS, Ms. MENG, Mrs. NAPOLITANO, Ms. NORTON, Mr. PAYNE, Mr. RASKIN, Mr. RICHMOND, Ms. ROYBAL-ALLARD, Mr. RUSH, Mr. SABLAN, Ms. SÁNCHEZ, Mr. SCHIFF, Mr. SCOTT of Virginia, Mr. SERRANO, Ms. SEWELL of Alabama, Mr. SWALWELL of California, Mr. TAKANO, Mrs. TORRES, Ms. VELÁZQUEZ, Ms. WILSON of Florida, Mrs. WATSON COLEMAN, and Mr. KRISHNAMOORTHY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Agriculture, Education and the Workforce, the Budget, the Judiciary, Veterans' Affairs, Armed Services, and Natural Resources, 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 2018”.

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

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

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- Sec. 3. Findings.

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1 **SEC. 3. FINDINGS.**

2 The Congress finds as follows:

3 (1) The population of racial and ethnic minori-
4 ties is expected to increase over the next few dec-
5 ades, yet racial and ethnic minorities have the poor-
6 est health status and face substantial cultural, so-
7 cial, and economic barriers to obtaining quality
8 health care.

9 (2) Health disparities are a function of not only
10 access to health care, but also the social deter-
11 minants of health—including the environment, the
12 physical structure of communities, nutrition and
13 food options, educational attainment, employment,
14 race, ethnicity, sex, geography, language preference,
15 immigrant or citizenship status, sexual orientation,
16 gender identity, socioeconomic status, or disability
17 status—that directly and indirectly affect the health,
18 health care, and wellness of individuals and commu-
19 nities.

20 (3) By 2020, the Nation will face a shortage of
21 health care providers and allied health workers and
22 this shortage disproportionately affects health pro-

1 fessional shortage areas where many racial and eth-
2 nic minority populations reside.

3 (4) All efforts to reduce health disparities and
4 barriers to quality health services require better and
5 more consistent data.

6 (5) A full range of culturally and linguistically
7 appropriate health care and public health services
8 must be available and accessible in every community.

9 (6) Racial and ethnic minorities and under-
10 served populations must be included early and equi-
11 tably in health reform innovations.

12 (7) Efforts to improve minority health have
13 been limited by inadequate resources in funding,
14 staffing, stewardship, and accountability. Targeted
15 investments that are focused on disparities elimi-
16 nation must be made in providing care and services
17 that are community-based, including prevention and
18 policies addressing social determinants of health.

19 (8) In 2011, the Department of Health and
20 Human Services developed the HHS Action Plan to
21 Reduce Racial and Ethnic Health Disparities and
22 the National Stakeholder Strategy for Achieving
23 Health Equity, two strategic plans that represent
24 the country's first coordinated roadmap to reducing
25 health disparities. Along with the National Preven-

1 tion Strategy, Healthy People 2020, and the Na-
2 tional Health Care Quality Strategy, as well as crit-
3 ical resources such as the 2012 National Healthcare
4 Quality and Disparities Reports, these comprehen-
5 sive plans will work to increase the number of Amer-
6 icans who are healthy at every stage of life.

7 (9) The Department of Health and Human
8 Services has also reviewed and advanced updated
9 clinical guidelines and developed other strategic
10 planning documents—

11 (A) to combat health disparities with a
12 high impact on minority populations including
13 the National HIV/AIDS Strategy, the Action
14 Plan for the Prevention, Care, and Treatment
15 of Viral Hepatitis; and

16 (B) to provide high-quality family planning
17 services including recommendations of the Cen-
18 ters for Disease Control and Prevention and the
19 Office of Population Affairs.

20 (10) The Patient Protection and Affordable
21 Care Act, as amended by the Health Care and Edu-
22 cation Reconciliation Act, represents the biggest ad-
23 vancement for minority health in the last 40 years.

1 **TITLE I—DATA COLLECTION**
2 **AND REPORTING**

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

5 (a) **PURPOSE.**—It is the purpose of this section to
6 promote data collection, analysis, and reporting by race,
7 ethnicity, sex, primary language, sexual orientation, dis-
8 ability status, gender identity, and socioeconomic status
9 among federally supported health programs.

10 (b) **AMENDMENT.**—Title XXXIV of the Public
11 Health Service Act, as added by titles II and III of this
12 Act, is further amended by inserting after subtitle A the
13 following:

14 **“Subtitle B—Strengthening Data**
15 **Collection, Improving Data**
16 **Analysis, and Expanding Data**
17 **Reporting**

18 **“SEC. 3431. HEALTH DISPARITY DATA.**

19 **“(a) REQUIREMENTS.—**

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

1 “(A) require the collection, by the agency
2 or program involved, of data on the race, eth-
3 nicity, sex, primary language, sexual orienta-
4 tion, disability status, gender identity, and so-
5 cioeconomic status of each applicant for and re-
6 cipient of health-related assistance under such
7 program—

8 “(i) using, at a minimum, standards
9 for data collection on race, ethnicity, sex,
10 primary language, sexual orientation, dis-
11 ability status, gender identity, and socio-
12 economic status developed under section
13 3101;

14 “(ii) collecting data for additional
15 population groups if such groups can be
16 aggregated into the race and ethnicity cat-
17 egories outlined by standards developed
18 under section 3101;

19 “(iii) additionally referring, where
20 practicable, to the standards developed by
21 the Institute of Medicine in ‘Race, Eth-
22 nicity, and Language Data: Standardiza-
23 tion for Health Care Quality Improve-
24 ment’; and

1 “(iv) where practicable, through self-
2 reporting;

3 “(B) with respect to the collection of the
4 data described in subparagraph (A), for appli-
5 cants and recipients who are minors, require
6 communication assistance in speech or writing,
7 and for applicants and recipients who are other-
8 wise legally incapacitated, require that—

9 “(i) such data be collected from the
10 parent or legal guardian of such an appli-
11 cant or recipient; and

12 “(ii) the primary language of the par-
13 ent or legal guardian of such an applicant
14 or recipient be collected;

15 “(C) systematically analyze such data
16 using the smallest appropriate units of analysis
17 feasible to detect racial and ethnic disparities,
18 as well as disparities along the lines of primary
19 language, sex, disability status, sexual orienta-
20 tion, gender identity, and socioeconomic status
21 in health and health care, and report the results
22 of such analysis to the Secretary, the Director
23 of the Office for Civil Rights, each agency listed
24 in section 3101(c)(1), the Committee on
25 Health, Education, Labor, and Pensions and

1 the Committee on Finance of the Senate, and
2 the Committee on Energy and Commerce and
3 the Committee on Ways and Means of the
4 House of Representatives;

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

7 “(E) ensure that the provision of assist-
8 ance to an applicant or recipient of assistance
9 is not denied or otherwise adversely affected be-
10 cause of the failure of the applicant or recipient
11 to provide race, ethnicity, primary language,
12 sex, sexual orientation, disability status, gender
13 identity, and socioeconomic status data.

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

16 “(A) permit the use of information col-
17 lected under this subsection in a manner that
18 would adversely affect any individual providing
19 any such information; or

20 “(B) diminish existing or future require-
21 ments on health care providers to collect data.

22 “(3) NO COMPELLED DISCLOSURE OF DATA.—
23 This title does not authorize any health care pro-
24 vider, Federal official, or other entity to compel the
25 disclosure of any data collected under this title. The

1 disclosure of any such data by an individual pursu-
2 ant to this title shall be strictly voluntary.

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) are
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, to improve the collection, analysis,
24 and reporting of racial, ethnic, sex, primary language, sex-
25 ual orientation, disability status, gender identity, and so-

1 socioeconomic status data at the Federal, State, territorial,
2 Tribal, and local levels, including data to be collected
3 under subsection (a), and to ensure that data collection
4 activities carried out under this section are in compliance
5 with standards developed under section 3101. The Data
6 Council of the Department of Health and Human Serv-
7 ices, in consultation with the National Committee on Vital
8 Health Statistics, the Office of Minority Health, Office on
9 Women’s Health, and other appropriate public and private
10 entities, shall make recommendations to the Secretary
11 concerning the development, implementation, and revision
12 of the national plan. Such plan shall include recommenda-
13 tions on how to—

14 “(1) implement subsection (a) while minimizing
15 the cost and administrative burdens of data collec-
16 tion and reporting;

17 “(2) expand knowledge among Federal agen-
18 cies, States, territories, Indian Tribes, counties, mu-
19 nicipalities, health providers, health plans, and the
20 general public that data collection, analysis, and re-
21 porting by race, ethnicity, primary language, sexual
22 orientation, disability status, gender identity, and so-
23 cioeconomic status is legal and necessary to assure
24 equity and nondiscrimination in the quality of health
25 care services;

1 “(3) ensure that future patient record systems
2 follow Federal standards promulgated under the
3 HITECH Act for the collection and meaningful use
4 of electronic health data on race, ethnicity, primary
5 language, sexual orientation, disability status, gen-
6 der identity, and socioeconomic status;

7 “(4) improve health and health care data collec-
8 tion and analysis for more population groups if such
9 groups can be aggregated into the minimum race
10 and ethnicity categories, including exploring the fea-
11 sibility of enhancing collection efforts in States,
12 counties, and municipalities for racial and ethnic
13 groups that comprise a significant proportion of the
14 population of the State, county, or municipality;

15 “(5) provide researchers with greater access to
16 racial, ethnic, primary language, sexual orientation,
17 disability status, gender identity, and socioeconomic
18 status data, subject to privacy and confidentiality
19 regulations; and

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

22 “(d) COMPLIANCE WITH STANDARDS.—Data col-
23 lected under subsection (a) shall be obtained, maintained,
24 and presented (including for reporting purposes) in ac-
25 cordance with standards developed under section 3101.

1 “(e) ANALYSIS OF HEALTH DISPARITY DATA.—The
2 Secretary, acting through the Director of the Agency for
3 Healthcare Research and Quality and in coordination with
4 the Assistant Secretary for Planning and Evaluation, Ad-
5 ministrator of the Centers for Medicare & Medicaid Serv-
6 ices, the Director of the National Center for Health Statis-
7 tics, and the Director of the National Institutes of Health,
8 shall provide technical assistance to agencies of the De-
9 partment of Health and Human Services in meeting Fed-
10 eral standards for health disparity data collection and for
11 analysis of racial, ethnic, and other disparities in health
12 and health care in public programs by—

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

15 “(2) specifying the clinical, diagnostic, or thera-
16 peutic measures which should be monitored;

17 “(3) developing new quality measures relating
18 to racial and ethnic disparities and their overlap
19 with other disparity factors 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 “(f) PRIMARY LANGUAGE.—References in this sec-
2 tion—

3 “(1) to primary language data, include spoken
4 and written primary language data; and

5 “(2) to primary language data collection activi-
6 ties, include identifying, collecting, storing, tracking,
7 and analyzing primary language data and informa-
8 tion on the methods used to meet the language ac-
9 cess needs of limited-English-proficient individuals.

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

12 “(1) under the Social Security Act (42 U.S.C.
13 301 et seq.) that pays for health care and services;
14 and

15 “(2) under this Act that provides Federal finan-
16 cial assistance for health care, biomedical research,
17 or health services research and or is designed to im-
18 prove the public’s health.

19 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated to carry out this section
21 such sums as may be necessary for each of fiscal years
22 2019 through 2024.

1 **“SEC. 3432. ESTABLISHING GRANTS FOR DATA COLLECTION**
2 **IMPROVEMENT ACTIVITIES.**

3 “(a) IN GENERAL.—The Secretary, acting through
4 the Director of the Agency for Healthcare Research and
5 Quality and in consultation with the Deputy Assistant
6 Secretary for Minority Health, the Director of the Na-
7 tional Institutes of Health, the Assistant Secretary for
8 Planning and Evaluation, and the Director of the National
9 Center for Health Statistics, shall establish a technical as-
10 sistance program under which the Secretary provides
11 grants to eligible entities to assist such entities in com-
12 plying with section 3431.

13 “(b) TYPES OF ASSISTANCE.—Grants provided under
14 this section may include grants to—

15 “(1) enhance or upgrade computer technology
16 that will facilitate racial, ethnic, primary language,
17 sexual orientation, disability status, gender identity,
18 and socioeconomic status data collection, analysis,
19 and reporting;

20 “(2) improve methods for health data collection
21 and analysis, including additional population groups
22 if such groups can be aggregated into the race and
23 ethnicity categories outlined by standards developed
24 under section 3101;

1 “(3) develop mechanisms for submitting col-
2 lected data subject to existing privacy and confiden-
3 tiality regulations; and

4 “(4) develop educational programs to inform
5 health plans, health providers, health-related agen-
6 cies, and the general public that data collection and
7 reporting by race, ethnicity, primary language, sex-
8 ual orientation, disability status, gender identity,
9 and socioeconomic status are legal and essential for
10 eliminating health and health care disparities.

11 “(c) ELIGIBLE ENTITY.—To be eligible for grants
12 under this section, an entity shall be a State, territory,
13 Indian Tribe, municipality, county, health provider, health
14 care organization, or health plan making a demonstrated
15 effort to bring data collections into compliance with sec-
16 tion 3431.

17 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated to carry out this section
19 such sums as may be necessary for each of fiscal years
20 2019 through 2024.

21 **“SEC. 3433. OVERSAMPLING OF UNDERREPRESENTED**
22 **GROUPS IN FEDERAL HEALTH SURVEYS.**

23 “(a) NATIONAL STRATEGY.—

24 “(1) IN GENERAL.—The Secretary of Health
25 and Human Services, acting through the Director of

1 the National Center for Health Statistics of the Cen-
2 ters for Disease Control and Prevention, and other
3 agencies within the Department of Health and
4 Human Services as the Secretary determines appro-
5 priate, shall develop and implement an ongoing and
6 sustainable national strategy for oversampling
7 underrepresented populations within the categories
8 of race, ethnicity, sex, primary language, sexual ori-
9 entation, disability status, gender identity, and socio-
10 economic status as determined appropriate by the
11 Secretary in Federal health surveys and program
12 data collections. Such national strategy shall include
13 a strategy for oversampling of Asian Americans, Na-
14 tive Hawaiians and Pacific Islanders.

15 “(2) CONSULTATION.—In developing and imple-
16 menting a national strategy, as described in para-
17 graph (1), not later than 180 days after the date of
18 the enactment of the this section, the Secretary
19 shall—

20 “(A) consult with representatives of com-
21 munity groups, nonprofit organizations, non-
22 governmental organizations, and government
23 agencies working with underrepresented popu-
24 lations;

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

5 “(C) consult on, and use as models, the
6 2014 National Health Interview Survey over-
7 sample of Native Hawaiian and Pacific Islander
8 populations and the 2017 Behavioral Risk Fac-
9 tor Surveillance System oversample of American
10 Indian and Alaska Native communities.

11 “(b) PROGRESS REPORT.—Not later than 2 years
12 after the date of the enactment of this section, the Sec-
13 retary shall submit to the Congress a progress report,
14 which shall include the national strategy described in sub-
15 section (a)(1).

16 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
17 carry out this section, there are authorized to be appro-
18 priated such sums as may be necessary for fiscal years
19 2019 through 2024.”.

20 **SEC. 102. ELIMINATION OF PREREQUISITE OF DIRECT AP-**
21 **PROPRIATIONS FOR DATA COLLECTION AND**
22 **ANALYSIS.**

23 Section 3101 of the Public Health Service Act (42
24 U.S.C. 300kk) is amended—

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

1 (2) by redesignating subsection (i) as subsection
2 (h).

3 **SEC. 103. 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 “COLLECTION OF RACE AND ETHNICITY DATA BY THE
9 SOCIAL SECURITY ADMINISTRATION

10 “SEC. 1150C. (a) REQUIREMENT.—The Commis-
11 sioner of Social Security, in consultation with the Admin-
12 istrator of the Centers for Medicare & Medicaid Services,
13 shall—

14 “(1) require the collection of data on the race,
15 ethnicity, primary language, and disability status of
16 all applicants for Social Security account numbers or
17 benefits under title II or part A of title XVIII and
18 all individuals with respect to whom the Commis-
19 sioner maintains records of wages and self-employ-
20 ment income in accordance with reports received by
21 the Commissioner or the Secretary of the Treas-
22 ury—

23 “(A) using, at a minimum, standards for
24 data collection on race, ethnicity, primary lan-
25 guage, and disability status developed under
26 section 3101 of the Public Health Service Act;

1 “(B) where practicable, collecting data for
2 additional population groups if such groups can
3 be aggregated into the race and ethnicity cat-
4 egories outlined by standards developed under
5 section 3101 of the Public Health Service Act;
6 and

7 “(C) additionally referring, where prac-
8 ticable, to the standards developed by the Insti-
9 tute of Medicine in ‘Race, Ethnicity, and Lan-
10 guage Data: Standardization for Health Care
11 Quality Improvement’ (released August 31,
12 2009);

13 “(2) with respect to the collection of the data
14 described in paragraph (1) for applicants who are
15 under 18 years of age or otherwise legally incapac-
16 itated, require that—

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

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

22 “(3) require that such data be uniformly ana-
23 lyzed and reported at least annually to the Commis-
24 sioner of Social Security;

1 “(4) be responsible for storing the data re-
2 ported under paragraph (3);

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

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

8 “(7) ensure that the provision of assistance to
9 an applicant is not denied or otherwise adversely af-
10 fected because of the failure of the applicant to pro-
11 vide race, ethnicity, primary language, and disability
12 status data.

13 “(b) PROTECTION OF DATA.—The Commissioner of
14 Social Security shall ensure (through the promulgation of
15 regulations or otherwise) that all data collected pursuant
16 to subsection (a) are protected—

17 “(1) under the same privacy protections as the
18 Secretary applies to health data under the regula-
19 tions promulgated under section 264(c) of the
20 Health Insurance Portability and Accountability Act
21 of 1996 (Public Law 104–191; 110 Stat. 2033) re-
22 lating to the privacy of individually identifiable
23 health information and other protections; and

24 “(2) from all inappropriate internal use by any
25 entity that collects, stores, or receives the data, in-

1 including use of such data in determinations of eligi-
2 bility (or continued eligibility) in health plans, and
3 from other inappropriate uses, as defined by the
4 Secretary.

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

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

14 “(e) **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 2019 through 2024.”.

18 **SEC. 104. REVISION OF HIPAA CLAIMS STANDARDS.**

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

1 (1) the use, at a minimum, of standards for
2 data collection on race, ethnicity, primary language,
3 disability, sex, sexual orientation, and gender iden-
4 tity developed under section 3101 of the Public
5 Health Service Act (42 U.S.C. 300kk); and

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

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

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

22 **SEC. 105. NATIONAL CENTER FOR HEALTH STATISTICS.**

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

1 (1) in paragraph (1), by striking “2003” and
2 inserting “2022”;

3 (2) in paragraph (2), in the first sentence, by
4 striking “2003” and inserting “2022”; and

5 (3) in paragraph (3), by striking “2002” and
6 inserting “2022”.

7 **SEC. 106. DISPARITIES DATA COLLECTED BY THE FEDERAL**
8 **GOVERNMENT.**

9 (a) **COLLECTION; SUBMISSION.**—Not later than 180
10 days after the date of the enactment of this Act, and Jan-
11 uary 31 of each year thereafter, each department, agency,
12 and office of the Federal Government that has collected
13 data on race, ethnicity, sex, primary language, sexual ori-
14 entation, disability status, gender identity, or socio-
15 economic status during the preceding calendar year shall
16 submit such data to a centralized electronic repository of
17 Government data on factors related to the health and well-
18 being of the American population.

19 (b) **ANALYSIS; PUBLIC AVAILABILITY; REPORTING.**—
20 Not later than April 30, 2018, and each April 30 there-
21 after, the Secretary of Health and Human Services, acting
22 through the Assistant Secretary for Planning and Evalua-
23 tion, the Assistant Secretary for Health, the Director of
24 the Agency for Healthcare Research and Quality, the Di-
25 rector of the National Center for Health Statistics, the

1 Administrator of the Centers for Medicare & Medicaid
2 Services, the Director of the National Institute on Minor-
3 ity Health and Health Disparities, and the Deputy Assist-
4 ant Secretary for Minority Health, shall—

5 (1) prepare and make available datasets for
6 public use that relate to disparities in health status,
7 health care access, health care quality, health out-
8 comes, public health, and other areas of health and
9 well-being by factors that include race, ethnicity,
10 sex, primary language, sexual orientation, disability
11 status, gender identity, and socioeconomic status;

12 (2) ensure that these data sets are publicly
13 identified on a centralized electronic repository of
14 Government data as “disparities” data; and

15 (3) submit a report to the Congress on the
16 availability and use of such data by public stake-
17 holders.

18 **SEC. 107. DATA COLLECTION AND ANALYSIS GRANTS TO MI-**

19 **NORITY-SERVING INSTITUTIONS.**

20 (a) **AUTHORITY.**—The Secretary of Health and
21 Human Services, acting through the National Institute on
22 Minority Health and Health Disparities and the Deputy
23 Assistant Secretary for Minority Health, shall award
24 grants to access and analyze racial and ethnic, and where
25 possible other health disparity data, to monitor and report

1 on progress to reduce and eliminate disparities in health
2 and health care.

3 (b) ELIGIBLE ENTITY.—In this section, the term “el-
4 ible entity” means a historically Black college or univer-
5 sity, a Hispanic-serving institution, a Tribal college or uni-
6 versity, or an Asian American, Native American, or Pacific
7 Islander-serving institution with an accredited public
8 health, health policy, or health services research program.

9 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
10 out this section, there are authorized to be appropriated
11 such sums as may be necessary for fiscal years 2019
12 through 2024.

13 **SEC. 108. STANDARDS FOR MEASURING SEXUAL ORIENTA-**
14 **TION AND GENDER IDENTITY IN COLLECTION**
15 **OF HEALTH DATA.**

16 Section 3101(a) of the Public Health Service Act (42
17 U.S.C. 300kk(a)) is amended—

18 (1) in paragraph (1)(A), by inserting “sexual
19 orientation, gender identity,” before “and disability
20 status”;

21 (2) in paragraph (1)(C), by inserting “sexual
22 orientation, gender identity,” before “and disability
23 status”; and

1 (3) in paragraph (2)(B), by inserting “sexual
2 orientation, gender identity,” before “and disability
3 status”.

4 **SEC. 109. STANDARDS FOR MEASURING SOCIOECONOMIC**
5 **STATUS IN COLLECTION OF HEALTH DATA.**

6 Section 3101(a) of the Public Health Service Act (42
7 U.S.C. 300kk(a)), as amended, is amended—

8 (1) in paragraph (1)(A), by inserting “socio-
9 economic status,” before “and disability status”;

10 (2) in paragraph (1)(C), by inserting “socio-
11 economic status,” before “and disability status”; and

12 (3) in paragraph (2)(B), by inserting “socio-
13 economic status,” before “and disability status”.

14 **SEC. 110. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
15 **RESPECT TO RACIAL AND ETHNIC BACK-**
16 **GROUND.**

17 (a) IN GENERAL.—Chapter V of the Federal Food,
18 Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amend-
19 ed by adding after section 505F the following:

20 **“SEC. 505G. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
21 **RESPECT TO RACIAL AND ETHNIC BACK-**
22 **GROUND.**

23 “(a) PREAPPROVAL STUDIES.—If there is evidence
24 that there may be a disparity on the basis of racial or

1 ethnic background as to the safety or effectiveness of a
2 drug, then—

3 “(1)(A) the investigations required under sec-
4 tion 505(b)(1)(A) shall include adequate and well-
5 controlled investigations of the disparity; or

6 “(B) the evidence required under section 351(a)
7 of the Public Health Service Act for approval of a
8 biologics license application for the drug shall in-
9 clude adequate and well-controlled investigations of
10 the disparity; and

11 “(2) if the investigations confirm that there is
12 a disparity, the labeling of the drug shall include ap-
13 propriate information about the disparity.

14 “(b) POSTMARKET STUDIES.—

15 “(1) IN GENERAL.—If there is evidence that
16 there may be a disparity on the basis of racial or
17 ethnic background as to the safety or effectiveness
18 of a drug for which there is an approved application
19 under section 505 or a license under section 351 of
20 the Public Health Service Act, the Secretary may by
21 order require the holder of the approved application
22 or license to conduct, by a date specified by the Sec-
23 retary, postmarketing studies to investigate the dis-
24 parity.

1 “(2) LABELING.—If the Secretary determines
2 that the postmarket studies confirm that there is a
3 disparity described in paragraph (1), the labeling of
4 the drug shall include appropriate information about
5 the disparity.

6 “(3) STUDY DESIGN.—The Secretary may
7 specify all aspects of study design, including the
8 number of studies and study participants, and the
9 other demographic characteristics of study partici-
10 pants included, in the order requiring postmarket
11 studies of the drug.

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

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

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

24 “(1) evidence that there is a disparity on the
25 basis of racial or ethnic background as to safety or

1 effectiveness of a drug in the same chemical class as
2 the drug;

3 “(2) evidence that there is a disparity on the
4 basis of racial or ethnic background in the way the
5 drug is metabolized; and

6 “(3) other evidence as the Secretary may deter-
7 mine.

8 “(d) APPLICATIONS UNDER SECTIONS 505(b)(2)
9 AND 505(j).—

10 “(1) IN GENERAL.—A drug for which an appli-
11 cation has been submitted or approved under section
12 505(j) shall not be considered ineligible for approval
13 under that section or misbranded under section 502
14 on the basis that the labeling of the drug omits in-
15 formation relating to a disparity on the basis of ra-
16 cial or ethnic background as to the safety or effec-
17 tiveness of the drug, whether derived from investiga-
18 tions or studies required under this section or de-
19 rived from other sources, when the omitted informa-
20 tion is protected by patent or by exclusivity under
21 clause (iii) or (iv) of section 505(j)(5)(B).

22 “(2) LABELING.—Notwithstanding clauses (iii)
23 and (iv) of section 505(j)(5)(B), the Secretary may
24 require that the labeling of a drug approved under
25 section 505(j) that omits information relating to a

1 disparity on the basis of racial or ethnic background
2 as to the safety or effectiveness of the drug include
3 a statement of any appropriate contraindications,
4 warnings, or precautions related to the disparity
5 that the Secretary considers necessary.”.

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

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

14 (c) DRUG FEES.—Section 736(a)(1)(A)(ii) of the
15 Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379h)
16 is amended by adding after “are required” the following:
17 “, including supplements required under section 505G”.

18 **SEC. 111. IMPROVING HEALTH DATA REGARDING NATIVE**

19 **HAWAIIANS AND OTHER PACIFIC ISLANDERS.**

20 Part B of title III of the Public Health Service Act
21 (42 U.S.C. 243 et seq.) is amended by inserting after sec-
22 tion 317U, as added, the following:

23 **“SEC. 317V. NATIVE HAWAIIAN AND OTHER PACIFIC IS-**

24 **LANDER HEALTH DATA.**

25 “(a) DEFINITIONS.—In this section:

1 “(1) COMMUNITY GROUP.—The term ‘commu-
2 nity group’ means a group of NHOPI who are orga-
3 nized at the community level, and may include a
4 church group, social service group, national advocacy
5 organization, or cultural group.

6 “(2) NONPROFIT, NONGOVERNMENTAL ORGANI-
7 ZATION.—The term ‘nonprofit, nongovernmental or-
8 ganization’ means a group of NHOPI with a dem-
9 onstrated history of addressing NHOPI issues, in-
10 cluding a NHOPI coalition.

11 “(3) DESIGNATED ORGANIZATION.—The term
12 ‘designated organization’ means an entity estab-
13 lished to represent NHOPI populations and which
14 has statutory responsibilities to provide, or has com-
15 munity support for providing, health care.

16 “(4) GOVERNMENT REPRESENTATIVES.—The
17 term ‘government representatives’ means representa-
18 tives from Hawaii, American Samoa, the Common-
19 wealth of the Northern Mariana Islands, the Fed-
20 erated States of Micronesia, Guam, the Republic of
21 Palau, and the Republic of the Marshall Islands.

22 “(5) NATIVE HAWAIIANS AND OTHER PACIFIC
23 ISLANDERS (NHOPI).—The term ‘Native Hawaiians
24 and Other Pacific Islanders’ or ‘NHOPI’ means peo-
25 ple having origins in any of the original peoples of

1 American Samoa, the Commonwealth of the North-
2 ern Mariana Islands, the Federated States of Micro-
3 nesia, Guam, Hawaii, the Republic of the Marshall
4 Islands, the Republic of Palau, or any other Pacific
5 island.

6 “(6) INSULAR AREA.—The term ‘insular area’
7 means Guam, the Commonwealth of Northern Mar-
8 iana Islands, American Samoa, the United States
9 Virgin Islands, the Federated States of Micronesia,
10 the Republic of Palau, or the Republic of the Mar-
11 shall Islands.

12 “(b) NATIONAL STRATEGY.—

13 “(1) IN GENERAL.—The Secretary, acting
14 through the Director of the National Center for
15 Health Statistics (referred to in this section as
16 ‘NCHS’) of the Centers for Disease Control and
17 Prevention, and other agencies within the Depart-
18 ment of Health and Human Services as the Sec-
19 retary determines appropriate, shall develop and im-
20 plement an ongoing and sustainable national strat-
21 egy for identifying and evaluating the health status
22 and health care needs of NHOPI populations living
23 in the continental United States, Hawaii, American
24 Samoa, the Commonwealth of the Northern Mariana
25 Islands, the Federated States of Micronesia, Guam,

1 the Republic of Palau, and the Republic of the Mar-
2 shall Islands.

3 “(2) CONSULTATION.—In developing and imple-
4 menting a national strategy, as described in para-
5 graph (1), not later than 180 days after the date of
6 enactment of the Health Equity and Accountability
7 Act of 2018, the Secretary—

8 “(A) shall consult with representatives of
9 community groups, designated organizations,
10 and nonprofit, nongovernmental organizations
11 and with government representatives of NHOPI
12 populations; and

13 “(B) may solicit the participation of rep-
14 resentatives from other Federal departments.

15 “(c) PRELIMINARY HEALTH SURVEY.—

16 “(1) IN GENERAL.—The Secretary, acting
17 through the Director of NCHS, shall conduct a pre-
18 liminary health survey in order to identify the major
19 areas and regions in the continental United States,
20 Hawaii, American Samoa, the Commonwealth of the
21 Northern Mariana Islands, the Federated States of
22 Micronesia, Guam, the Republic of Palau, and the
23 Republic of the Marshall Islands in which NHOPI
24 people reside.

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

4 “(A) useful in determining health status
5 and health care needs; or

6 “(B) required for developing or imple-
7 menting a national strategy.

8 “(3) METHODOLOGY.—Methodology for the
9 health survey described in paragraph (1), including
10 plans for designing questions, implementation, sam-
11 pling, and analysis, shall be developed in consulta-
12 tion with community groups, designated organiza-
13 tions, nonprofit, nongovernmental organizations, and
14 government representatives of NHOPI populations,
15 as determined by the Secretary.

16 “(4) TIMEFRAME.—The survey required under
17 this subsection shall be completed not later than 18
18 months after the date of enactment of the Health
19 Equity and Accountability Act of 2018.

20 “(d) PROGRESS REPORT.—Not later than 2 years
21 after the date of enactment of the Health Equity and Ac-
22 countability Act of 2018, the Secretary shall submit to
23 Congress a progress report, which shall include the na-
24 tional strategy described in subsection (b)(1).

25 “(e) STUDY AND REPORT BY THE IOM.—

1 “(1) IN GENERAL.—The Secretary shall enter
2 into an agreement with the Institute of Medicine
3 (IOM) to conduct a study, with input from stake-
4 holders in insular areas, on the following:

5 “(A) The standards and definitions of
6 health care applied to health care systems in in-
7 sular areas and the appropriateness of such
8 standards and definitions.

9 “(B) The status and performance of health
10 care systems in insular areas, evaluated based
11 upon standards and definitions, as the Sec-
12 retary determines.

13 “(C) The effectiveness of donor aid in ad-
14 dressing health care needs and priorities in in-
15 sular areas.

16 “(D) The progress toward implementation
17 of recommendations of the Committee on
18 Health Care Services in the United States—As-
19 sociated Pacific Basin of the Institute of Medi-
20 cine that are set forth in the 1998 report, ‘Pa-
21 cific Partnerships for Health: Charting a New
22 Course for the 21st Century’.

23 “(2) REPORT.—An agreement described in
24 paragraph (1) shall require the Institute of Medicine
25 to submit to the Secretary and to Congress, not

1 later than 2 years after the date of the enactment
2 of the Health Equity and Accountability Act of
3 2018, a report containing a description of the results
4 of the study conducted under paragraph (1), includ-
5 ing the conclusions and recommendations of the In-
6 stitute of Medicine for each of the items described
7 in subparagraphs (A) through (D) of such para-
8 graph.

9 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
10 carry out this section, there are authorized to be appro-
11 priated such sums as may be necessary for fiscal years
12 2019 through 2024.”.

13 **SEC. 112. CLARIFICATION OF SIMPLIFIED ADMINISTRATIVE**
14 **REPORTING REQUIREMENT.**

15 Section 11(a) of the Food and Nutrition Act of 2008
16 (7 U.S.C. 2020(a)) is amended by adding at the end the
17 following:

18 “(5) SIMPLIFIED ADMINISTRATIVE REPORTING
19 REQUIREMENT.—The administrative notification re-
20 quirement under section 421(e)(2) of the Personal
21 Responsibility and Work Opportunity Reconciliation
22 Act of 1996 (8 U.S.C. 1631(e)(2)) shall be satisfied
23 by the submission by an agency of a report on the
24 aggregate number of exceptions granted under such
25 section by such agency in each year.”.

1 **TITLE II—CULTURALLY AND LIN-**
2 **GUISTICALLY APPROPRIATE**
3 **HEALTH AND HEALTH CARE**

4 **SEC. 201. DEFINITIONS.**

5 In this title, the definitions contained in section 3400
6 of the Public Health Service Act, as added by section 202,
7 shall apply.

8 **SEC. 202. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
9 **ACT.**

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

11 (1) Effective communication is essential to
12 meaningful access to quality physical and mental
13 health care.

14 (2) Research indicates that the lack of appro-
15 priate language services creates language barriers
16 that result in increased risk of misdiagnosis, ineffec-
17 tive treatment plans and poor health outcomes for
18 limited-English-proficient individuals and individuals
19 with communication disabilities such as hearing, vi-
20 sion, or print impairments.

21 (3) The number of limited-English-speaking
22 residents in the United States who speak English
23 less than very well and, therefore, cannot effectively
24 communicate with health and social service providers
25 continues to increase significantly.

1 (4) The responsibility to fund language services
2 in the provision of health care and health-care-re-
3 lated services to limited-English-proficient individ-
4 uals and individuals with communication disabilities
5 such as hearing, vision, or print impairments is a so-
6 cietal one that cannot fairly be visited solely upon
7 the health care, public health, or social services com-
8 munity.

9 (5) Title VI of the Civil Rights Act of 1964
10 prohibits discrimination based on the grounds of
11 race, color, or national origin by any entity receiving
12 Federal financial assistance. In order to avoid dis-
13 crimination on the grounds of national origin, all
14 programs or activities administered by the Depart-
15 ment must take adequate steps to ensure that their
16 policies and procedures do not deny or have the ef-
17 fect of denying limited-English-proficient individuals
18 with equal access to benefits and services for which
19 such persons qualify.

20 (6) Both the Americans with Disabilities Act
21 and the Rehabilitation Act of 1973 prohibit discrimi-
22 nation on the basis of disability and require the pro-
23 vision of appropriate auxiliary aids and services nec-
24 essary to ensure effective communication with indi-
25 viduals with disabilities. The type of auxiliary aid or

1 service necessary to ensure effective communication
2 will vary in accordance with the method of commu-
3 nication used by the individual; the nature, length,
4 and complexity of the communication involved; and
5 the context in which the communication is taking
6 place. A public accommodation should consult with
7 individuals with disabilities whenever possible to de-
8 termine what type of auxiliary aid is needed to en-
9 sure effective communication, but the ultimate deci-
10 sion as to what measures to take rests with the pub-
11 lic accommodation, provided that the method chosen
12 results in effective communication. In order to be ef-
13 fective, auxiliary aids and services must be provided
14 in accessible formats, in a timely manner, and in
15 such a way as to protect the privacy and independ-
16 ence of the individual with a disability.

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

21 (8) All members of the health care and health-
22 care-related-services community should continue to
23 educate their staff and constituents about limited-
24 English-proficient and disability communication
25 issues and help them identify resources to improve

1 access to quality care for limited-English-proficient
 2 individuals and individuals with communication dis-
 3 abilities such as hearing, vision, or print impair-
 4 ments.

5 (9) Access to English as a second language, and
 6 sign language instructions, readers, and other auxil-
 7 iary aids and services, are essential to ensure effec-
 8 tive communication and eliminate the language bar-
 9 riers that impede access to health care.

10 (10) Competent language services in health care
 11 settings should be available as a matter of course.

12 (b) AMENDMENT.—The Public Health Service Act
 13 (42 U.S.C. 201 et seq.) is amended by adding at the end
 14 the following:

15 **“TITLE XXXIV—CULTURALLY**
 16 **AND LINGUISTICALLY APPRO-**
 17 **PRIATE HEALTH CARE**

18 **“SEC. 3400. DEFINITIONS.**

19 “In this title:

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

23 “(2) CULTURAL COMPETENCE.—The term ‘cul-
 24 tural competence’ means a set of congruent behav-
 25 iors, attitudes, and policies that come together in a

1 system, agency, or among professionals that enables
2 effective work in cross-cultural situations. In the
3 preceding sentence—

4 “(A) the term ‘cultural’ refers to inte-
5 grated patterns of human behavior that include
6 the language, thoughts, communications, ac-
7 tions, customs, beliefs, values, and institutions
8 of racial, ethnic, religious, or social groups, in-
9 cluding lesbian, gay, bisexual, transgender,
10 queer, and questioning individuals, and individ-
11 uals with physical and mental disabilities; and

12 “(B) the term ‘competence’ implies having
13 the capacity to function effectively as an indi-
14 vidual and an organization within the context of
15 the cultural beliefs, behaviors, and needs pre-
16 sented by consumers and their communities.

17 “(3) EFFECTIVE COMMUNICATION.—The term
18 ‘effective communication’ means an exchange of in-
19 formation between the provider of health care or
20 health-care-related services and the recipient of such
21 services who is limited in English proficiency, or has
22 a communication impairment such as a hearing, vi-
23 sion, speaking, or learning impairment, that enables
24 access, understanding, and benefit from health care

1 or health-care-related services, and full participation
2 in the development of their treatment plan.

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

7 “(5) HEALTH CARE GROUP.—The term ‘health
8 care group’ means a group of physicians organized,
9 at least in part, for the purposes of providing physi-
10 cians’ services under the Medicaid, SCHIP, or Medi-
11 care programs and may include a hospital and any
12 other individual or entity furnishing services covered
13 under the Medicaid, SCHIP, or Medicare programs
14 that is affiliated with the health care group.

15 “(6) HEALTH EDUCATOR.—The term ‘health
16 educator’ includes a baccalaureate prepared profes-
17 sional responsible for designing, implementing, and
18 evaluating individual and population health pro-
19 motion and chronic disease prevention programs.

20 “(7) HEALTH CARE SERVICES.—The term
21 ‘health care services’ means services that address
22 physical as well as mental health conditions in all
23 care settings.

24 “(8) HEALTH-CARE-RELATED SERVICES.—The
25 term ‘health-care-related services’ means human or

1 social services programs or activities that provide ac-
2 cess, referrals or links to health care.

3 “(9) INDIAN TRIBE.—The term ‘Indian Tribe’
4 means any Indian Tribe, band, nation, or other or-
5 ganized group or community, including any Alaska
6 Native village or group or regional or village cor-
7 poration as defined in or established pursuant to the
8 Alaska Native Claims Settlement Act (85 Stat. 688)
9 (43 U.S.C. 1601 et seq.), which is recognized as eli-
10 gible for the special programs and services provided
11 by the United States to Indians because of their sta-
12 tus as Indians.

13 “(10) INTEGRATED HEALTH CARE DELIVERY
14 SYSTEM.—The term ‘integrated health care delivery
15 system’ means an interdisciplinary system that
16 brings together providers from the primary health,
17 mental health, substance use and related disciplines
18 to improve the health outcomes of an individual.
19 Providers may include but are not limited to hos-
20 pitals, health, mental health or substance use clinics
21 and providers, home health agencies, ambulatory
22 surgery centers, skilled nursing facilities, rehabilita-
23 tion centers, and employed, independent, or con-
24 tracted physicians.

1 “(11) INDIVIDUAL WITH A DISABILITY.—The
2 term ‘individual with a disability’ means any indi-
3 vidual who has a disability as defined for the pur-
4 pose of section 504 of the Rehabilitation Act of
5 1973. Where this title references regulatory provi-
6 sions applicable to a ‘handicapped individual’, the
7 term ‘handicapped individual’ in such provisions
8 shall be treated to have the same meaning as the
9 term ‘individual with a disability’ as defined in this
10 section.

11 “(12) INDIVIDUAL WITH LIMITED-ENGLISH
12 PROFICIENCY.—The term ‘individual with limited-
13 English proficiency’ means an individual whose pri-
14 mary language for communication is not English
15 and who has a limited ability to read, write, speak,
16 or understand English.

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

22 “(14) LANGUAGE ACCESS.—The term ‘language
23 access’ means the provision of language services to
24 an individual with limited-English proficiency or an
25 individual with communication disabilities designed

1 to enhance that individual's access to, understanding
2 of, or benefit from health care or health-care-related
3 services.

4 “(15) LANGUAGE ASSISTANCE SERVICES.—The
5 term ‘language assistance services’ includes—

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

13 “(B) written translation, performed by a
14 qualified translator, of written content in paper
15 or electronic form into languages other than
16 English; and

17 “(C) taglines.

18 “(16) MEDICARE, MEDICAID, AND SCHIP.—The
19 terms ‘Medicare’, ‘Medicaid’, and ‘SCHIP’ mean the
20 respective programs under titles XVIII, XIX, and
21 XXI of the Social Security Act.

22 “(17) MINORITY.—

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

1 “(B) POPULATIONS.—The term ‘minority’,
2 with respect to populations, refers to racial and
3 ethnic minority groups, members of sexual and
4 gender minority groups, and individuals with a
5 disability.

6 “(18) MINORITY GROUP.—The term ‘minority
7 group’ has the meaning given the term ‘racial and
8 ethnic minority group’.

9 “(19) QUALIFIED INTERPRETER FOR AN INDI-
10 VIDUAL WITH LIMITED-ENGLISH PROFICIENCY.—
11 The term ‘qualified interpreter for an individual with
12 limited-English proficiency’ means an interpreter
13 who via a remote interpreting service or an on-site
14 appearance—

15 “(A) adheres to generally accepted inter-
16 preter ethics principles, including client con-
17 fidentiality;

18 “(B) has demonstrated proficiency in
19 speaking and understanding both spoken
20 English and one or more other spoken lan-
21 guages; and

22 “(C) is able to interpret effectively, accu-
23 rately, and impartially, both receptively and ex-
24 pressly, to and from such languages and

1 English, using any necessary specialized vocab-
2 ulary, terminology, and phraseology.

3 “(20) QUALIFIED TRANSLATOR.—The term
4 ‘qualified translator’ means a translator who—

5 “(A) adheres to generally accepted trans-
6 lator ethics principles, including client confiden-
7 tiality;

8 “(B) has demonstrated proficiency in writ-
9 ing and understanding both written English
10 and one or more other written non-English lan-
11 guages; and

12 “(C) is able to translate effectively, accu-
13 rately, and impartially to and from such lan-
14 guages and English, using any necessary spe-
15 cialized vocabulary, terminology, and phrase-
16 ology.

17 “(21) 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 “(22) SEXUAL AND GENDER MINORITY
25 GROUP.—The term ‘sexual and gender minority

1 group’ encompasses lesbian, gay, bisexual, and
2 transgender populations, as well as those whose sex-
3 ual orientation, gender identity and expression, or
4 reproductive development varies from traditional, so-
5 cietal, cultural, or physiological norms.

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

14 “(24) SECRETARY.—The term ‘Secretary’
15 means the Secretary of Health and Human Services.

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

21 “(26) STATE.—The term ‘State’ means each of
22 the several States, the District of Columbia, the
23 Commonwealth of Puerto Rico, the Indian Tribes,
24 the United States Virgin Islands, Guam, American

1 Samoa, and the Commonwealth of the Northern
2 Mariana Islands.

3 “(27) TELEPHONIC INTERPRETATION.—The
4 term ‘telephonic interpretation’ (also known as over
5 the phone interpretation or OPI) means a method of
6 interpretation for which the interpreter is not in the
7 physical presence of the provider of health care or
8 related services and the limited-English-proficient re-
9 cipient of such services but is connected via tele-
10 phone.

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

17 “(29) VIDEO REMOTE INTERPRETING SERV-
18 ICES.—The term ‘video remote interpreting services’
19 means the provision, through a qualified interpreter
20 for an individual with limited-English proficiency, of
21 video remote interpreting services in health pro-
22 grams and activities.

23 “(A) in real-time, full-motion video, and
24 audio over a dedicated high-speed, wide-band-
25 width video connection or wireless connection

1 that delivers high quality video images that do
2 not produce lags, choppy, blurry, or grainy im-
3 ages, or irregular pauses in communication; and

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

6 “(30) VITAL DOCUMENT.—The term ‘vital doc-
7 ument’ includes but is not limited to applications for
8 government programs that provide health care serv-
9 ices, medical or financial consent forms, financial as-
10 sistance documents, letters containing important in-
11 formation regarding patient instructions (such as
12 prescriptions, referrals to other providers, and dis-
13 charge plans) and participation in a program (such
14 as a Medicaid managed care program), notices per-
15 taining to the reduction, denial, or termination of
16 services or benefits, notices of the right to appeal
17 such actions, and notices advising limited-English-
18 proficient individuals and individuals with commu-
19 nication disabilities of the availability of free lan-
20 guage services, alternative formats, and other out-
21 reach materials.

22 **“SEC. 3401. IMPROVING ACCESS TO SERVICES FOR INDIVID-**
23 **UALS WITH LIMITED-ENGLISH PROFICIENCY.**

24 “(a) PURPOSE.—As provided in Executive Order
25 13166, it is the purpose of this section—

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

5 “(2) to require each Federal agency to examine
6 the services it provides and develop and implement
7 a system by which limited-English-proficient individ-
8 uals can obtain cultural competence and meaningful
9 access to those services consistent with, and without
10 substantially burdening, the fundamental mission of
11 the agency;

12 “(3) to require each Federal agency to ensure
13 that recipients of Federal financial assistance pro-
14 vide cultural competence and meaningful access to
15 their limited-English-proficient applicants and bene-
16 ficiaries;

17 “(4) to ensure that recipients of Federal finan-
18 cial assistance take reasonable steps, consistent with
19 the guidelines set forth in the limited-English pro-
20 ficient Guidance of the Department of Justice (as
21 issued on June 12, 2002), to ensure cultural com-
22 petence and meaningful access to their programs
23 and activities by limited-English-proficient individ-
24 uals; and

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

5 “(b) **FEDERALLY CONDUCTED PROGRAMS AND AC-**
6 **TIVITIES.—**

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

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

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

24 “(B) the policies and procedures for identi-
25 fying, assessing, and meeting the language

1 needs and cultural competence needs of its lim-
2 ited-English-proficient beneficiaries served by
3 federally conducted programs and activities;

4 “(C) the steps the agency will take for its
5 federally conducted programs and activities to
6 improve cultural competence to provide a range
7 of language assistance options, notice to lim-
8 ited-English-proficient individuals of the right
9 to competent language services, periodic train-
10 ing of staff, monitoring and quality assessment
11 of the language services and, in appropriate cir-
12 cumstances, the translation of written mate-
13 rials;

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

23 “(E) the resources the agency will provide
24 to improve cultural competence to assist recipi-
25 ents of Federal funds to improve access to

1 health care or health-care-related programs and
2 activities for limited-English-proficient individ-
3 uals;

4 “(F) the resources the agency will provide
5 to ensure that competent language assistance is
6 provided to limited-English-proficient patients
7 by interpreters or trained bilingual staff; and

8 “(G) the resources the agency will provide
9 to ensure that family, particularly minor chil-
10 dren, and friends are not used to provide inter-
11 pretation services, except—

12 “(i) in the case of a medical emer-
13 gency where delay directly associated with
14 obtaining a competent interpreter would
15 jeopardize the health of the patient; or

16 “(ii) on request of the patient, who
17 has been informed in his or her preferred
18 language of the availability of free inter-
19 pretation services, if the health care serv-
20 ices provider has determined that the fam-
21 ily or friend can provide competent inter-
22 preter services as defined in section 3400.

23 “(3) SUBMISSION OF PLAN TO DOJ.—Each
24 agency that is required to prepare a plan under
25 paragraph (1) shall send a copy of such plan to the

1 Department of Justice, which shall serve as the cen-
2 tral repository of such plans.

3 “(4) RULE OF CONSTRUCTION.—Paragraph
4 (2)(G)(i) shall not be construed to mean that emer-
5 gency rooms or similar entities that regularly pro-
6 vide health care services in medical emergencies are
7 exempt from legal or regulatory requirements related
8 to competent interpreter services.

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

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

1 “(2) REQUIREMENTS.—The agency-specific
2 guidance developed under paragraph (1) shall take
3 into account the types of health care services pro-
4 vided by the recipients, the individuals served by the
5 recipients, and other factors set out in such stand-
6 ards.

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

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

17 “(d) CONSULTATIONS.—

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

1 portunity to provide input with respect to the actions
2 of the agency.

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

5 “(A) particular needs of the limited-
6 English-proficient individuals served by the
7 agency;

8 “(B) particular needs of the limited-
9 English-proficient individuals served by the
10 agency’s recipients of Federal financial assist-
11 ance; and

12 “(C) burdens of compliance with the agen-
13 cy guidance and this section for the agency and
14 its recipients.

15 **“SEC. 3402. NATIONAL STANDARDS FOR CULTURALLY AND**
16 **LINGUISTICALLY APPROPRIATE SERVICES IN**
17 **HEALTH CARE.**

18 “(a) APPLICABILITY.—This section applies to any
19 health program or activity, any part of which is receiving
20 Federal financial assistance, including credits, subsidies,
21 or contracts of insurance, or any program or activity that
22 is administered by an executive agency or any entity estab-
23 lished under title I of the Patient Protection and Afford-
24 able Care Act (or amendments made thereby), as such
25 programs, activities, agencies, and entities are described

1 in section 1557(a) of the Patient Protection and Afford-
2 able Care Act.

3 “(b) STANDARDS.—The programs, activities, agen-
4 cies, and entities described in subsection (a)—

5 “(1) shall implement strategies to recruit, re-
6 tain, and promote individuals at all levels to main-
7 tain a diverse staff and leadership that can provide
8 culturally and linguistically appropriate health care
9 to patient populations of the service area of the pro-
10 grams, activities, agencies, and entities;

11 “(2) shall educate and train governance, leader-
12 ship, and workforce at all levels and across all dis-
13 ciplines of the programs, activities, agencies, and en-
14 tities in culturally and linguistically appropriate poli-
15 cies and practices on an ongoing basis;

16 “(3) shall offer and provide language assist-
17 ance, including trained bilingual staff and inter-
18 preter services, to individuals who have limited-
19 English proficiency or other communication needs,
20 at no cost to them at all points of contact, and dur-
21 ing all hours of operation, to facilitate timely access
22 to all health care and services;

23 “(4) shall notify patients, in a culturally appro-
24 priate manner, of their right to receive language as-

1 assistance services in their primary language, verbally
2 and in writing;

3 “(5) shall not—

4 “(A) require an individual with limited-
5 English proficiency to provide his or her own
6 interpreter;

7 “(B) rely on an adult accompanying an in-
8 dividual with limited-English proficiency to in-
9 terpret or facilitate communication, except—

10 “(i) in an emergency involving an im-
11 minent threat to the safety or welfare of
12 an individual or the public where there is
13 no qualified interpreter for the individual
14 with limited-English proficiency imme-
15 diately available; or

16 “(ii) where the individual with limited-
17 English proficiency specifically requests
18 that the accompanying adult interpret or
19 facilitate communication, the accom-
20 panying adult agrees to provide such as-
21 sistance, and reliance on that adult for
22 such assistance is appropriate under the
23 circumstances;

24 “(C) rely on a minor child to interpret or
25 facilitate communication, except in an emer-

1 gency involving an imminent threat to the safe-
2 ty or welfare of an individual or the public
3 where there is no qualified interpreter for the
4 individual with limited-English proficiency im-
5 mediately available; or

6 “(D) rely on staff other than qualified bi-
7 lingual or multilingual staff to communicate di-
8 rectly with individuals;

9 “(6) shall for each eligible LEP language group
10 that constitutes 5 percent or 500 individuals, which-
11 ever is less, of the population of persons eligible to
12 be served or likely to be affected or encountered in
13 the service area of the organization, make avail-
14 able—

15 “(A) easily understood patient-related ma-
16 terials, including print and multimedia mate-
17 rials;

18 “(B) information or notices about termi-
19 nation of benefits; and

20 “(C) signage;

21 “(7) shall develop and implement clear goals,
22 policies, operational plans, and management, ac-
23 countability, and oversight mechanisms to provide
24 culturally and linguistically appropriate services and

1 infuse them throughout the organization’s planning
2 and operations;

3 “(8) shall conduct initial and ongoing organiza-
4 tional assessments of culturally and linguistically ap-
5 propriate services-related activities and integrate
6 valid linguistic, competence-related National Stand-
7 ards for Culturally and Linguistically Appropriate
8 Services (CLAS) measures into the internal audits,
9 performance improvement programs, patient satis-
10 faction assessments, continuous quality improvement
11 activities, and outcomes-based evaluations of the or-
12 ganization and develop ways to standardize the as-
13 sessments;

14 “(9) shall ensure that, consistent with the pri-
15 vacy protections provided for under the regulations
16 promulgated under section 264(c) of the Health In-
17 surance Portability and Accountability Act of 1996,
18 data on an individual required to be collected pursu-
19 ant to section 3101, including the individual’s alter-
20 native format preferences and policy modification
21 needs, are—

22 “(A) collected in health records;

23 “(B) integrated into the organization’s
24 management information systems; and

25 “(C) periodically updated;

1 “(10) shall maintain a current demographic,
2 cultural, and epidemiological profile of the commu-
3 nity, conduct regular assessments of community
4 health assets and needs, and use the results to accu-
5 rately plan for and implement services that respond
6 to the cultural and linguistic characteristics of the
7 service area of the organization;

8 “(11) shall develop participatory, collaborative
9 partnerships with communities and utilize a variety
10 of formal and informal mechanisms to facilitate
11 community and patient involvement in designing,
12 implementing, and evaluating policies and practices
13 to ensure culturally and linguistically appropriate
14 service-related activities;

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

20 “(13) shall regularly make available to the pub-
21 lic information about their progress and successful
22 innovations in implementing the standards under
23 this section and provide public notice in their com-
24 munities about the availability of this information;
25 and

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

7 **“SEC. 3403. ROBERT T. MATSUI CENTER FOR CULTURAL**
8 **AND LINGUISTIC COMPETENCE IN HEALTH**
9 **CARE.**

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

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

21 “(2) TRANSLATION OF WRITTEN MATERIAL.—

22 “(A) The Center shall provide, directly or
23 through contract, vital documents from com-
24 petent translation services for providers of
25 health care and health-care-related services at

1 no cost to such providers. Materials may be
2 submitted for translation into non-English lan-
3 guages. Translation services shall be provided
4 in a timely and reasonable manner. The quality
5 of such translation services shall be monitored
6 and reported publicly.

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

18 “(3) TOLL-FREE CUSTOMER SERVICE TELE-
19 PHONE NUMBER.—The Center shall provide,
20 through a toll-free number, a customer service line
21 for LEP individuals—

22 “(A) to obtain information about federally
23 conducted or funded health programs, including
24 Medicare, Medicaid, and SCHIP;

1 “(B) to obtain assistance with applying for
2 or accessing these programs and understanding
3 Federal notices written in English; and

4 “(C) to learn how to access language serv-
5 ices.

6 “(4) HEALTH INFORMATION CLEARING-
7 HOUSE.—

8 “(A) IN GENERAL.—The Center shall de-
9 velop and maintain an information clearing-
10 house to facilitate the provision of language
11 services by providers of health care and health-
12 care-related services to reduce medical errors,
13 improve medical outcomes, to improve cultural
14 competence, reduce health care costs caused by
15 miscommunication with individuals with lim-
16 ited-English proficiency, and reduce or elimi-
17 nate the duplication of effort to translate mate-
18 rials. The clearinghouse shall make such infor-
19 mation available on the internet and in print.
20 Such information shall include the information
21 described in the succeeding provisions of this
22 paragraph.

23 “(B) DOCUMENT TEMPLATES.—The Cen-
24 ter shall collect and evaluate for accuracy, de-
25 velop, and make available templates for stand-

1 ard documents that are necessary for patients
2 and consumers to access and make educated de-
3 cisions about their health care, including the
4 following:

5 “(i) Administrative and legal docu-
6 ments, including—

7 “(I) intake forms;

8 “(II) Medicare, Medicaid, and
9 SCHIP forms, including eligibility in-
10 formation;

11 “(III) forms informing patient of
12 HIPAA compliance and consent; and

13 “(IV) documents concerning in-
14 formed consent, advanced directives,
15 and waivers of rights.

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

20 “(iii) Public health, patient education,
21 and outreach materials, such as immuniza-
22 tion notices, health warnings, or screening
23 notices.

1 “(iv) Additional health or health-care-
2 related materials as determined appro-
3 priate by the Director of the Center.

4 “(C) STRUCTURE OF FORMS.—In oper-
5 ating the clearinghouse, the Center shall—

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

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

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

16 “(iv) facilitate access to these docu-
17 ments;

18 “(v) provide technical assistance with
19 respect to the access and use of such infor-
20 mation; and

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

24 “(D) LANGUAGE ASSISTANCE PRO-
25 GRAMS.—The Center shall provide for the col-

1 lection and dissemination of information on cur-
2 rent examples of language assistance programs
3 and strategies to improve language services for
4 LEP individuals, including case studies using
5 de-identified patient information, program sum-
6 maries, and program evaluations.

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

15 “(i) tenets of culturally and linguis-
16 tically competent care;

17 “(ii) cultural and linguistic com-
18 petence self-assessment tools;

19 “(iii) cultural and linguistic com-
20 petence training tools;

21 “(iv) strategic plans to increase cul-
22 tural and linguistic competence in different
23 types of providers of health care and
24 health-care-related services, including re-

1 gional collaborations among health care or-
2 ganizations; and

3 “(v) cultural and linguistic com-
4 petence information for educators, practi-
5 tioners, and researchers.

6 “(F) INFORMATION ABOUT PROGRESS.—

7 The Center shall regularly collect and make
8 publicly available information about the
9 progress of entities receiving grants under sec-
10 tion 3404 regarding successful innovations in
11 implementing the obligations under this sub-
12 section and provide public notice in the entities’
13 communities about the availability of this infor-
14 mation.

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

19 “(c) AVAILABILITY OF LANGUAGE ACCESS.—The Di-
20 rector shall collaborate with the Deputy Assistant Sec-
21 retary for Minority Health, the Administrator of the Cen-
22 ters for Medicare & Medicaid Services, and the Adminis-
23 trator of the Health Resources and Services Administra-
24 tion to notify health care providers and health care organi-

1 zations about the availability of language access services
2 by the Center.

3 “(d) EDUCATION.—The Secretary, directly or
4 through contract, shall undertake a national education
5 campaign to inform providers, LEP individuals, health
6 professionals, graduate schools, and community health
7 centers about—

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

10 “(2) the value of using trained interpreters and
11 the risks associated with using family members,
12 friends, minors, and untrained bilingual staff;

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

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

17 “(e) AUTHORIZATION OF APPROPRIATIONS.—In ad-
18 dition to the amounts authorized under subsection
19 (e)(8)(F), there are authorized to be appropriated to carry
20 out this section \$5,000,000 for each of fiscal years 2019
21 through 2023.

22 **“SEC. 3404. INNOVATIONS IN CULTURAL AND LINGUISTIC**
23 **COMPETENCE GRANTS.**

24 “(a) IN GENERAL.—The Secretary, acting through
25 the Director of the Agency for Healthcare Research and

1 Quality, shall award grants to eligible entities to enable
2 such entities to design, implement, and evaluate innova-
3 tive, cost-effective programs to improve cultural com-
4 petence and language access in health care for individuals
5 with limited-English proficiency. The Director of the
6 Agency for Healthcare Research and Quality shall coordi-
7 nate with, and ensure the participation of, other agencies
8 including the Health Resources and Services Administra-
9 tion, the Center on Minority Health and Health Dispari-
10 ties at the National Institutes of Health, and the Office
11 of Minority Health, regarding the design and evaluation
12 of the grants program.

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

15 “(1) be—

16 “(A) a city, county, Indian Tribe, State,
17 territory, or subdivision thereof;

18 “(B) an organization described in section
19 501(c)(3) of the Internal Revenue Code of 1986
20 and exempt from tax under section 501(a) of
21 such Code;

22 “(C) a community health, mental health,
23 or substance use center or clinic;

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

1 “(E) an integrated health care delivery
2 system;

3 “(F) a public hospital;

4 “(G) a health care group, university, or
5 college; or

6 “(H) other entity designated by the Sec-
7 retary; and

8 “(2) prepare and submit to the Secretary an
9 application, at such time, in such manner, and ac-
10 companied by such additional information as the
11 Secretary may require.

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

14 “(1) develop, implement, and evaluate models of
15 providing competent interpretation services through
16 onsite interpretation, telephonic interpretation, or
17 video interpretation;

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

23 “(3) develop and maintain a needs assessment
24 that identifies the current demographic, cultural,
25 and epidemiological profile of the community to ac-

1 curately plan for and implement language services
2 needed in service area of the organization;

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

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

9 “(6) develop and implement grievance resolu-
10 tion processes that are culturally and linguistically
11 sensitive and capable of identifying, preventing, and
12 resolving complaints by LEP individuals;

13 “(7) develop short-term medical mental health
14 interpretation training courses and incentives for bi-
15 lingual health care staff who are asked to interpret
16 in the workplace;

17 “(8) develop formal training programs, includ-
18 ing continued professional development and edu-
19 cation programs as well as supervision, for individ-
20 uals interested in becoming dedicated health care in-
21 terpreters and culturally competent providers;

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

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

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

6 “(12) develop, implement, and evaluate models
7 of improving cultural competence, including cultural
8 competence programs for community health workers;
9 and

10 “(13) 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 in improving language access.

1 “(e) EVALUATION.—

2 “(1) BY GRANTEES.—An entity that receives a
3 grant under this section shall submit to the Sec-
4 retary an evaluation that describes, in the manner
5 and to the extent required by the Secretary, the ac-
6 tivities carried out with funds received under the
7 grant, and how such activities improved access to
8 health and health-care-related services and the qual-
9 ity of health care for individuals with limited-English
10 proficiency. Such evaluation shall be collected and
11 disseminated through the Robert T. Matsui Center
12 for Cultural and Linguistic Competence in Health
13 Care established under section 3403. The Director
14 of the Agency for Healthcare Research and Quality
15 shall notify grantees of the availability of technical
16 assistance for the evaluation and provide such assist-
17 ance upon request.

18 “(2) BY SECRETARY.—The Director of the
19 Agency for Healthcare Research and Quality shall
20 evaluate or arrange with other individuals or organi-
21 zations to evaluate projects funded under this sec-
22 tion.

23 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
24 is authorized to be appropriated to carry out this section,
25 \$5,000,000 for each of fiscal years 2019 through 2023.

1 **“SEC. 3405. 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
25 \$5,000,000 for each of fiscal years 2019 through 2023.”.

1 **SEC. 203. PILOT PROGRAM FOR IMPROVEMENT AND DE-**
2 **VELOPMENT OF STATE MEDICAL INTER-**
3 **PRETING SERVICES.**

4 (a) **GRANTS AUTHORIZED.**—The Secretary shall
5 award one grant in accordance with this section to each
6 of three States to assist each such State in designing, im-
7 plementing, and evaluating a statewide program to provide
8 onsite interpreter services under Medicaid.

9 (b) **GRANT PERIOD.**—A grant awarded under this
10 section is authorized for a period of three fiscal years be-
11 ginning on October 1, 2019.

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

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

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

18 (3) that has a high growth rate of the popu-
19 lation of LEP individuals, as determined by the Sec-
20 retary; and

21 (4) that has a population of qualified LEP en-
22 rollees that is linguistically diverse, requiring inter-
23 preter services in at least 200 non-English lan-
24 guages.

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

1 (1) ensure that all health care providers in the
2 State participating in the State plan under Medicaid
3 have access to onsite interpreter services, for the
4 purpose of enabling effective communication between
5 such providers and qualified LEP enrollees during
6 the furnishing of items and services and administra-
7 tive interactions;

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

9 (A) a statewide health care information
10 technology system that is designed to achieve
11 efficiencies and economies of scale with respect
12 to onsite interpreter services provided to health
13 care providers in the State participating in the
14 State plan under Medicaid; and

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

17 (i) procuring and scheduling inter-
18 preter services for qualified LEP enrollees;

19 (ii) procuring and scheduling inter-
20 preter services for LEP individuals seeking
21 to enroll in the State plan under Medicaid;

22 (iii) ensuring that interpreters receive
23 payment for interpreter services rendered
24 under the system; and

1 (iv) consulting regularly with organi-
2 zations representing consumers, inter-
3 preters, and health care providers; and

4 (3) develop mechanisms to establish, improve,
5 and strengthen the competency of the medical inter-
6 pretation workforce that serves qualified LEP enroll-
7 ees in the State, including a national certification
8 process that is valid, credible, and vendor-neutral.

9 (e) APPLICATION.—To receive a grant under this sec-
10 tion, a State shall submit an application at such time and
11 containing such information as the Secretary may require,
12 which shall include the following:

13 (1) A description of the language access needs
14 of individuals in the State enrolled in the State plan
15 under Medicaid.

16 (2) A description of the extent to which the
17 program will—

18 (A) use the grant funds for the purposes
19 described in subsection (d);

20 (B) meet the health care needs of rural
21 populations of the State; and

22 (C) collect information that accurately
23 tracks the language services requested by con-
24 sumers as compared to the language services

1 provided by health care providers in the State
2 participating in the State plan under Medicaid.

3 (3) A description of how the program will be
4 evaluated, including a proposal for collaboration with
5 organizations representing interpreters, consumers,
6 and LEP individuals.

7 (f) DEFINITIONS.—In this section:

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

10 (A) who is limited-English proficient; and

11 (B) who is enrolled in a State plan under
12 Medicaid.

13 (2) STATE.—The term “State” has the mean-
14 ing given the term in section 1101(a)(1) of the So-
15 cial Security Act (42 U.S.C. 1301(a)(1)), for pur-
16 poses of title XIX of such Act.

17 (3) UNITED STATES.—The term “United
18 States” has the meaning given the term in section
19 1101(a)(2) of the Social Security Act (42 U.S.C.
20 1301(a)(2)), for purposes of title XIX of such Act.

21 (g) FUNDING.—

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

1 (2) AVAILABILITY OF FUNDS.—The funds au-
2 thorized by paragraph (1) shall be available without
3 fiscal year limitation.

4 (3) INCREASED FEDERAL FINANCIAL PARTICI-
5 PATION.—Section 1903(a)(2)(E) of the Social Secu-
6 rity Act (42 U.S.C. 1396b(a)(2)(E)), as amended by
7 section 205(d)(1) of this Act, is further amended by
8 inserting “(or, in the case of a State receiving a
9 grant under section 203 of the Health Equity and
10 Accountability Act of 2018, 100 percent for each
11 quarter occurring during the grant period)” after
12 “90 percent”.

13 (h) LIMITATION.—No Federal funds under this sec-
14 tion may be used to provide interpreter services from a
15 location outside the United States.

16 **SEC. 204. TRAINING TOMORROW'S DOCTORS FOR CUL-**
17 **TURALLY AND LINGUISTICALLY APPRO-**
18 **PRIATE CARE: GRADUATE MEDICAL EDU-**
19 **CATION.**

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

24 “(L) TREATMENT OF CULTURALLY COM-
25 PETENCY TRAINING.—In determining a hos-

1 pital’s number of full-time equivalent residents
2 for purposes of this subsection, all the time that
3 is spent by an intern or resident in an approved
4 medical residency training program for edu-
5 cation and training in cultural competency and
6 linguistically appropriate service delivery shall
7 be counted toward the determination of full-
8 time equivalency.”.

9 (b) **INDIRECT MEDICAL EDUCATION.**—Section
10 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
11 1395ww(d)(5)(B)) is amended—

12 (1) by redesignating the clause (x) added by
13 section 5505(b) of the Patient Protection and Af-
14 fordable Care Act as clause (xi); and

15 (2) by adding at the end the following new
16 clause:

17 “(xii) The provisions of subparagraph (L) of
18 subsection (h)(4) shall apply under this subpara-
19 graph in the same manner as they apply under such
20 subsection.”.

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

1 **SEC. 205. FEDERAL REIMBURSEMENT FOR CULTURALLY**
2 **AND LINGUISTICALLY APPROPRIATE SERV-**
3 **ICES UNDER THE MEDICARE, MEDICAID, AND**
4 **STATE CHILDREN'S HEALTH INSURANCE**
5 **PROGRAMS.**

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

8 (1) ESTABLISHMENT.—

9 (A) IN GENERAL.—Not later than 6
10 months after the date of the enactment of this
11 Act, the Secretary of Health and Human Serv-
12 ices, acting through the Centers for Medicare &
13 Medicaid Services and in consultation with the
14 Center for Medicare and Medicaid Innovation,
15 shall establish a demonstration program under
16 which the Secretary shall award grants to eligi-
17 ble Medicare service providers to improve com-
18 munication between such providers and Medi-
19 care beneficiaries who are English learners, in-
20 cluding beneficiaries who live in diverse and un-
21 derserved communities.

22 (B) APPLICATION OF INNOVATION
23 RULES.—The demonstration project under sub-
24 paragraph (A) shall be conducted in a manner
25 that is consistent with the applicable provisions

1 of subsections (b), (c), and (d) of section 1115A
2 of the Social Security Act (42 U.S.C. 1315a).

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

6 (D) GRANT PERIOD.—Except as provided
7 under paragraph (2)(D), each grant awarded
8 under this subsection shall be for a 3-year pe-
9 riod.

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

13 (A) MEDICARE PROVIDER.—The entity
14 must be—

15 (i) a provider of services under part A
16 of title XVIII of the Social Security Act;

17 (ii) a provider of services under part
18 B of such title;

19 (iii) a Medicare Advantage organiza-
20 tion offering a Medicare Advantage plan
21 under part C of such title; or

22 (iv) a PDP sponsor offering a pre-
23 scription drug plan under part D of such
24 title.

1 (B) UNDERSERVED COMMUNITIES.—The
2 entity must serve a community that, with re-
3 spect to necessary language services for improv-
4 ing access and utilization of health care among
5 English learners, is disproportionately under-
6 served.

7 (C) APPLICATION.—The entity must pre-
8 pare and submit to the Secretary an applica-
9 tion, at such time, in such manner, and accom-
10 panied by such additional information as the
11 Secretary may require.

12 (D) REPORTING.—In the case of a grantee
13 that received a grant under this subsection in
14 a previous year, such grantee is only eligible for
15 continued payments under a grant under this
16 subsection if the grantee met the reporting re-
17 quirements under paragraph (9) for such year.
18 If a grantee fails to meet the requirement of
19 such paragraph for the first year of a grant, the
20 Secretary may terminate the grant and solicit
21 applications from new grantees to participate in
22 the demonstration program.

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

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

3 (B) at least 6 grants to service providers
4 described in paragraph (2)(A)(ii);

5 (C) at least 6 grants to organizations de-
6 scribed in paragraph (2)(A)(iii); and

7 (D) at least 6 grants to sponsors described
8 in paragraph (2)(A)(iv).

9 (4) CONSIDERATIONS IN AWARDING GRANTS.—

10 (A) VARIATION IN GRANTEES.—In award-
11 ing grants under this subsection, the Secretary
12 shall select grantees to ensure the following:

13 (i) The grantees provide many dif-
14 ferent types of language services.

15 (ii) The grantees serve Medicare bene-
16 ficiaries who speak different languages,
17 and who, as a population, have differing
18 needs for language services.

19 (iii) The grantees serve Medicare
20 beneficiaries in both urban and rural set-
21 tings.

22 (iv) The grantees serve Medicare
23 beneficiaries in at least two geographic re-
24 gions, as defined by the Secretary.

1 (v) The grantees serve Medicare bene-
2 ficiaries in at least two large metropolitan
3 statistical areas with racial, ethnic, sexual,
4 gender, disability, and economically diverse
5 populations.

6 (B) PRIORITY FOR PARTNERSHIPS WITH
7 COMMUNITY ORGANIZATIONS AND AGENCIES.—
8 In awarding grants under this subsection, the
9 Secretary shall give priority to eligible entities
10 that have a partnership with—

11 (i) a community organization; or
12 (ii) a consortia of community organi-
13 zations, State agencies, and local agencies,
14 that has experience in providing language serv-
15 ices.

16 (5) USE OF FUNDS FOR COMPETENT LANGUAGE
17 SERVICES.—

18 (A) IN GENERAL.—Subject to subpara-
19 graph (E), a grantee may only use grant funds
20 received under this subsection to pay for the
21 provision of competent language services to
22 Medicare beneficiaries who are English learn-
23 ers.

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

4 (i) interpreter and translation services
5 that—

6 (I) subject to the exceptions
7 under subparagraph (C)—

8 (aa) if the grantee operates
9 in a State that has statewide
10 health care interpreter standards,
11 meet the State standards cur-
12 rently in effect; or

13 (bb) if the grantee operates
14 in a State that does not have
15 statewide health care interpreter
16 standards, utilizes competent in-
17 terpreters who follow the Na-
18 tional Council on Interpreting in
19 Health Care’s Code of Ethics and
20 Standards of Practice; and

21 (II) that, in the case of inter-
22 preter services, are provided
23 through—

24 (aa) onsite interpretation;

1 (bb) telephonic interpreta-
2 tion; or

3 (cc) video interpretation;
4 and

5 (ii) the direct provision of health care
6 or health-care-related services by a com-
7 petent bilingual health care provider.

8 (C) EXCEPTIONS.—The requirements of
9 subparagraph (B)(i)(I) do not apply, with re-
10 spect to interpreter and translation services and
11 a grantee—

12 (i) in the case of a Medicare bene-
13 ficiary who is an English learner if—

14 (I) such beneficiary has been in-
15 formed, in the beneficiary's primary
16 language, of the availability of free in-
17 terpreter and translation services and
18 the beneficiary instead requests that a
19 family member, friend, or other per-
20 son provide such services; and

21 (II) the grantee documents such
22 request in the beneficiary's medical
23 record; or

24 (ii) in the case of a medical emergency
25 where the delay directly associated with ob-

1 taining a competent interpreter or trans-
2 lation services would jeopardize the health
3 of the patient.

4 Clause (ii) shall not be construed to exempt
5 emergency rooms or similar entities that regu-
6 larly provide health care services in medical
7 emergencies to patients who are English learn-
8 ers from any applicable legal or regulatory re-
9 quirements related to providing competent in-
10 terpreter and translation services without undue
11 delay.

12 (D) MEDICARE ADVANTAGE ORGANIZA-
13 TIONS AND PDP SPONSORS.—If a grantee is a
14 Medicare Advantage organization offering a
15 Medicare Advantage plan under part C of title
16 XVIII of the Social Security Act or a PDP
17 sponsor offering a prescription drug plan under
18 part D of such title, such entity must provide
19 at least 50 percent of the grant funds that the
20 entity receives under this subsection directly to
21 the entity’s network providers (including all
22 health providers and pharmacists) for the pur-
23 pose of providing support for such providers to
24 provide competent language services to Medi-
25 care beneficiaries who are English learners.

1 (E) ADMINISTRATIVE AND REPORTING
2 COSTS.—A grantee may use up to 10 percent of
3 the grant funds to pay for administrative costs
4 associated with the provision of competent lan-
5 guage services and for reporting required under
6 paragraph (9).

7 (6) DETERMINATION OF AMOUNT OF GRANT
8 PAYMENTS.—

9 (A) IN GENERAL.—Payments to grantees
10 under this subsection shall be calculated based
11 on the estimated numbers of Medicare bene-
12 ficiaries who are English learners in a grantee’s
13 service area utilizing—

14 (i) data on the numbers of English
15 learners who speak English less than “very
16 well” from the most recently available data
17 from the Bureau of the Census or other
18 State-based study the Secretary determines
19 likely to yield accurate data regarding the
20 number of such individuals in such service
21 area; or

22 (ii) data provided by the grantee, if
23 the grantee routinely collects data on the
24 primary language of the Medicare bene-
25 ficiaries that the grantee serves and the

1 Secretary determines that the data is accu-
2 rate and shows a greater number of
3 English learners than would be estimated
4 using the data under clause (i).

5 (B) DISCRETION OF SECRETARY.—Subject
6 to subparagraph (C), the amount of payment
7 made to a grantee under this subsection may be
8 modified annually at the discretion of the Sec-
9 retary, based on changes in the data under sub-
10 subparagraph (A) with respect to the service area
11 of a grantee for the year.

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

16 (7) ASSURANCES.—Grantees under this sub-
17 section shall, as a condition of receiving a grant
18 under this subsection—

19 (A) ensure that clinical and support staff
20 receive appropriate ongoing education and
21 training in linguistically appropriate service de-
22 livery;

23 (B) ensure the linguistic competence of bi-
24 lingual providers;

1 (C) offer and provide appropriate language
2 services at no additional charge to each patient
3 who is an English learner for all points of con-
4 tact between the patient and the grantee, in a
5 timely manner during all hours of operation;

6 (D) notify Medicare beneficiaries of their
7 right to receive language services in their pri-
8 mary language;

9 (E) post signage in the primary languages
10 commonly used by the patient population in the
11 service area of the organization; and

12 (F) ensure that—

13 (i) primary language data are col-
14 lected for recipients of language services
15 and such data are consistent with stand-
16 ards developed under title XXXIV of the
17 Public Health Service Act, as added by
18 section 202 of this Act, to the extent such
19 standards are available upon the initiation
20 of the demonstration program; and

21 (ii) consistent with the privacy protec-
22 tions provided under the regulations pro-
23 mulgated pursuant to section 264(c) of the
24 Health Insurance Portability and Account-
25 ability Act of 1996 (42 U.S.C. 1320d-2

1 note), if the recipient of language services
2 is a minor or is incapacitated, primary lan-
3 guage data are collected on the parent or
4 legal guardian of such recipient.

5 (8) NO COST SHARING.—Medicare beneficiaries
6 who are English learners shall not have to pay cost
7 sharing or co-payments for competent language serv-
8 ices provided under this demonstration program.

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

14 (A) The number of Medicare beneficiaries
15 to whom competent language services are pro-
16 vided.

17 (B) The primary languages of those Medi-
18 care beneficiaries.

19 (C) The types of language services pro-
20 vided to such beneficiaries.

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

1 (E) The types of interpretation services
2 provided to such beneficiaries, and the approxi-
3 mate length of time such service is provided to
4 such beneficiaries.

5 (F) The costs of providing competent lan-
6 guage services.

7 (G) An account of the training or accredi-
8 tation of bilingual staff, interpreters, and trans-
9 lators providing services funded by the grant
10 under this subsection.

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

17 (A) An analysis of the patient outcomes
18 and the costs of furnishing care to the Medicare
19 beneficiaries who are English learners partici-
20 pating in the project as compared to such out-
21 comes and costs for such Medicare beneficiaries
22 not participating, based on the data provided
23 under paragraph (9) and any other information
24 available to the Secretary.

1 (B) The effect of delivering language serv-
2 ices on—

3 (i) Medicare beneficiary access to care
4 and utilization of services;

5 (ii) the efficiency and cost effective-
6 ness of health care delivery;

7 (iii) patient satisfaction;

8 (iv) health outcomes; and

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

12 (C) The extent to which bilingual staff, in-
13 terpreters, and translators providing services
14 under such demonstration were trained or ac-
15 credited and the nature of accreditation or
16 training needed by type of provider, service, or
17 other category as determined by the Secretary
18 to ensure the provision of high-quality interpre-
19 tation, translation, or other language services to
20 Medicare beneficiaries if such services are ex-
21 panded pursuant to subsection (c) of section
22 1907 of this Act.

23 (D) Recommendations, if any, regarding
24 the extension of such project to the entire Medi-
25 care Program, subject to the provisions of sec-

1 tion 1115A(c) of the Social Security Act (42
2 U.S.C. 1315a(c)).

3 (11) APPROPRIATIONS.—There is appropriated
4 to carry out this subsection, in equal parts from the
5 Federal Hospital Insurance Trust Fund under sec-
6 tion 1817 of the Social Security Act (42 U.S.C.
7 1395i) and the Federal Supplementary Medical In-
8 surance Trust Fund under section 1841 of such Act
9 (42 U.S.C. 1395t), \$16,000,000 for each fiscal year
10 of the demonstration program.

11 (12) ENGLISH LEARNER DEFINED.—In this
12 subsection, the term “English learner” has the
13 meaning given such term in section 8101(20) of the
14 Elementary and Secondary Education Act of 1965,
15 except that subparagraphs (A), (B), and (D) of such
16 section shall not apply.

17 (b) LANGUAGE SERVICES UNDER THE MEDICARE
18 PROGRAM.—

19 (1) INCLUSION AS RURAL HEALTH CLINIC
20 SERVICES.—Section 1861 of the Social Security Act
21 (42 U.S.C. 1395x) is amended—

22 (A) in subsection (aa)(1)—

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

1 (ii) by adding “and” at the end of
2 subparagraph (C); and

3 (iii) by inserting after subparagraph
4 (C) the following new subparagraph:

5 “(D) language assistance services as defined in
6 subsection (iii)(1),”; and

7 (B) by adding at the end the following new
8 subsection:

9 “Language Assistance Services and Related Terms

10 “(iii)(1) The term ‘language assistance services’ has
11 the same meaning given the term ‘language or language
12 assistance services’ in section 3400 of the Public Health
13 Service Act.

14 “(2) The term ‘interpreter services’ has the meaning
15 given the term ‘qualified interpreter for an individual with
16 limited-English proficiency’ in section 3400(3) of the Pub-
17 lic Health Service Act.

18 “(3) The term ‘qualified interpreter for an individual
19 with limited-English proficiency’ means an interpreter who
20 via a remote interpreting service or an onsite appear-
21 ance—

22 “(A) adheres to generally accepted interpreter
23 ethics principles, including client confidentiality;

1 “(B) has demonstrated proficiency in speaking
2 and understanding both spoken English and at least
3 one other spoken language; and

4 “(C) is able to interpret effectively, accurately,
5 and impartially and in a culturally competent man-
6 ner, both receptively and expressly, to and from such
7 language(s) and English, using any necessary spe-
8 cialized vocabulary, terminology, and phraseology.

9 “(4) The term ‘qualified translator’ means a trans-
10 lator who—

11 “(A) adheres to generally accepted translator
12 ethics principles, including client confidentiality;

13 “(B) has demonstrated proficiency in writing
14 and understanding both written English and at least
15 one other written non-English language; and

16 “(C) is able to translate effectively, accurately,
17 and impartially to and from such language(s) and
18 English, using any necessary specialized vocabulary,
19 terminology, and phraseology.

20 “(5) The term ‘English learner’ has the meaning
21 given such term in section 8101(20) of the Elementary
22 and Secondary Education Act of 1965, except that sub-
23 paragraphs (A), (B), and (D) of such section shall not
24 apply.”.

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

4 (A) by striking “and” at the end of sub-
5 paragraph (I);

6 (B) by striking the period at the end of
7 subparagraph (J) and inserting “; and”; and

8 (C) by adding at the end the following new
9 subparagraph:

10 “(K) language services (as defined in para-
11 graph (1) of section 1861(iii)) furnished by an
12 interpreter (as defined in paragraph (3) of such
13 section) or translator.”.

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

16 (A) by striking “and” at the end of para-
17 graph (8);

18 (B) by striking the period at the end of
19 paragraph (9) and inserting “; and”; and

20 (C) by inserting after paragraph (9) the
21 following new paragraph:

22 “(10) in the case of language services described
23 in section 1861(iii)(1), 100 percent of the reasonable
24 charges for such services, as determined in consulta-

1 tion with the Medicare Payment Advisory Commis-
2 sion; and”.

3 (4) WAIVER OF BUDGET NEUTRALITY.—For
4 the 3-year period beginning on the date of enact-
5 ment of this section, the budget neutrality provision
6 of section 1848(c)(2)(B)(ii) of the Social Security
7 Act (42 U.S.C. 1395w-4(c)(2)(B)(ii)) shall not
8 apply with respect to language services (as such
9 term is defined in section 1861(iii)(1) of such Act).
10 (c) MEDICARE PARTS C AND D.—

11 (1) IN GENERAL.—Medicare Advantage plans
12 under part C of the Social Security Act and pre-
13 scription drug plans under part D of such Act shall
14 comply with title VI of the Civil Rights Act of 1964
15 and section 1557 of the Patient Protection and Af-
16 fordable Care Act (42 U.S.C. 18116) to provide ef-
17 fective language services to enrollees of such plans.

18 (2) MEDICARE ADVANTAGE PLANS AND PRE-
19 SCRIPTION DRUG PLANS REPORTING REQUIRE-
20 MENT.—Section 1857(e) of the Social Security Act
21 (42 U.S.C. 1395w-27(e)) is amended by adding at
22 the end the following new paragraph:

23 “(5) REPORTING REQUIREMENTS RELATING TO
24 EFFECTIVE LANGUAGE SERVICES.—A contract under
25 this part shall require a Medicare Advantage organi-

1 zation (and, through application of section 1860D–
2 12(b)(3)(D), a contract under section 1860D–12
3 shall require a PDP sponsor) to annually submit
4 (for each year of the contract) a report that contains
5 information on the plan’s internal policies and proce-
6 dures related to recruitment and retention efforts di-
7 rected to workforce diversity and linguistically and
8 culturally appropriate provision of services in each of
9 the following contexts:

10 “(A) The collection of data in a manner
11 that meets the requirements of title I of the
12 Health Equity and Accountability Act of 2018,
13 regarding the enrollee population.

14 “(B) Education of staff and contractors
15 who have routine contact with enrollees regard-
16 ing the various needs of the diverse enrollee
17 population.

18 “(C) Evaluation of the health plan’s lan-
19 guage services programs and services with re-
20 spect to the plan’s enrollee population, such as
21 through analysis of complaints or satisfaction
22 survey results.

23 “(D) Methods by which the plan provides
24 to the Secretary information regarding the eth-
25 nic diversity of the plan’s enrollee population.

1 “(E) The periodic provision of educational
2 information to plan enrollees on the plan’s lan-
3 guage services and programs.”.

4 (d) IMPROVING LANGUAGE SERVICES IN MEDICAID
5 AND CHIP.—

6 (1) PAYMENTS TO STATES.—Section
7 1903(a)(2)(E) of the Social Security Act (42 U.S.C.
8 1396b(a)(2)(E)) is amended by—

9 (A) striking “75” and inserting “90”;

10 (B) striking “translation or interpretation
11 services” and inserting “language services”;
12 and

13 (C) striking “children of families” and in-
14 serting “individuals”.

15 (2) STATE PLAN REQUIREMENTS.—Section
16 1902(a)(10)(A) of the Social Security Act (42
17 U.S.C. 1396a(a)(10)(A)) is amended by striking
18 “and (28)” and inserting “(28), and (29)”.

19 (3) DEFINITION OF MEDICAL ASSISTANCE.—
20 Section 1905(a) of the Social Security Act (42
21 U.S.C. 1396d(a)) is amended by—

22 (A) in paragraph (28), by striking “and”
23 at the end;

24 (B) by redesignating paragraph (29) as
25 paragraph (30); and

1 (C) by inserting after paragraph (28) the
2 following new paragraph:

3 “(29) language services, as such term is defined
4 in section 1861(iii)(1), provided in a timely manner
5 to English learners (as defined in section
6 1861(iii)(5)) who need such services; and”.

7 (4) USE OF DEDUCTIONS AND COST SHAR-
8 ING.—Section 1916(a)(2) of the Social Security Act
9 (42 U.S.C. 1396o(2)) is amended by—

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

12 (B) by striking “; and” at the end of sub-
13 paragraph (E) and inserting “, or”; and

14 (C) by adding at the end the following new
15 subparagraph:

16 “(F) language services described in section
17 1905(a)(29); and”.

18 (5) CHIP COVERAGE REQUIREMENTS.—Section
19 2103 of the Social Security Act (42 U.S.C. 1397cc)
20 is amended—

21 (A) in subsection (a), in the matter before
22 paragraph (1), by striking “and (7)” and in-
23 serting “(7), and (9)”; and

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

1 “(9) LANGUAGE SERVICES.—The child health
2 assistance provided to a targeted low-income child
3 shall include coverage of language services, as such
4 term is defined in section 1861(iii)(1), provided in a
5 timely manner to English learners (as defined in
6 section 1861(iii)(5)) who need such services.”; and

7 (C) in subsection (e)(2)—

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

10 (ii) by inserting “or subsection (c)(9)”
11 after “subsection (c)(1)(D)”.

12 (6) DEFINITION OF CHILD HEALTH ASSIST-
13 ANCE.—Section 2110(a)(27) of the Social Security
14 Act (42 U.S.C. 1397jj) is amended by striking
15 “translation” and inserting “language services as
16 described in section 2103(c)(9)”.

17 (7) STATE DATA COLLECTION.—Pursuant to
18 the reporting requirement described in section
19 2107(b)(1) of the Social Security Act (42 U.S.C.
20 1397gg(b)(1)), the Secretary of Health and Human
21 Services shall require that States collect data on—

22 (A) the primary language of individuals re-
23 ceiving child health assistance under title XXI
24 of the Social Security Act; and

1 (B) in the case of such individuals who are
2 minors or incapacitated, the primary language
3 of the individual’s parent or guardian.

4 (8) CHIP PAYMENTS TO STATES.—Section
5 2105 of the Social Security Act (42 U.S.C.
6 1397ee(c)) is amended—

7 (A) in subsection (a)(1), by striking “75”
8 and inserting “90”; and

9 (B) in subsection (c)(2)(A), by inserting
10 before the period at the end the following: “,
11 except that expenditures pursuant to clause (iv)
12 of subparagraph (D) of such paragraph shall
13 not count towards this total”.

14 (e) 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 English learn-
24 ers in an amount equal to an eligible entity’s el-
25 igible costs for such services for the quarter.

1 (B) FUNDING.—Out of any funds in the
2 Treasury not otherwise appropriated, there are
3 appropriated to the Secretary of Health and
4 Human Services such sums as may be nec-
5 essary for each of fiscal years 2017 through
6 2021.

7 (C) RELATION TO MEDICAID DSH.—Pay-
8 ments under this subsection shall not offset or
9 reduce payments under section 1923 of the So-
10 cial Security Act, nor shall payments under
11 such section be considered when determining
12 uncompensated costs associated with the provi-
13 sion of language services.

14 (2) METHODOLOGY FOR PAYMENT OF
15 CLAIMS.—

16 (A) IN GENERAL.—The Secretary shall es-
17 tablish a methodology to determine the average
18 per person cost of language services.

19 (B) DIFFERENT ENTITIES.—In estab-
20 lishing such methodology, the Secretary may es-
21 tablish different methodologies for different
22 types of eligible entities.

23 (C) NO INDIVIDUAL CLAIMS.—The Sec-
24 retary may not require eligible entities to sub-
25 mit individual claims for language services for

1 individual patients as a requirement for pay-
2 ment under this subsection.

3 (3) DATA COLLECTION INSTRUMENT.—For pur-
4 poses of this subsection, the Secretary shall create a
5 standard data collection instrument that is con-
6 sistent with any existing reporting requirements by
7 the Secretary or relevant accrediting organizations
8 regarding the number of individuals to whom lan-
9 guage access are provided.

10 (4) GUIDELINES.—Not later than 6 months
11 after the date of enactment of this Act, the Sec-
12 retary of Health and Human Services shall establish
13 and distribute guidelines concerning the implementa-
14 tion of this subsection.

15 (5) REPORTING REQUIREMENTS.—

16 (A) REPORT TO SECRETARY.—Entities re-
17 ceiving payment under this subsection shall pro-
18 vide the Secretary with a quarterly report on
19 how the entity used such funds. Such report
20 shall contain aggregate (and may not contain
21 individualized) data collected using the instru-
22 ment under paragraph (3) and shall otherwise
23 be in a form and manner determined by the
24 Secretary.

1 (B) REPORT TO CONGRESS.—Not later
2 than 2 years after the date of enactment of this
3 Act, and every 2 years thereafter, the Secretary
4 shall submit a report to Congress concerning
5 the implementation of this subsection.

6 (6) DEFINITIONS.—In this subsection:

7 (A) ELIGIBLE COSTS.—The term “eligible
8 costs” means, with respect to an eligible entity
9 that provides language services to English
10 learners, the product of—

11 (i) the average per person cost of lan-
12 guage services, determined according to
13 the methodology devised under paragraph
14 (2); and

15 (ii) the number of English learners
16 who are provided language services by the
17 entity and for whom no reimbursement is
18 available for such services under the
19 amendments made by subsections (a), (b),
20 (c), or (d) or by private health insurance.

21 (B) ELIGIBLE ENTITY.—The term “eligible
22 entity” means an entity that—

23 (i) is a Medicaid provider that is—

24 (I) a physician;

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

6 (III) a federally qualified health
7 center (as defined in section
8 1905(l)(2)(B) of the Social Security
9 Act (42 U.S.C. 1396d(l)(2)(B)));

10 (ii) provide language services to at
11 least 8 percent of the entity's total number
12 of patients, not later than 6 months after
13 the date of the enactment of the Act; and

14 (iii) prepare and submit an applica-
15 tion to the Secretary, at such time, in such
16 manner, and accompanied by such infor-
17 mation as the Secretary may require to as-
18 certain the entity's eligibility for funding
19 under this subsection.

20 (C) ENGLISH LEARNER.—The term
21 “English learner” has the meaning given such
22 term in section 8101(20) of the Elementary
23 and Secondary Education Act of 1965, except
24 that subparagraphs (A), (B), and (D) of such
25 section shall not apply.

1 (D) LANGUAGE SERVICES.—The term
2 “language services” has the meaning given such
3 term in section 1861(iii)(1) of the Social Secu-
4 rity Act.

5 (f) APPLICATION OF CIVIL RIGHTS ACT OF 1964 AND
6 OTHER LAWS.—Nothing in this section shall be construed
7 to limit otherwise existing obligations of recipients of Fed-
8 eral financial assistance under title VI of the Civil Rights
9 Act of 1964 (42 U.S.C. 2000(d) et seq.) or other laws
10 that protect the civil rights of individuals.

11 (g) EFFECTIVE DATE.—

12 (1) IN GENERAL.—Except as otherwise pro-
13 vided and subject to paragraph (2), the amendments
14 made by this section shall take effect on January 1,
15 2017.

16 (2) EXCEPTION IF STATE LEGISLATION RE-
17 QUIRED.—In the case of a State plan for medical as-
18 sistance under title XIX of the Social Security Act
19 which the Secretary of Health and Human Services
20 determines requires State legislation (other than leg-
21 islation appropriating funds) in order for the plan to
22 meet the additional requirement imposed by the
23 amendments made by this section, the State plan
24 shall not be regarded as failing to comply with the
25 requirements of such title solely on the basis of its

1 failure to meet this additional requirement before
2 the first day of the first calendar quarter beginning
3 after the close of the first regular session of the
4 State legislature that begins after the date of the en-
5 actment of this Act. For purposes of the previous
6 sentence, in the case of a State that has a 2-year
7 legislative session, each year of such session shall be
8 deemed to be a separate regular session of the State
9 legislature.

10 **SEC. 206. INCREASING UNDERSTANDING OF AND IMPROV-**
11 **ING HEALTH LITERACY.**

12 (a) IN GENERAL.—The Secretary, acting through the
13 Director of the Agency for Healthcare Research and Qual-
14 ity and the Administrator of the Health Resources and
15 Services Administration, in consultation with the Director
16 of the National Institute on Minority Health and Health
17 Disparities and the Deputy Assistant Secretary for Minor-
18 ity Health, shall award grants to eligible entities to im-
19 prove health care for patient populations that have low
20 functional health literacy.

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

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

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

5 (c) USE OF FUNDS.—

6 (1) AGENCY FOR HEALTHCARE RESEARCH AND
7 QUALITY.—Grants awarded under subsection (a)
8 through the Agency for Healthcare Research and
9 Quality shall be used—

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

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

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

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

18 (2) HEALTH RESOURCES AND SERVICES ADMIN-
19 ISTRATION.—Grants awarded under subsection (a)
20 through the Health Resources and Services Adminis-
21 tration shall be used to conduct demonstration
22 projects for interventions for patients with low
23 health literacy that may include—

1 (A) the development of new disease man-
2 agement programs for patients with low health
3 literacy;

4 (B) the tailoring of existing disease man-
5 agement programs addressing mental, physical,
6 oral, and behavioral health conditions for pa-
7 tients with low health literacy;

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

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

12 (E) the conduct of educational campaigns
13 for patients and providers about low health lit-
14 eracy; and

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

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

22 (e) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to carry out this section,
24 such sums as may be necessary for each of fiscal years
25 2019 through 2023.

1 **SEC. 207. ASSURANCES FOR RECEIVING FEDERAL FUNDS.**

2 (a) IN GENERAL.—Any health program or activity,
3 any part of which is receiving Federal financial assistance,
4 including credits, subsidies, or contracts of insurance, and
5 any program or activity that is administered by an execu-
6 tive agency or any entity established under title I of the
7 Patient Protection and Affordable Care Act (or amend-
8 ments made thereby), as such programs, activities, agen-
9 cies, and entities are described in section 1557(a) of the
10 Patient Protection and Affordable Care Act (42 U.S.C.
11 18116), in order to ensure the right of LEP individuals
12 to receive access to quality health care, shall—

13 (1) ensure that appropriate clinical and support
14 staff receive ongoing education and training in lin-
15 guistically appropriate service delivery;

16 (2) offer and provide appropriate language as-
17 sistance services at no additional charge to each pa-
18 tient with limited-English-proficiency at all points of
19 contact, in a timely manner during all hours of oper-
20 ation;

21 (3) notify patients of their right to receive lan-
22 guage services in their primary language; and

23 (4) utilize only qualified interpreters for an in-
24 dividual with limited-English proficiency or qualified
25 translators, as defined in section 3400 of the Public
26 Health Service Act.

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

3 (1) When a patient (who has been informed in
4 his or her primary language of the availability of
5 free interpreter and translation services) requests
6 the use of family, friends, or other persons untrained
7 in interpretation or translation if the following con-
8 ditions are met:

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

11 (B) The recipient informs the patient that
12 he or she has the option of having the recipient
13 provide an interpreter for him or her without
14 charge, or of using his or her own interpreter.

15 (C) The recipient informs the patient that
16 the recipient may not require an LEP person to
17 use a family member or friend as an inter-
18 preter.

19 (D) The recipient evaluates whether the
20 person the patient wishes to use as an inter-
21 preter is competent. If the recipient has reason
22 to believe that the interpreter is not competent,
23 the recipient provides the recipient's own inter-
24 preter to protect the recipient from liability if

1 the patient's interpreter is later found not com-
2 petent.

3 (E) If the recipient has reason to believe
4 that there is a conflict of interest between the
5 interpreter and patient, the recipient may not
6 use the patient's interpreter.

7 (F) The recipient has the patient sign a
8 waiver, witnessed by at least 1 individual not
9 related to the patient, that includes the infor-
10 mation stated in subparagraphs (A) through
11 (E) and is translated into the patient's lan-
12 guage.

13 (2) When a medical emergency exists and the
14 delay directly associated with obtaining competent
15 interpreter or translation services would jeopardize
16 the health of the patient, but only until a competent
17 interpreter or translation service is available.

18 (c) RULE OF CONSTRUCTION.—Subsection (b)(2)
19 shall not be construed to mean that emergency rooms or
20 similar entities that regularly provide health care services
21 in medical emergencies are exempt from legal or regu-
22 latory requirements related to competent interpreter serv-
23 ices.

1 **SEC. 208. REPORT ON FEDERAL EFFORTS TO PROVIDE CUL-**
2 **TURALLY AND LINGUISTICALLY APPRO-**
3 **PRIATE HEALTH CARE SERVICES.**

4 (a) REPORT.—Not later than 1 year after the date
5 of enactment of this Act and annually thereafter, the Sec-
6 retary of Health and Human Services shall enter into a
7 contract with the National Academy of Medicine for the
8 preparation and publication of a report that describes
9 Federal efforts to ensure that all individuals with limited-
10 English proficiency have meaningful access culturally com-
11 petent to health care and health-care-related services.
12 Such report shall include—

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

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

19 (3) recommendations on the development and
20 implementation of policies and practices by providers
21 of health care and health-care-related services for
22 limited-English-proficient individuals;

23 (4) recommend guidelines or standards for
24 health literacy and plain language, informed consent,
25 discharge instructions, and written communications,
26 and for improvement of health care access;

1 (5) a description of the effect of providing lan-
2 guage services on quality of health care and access
3 to care; and

4 (6) a description of the costs associated with or
5 savings related to the provision of language services.

6 (b) **AUTHORIZATION OF APPROPRIATIONS.**—There
7 are authorized to be appropriated to carry out this section
8 such sums as may be necessary for each of fiscal years
9 2019 through 2023.

10 **SEC. 209. ENGLISH FOR SPEAKERS OF OTHER LANGUAGES.**

11 (a) **GRANTS AUTHORIZED.**—The Secretary of Edu-
12 cation is authorized to provide grants to eligible entities
13 for the provision of English as a second language (in this
14 section referred to “ESL”) instruction and shall deter-
15 mine, after consultation with appropriate stakeholders, the
16 mechanism for administering and distributing such
17 grants.

18 (b) **ELIGIBLE ENTITY DEFINED.**—For purposes of
19 this section, the term “eligible entity” means a State or
20 community-based organization that employs, and serves,
21 minority populations.

22 (c) **APPLICATION.**—An eligible entity may apply for
23 a grant under this section by submitting such information
24 as the Secretary may require and in such form and man-
25 ner as the Secretary may require.

1 (d) USE OF GRANT.—As a condition of receiving a
2 grant under this section, an eligible entity shall—

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

10 (2) develop a plan, including, where appro-
11 priate, public-private partnerships, for making ESL
12 instruction progressively available to all individuals
13 seeking instruction; and

14 (3) maintain current ESL instruction efforts by
15 using the additional funds to supplement rather
16 than supplant any funds expended for ESL instruc-
17 tion in the State as of January 1, 2019.

18 (e) ADDITIONAL DUTIES OF THE SECRETARY.—The
19 Secretary of Education shall—

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

23 (2) collect data from State and local govern-
24 ments to identify the unmet needs of English lan-

1 guage learners for appropriate ESL instruction, in-
2 cluding—

3 (A) the preferred written and spoken lan-
4 guage of such English language learners;

5 (B) the extent of waiting lists including
6 how many programs maintain waiting lists and,
7 for programs that do not have waiting lists, the
8 reasons why not;

9 (C) the availability of programs to geo-
10 graphically isolated communities;

11 (D) the impact of course enrollment poli-
12 cies, including open enrollment, on the avail-
13 ability of ESL instruction;

14 (E) the number individuals in the State
15 and each participating locality;

16 (F) the effectiveness of the instruction in
17 meeting the needs of individuals receiving in-
18 struction and those needing instruction;

19 (G) as assessment of the need for pro-
20 grams that integrate job training and ESL in-
21 struction, to assist individuals to obtain better
22 jobs; and

23 (H) the availability of ESL slots by State
24 and locality;

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

4 (4) not later than 1 year after the date of en-
5 actment of this Act, issue a report to Congress that
6 assesses the information collected in paragraphs (1),
7 (2), and (3) and makes recommendations on steps
8 that should be taken to progressively realize the goal
9 of making ESL instruction available to all English
10 language learners seeking instruction.

11 (f) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated to the Secretary of Edu-
13 cation \$250,000,000 for each of fiscal years 2019 through
14 2022 to carry out this section.

15 **SEC. 210. IMPLEMENTATION.**

16 (a) GENERAL PROVISIONS.—

17 (1) A State shall not be immune under the
18 Eleventh Amendment of the Constitution of the
19 United States from suit in Federal court for failing
20 to provide the language access funded pursuant to
21 this title.

22 (2) In a suit against a State for a violation of
23 this title, remedies (including remedies at both at
24 law and in equity) are available for such a violation
25 to the same extent as such remedies are available for

1 such a violation in the suit against any public or pri-
2 vate entity other than a State.

3 (b) **RULE OF CONSTRUCTION.**—Nothing in this title
4 shall be construed to limit otherwise existing obligations
5 of recipients of Federal financial assistance under title VI
6 of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et
7 seq.) or any other statute.

8 **SEC. 211. LANGUAGE ACCESS SERVICES.**

9 (a) **ESSENTIAL BENEFITS.**—Section 1302(b)(1) of
10 the Patient Protection and Affordable Care Act (42
11 U.S.C. 18022(b)(1)) is amended by adding at the end the
12 following:

13 “(K) Language access services, including
14 oral interpretation and written translations.”.

15 (b) **EMPLOYER-SPONSORED MINIMUM ESSENTIAL**
16 **COVERAGE.**—

17 (1) **IN GENERAL.**—Section 36B(e)(2)(C) of the
18 Internal Revenue Code of 1986 is amended by redesi-
19 gnating clauses (iii) and (iv) as clauses (iv) and (v),
20 respectively, and by inserting after clause (ii) the fol-
21 lowing new clause:

22 “(iii) **COVERAGE MUST INCLUDE LAN-**
23 **GUAGE ACCESS AND SERVICES.**—Except as
24 provided in clause (iv), an employee shall
25 not be treated as eligible for minimum es-

1 sential coverage if such coverage consists
2 of an eligible employer-sponsored plan (as
3 defined in section 5000A(f)(2)) and the
4 plan does not provide coverage for lan-
5 guage access services, including oral inter-
6 pretation and written translations.”.

7 (2) CONFORMING AMENDMENTS.—

8 (A) Section 36B(c)(2)(C) of such Code is
9 amended by striking “clause (iii)” each place it
10 appears in clauses (i) and (ii) and inserting
11 “clause (iv)”.

12 (B) Section 36B(c)(2)(C)(iv) of such Code,
13 as redesignated by this subsection, is amended
14 by striking “(i) and (ii)” and inserting “(i), (ii),
15 and (iii)”.

16 (c) QUALITY REPORTING.—Section 2717(a)(1) of the
17 Public Health Service Act (42 U.S.C. 300gg–17(a)(1)) is
18 amended—

19 (1) by striking “and” at the end of subpara-
20 graph (C);

21 (2) by striking the period at the end of sub-
22 paragraph (D) and inserting “; and”; and

23 (3) by adding at the end the following new sub-
24 paragraph:

1 “(E) reduce health disparities through the
2 provision of language access services, including
3 oral interpretation and written translations.”.

4 (d) REGULATIONS REGARDING INTERNAL CLAIMS
5 AND APPEALS AND EXTERNAL REVIEW PROCESSES FOR
6 HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—
7 The Secretary of the Treasury, the Secretary of Labor,
8 and the Secretary of Health and Human Services shall
9 amend the regulations in section 54.9815–2719T(e) of
10 title 26, Code of Federal Regulations, section 2590.715–
11 2719(e) of title 29, Code of Federal Regulations, and sec-
12 tion 147.136(e) of title 45, Code of Federal Regulations,
13 respectively, to require group health plans and health in-
14 surance issuers offering group or individual health insur-
15 ance coverage to which such sections apply—

16 (1) to provide oral interpretation services with-
17 out any threshold requirements;

18 (2) to provide in the English versions of all no-
19 tices a statement prominently displayed in not less
20 than 15 non-English languages clearly indicating
21 how to access the language services provided by the
22 plan or issuer; and

23 (3) with respect to written translations of no-
24 tices, to apply a threshold that 5 percent of the pop-
25 ulation or at least 500 individuals per service area

1 are literate only in the same non-English language
2 in lieu of 10 percent or more residing in a county.

3 (e) DATA COLLECTION AND REPORTING.—The Sec-
4 retary of Health and Human Services shall—

5 (1) amend the single streamlined application
6 form developed pursuant to section 1413 of the Pa-
7 tient Protection and Affordable Care Act (42 U.S.C.
8 18083) to collect the preferred spoken and written
9 language for each household member applying for
10 coverage under a qualified health plan through an
11 Exchange under title I of the Patient Protection and
12 Affordable Care Act;

13 (2) require navigators, certified application
14 counselors, and other enrollment assisters to collect
15 and report requests for language assistance; and

16 (3) require the Federal and State call centers
17 established pursuant to section 1311(d)(4)(b) of the
18 Patient Protection and Affordable Care Act (42
19 U.S.C. 18031(d)(4)(b)) to submit an annual report
20 documenting the number of language assistance re-
21 quests, the types of languages requested, the range
22 and average wait time for a consumer to speak with
23 an interpreter, and any steps the call center and lan-
24 guage line have taken to actively address some of
25 the consumer complaints.

1 (f) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to plan years beginning after the
3 date of the enactment of this Act.

4 **TITLE III—HEALTH WORKFORCE**
5 **DIVERSITY**

6 **SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
7 **ACT.**

8 Title XXXIV of the Public Health Service Act, as
9 added by section 202, is amended by adding at the end
10 the following:

11 **“Subtitle A—Diversifying the**
12 **Health Care Workplace**

13 **“SEC. 3411. NATIONAL WORKING GROUP ON WORKFORCE**
14 **DIVERSITY.**

15 “(a) IN GENERAL.—The Secretary, acting through
16 the Bureau of Health Workforce within the Health Re-
17 sources and Services Administration, shall award a grant
18 to an entity determined appropriate by the Secretary for
19 the establishment of a national working group on work-
20 force diversity.

21 “(b) REPRESENTATION.—In establishing the national
22 working group under subsection (a):

23 “(1) The grantee shall ensure that the group
24 has representatives of the following:

1 “(A) The Health Resources and Services
2 Administration.

3 “(B) The Department of Health and
4 Human Services Data Council.

5 “(C) The Office of Minority Health of the
6 Department of Health and Human Services.

7 “(D) The Substance Abuse and Mental
8 Health Services Administration.

9 “(E) The Bureau of Labor Statistics of
10 the Department of Labor.

11 “(F) The Public Health Practice Program
12 Office—Office of Workforce Policy and Plan-
13 ning.

14 “(G) The National Institute on Minority
15 Health and Health Disparities.

16 “(H) The Agency for Healthcare Research
17 and Quality.

18 “(I) The Institute of Medicine Study Com-
19 mittee for the 2004 workforce diversity report.

20 “(J) The Indian Health Service.

21 “(K) The Department of Education.

22 “(L) Minority-serving academic institu-
23 tions.

24 “(M) Consumer organizations.

1 “(N) Health professional associations, in-
2 cluding those that represent underrepresented
3 minority populations.

4 “(O) Researchers in the area of health
5 workforce.

6 “(P) Health workforce accreditation enti-
7 ties.

8 “(Q) Private (including nonprofit) founda-
9 tions that have sponsored workforce diversity
10 initiatives.

11 “(R) Local and State health departments.

12 “(S) Representatives of community mem-
13 bers to be included on admissions committees
14 for health profession schools pursuant to sub-
15 section (c)(8).

16 “(T) National community-based organiza-
17 tions that serve as a national intermediary to
18 their urban affiliate members and have dem-
19 onstrated capacity to train health care profes-
20 sionals.

21 “(U) Other entities determined appropriate
22 by the Secretary.

23 “(V) The Veterans Health Administration.

24 “(2) The grantee shall ensure that, in addition
25 to the representatives under paragraph (1), the

1 group has not less than 5 health professions stu-
2 dents representing various health profession fields
3 and levels of training.

4 “(c) ACTIVITIES.—The working group established
5 under subsection (a) shall convene at least twice each year
6 to complete the following activities:

7 “(1) Review current public and private health
8 workforce diversity initiatives.

9 “(2) Identify successful health workforce diver-
10 sity programs and practices.

11 “(3) Examine challenges relating to the devel-
12 opment and implementation of health workforce di-
13 versity initiatives.

14 “(4) Draft a national strategic work plan for
15 health workforce diversity, including recommenda-
16 tions for public and private sector initiatives.

17 “(5) Develop a framework and methods for the
18 evaluation of current and future health workforce di-
19 versity initiatives.

20 “(6) Develop recommended standards for work-
21 force diversity that could be applicable to all health
22 professions programs and programs funded under
23 this Act.

24 “(7) Develop guidelines to train health profes-
25 sionals to care for a diverse population.

1 “(8) Develop a workforce data collection or
2 tracking system to identify where racial and ethnic
3 minority health professionals practice.

4 “(9) Develop a strategy for the inclusion of
5 community members on admissions committees for
6 health profession schools.

7 “(10) Helping with monitoring and implementa-
8 tion of standards for diversity, equity, and inclusion.

9 “(11) Other activities determined appropriate
10 by the Secretary.

11 “(d) ANNUAL REPORT.—Not later than 1 year after
12 the establishment of the working group under subsection
13 (a), and annually thereafter, the working group shall pre-
14 pare and make available to the general public for com-
15 ment, an annual report on the activities of the working
16 group. Such report shall include the recommendations of
17 the working group for improving health workforce diver-
18 sity.

19 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
20 is authorized to be appropriated to carry out this section
21 such sums as may be necessary for each of fiscal years
22 2019 through 2024.

1 **“SEC. 3412. TECHNICAL CLEARINGHOUSE FOR HEALTH**
2 **WORKFORCE DIVERSITY.**

3 “(a) IN GENERAL.—The Secretary, acting through
4 the Deputy Assistant Secretary for Minority Health, and
5 in collaboration with the Bureau of Health Workforce
6 within the Health Resources and Services Administration,
7 the National Institute on Minority Health and Health Dis-
8 parities, shall establish a technical clearinghouse on health
9 workforce diversity within the Office of Minority Health
10 and coordinate current and future clearinghouses.

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

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

16 “(2) Statistical information relating to under-
17 represented minority representation in health and al-
18 lied health professions and occupations.

19 “(3) Model health workforce diversity practices
20 and programs, including integrated models of care.

21 “(4) Admissions policies that promote health
22 workforce diversity and are in compliance with Fed-
23 eral and State laws.

24 “(5) Retainment policies that promote comple-
25 tion of health profession degrees for underserved
26 populations.

1 “(6) Lists of scholarship, loan repayment, and
2 loan cancellation grants as well as fellowship infor-
3 mation for underserved populations for health pro-
4 fessions schools.

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

7 “(c) CONSULTATION.—In carrying out this section,
8 the Secretary shall consult with non-Federal entities which
9 may include minority health professional associations and
10 minority sections of major health professional associations
11 to ensure the adequacy and accuracy of information.

12 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
13 is authorized to be appropriated to carry out this section
14 such sums as may be necessary for each of fiscal years
15 2019 through 2024.

16 **“SEC. 3413. SUPPORT FOR INSTITUTIONS COMMITTED TO**
17 **WORKFORCE DIVERSITY, EQUITY, AND IN-**
18 **CLUSION.**

19 “(a) IN GENERAL.—The Secretary, acting through
20 the Administrator of the Health Resources and Services
21 Administration and the Centers for Disease Control and
22 Prevention, 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 univer-
6 sities;

7 “(B) Hispanic-serving health professions
8 schools;

9 “(C) Hispanic-serving institutions;

10 “(D) Tribal colleges and universities;

11 “(E) Asian-American, Native American,
12 and Pacific Islander-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, including national and
22 regional community-based organizations with
23 demonstrated commitment to a diversified
24 workforce—

1 “(i) located in communities with pre-
2 dominantly underrepresented minority pop-
3 ulations;

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

7 “(iii) in which at least 20 percent of
8 the enrolled participants are underrep-
9 resented minorities; and

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

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

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

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

1 “(3) postbaccalaureate programs;

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

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

7 “(6) mentoring programs;

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

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

13 “(9) leadership training.

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

19 “(e) DEFINITION.—In this section, the term ‘Asian-
20 American, Native American, and Pacific Islander-serving
21 institutions’ has the same meaning as the term ‘Asian
22 American and Native American Pacific Islander-serving
23 institution’ as defined in section 371(c) of the Higher
24 Education Act of 1965 (20 U.S.C. 1067q(c)).

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 2019 through 2024.

5 **“SEC. 3414. CAREER DEVELOPMENT FOR SCIENTISTS AND**
6 **RESEARCHERS.**

7 “(a) IN GENERAL.—The Secretary, acting through
8 the Director of the National Institutes of Health, the Di-
9 rector of the Centers for Disease Control and Prevention,
10 the Commissioner of Food and Drugs, the Director of the
11 Agency for Healthcare Research and Quality, and the Ad-
12 ministrator of the Health Resources and Services Admin-
13 istration, shall award grants that expand existing opportu-
14 nities for scientists and researchers and promote the inclu-
15 sion of underrepresented minorities in the health profes-
16 sions.

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 2019 through 2024.

5 **“SEC. 3415. CAREER SUPPORT FOR NONRESEARCH HEALTH**
6 **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 & Medicaid
13 Services, shall establish a program to award grants to eli-
14 gible individuals for career support in nonresearch-related
15 health and wellness professions.

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, an individual working in a health
21 or wellness profession (including mental and behav-
22 ioral health), or a faculty member of such a school;
23 and

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

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

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

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

11 “(3) to pay, or as reimbursement for payments
12 of, student loans or training or credentialing costs
13 for individuals who are health professionals and are
14 focused on health issues affecting underserved com-
15 munities, including racial and ethnic minority com-
16 munities; and

17 “(4) to establish and promote leadership train-
18 ing programs to decrease health disparities and to
19 increase cultural competence with the goal of in-
20 creasing diversity in leadership positions.

21 “(d) DEFINITION.—In this section, the term ‘career
22 in nonresearch-related health and wellness professions’
23 means employment or intended employment in the field
24 of public health, health policy, health management, health
25 administration, medicine, nursing, pharmacy, psychology,

1 social work, psychiatry, other mental and behavioral
2 health, allied health, community health, social work, or
3 other fields determined appropriate by the Secretary,
4 other than in a position that involves research.

5 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
6 is authorized to be appropriated to carry out this section
7 such sums as may be necessary for each of fiscal years
8 2019 through 2024.

9 **“SEC. 3416. RESEARCH ON THE EFFECT OF WORKFORCE DI-**
10 **VERSITY ON QUALITY.**

11 “(a) IN GENERAL.—The Director of the Agency for
12 Healthcare Research and Quality, in collaboration with
13 the Deputy Assistant Secretary for Minority Health and
14 the Director of the National Institute on Minority Health
15 and Health Disparities, shall award grants to eligible enti-
16 ties to expand research on the link between health work-
17 force diversity and quality health care.

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

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

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

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

5 “(1) language access;

6 “(2) cultural competence;

7 “(3) patient satisfaction;

8 “(4) timeliness of care;

9 “(5) safety of care;

10 “(6) effectiveness of care;

11 “(7) efficiency of care;

12 “(8) patient outcomes;

13 “(9) community engagement;

14 “(10) resource allocation;

15 “(11) organizational structure;

16 “(12) compliance of care; or

17 “(13) other topics determined appropriate by
18 the Director.

19 “(d) PRIORITY.—In awarding grants under sub-
20 section (a), the Director shall give individualized consider-
21 ation to all relevant aspects of the applicant’s background.
22 Consideration of prior research experience involving the
23 health of underserved communities shall be such a factor.

24 “(e) 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 2019 through 2024.

3 **“SEC. 3417. HEALTH DISPARITIES EDUCATION PROGRAM.**

4 “(a) ESTABLISHMENT.—The Secretary, acting
5 through the National Institute on Minority Health and
6 Health Disparities and in collaboration with the Office of
7 Minority Health, the Office for Civil Rights, the Centers
8 for Disease Control and Prevention, the Centers for Medi-
9 care & Medicaid Services, the Health Resources and Serv-
10 ices Administration, and other appropriate public and pri-
11 vate entities, shall establish and coordinate a health and
12 health care disparities education program to support, de-
13 velop, and implement educational initiatives and outreach
14 strategies that inform health care professionals and the
15 public about the existence of and methods to reduce racial
16 and ethnic disparities in health and health care.

17 “(b) ACTIVITIES.—The Secretary, through the edu-
18 cation program established under subsection (a), shall,
19 through the use of public awareness and outreach cam-
20 paigns targeting the general public and the medical com-
21 munity at large—

22 “(1) disseminate scientific evidence for the ex-
23 istence and extent of racial and ethnic disparities in
24 health care, including disparities that are not other-
25 wise attributable to known factors such as access to

1 care, patient preferences, or appropriateness of
2 intervention, as described in the 2002 Institute of
3 Medicine Report entitled ‘Unequal Treatment: Con-
4 fronting Racial and Ethnic Disparities in Health
5 Care’, as well as the impact of disparities related to
6 age, disability status, socioeconomic status, sex, gen-
7 der identity, and sexual orientation on racial and
8 ethnic minorities;

9 “(2) disseminate new research findings to
10 health care providers and patients to assist them in
11 understanding, reducing, and eliminating health and
12 health care disparities;

13 “(3) disseminate information about the impact
14 of linguistic and cultural barriers on health care
15 quality and the obligation of health providers who
16 receive Federal financial assistance to ensure that
17 people with limited-English proficiency have access
18 to language access services;

19 “(4) disseminate information about the impor-
20 tance and legality of racial, ethnic, disability status,
21 socioeconomic status, sex, gender identity, and sex-
22 ual orientation, and primary language data collec-
23 tion, analysis, and reporting;

1 “(5) design and implement specific educational
2 initiatives to health care providers relating to health
3 and health care disparities;

4 “(6) assess the impact of the programs estab-
5 lished under this section in raising awareness of
6 health and health care disparities and providing in-
7 formation on available resources; and

8 “(7) design and implement specific educational
9 initiatives to educate the health care workforce relat-
10 ing to unconscious bias.

11 “(c) 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 2019 through 2024.”.

15 **SEC. 302. HISPANIC-SERVING HEALTH PROFESSIONS**
16 **SCHOOLS.**

17 Part B of title VII of the Public Health Service Act
18 (42 U.S.C. 293 et seq.) is amended by adding at the end
19 the following:

20 **“SEC. 742. HISPANIC-SERVING INSTITUTIONS, HISTORI-**
21 **CALLY BLACK COLLEGES & UNIVERSITIES,**
22 **AND TRIBAL COLLEGES.**

23 “(a) IN GENERAL.—The Secretary, acting through
24 the Administrator of the Health and Human Resources
25 and Services Administration, shall establish grants from

1 the Department of Education to Hispanic-serving Institu-
2 tions, Historically Black Colleges & Universities, and Trib-
3 al Colleges, including Regional community based organiza-
4 tions and national minority medical associations, for schol-
5 arships and counseling services to prepare underrep-
6 resented minority individuals to enroll in and graduate
7 from health professional schools and to increase services
8 for qualified students, including—

9 “(1) mentoring with underrepresented health
10 professionals; and

11 “(2) providing financial assistance information
12 for continued education and applications to health
13 professional schools.

14 “(b) ELIGIBILITY.—In subsection (a), the term ‘His-
15 panic-serving Institutions’ means an entity that—

16 “(1) is a school or program under section
17 799B;

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

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

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

1 “(5) has a significant number of graduates who
2 are providing health services to medically under-
3 served populations or to individuals in health profes-
4 sional shortage areas; and

5 “(6) is a Regional Hispanic Center of Excel-
6 lence.

7 “(c) CERTAIN LOAN REPAYMENT PROGRAMS.—In
8 carrying out the National Health Service Corps loan re-
9 payment program and loan repayment programs of the
10 Centers for Disease Control and Prevention, the Secretary
11 shall ensure that loan repayments of not less than \$50,000
12 per year are awarded for repayment of loans incurred for
13 enrollment or participation in schools and programs de-
14 scribed in this section.”.

15 **SEC. 303. LOAN REPAYMENT PROGRAM OF CENTERS FOR**
16 **DISEASE CONTROL AND PREVENTION.**

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

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

20 (2) by inserting before the period at the end the
21 following: “, \$750,000 for fiscal year 2019, and such
22 sums as may be necessary for each of the fiscal
23 years 2020 through 2024”.

1 **SEC. 304. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
2 **GREE PROGRAMS AT SCHOOLS OF PUBLIC**
3 **HEALTH AND SCHOOLS OF ALLIED HEALTH.**

4 Part B of title VII of the Public Health Service Act
5 (42 U.S.C. 293 et seq.), as amended by section 302, is
6 further amended by adding at the end the following:

7 **“SEC. 743. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
8 **GREE PROGRAMS.**

9 “(a) COOPERATIVE AGREEMENTS.—The Secretary,
10 acting through the Administrator of the Health Resources
11 and Services Administration, in consultation with the Di-
12 rector of the Centers for Disease Control and Prevention,
13 the Director of the Agency for Healthcare Research and
14 Quality, and the Deputy Assistant Secretary for Minority
15 Health, shall award cooperative agreements to schools of
16 public health and schools of allied health to design and
17 implement online degree programs.

18 “(b) PRIORITY.—In awarding cooperative agreements
19 under this section, the Secretary shall give priority to any
20 school of public health or school of allied health that has
21 an established track record of serving medically under-
22 served communities.

23 “(c) REQUIREMENTS.—Recipients of cooperative
24 agreements under this section shall design and implement
25 an online degree program that meets the following restric-
26 tions:

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

4 “(2) Maintaining a significant enrollment of
5 underrepresented minority or disadvantaged stu-
6 dents.

7 “(3) Achieving a high completion rate of en-
8 rolled underrepresented minority or disadvantaged
9 students.

10 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
11 are authorized to be appropriated to carry out this section
12 such sums as may be necessary for each of fiscal years
13 2019 through 2024.”.

14 **SEC. 305. SENSE OF CONGRESS ON THE MISSION OF THE**
15 **NATIONAL HEALTH CARE WORKFORCE COM-**
16 **MISSION.**

17 It is the sense of Congress that the National Health
18 Care Workforce Commission established by section 5101
19 of the Patient Protection and Affordable Care Act (42
20 U.S.C. 294q) should, in carrying out its assigned duties
21 under that section, give attention to the needs of racial
22 and ethnic minorities, individuals with lower socio-
23 economic status, individuals with mental, developmental,
24 and physical disabilities, lesbian, gay, bisexual,
25 transgender, queer, and questioning populations, and indi-

1 viduals who are members of multiple minority or special
2 population groups.

3 **SEC. 306. SCHOLARSHIP AND FELLOWSHIP PROGRAMS.**

4 Subtitle A of title XXXIV of the Public Health Serv-
5 ice Act, as added by section 301, is further amended by
6 inserting after section 3417 the following:

7 **“SEC. 3418. DAVID SATCHER PUBLIC HEALTH AND HEALTH**
8 **SERVICES CORPS.**

9 “(a) IN GENERAL.—The Administrator of the Health
10 Resources and Services Administration and the Director
11 of the Centers for Disease Control and Prevention, in col-
12 laboration with the Deputy Assistant Secretary for Minor-
13 ity Health, shall award grants to eligible entities to in-
14 crease awareness among postprimary and postsecondary
15 students of career opportunities in the health professions.

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

18 “(1) be a clinical, public health, or health serv-
19 ices organization, community-based or nonprofit en-
20 tity, or other entity determined appropriate by the
21 Director of the Centers for Disease Control and Pre-
22 vention;

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

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

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

7 “(c) USE OF FUNDS.—Grant awards under sub-
8 section (a) shall be used to support internships that will
9 increase awareness among students of non-research-based,
10 career opportunities in the following health professions:

11 “(1) Medicine.

12 “(2) Nursing.

13 “(3) Public Health.

14 “(4) Pharmacy.

15 “(5) Health administration and management.

16 “(6) Health policy.

17 “(7) Psychology.

18 “(8) Dentistry.

19 “(9) International health.

20 “(10) Social work.

21 “(11) Allied health.

22 “(12) Psychiatry.

23 “(13) Hospice care.

24 “(14) Community health, patient navigation,
25 and peer support.

1 “(15) Other professions deemed appropriate by
2 the Director of the Centers for Disease Control and
3 Prevention.

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

8 “(1) serve a high proportion of individuals from
9 disadvantaged backgrounds;

10 “(2) have experience in health disparity elimi-
11 nation programs;

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

14 “(4) provide counseling or other services de-
15 signed to assist disadvantaged individuals in success-
16 fully completing their education at the postsecondary
17 level.

18 “(e) STIPENDS.—The Secretary may approve sti-
19 pends under this section for individuals for any period of
20 education in student-enhancement programs (other than
21 regular courses) at health professions schools, programs,
22 or entities, except that such a stipend may not be provided
23 to an individual for more than 6 months, and such a sti-
24 pend may not exceed \$20 per day (notwithstanding any
25 other provision of law regarding the amount of stipends).

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 2019 through 2024.

5 **“SEC. 3419. LOUIS STOKES PUBLIC HEALTH SCHOLARS**
6 **PROGRAM.**

7 “(a) IN GENERAL.—The Director of the Centers for
8 Disease Control and Prevention, in collaboration with the
9 Deputy Assistant Secretary for Minority Health, shall
10 award scholarships to postsecondary students who seek a
11 career in public health.

12 “(b) ELIGIBILITY.—To be eligible to receive a schol-
13 arship under subsection (a), an individual shall—

14 “(1) have interest, knowledge, or skill in public
15 health research or public health practice, or other
16 health professions as determined appropriate by the
17 Director of the Centers for Disease Control and Pre-
18 vention;

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

21 “(3) demonstrate promise for becoming a leader
22 in public health;

23 “(4) secure admission to a 4-year institution of
24 higher education;

25 “(5) comply with subsection (e); and

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

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

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

10 “(1) are from disadvantaged backgrounds;

11 “(2) have secured admissions to a minority-
12 serving institution; and

13 “(3) have identified a health professional as a
14 mentor at their school or institution and an aca-
15 demic advisor to assist in the completion of their
16 baccalaureate degree.

17 “(e) SCHOLARSHIPS.—The Secretary may approve
18 payment of scholarships under this section for such indi-
19 viduals for any period of education in student under-
20 graduate tenure, except that such a scholarship may not
21 be provided to an individual for more than 4 years, and
22 such scholarships may not exceed \$10,000 per academic
23 year (notwithstanding any other provision of law regard-
24 ing the amount of scholarship).

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 2019 through 2024.

5 **“SEC. 3420. PATSY MINK HEALTH AND GENDER RESEARCH**
6 **FELLOWSHIP PROGRAM.**

7 “(a) IN GENERAL.—The Director of the Centers for
8 Disease Control and Prevention, in collaboration with the
9 Deputy Assistant Secretary for Minority Health, the Ad-
10 ministrator of the Substance Abuse and Mental Health
11 Services Administration, and the Director of the Indian
12 Health Services, shall award research fellowships to post-
13 baccalaureate students to conduct research that will exam-
14 ine gender and health disparities and to pursue a career
15 in the health professions.

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

18 “(1) have experience in health research or pub-
19 lic health practice;

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

22 “(3) have expressed an interest in the health
23 professions;

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

1 “(5) secure admission to a health professions
2 school or graduate program with an emphasis in
3 gender studies;

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

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

8 “(c) USE OF FUNDS.—Amounts received under an
9 award under subsection (a) shall be used to support oppor-
10 tunities for students to become researchers and advance
11 the research base on the intersection between gender and
12 health.

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

17 “(1) are from disadvantaged backgrounds; and

18 “(2) have identified a mentor and academic ad-
19 visor who will assist in the completion of their grad-
20 uate or professional degree and have secured a re-
21 search assistant position with a researcher working
22 in the area of gender and health.

23 “(e) FELLOWSHIPS.—The Director of the Centers for
24 Disease Control and Prevention may approve fellowships
25 for individuals under this section for any period of edu-

1 cation in the student’s graduate or health profession ten-
2 ure, except that such a fellowship may not be provided
3 to an individual for more than 3 years, and such a fellow-
4 ship may not exceed \$18,000 per academic year (notwith-
5 standing any other provision of law regarding the amount
6 of fellowship).

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 2019 through 2024.

11 **“SEC. 3420A. PAUL DAVID WELLSTONE INTERNATIONAL**
12 **HEALTH FELLOWSHIP PROGRAM.**

13 “(a) IN GENERAL.—The Director of the Agency for
14 Healthcare Research and Quality, in collaboration with
15 the Deputy Assistant Secretary for Minority Health, shall
16 award research fellowships to college students or recent
17 graduates to advance their understanding of international
18 health.

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

21 “(1) have educational experience in the field of
22 international health;

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

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

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

5 “(5) comply with subsection (e); and

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

9 “(c) USE OF FUNDS.—Amounts received under an
10 award under subsection (a) shall be used to support oppor-
11 tunities for students to become health professionals and
12 to advance their knowledge about international issues re-
13 lating to health care access and quality.

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

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

18 “(2) have identified a mentor at a health pro-
19 fessions school or institution, an academic advisor to
20 assist in the completion of their graduate or profes-
21 sional degree, and an advisor from an international
22 health non-governmental organization, private volun-
23 teer organization, or other international institution
24 or program that focuses on increasing health care

1 access and quality for residents in developing coun-
2 tries.

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

11 “(f) 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 2019 through 2024.

15 **“SEC. 3420B. EDWARD R. ROYBAL HEALTH SCHOLAR PRO-**
16 **GRAM.**

17 “(a) IN GENERAL.—The Director of the Agency for
18 Healthcare Research and Quality, the Director of the Cen-
19 ters for Medicare and Medicaid Services, and the Adminis-
20 trator for Health Resources and Services Administration,
21 in collaboration with the Deputy Assistant Secretary for
22 Minority Health, shall award grants to eligible entities to
23 expose entering graduate students to the health profes-
24 sions.

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

3 “(1) be a clinical, public health, or health serv-
4 ices organization, community-based, academic, or
5 nonprofit entity, or other entity determined appro-
6 priate by the Director of the Agency for Healthcare
7 Research and Quality;

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

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

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

15 “(c) USE OF FUNDS.—Amounts received under a
16 grant awarded under subsection (a) shall be used to sup-
17 port opportunities that expose students to non-research-
18 based health professions, including—

19 “(1) public health policy;

20 “(2) health care and pharmaceutical policy;

21 “(3) health care administration and manage-
22 ment;

23 “(4) health economics; and

24 “(5) other professions determined appropriate
25 by the Director of the Agency for Healthcare Re-

1 search and Quality, the Director of the Centers for
2 Medicare and Medicaid Services, and the Adminis-
3 trator for Health Resources and Services Adminis-
4 tration.

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

9 “(1) have experience with health disparity elimi-
10 nation programs;

11 “(2) facilitate training in the fields described in
12 subsection (c); and

13 “(3) provide counseling or other services de-
14 signed to assist such individuals in successfully com-
15 pleting their education at the postsecondary level.

16 “(e) STIPENDS.—The Secretary may approve the
17 payment of stipends for individuals under this section for
18 any period of education in student-enhancement programs
19 (other than regular courses) at health professions schools
20 or entities, except that such a stipend may not be provided
21 to an individual for more than 2 months, and such a sti-
22 pend may not exceed \$100 per day (notwithstanding any
23 other provision of law regarding the amount of stipends).

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 2019 through 2024.

3 **“SEC. 3420C. LEADERSHIP FELLOWSHIP PROGRAMS.**

4 “The Secretary of Health and Human Services shall
5 award grants to entities to develop leadership fellowship
6 programs for underrepresented health professionals to be-
7 come future leaders in public health and health care deliv-
8 ery institutions.”.

9 **SEC. 307. MCNAIR POSTBACCALAUREATE ACHIEVEMENT**
10 **PROGRAM.**

11 Section 402E of the Higher Education Act of 1965
12 (20 U.S.C. 1070a–15) is amended by striking subsection
13 (g) and inserting the following:

14 “(g) **COLLABORATION IN HEALTH PROFESSION DI-**
15 **VERSITY TRAINING PROGRAMS.**—The Secretary shall co-
16 ordinate with the Secretary of Health and Human Serv-
17 ices to ensure that there is collaboration between the goals
18 of the program under this section and programs of the
19 Health Resources and Services Administration that pro-
20 mote health workforce diversity. The Secretary of Edu-
21 cation shall take such measures as may be necessary to
22 encourage students participating in projects assisted
23 under this section to consider health profession careers.

24 “(h) **FUNDING.**—From amounts appropriated pursu-
25 ant to the authority of section 402A(g), the Secretary

1 shall, to the extent practicable, allocate funds for projects
2 authorized by this section in an amount which is not less
3 than \$31,000,000 for each of the fiscal years 2019
4 through 2025.”.

5 **SEC. 308. RULES FOR DETERMINATION OF FULL-TIME**
6 **EQUIVALENT RESIDENTS FOR COST-REPORT-**
7 **ING PERIODS.**

8 (a) DGME DETERMINATIONS.—Section 1886(h)(4)
9 of the Social Security Act (42 U.S.C. 1395ww(h)(4)), as
10 amended by section 204(a), is amended—

11 (1) in subparagraph (E), by striking “Subject
12 to subparagraphs (J) and (K), such rules” and in-
13 sserting “Subject to subparagraphs (J), (K), and
14 (M), such rules”;

15 (2) in subparagraph (J), by striking “Such
16 rules” and inserting “Subject to subparagraph (M),
17 such rules”;

18 (3) in subparagraph (K), by striking “In deter-
19 mining” and inserting “Subject to subparagraph
20 (M), in determining”; and

21 (4) by adding at the end the following new sub-
22 paragraph:

23 “(M) TREATMENT OF CERTAIN RESIDENTS
24 AND INTERNS.—For purposes of cost-reporting
25 periods beginning on or after October 1, 2016,

1 in determining the hospital's number of full-
2 time equivalent residents for purposes of this
3 paragraph, all the time spent by an intern or
4 resident in an approved medical residency train-
5 ing program shall be counted toward the deter-
6 mination of full-time equivalency if the hos-
7 pital—

8 “(i) is recognized as a subsection (d)
9 hospital;

10 “(ii) is recognized as a subsection (d)
11 Puerto Rico hospital;

12 “(iii) is reimbursed under a reim-
13 bursement system authorized under section
14 1814(b)(3); or

15 “(iv) is a provider-based hospital out-
16 patient department.”.

17 (b) **IME DETERMINATIONS.**—Section
18 1886(d)(5)(B)(x) of the Social Security Act (42 U.S.C.
19 1395ww(d)(5)(B)(x)) is amended—

20 (1) in subclause (II), by striking “In deter-
21 mining” and inserting “Subject to subclause (IV), in
22 determining”;

23 (2) in subclause (III), by striking “In deter-
24 mining” and inserting “Subject to subclause (IV), in
25 determining”; and

1 (3) by inserting after subclause (III) the fol-
2 lowing new subclause:

3 “(IV) The provisions of subparagraph (L)
4 of subsection (h)(4) shall apply under this sub-
5 paragraph in the same manner as they apply
6 under such subsection.”.

7 **SEC. 309. DEVELOPING AND IMPLEMENTING STRATEGIES**
8 **FOR LOCAL HEALTH EQUITY.**

9 (a) GRANTS.—The Secretaries of Health and Human
10 Services, Education, and Labor, acting jointly, shall make
11 grants to academic institutions for the purposes of—

12 (1) in accordance with subsection (b), devel-
13 oping capacity—

14 (A) to build an evidence base for successful
15 strategies for increasing local health equity; and

16 (B) to serve as national models of driving
17 local health equity;

18 (2) in accordance with subsection (c), devel-
19 oping a strategic partnership with the community in
20 which the academic institution is located; and

21 (3) collecting data on, and periodically evalu-
22 ating, the effectiveness of the institution’s programs
23 funded through this section to enable the institution
24 to adapt accordingly for maximum efficiency and
25 success.

1 (b) DEVELOPING CAPACITY FOR INCREASING LOCAL
2 HEALTH EQUITY.—As a condition on receipt of a grant
3 under subsection (a), an academic institution shall agree
4 to use the grant to build an evidence base for successful
5 strategies for increasing local health equity, and to serve
6 as a national model of driving local health equity, by sup-
7 porting—

8 (1) resources to strengthen institutional metrics
9 and capacity to execute institutionwide health work-
10 force goals that can serve as models for increasing
11 health equity in communities across the country;

12 (2) collaborations among a cohort of institu-
13 tions in implementing systemic change, partnership
14 development, and programmatic efforts supportive of
15 health equity goals across disciplines and popu-
16 lations; and

17 (3) enhanced or newly developed data systems
18 and research infrastructure capable of informing
19 current and future workforce efforts and building a
20 foundation for a broader research agenda targeting
21 urban health disparities.

22 (c) STRATEGIC PARTNERSHIPS.—As a condition on
23 receipt of a grant under subsection (a), an academic insti-
24 tution shall agree to use the grant to develop a strategic

1 partnership with the community in which the institution
2 is located for the purposes of—

3 (1) strengthening connections between the insti-
4 tution and the community—

5 (A) to improve evaluation of and address
6 the community’s health and health workforce
7 needs; and

8 (B) to engage the community in health
9 workforce development;

10 (2) developing, enhancing, or accelerating inno-
11 vative undergraduate and graduate programs in the
12 biomedical sciences and health professions; and

13 (3) strengthening pipeline programs in the bio-
14 medical sciences and health professions, including by
15 developing partnerships between institutions of high-
16 er education and elementary and secondary schools
17 to recruit the next generation of health professionals
18 earlier in the pipeline to a health care career.

19 **SEC. 310. LOAN FORGIVENESS FOR MENTAL AND BEHAV-**
20 **IORAL HEALTH SOCIAL WORKERS.**

21 Section 455 of the Higher Education Act of 1965 (20
22 U.S.C. 1087e) is amended by adding at the end the fol-
23 lowing new subsection:

24 “(r) REPAYMENT PLAN FOR MENTAL AND BEHAV-
25 IORAL HEALTH SOCIAL WORKERS.—

1 “(1) IN GENERAL.—The Secretary shall cancel
2 the balance of interest and principal due on any eli-
3 gible Federal Direct Loan not in default for a bor-
4 rower who—

5 “(A) has made 120 monthly payments on
6 the eligible Federal Direct Loan after October
7 1, 2016, pursuant to any one or a combination
8 of the following—

9 “(i) payments under an income-based
10 repayment plan under section 493C;

11 “(ii) payments under a standard re-
12 payment plan under subsection (d)(1)(A),
13 based on a 10-year repayment period;

14 “(iii) monthly payments under a re-
15 payment plan under subsection (d)(1) or
16 (g) of not less than the monthly amount
17 calculated under subsection (d)(1)(A),
18 based on a 10-year repayment period; or

19 “(iv) payments under an income con-
20 tingent repayment plan under subsection
21 (d)(1)(D); and

22 “(B)(i) is employed as a mental health or
23 behavioral health social worker, as defined by
24 the Secretary by regulation, at the time of such
25 forgiveness; and

1 “(ii) has been employed as such a mental
2 health or behavioral health social worker during
3 the period in which the borrower makes each of
4 the 120 payments as described in subparagraph
5 (A).

6 “(2) LOAN CANCELLATION AMOUNT.—After the
7 conclusion of the employment period described in
8 paragraph (1), the Secretary shall cancel the obliga-
9 tion to repay the balance of principal and interest
10 due as of the time of such cancellation, on the eligi-
11 ble Federal Direct Loans made to the borrower
12 under this part.

13 “(3) INELIGIBILITY FOR DOUBLE BENEFITS.—
14 No borrower may, for the same employment as a
15 mental health or behavioral health social worker, re-
16 ceive a reduction of loan obligations under both this
17 subsection and subsection (m), 428J, 428K, 428L,
18 or 460.

19 “(4) DEFINITION OF ELIGIBLE FEDERAL DI-
20 RECT LOAN.—In this subsection, the term ‘eligible
21 Federal Direct Loan’ means a Federal Direct Staf-
22 ford Loan, Federal Direct PLUS Loan, Federal Di-
23 rect Unsubsidized Stafford Loan, or a Federal Di-
24 rect Consolidation Loan.”.

1 **SEC. 311. HEALTH PROFESSIONS WORKFORCE FUND.**

2 (a) PURPOSE.—It is the purpose of this section to
3 establish a Health Professions Workforce Fund to be ad-
4 ministered through the Health Resources and Services Ad-
5 ministration within the Department of Health and Human
6 Services to provide for expanded and sustained national
7 investment in the health professions and nursing work-
8 force development programs under title VII and title VIII
9 of the Public Health Service Act.

10 (b) ESTABLISHING THE HEALTH PROFESSIONS
11 WORKFORCE FUND.—There is authorized to be appro-
12 priated, and there is appropriated, out of any monies in
13 the Treasury not otherwise appropriated, to the Health
14 Professions Workforce Fund—

15 (1) \$355,000,000 for fiscal year 2019;

16 (2) \$375,000,000 for fiscal year 2020;

17 (3) \$392,000,000 for fiscal year 2021;

18 (4) \$412,000,000 for fiscal year 2022;

19 (5) \$432,000,000 for fiscal year 2023;

20 (6) \$454,000,000 for fiscal year 2024;

21 (7) \$476,000,000 for fiscal year 2025;

22 (8) \$500,000,000 for fiscal year 2026;

23 (9) \$525,000,000 for fiscal year 2027; and

24 (10) \$552,000,000 for fiscal year 2028.

25 (c) FUNDING.—

1 (1) For the purpose of carrying out health pro-
2 fessions education programs authorized under title
3 VII of the Public Health Service Act, in addition to
4 any other amounts authorized to be appropriated for
5 such purpose, there is authorized to be appropriated
6 out of any monies in the Health Professions Work-
7 force Fund, the following:

8 (A) \$240,000,000 for fiscal year 2019.

9 (B) \$253,000,000 for fiscal year 2020.

10 (C) \$265,000,000 for fiscal year 2021.

11 (D) \$278,000,000 for fiscal year 2022.

12 (E) \$292,000,000 for fiscal year 2023.

13 (F) \$307,000,000 for fiscal year 2024.

14 (G) \$322,000,000 for fiscal year 2025.

15 (H) \$338,000,000 for fiscal year 2026.

16 (I) \$355,000,000 for fiscal year 2027.

17 (J) \$373,000,000 for fiscal year 2028.

18 (2) For the purpose of carrying out nursing
19 workforce development programs authorized under
20 Title VIII of the Public Health Service Act, in addi-
21 tion to any other amounts authorized to be appro-
22 priated for such purpose, there is authorized to be
23 appropriated out of any monies in the Health Pro-
24 fessions Workforce Fund, the following:

25 (A) \$115,000,000 for fiscal year 2019.

- 1 (B) \$122,000,000 for fiscal year 2020.
2 (C) \$127,000,000 for fiscal year 2021.
3 (D) \$134,000,000 for fiscal year 2022.
4 (E) \$140,000,000 for fiscal year 2023.
5 (F) \$147,000,000 for fiscal year 2024.
6 (G) \$154,000,000 for fiscal year 2025.
7 (H) \$162,000,000 for fiscal year 2026.
8 (I) \$170,000,000 for fiscal year 2027.
9 (J) \$179,000,000 for fiscal year 2028.

10 **SEC. 312. FINDINGS; SENSE OF CONGRESS RELATING TO**
11 **GRADUATE MEDICAL EDUCATION.**

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

13 (1) Projections by the Association of American
14 Medical Colleges (AAMC) and other expert entities,
15 such as the Health Resources and Services Adminis-
16 tration (HRSA), have indicated a nationwide short-
17 age of up to 104,900 physicians, split evenly be-
18 tween primary care and specialists, by 2030.

19 (2) Primarily due to the growing and aging
20 population, over the next decade, physician demand
21 is expected to grow up to 17 percent.

22 (3) The United States Census Bureau estimates
23 that the United States population will grow from
24 321 million in 2015 to 347 million in 2025. Further,
25 the number of Medicare beneficiaries is estimated to

1 increase from 47.8 million in 2015 to approximately
2 66 million in 2025.

3 (4) Approximately 36 percent of practicing phy-
4 sicians are over the age of 55 and are likely to retire
5 within the next decade.

6 (5) A nationwide physician shortage will result
7 in many Americans waiting longer and traveling far-
8 ther for health care; seeking nonemergent care in
9 emergency departments; and delaying treatment
10 until their health care needs become more serious,
11 complex, and costly.

12 (6) Changing demographics (such as an aging
13 population), new health care delivery models (such
14 as medical homes), and other factors (such as dis-
15 aster preparedness) are contributing to a shortage of
16 both generalist and specialist physicians.

17 (7) These shortages will have the most severe
18 impact on vulnerable and underserved populations,
19 including racial/ethnic minorities and the approxi-
20 mately 20 percent of Americans who live in rural or
21 inner-city locations designated as health professional
22 shortage areas.

23 (8) The AAMC's Health Care Utilization Eq-
24 uity model estimates that if racial and ethnic minori-
25 ties and individuals from rural areas utilized health

1 care in a similar way to their Caucasian counter-
2 parts living in metropolitan areas, the physician
3 shortage would require an additional 96,000 physi-
4 cians.

5 (9) To address the physician shortage, medical
6 education and training need to be accessible for stu-
7 dents and physicians from all backgrounds. Inter-
8 national graduates play an important role in U.S.
9 health care, representing roughly 25 percent of the
10 health care workforce. Immigration pathways like
11 student, exchange-visitor, and employment visas, and
12 programs like the National Interest Waiver and
13 Conrad 30 J-1 Visa Waiver, help improve health ac-
14 cess across the country.

15 (10) United States medical schools have com-
16 mitted to and have initiated a 30 percent increase
17 in enrollment by 2017 to help reduce the Nation's
18 shortage of quality physicians.

19 (11) An increase in United States medical
20 school graduates must be accompanied by an in-
21 crease of 4,000 graduate medical education (GME)
22 training positions each year.

23 (12) Graduate medical education programs and
24 teaching hospitals provide venues in which the next
25 generation of physicians learns to work collabo-

1 ratively with other physicians and health profes-
2 sionals, adopt more efficient care delivery models
3 (such as care coordination and medical homes), in-
4 corporate health information technology and elec-
5 tronic health records in every aspect of their work,
6 apply new methods of assuring quality and safety,
7 and participate in groundbreaking clinical and public
8 health research.

9 (13) The Medicare Program under title XVIII
10 of the Social Security Act (having more beneficiaries
11 than any other health care program), supports its
12 “fair share” of the costs associated with graduate
13 medical education (GME).

14 (14) In general, the level of support of graduate
15 medical education by the Medicare Program has
16 been capped since 1997 and has not been increased
17 to support the expansion of graduate medical edu-
18 cation programs needed to avert the projected physi-
19 cian shortage or to accommodate the increase in
20 United States medical school graduates.

21 (b) SENSE OF CONGRESS.—It is the sense of Con-
22 gress that eliminating the limit of the number of residency
23 positions that receive some level of Medicare support
24 under section 1886(h) of the Social Security Act (42

1 U.S.C. 1395ww(h)), also referred to as the Medical grad-
2 uate medical education cap, is critical to—

3 (1) ensuring an appropriate supply of physi-
4 cians to meet the Nation’s health care needs;

5 (2) facilitating equitable access for all who seek
6 health care; and

7 (3) mitigating disparities in health and health
8 care.

9 **SEC. 313. CAREER SUPPORT FOR SKILLED, INTERNATION-**
10 **ALLY EDUCATED HEALTH PROFESSIONALS.**

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

12 (1) According to the Association of Schools of
13 Public Health, projections indicate a nationwide
14 shortage of up to 250,000 public health workers
15 needed by 2020.

16 (2) Similar trends are projected for other health
17 professions indicating shortages across disciplines,
18 including within the fields of nursing (500,000 by
19 2025), dentistry (15,000 by 2025), pharmacy
20 (38,000 by 2030), mental and behavioral health, pri-
21 mary care (46,000 by 2025), and community and al-
22 lied health.

23 (3) A nationwide health workforce shortage will
24 result in serious health threats and more severe and
25 costly health care needs, due to, in part, a delayed

1 response to food-borne outbreaks, emerging infec-
2 tious diseases, natural disasters, fewer cancer
3 screenings, and delayed treatment.

4 (4) Vulnerable and underserved populations and
5 health professional shortage areas will be most se-
6 verely impacted by the health workforce shortage.

7 (5) According to the Migration Policy Institute,
8 over 2,000,000 college-educated immigrants in the
9 United States today are unemployed or under-
10 employed in low- or semi-skilled jobs that fail to
11 draw on their education and expertise.

12 (6) Approximately 2 out of every 5 internation-
13 ally educated immigrants are unemployed or under-
14 employed.

15 (7) According to Drexel University Center for
16 Labor Markets and Policy, underemployment for
17 internationally educated immigrant women is 28 per-
18 cent higher than for their male counterparts.

19 (8) According to the Drexel University Center
20 for labor markets and policy, the mean annual earn-
21 ings of underemployed immigrants were \$32,000, or
22 43 percent less than United States born college
23 graduates employed in the college labor market.

24 (9) According to Upwardly Global and the Wel-
25 come Back Initiative, with proper guidance and sup-

1 port, underemployed skilled immigrants typically in-
2 crease their income by 215 percent to 900 percent.

3 (10) According to the Brookings Institution and
4 the Partnership for a New American Economy, im-
5 migrants working in the health workforce are, on av-
6 erage, better educated than United States-born
7 workers in the health workforce.

8 (b) GRANTS TO ELIGIBLE ENTITIES.—

9 (1) AUTHORITY TO PROVIDE GRANTS.—The
10 Secretary of Health and Human Services acting
11 through the Bureau of Health Workforce within the
12 Health Resources and Services Administration, the
13 National Institute on Minority Health and Health
14 Disparities, or the Office of Minority Health (in this
15 section referred to as the “Secretary”) may award
16 grants to eligible entities to carry out activities de-
17 scribed in subsection (c).

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

20 (A) be a clinical, public health, or health
21 services organization, a community-based or
22 nonprofit entity, an academic institution, a
23 faith-based organization, a State, county, or
24 local government, an Area Health Education

1 Center, or another entity determined appro-
2 priate by the Secretary; and

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

6 (c) AUTHORIZED ACTIVITIES.—A grant awarded
7 under this section shall be used—

8 (1) to provide services to assist unemployed and
9 underemployed skilled immigrants, residing in the
10 United States, who have legal, permanent work au-
11 thorization and who are internationally educated
12 health professionals, enter into the American health
13 workforce with employment matching their health
14 professional skills and education, and advance in em-
15 ployment to positions that better match their health
16 professional education and expertise;

17 (2) to provide training opportunities to reduce
18 barriers to entry and advancement in the health
19 workforce for skilled, internationally educated immi-
20 grants;

21 (3) to educate employers regarding the abilities
22 and capacities of internationally educated health
23 professionals;

24 (4) to assist in the evaluation of foreign creden-
25 tials;

1 (5) to support preceptorships for international
2 medical graduates in hospital primary care training;
3 and

4 (6) to facilitate access to contextualized and ac-
5 celerated courses on English as a second language.

6 **TITLE IV—IMPROVING HEALTH**
7 **CARE ACCESS AND QUALITY**

8 **Subtitle A—Expansion of Coverage**

9 **SEC. 401. AMENDMENT TO THE PUBLIC HEALTH SERVICE**

10 **ACT.**

11 Title XXXIV of the Public Health Service Act, as
12 amended by titles I, II, III, and IX of this Act, is further
13 amended by inserting after subtitle C the following:

14 **“Subtitle D—Reconstruction and**
15 **Improvement Grants for Public**
16 **Health Care Facilities Serving**
17 **Pacific Islanders and the Insu-**
18 **lar Areas**

19 **“SEC. 3451. GRANT SUPPORT FOR QUALITY IMPROVEMENT**
20 **INITIATIVES.**

21 “(a) IN GENERAL.—The Secretary, in collaboration
22 with the Administrator of the Health Resources and Serv-
23 ices Administration, the Director of the Agency for
24 Healthcare Research and Quality, and the Administrator
25 of the Centers for Medicare & Medicaid Services, shall

1 award grants to eligible entities for the conduct of dem-
2 onstration projects to improve the quality of and access
3 to health care.

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

6 “(1) be a health center, hospital, health plan,
7 health system, community clinic, or other health en-
8 tity determined appropriate by the Secretary—

9 “(A) that, by legal mandate or explicitly
10 adopted mission, provides patients with access
11 to services regardless of their ability to pay;

12 “(B) that provides care or treatment for a
13 substantial number of patients who are unin-
14 sured, are receiving assistance under a State
15 program under title XIX of the Social Security
16 Act, or are members of vulnerable populations,
17 as determined by the Secretary; and

18 “(C)(i) with respect to which, not less than
19 50 percent of the entity’s patient population is
20 made up of racial and ethnic minorities; or

21 “(ii) that—

22 “(I) serves a disproportionate percent-
23 age of local, minority racial and ethnic pa-
24 tients, or that has a patient population, at

1 least 50 percent of which is limited-
2 English-proficient; and

3 “(II) provides an assurance that
4 amounts received under the grant will be
5 used only to support quality improvement
6 activities in the racial and ethnic popu-
7 lation served; and

8 “(2) prepare and submit to the Secretary an
9 application at such time, in such manner, and con-
10 taining such information as the Secretary may re-
11 quire.

12 “(c) PRIORITY.—In awarding grants under sub-
13 section (a), the Secretary shall give priority to applicants
14 under subsection (b)(2) that—

15 “(1) demonstrate an intent to operate as part
16 of a health care partnership, network, collaborative,
17 coalition, or alliance where each member entity con-
18 tributes to the design, implementation, and evalua-
19 tion of the proposed intervention; or

20 “(2) intend to use funds to carry out system-
21 wide changes with respect to health care quality im-
22 provement, including—

23 “(A) improved systems for data collection
24 and reporting;

1 “(B) innovative collaborative or similar
2 processes;

3 “(C) group programs with behavioral or
4 self-management interventions;

5 “(D) case management services;

6 “(E) physician or patient reminder sys-
7 tems;

8 “(F) educational interventions; or

9 “(G) other activities determined appro-
10 priate by the Secretary.

11 “(d) USE OF FUNDS.—An entity shall use amounts
12 received under a grant under subsection (a) to support
13 the implementation and evaluation of health care quality
14 improvement activities or minority health and health care
15 disparity reduction activities that include—

16 “(1) with respect to health care systems, activi-
17 ties relating to improving—

18 “(A) patient safety;

19 “(B) timeliness of care;

20 “(C) effectiveness of care;

21 “(D) efficiency of care;

22 “(E) patient centeredness; and

23 “(F) health information technology; and

24 “(2) with respect to patients, activities relating
25 to—

1 “(A) staying healthy;

2 “(B) getting well, mentally and physically;

3 “(C) living effectively with illness or dis-
4 ability;

5 “(D) coping with end-of-life issues; and

6 “(E) shared decisionmaking.

7 “(e) COMMON DATA SYSTEMS.—The Secretary shall
8 provide financial and other technical assistance to grant-
9 ees under this section for the development of common data
10 systems.

11 “(f) 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 2019 through 2024.

15 **“SEC. 3452. CENTERS OF EXCELLENCE.**

16 “(a) IN GENERAL.—The Secretary, acting through
17 the Administrator of the Health Resources and Services
18 Administration, shall designate centers of excellence at
19 public hospitals, and other health systems serving large
20 numbers of minority patients, that—

21 “(1) meet the requirements of section
22 3451(b)(1);

23 “(2) demonstrate excellence in providing care to
24 minority populations; and

1 “(3) demonstrate excellence in reducing dispari-
2 ties in health and health care.

3 “(b) REQUIREMENTS.—A hospital or health system
4 that serves as a center of excellence under subsection (a)
5 shall—

6 “(1) design, implement, and evaluate programs
7 and policies relating to the delivery of care in ra-
8 cially, ethnically, and linguistically diverse popu-
9 lations;

10 “(2) provide training and technical assistance
11 to other hospitals and health systems relating to the
12 provision of quality health care to minority popu-
13 lations; and

14 “(3) develop activities for graduate or con-
15 tinuing medical education that institutionalize a
16 focus on cultural competence training for health care
17 providers.

18 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
19 are authorized to be appropriated to carry out this section,
20 such sums as may be necessary for each of fiscal years
21 2019 through 2024.

1 **“SEC. 3453. RECONSTRUCTION AND IMPROVEMENT GRANTS**
2 **FOR PUBLIC HEALTH CARE FACILITIES SERV-**
3 **ING PACIFIC ISLANDERS AND THE INSULAR**
4 **AREAS.**

5 “(a) IN GENERAL.—The Secretary shall provide di-
6 rect financial assistance to designated health care pro-
7 viders and community health centers in American Samoa,
8 Guam, the Commonwealth of the Northern Mariana Is-
9 lands, the United States Virgin Islands, Puerto Rico, and
10 Hawaii for the purposes of reconstructing and improving
11 health care facilities and services in a culturally competent
12 and sustainable manner.

13 “(b) ELIGIBILITY.—To be eligible to receive direct fi-
14 nancial assistance under subsection (a), an entity shall be
15 a public health facility or community health center located
16 in American Samoa, Guam, the Commonwealth of the
17 Northern Mariana Islands, the United States Virgin Is-
18 lands, Puerto Rico, or Hawaii that—

19 “(1) is owned or operated by—

20 “(A) the Government of American Samoa,
21 Guam, the Commonwealth of the Northern
22 Mariana Islands, the United States Virgin Is-
23 lands, Puerto Rico, or Hawaii or a unit of local
24 government; or

25 “(B) a nonprofit organization; and

1 “(2)(A) provides care or treatment for a sub-
2 stantial number of patients who are uninsured, re-
3 ceiving assistance under a State program under a
4 title XVIII of the Social Security Act, or a State
5 program under title XIX of such Act, or who are
6 members of a vulnerable population, as determined
7 by the Secretary; or

8 “(B) serves a disproportionate percentage of
9 local, minority racial and ethnic patients.

10 “(c) REPORT.—Not later than 180 days after the
11 date of enactment of this title and annually thereafter, the
12 Secretary shall submit to the Congress and the President
13 a report that includes an assessment of health resources
14 and facilities serving populations in American Samoa,
15 Guam, the Commonwealth of the Northern Mariana Is-
16 lands, the United States Virgin Islands, Puerto Rico, and
17 Hawaii. In preparing such report, the Secretary shall—

18 “(1) consult with and obtain information on all
19 health care facilities needs from the entities de-
20 scribed in subsection (b);

21 “(2) include all amounts of Federal assistance
22 received by each entity in the preceding fiscal year;

23 “(3) review the total unmet needs of each juris-
24 diction for health care facilities, including needs for
25 renovation and expansion of existing facilities;

1 “(4) include a strategic plan for addressing the
2 needs of each jurisdiction identified in the report;
3 and

4 “(5) evaluate the effectiveness of the care pro-
5 vided by measuring patient outcomes and cost meas-
6 ures.

7 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated such sums as necessary
9 to carry out this section.”.

10 **SEC. 402. REMOVING CITIZENSHIP AND IMMIGRATION BAR-**
11 **RIERS TO ACCESS TO AFFORDABLE HEALTH**
12 **CARE UNDER ACA.**

13 (a) IN GENERAL.—

14 (1) PREMIUM TAX CREDITS.—Section 36B of
15 the Internal Revenue Code of 1986 is amended—

16 (A) in subsection (c)(1)(B)—

17 (i) by amending the heading to read
18 as follows: “SPECIAL RULE FOR CERTAIN
19 INDIVIDUALS INELIGIBLE FOR MEDICAID
20 DUE TO STATUS”, and

21 (ii) in clause (ii), by striking “lawfully
22 present in the United States, but” and in-
23 serting “who”, and

24 (B) by striking subsection (e).

1 (2) COST-SHARING REDUCTIONS.—Section 1402
2 of the Patient Protection and Affordable Care Act
3 (42 U.S.C. 18071) is amended by striking sub-
4 section (e).

5 (3) BASIC HEALTH PROGRAM ELIGIBILITY.—
6 Section 1331(e)(1)(B) of the Patient Protection and
7 Affordable Care Act (42 U.S.C. 18051(e)(1)(B)) is
8 amended by striking “lawfully present in the United
9 States”.

10 (4) RESTRICTIONS ON FEDERAL PAYMENTS.—
11 Section 1412 of the Patient Protection and Afford-
12 able Care Act (42 U.S.C. 18082) is amended by
13 striking subsection (d).

14 (5) REQUIREMENT TO MAINTAIN MINIMUM ES-
15 SENTIAL COVERAGE.—Section 5000A(d) of the In-
16 ternal Revenue Code of 1986 is amended by striking
17 paragraph (3) and by redesignating paragraph (4)
18 as paragraph (3).

19 (b) CONFORMING AMENDMENTS.—

20 (1) Section 1411(a) of the Patient Protection
21 and Affordable Care Act (42 U.S.C. 18081(a)) is
22 amended by striking paragraph (1) and redesign-
23 ating paragraphs (2), (3), and (4) as paragraphs
24 (1), (2), and (3), respectively.

1 (2) Section 1312(f) of the Patient Protection
2 and Affordable Care Act (42 U.S.C. 18032(f)) is
3 amended—

4 (A) in the heading, by striking “; ACCESS
5 LIMITED TO CITIZENS AND LAWFUL RESI-
6 DENTS”; and

7 (B) by striking paragraph (3).

8 **SEC. 403. STUDY ON THE UNINSURED.**

9 (a) IN GENERAL.—The Secretary of Health and
10 Human Services (in this section referred to as the “Sec-
11 retary”) shall—

12 (1) conduct a study, in accordance with the
13 standards under section 3101 of the Public Health
14 Service Act (42 U.S.C. 300kk), on the demographic
15 characteristics of the population of individuals who
16 do not have health insurance coverage or oral health
17 coverage; and

18 (2) predict, based on such study, the demo-
19 graphic characteristics of the population of individ-
20 uals who would remain without health insurance cov-
21 erage after the end of any annual open enrollment
22 or any special enrollment period or upon enactment
23 and implementation of any legislative changes to the
24 Patient Protection and Affordable Care Act that af-
25 fect the number of persons eligible for coverage.

1 (b) REPORTING REQUIREMENTS.—

2 (1) IN GENERAL.—Not later than 12 months
3 after the date of the enactment of this Act, the Sec-
4 retary shall submit to the Congress the results of
5 the study under subsection (a)(1) and the prediction
6 made under subsection (a)(2).

7 (2) REPORTING OF DEMOGRAPHIC CHARACTER-
8 ISTICS.—The Secretary shall—

9 (A) report the demographic characteristics
10 under paragraphs (1) and (2) of subsection (a)
11 on the basis of racial and ethnic group, and
12 shall stratify the reporting on each racial and
13 ethnic group by other demographic characteris-
14 tics that can impact access to health insurance
15 coverage, such as sexual orientation, gender
16 identity, primary language, disability status,
17 sex, socioeconomic status, age group, and citi-
18 zenship and immigration status, in a manner
19 consistent with title I of this Act; and

20 (B) not use such report to engage in or an-
21 ticipate any deportation or immigration related
22 enforcement action by any entity, including the
23 Department of Homeland Security.

1 **SEC. 404. MEDICAID IN THE TERRITORIES.**

2 (a) **ELIMINATION OF GENERAL MEDICAID FUNDING**
3 **LIMITATIONS (“CAP”) FOR TERRITORIES.—**

4 (1) **IN GENERAL.—**Section 1108 of the Social
5 Security Act (42 U.S.C. 1308) is amended—

6 (A) in subsection (f), in the matter before
7 paragraph (1), by striking “subsection (g)” and
8 inserting “subsections (g) and (h)”;

9 (B) in subsection (g)(2), in the matter be-
10 fore subparagraph (A), by inserting “and sub-
11 section (h)” after “paragraphs (3) and (5)”;
12 and

13 (C) by adding at the end the following new
14 subsection:

15 “(h) **SUNSET OF MEDICAID FUNDING LIMITATIONS**
16 **FOR PUERTO RICO, THE VIRGIN ISLANDS OF THE**
17 **UNITED STATES, GUAM, THE NORTHERN MARIANA IS-**
18 **LANDS, AND AMERICAN SAMOA.—**Subsections (f) and (g)
19 shall not apply to Puerto Rico, the Virgin Islands of the
20 United States, Guam, the Northern Mariana Islands, and
21 American Samoa beginning with fiscal year 2019.”.

22 (2) **CONFORMING AMENDMENTS.—**

23 (A) Section 1902(j) of the Social Security
24 Act (42 U.S.C. 1396a(j)) is amended by strik-
25 ing “, the limitation in section 1108(f),”.

1 (B) Section 1903(u) of the Social Security
2 Act (42 U.S.C. 1396b(u)) is amended by strik-
3 ing paragraph (4).

4 (C) Section 1323(c)(1) of the Patient Pro-
5 tection and Affordable Care Act (42 U.S.C.
6 18043(c)(1)) is amended by striking “2019”
7 and inserting “2018”.

8 (3) EFFECTIVE DATE.—The amendments made
9 by this section shall apply beginning with fiscal year
10 2019.

11 (b) ELIMINATION OF SPECIFIC FEDERAL MEDICAL
12 ASSISTANCE PERCENTAGE (FMAP) LIMITATION FOR
13 TERRITORIES.—Section 1905(b) of the Social Security
14 Act (42 U.S.C. 1396d(b)) is amended, in clause (2), by
15 inserting “for fiscal years before fiscal year 2019” after
16 “American Samoa”.

17 (c) APPLICATION OF MEDICAID WAIVER AUTHORITY
18 TO ALL OF THE TERRITORIES.—

19 (1) IN GENERAL.—Section 1902(j) of the Social
20 Security Act (42 U.S.C. 1396a(j)) is amended—

21 (A) by striking “American Samoa and the
22 Northern Mariana Islands” and inserting
23 “Puerto Rico, the Virgin Islands of the United
24 States, Guam, the Northern Mariana Islands,
25 and American Samoa”;

1 (B) by striking “American Samoa or the
2 Northern Mariana Islands” and inserting
3 “Puerto Rico, the Virgin Islands of the United
4 States, Guam, the Northern Mariana Islands,
5 or American Samoa”;

6 (C) by inserting “(1)” after “(j)”;

7 (D) by inserting “except as otherwise pro-
8 vided in this subsection,” after “Notwith-
9 standing any other requirement of this title”;
10 and

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

12 “(2) The Secretary may not waive under this sub-
13 section the requirement of subsection (a)(10)(A)(i)(IX)
14 (relating to coverage of adults formerly under foster care)
15 with respect to any territory.”.

16 (2) EFFECTIVE DATE.—The amendments made
17 by this section shall apply beginning October 1,
18 2018.

19 (d) PERMITTING MEDICAID DSH ALLOTMENTS FOR
20 TERRITORIES.—Section 1923(f) of the Social Security Act
21 (42 U.S.C. 1396) is amended—

22 (1) in paragraph (6), by adding at the end the
23 following new subparagraph:

24 “(C) TERRITORIES.—

1 “(i) FISCAL YEAR 2019.—For fiscal
2 year 2019, the DSH allotment for Puerto
3 Rico, the Virgin Islands of the United
4 States, Guam, the Northern Mariana Is-
5 lands, and American Samoa shall bear the
6 same ratio to \$150,000,000 as the ratio of
7 the number of individuals who are low-in-
8 come or uninsured and residing in such re-
9 spective territory (as estimated from time
10 to time by the Secretary) bears to the
11 sums of the number of such individuals re-
12 siding in all of the territories.

13 “(ii) SUBSEQUENT FISCAL YEAR.—
14 For each subsequent fiscal year, the DSH
15 allotment for each such territory is subject
16 to an increase in accordance with para-
17 graph (2).”; and

18 (2) in paragraph (9), by inserting before the pe-
19 riod at the end the following: “, and includes, begin-
20 ning with fiscal year 2019, Puerto Rico, the Virgin
21 Islands of the United States, Guam, the Northern
22 Mariana Islands, and American Samoa”.

1 **SEC. 405. EXTENSION OF MEDICARE SECONDARY PAYER.**

2 (a) IN GENERAL.—Section 1862(b)(1)(C) of the So-
3 cial Security Act (42 U.S.C. 1395y(b)(1)(C)) is amend-
4 ed—

5 (1) in the last sentence, by inserting “, and be-
6 fore January 1, 2019” after “prior to such date”;
7 and

8 (2) by adding at the end the following new sen-
9 tence: “Effective for items and services furnished on
10 or after January 1, 2019 (with respect to periods
11 beginning on or after the date that is 42 months
12 prior to such date), clauses (i) and (ii) shall be ap-
13 plied by substituting ‘42-month’ for ‘12-month’ each
14 place it appears in the first sentence.”.

15 (b) EFFECTIVE DATE.—The amendments made by
16 this section shall take effect on the date of enactment of
17 this Act. For purposes of determining an individual’s sta-
18 tus under section 1862(b)(1)(C) of the Social Security Act
19 (42 U.S.C. 1395y(b)(1)(C)), as amended by subsection
20 (a), an individual who is within the coordinating period
21 as of the date of enactment of this Act shall have that
22 period extended to the full 42 months described in the last
23 sentence of such section, as added by the amendment
24 made by subsection (a)(2).

1 **SEC. 406. BORDER HEALTH GRANTS.**

2 (a) **ELIGIBLE ENTITY DEFINED.**—In this section,
3 the term “eligible entity” means a State, public institution
4 of higher education, local government, Tribal government,
5 nonprofit health organization, community health center, or
6 community clinic receiving assistance under section 330
7 of the Public Health Service Act (42 U.S.C. 254b), that
8 is located in the border area.

9 (b) **AUTHORIZATION.**—From funds appropriated
10 under subsection (f), the Secretary of Health and Human
11 Services (in this section referred to as the “Secretary”),
12 acting through the United States members of the United
13 States-Mexico Border Health Commission, shall award
14 grants to eligible entities to address priorities and rec-
15 ommendations to improve the health of border area resi-
16 dents that are established by—

17 (1) the United States members of the United
18 States-Mexico Border Health Commission;

19 (2) the State border health offices; and

20 (3) the Secretary.

21 (c) **APPLICATION.**—An eligible entity that desires a
22 grant under subsection (b) shall submit an application to
23 the Secretary at such time, in such manner, and con-
24 taining such information as the Secretary may require.

1 (d) USE OF FUNDS.—An eligible entity that receives
2 a grant under subsection (b) shall use the grant funds
3 for—

4 (1) programs relating to—

5 (A) maternal and child health;

6 (B) primary care and preventative health;

7 (C) public health and public health infra-
8 structure;

9 (D) musculoskeletal health and obesity;

10 (E) health education and promotion;

11 (F) oral health;

12 (G) mental and behavioral health;

13 (H) substance abuse;

14 (I) health conditions that have a high prev-
15 alence in the border area;

16 (J) medical and health services research;

17 (K) workforce training and development;

18 (L) community health workers, patient
19 navigators, and promotoras;

20 (M) health care infrastructure problems in
21 the border area (including planning and con-
22 struction grants);

23 (N) health disparities in the border area;

24 (O) environmental health; and

1 (P) outreach and enrollment services with
2 respect to Federal programs (including pro-
3 grams authorized under titles XIX and XXI of
4 the Social Security Act (42 U.S.C. 1396 and
5 1397aa)); and

6 (2) other programs determined appropriate by
7 the Secretary.

8 (e) SUPPLEMENT, NOT SUPPLANT.—Amounts pro-
9 vided to an eligible entity awarded a grant under sub-
10 section (b) shall be used to supplement and not supplant
11 other funds available to the eligible entity to carry out the
12 activities described in subsection (d).

13 (f) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated to carry out this section,
15 \$200,000,000 for fiscal year 2019, and such sums as may
16 be necessary for each succeeding fiscal year.

17 **SEC. 407. REMOVING MEDICARE BARRIER TO HEALTH**
18 **CARE.**

19 (a) PART A.—Section 1818(a)(3) of the Social Secu-
20 rity Act (42 U.S.C. 1395i–2(a)(3)) is amended by striking
21 “an alien” and all that follows through “under this sec-
22 tion” and inserting “an individual who is lawfully present
23 in the United States”.

24 (b) PART B.—Section 1836(2) of the Social Security
25 Act (42 U.S.C. 1395o(2)) is amended by striking “an

1 alien” and all that follows through “under this part” and
2 inserting “an individual who is lawfully present in the
3 United States”.

4 **SEC. 408. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
5 **PROVIDED BY URBAN INDIAN HEALTH CEN-**
6 **TERS.**

7 (a) IN GENERAL.—The third sentence of section
8 1905(b) of the Social Security Act (42 U.S.C. 1396(b))
9 is amended by inserting “or are received through a pro-
10 gram operated by an urban Indian organization through
11 a grant or contract under title V of such Act” after “(as
12 defined in section 4 of the Indian Health Care Improve-
13 ment Act)”.

14 (b) EFFECTIVE DATE.—The amendment made by
15 this section shall apply to medical assistance provided on
16 or after the date of enactment of this Act.

17 **SEC. 409. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
18 **PROVIDED TO A NATIVE HAWAIIAN THROUGH**
19 **A FEDERALLY QUALIFIED HEALTH CENTER**
20 **OR A NATIVE HAWAIIAN HEALTH CARE SYS-**
21 **TEM UNDER THE MEDICAID PROGRAM.**

22 (a) IN GENERAL.—The third sentence of section
23 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)),
24 as amended by section 418(a), is amended by inserting
25 before the period the following: “; and, with respect to

1 medical assistance provided to a Native Hawaiian (as de-
2 fined in section 12(2) of the Native Hawaiian Health Care
3 Improvement Act) through a federally qualified health
4 center or a Native Hawaiian health care system (as de-
5 fined in section 12(6) of such Act), whether directly, by
6 referral, or under contract or other arrangement between
7 such federally qualified health center or Native Hawaiian
8 health care system and another health care provider”.

9 (b) EFFECTIVE DATE.—The amendment made by
10 this section shall apply to medical assistance provided on
11 or after the date of enactment of this Act.

12 **Subtitle B—Expansion of Access**

13 **SEC. 410. PROTECTING SENSITIVE LOCATIONS.**

14 Section 287 of the Immigration and Nationality Act
15 (8 U.S.C. 1357) is amended by adding at the end the fol-
16 lowing:

17 “(i)(1) In this subsection:

18 “(A) The term ‘appropriate committees of Con-
19 gress’ means—

20 “(i) the Committee on Homeland Security
21 and Governmental Affairs of the Senate;

22 “(ii) the Committee on the Judiciary of the
23 Senate;

24 “(iii) the Committee on Homeland Security
25 of the House of Representatives; and

1 “(iv) the Committee on the Judiciary of
2 the House of Representatives.

3 “(B) The term ‘enforcement action’—

4 “(i) means an apprehension, arrest, inter-
5 view, request for identification, search, or sur-
6 veillance for the purposes of immigration en-
7 forcement; and

8 “(ii) includes an enforcement action at, or
9 focused on, a sensitive location that is part of
10 a joint case led by another law enforcement
11 agency.

12 “(C) The term ‘exigent circumstances’ means a
13 situation involving—

14 “(i) the imminent risk of death, violence,
15 or physical harm to any person or property, in-
16 cluding a situation implicating terrorism or the
17 national security of the United States;

18 “(ii) the immediate arrest or pursuit of a
19 dangerous felon, terrorist suspect, or other indi-
20 vidual presenting an imminent danger; or

21 “(iii) the imminent risk of destruction of
22 evidence that is material to an ongoing criminal
23 case.

24 “(D) The term ‘prior approval’ means—

1 “(i) in the case of officers and agents of
2 U.S. Immigration and Customs Enforcement,
3 prior written approval to carry out an enforce-
4 ment action involving a specific individual or in-
5 dividuals authorized by—

6 “(I) the Assistant Director of Oper-
7 ations, Homeland Security Investigations;

8 “(II) the Executive Associate Director
9 of Homeland Security Investigations;

10 “(III) the Assistant Director for Field
11 Operations, Enforcement and Removal Op-
12 erations; or

13 “(IV) the Executive Associate Direc-
14 tor for Field Operations, Enforcement and
15 Removal Operations;

16 “(ii) in the case of officers and agents of
17 U.S. Customs and Border Protection, prior
18 written approval to carry out an enforcement
19 action involving a specific individual or individ-
20 uals authorized by—

21 “(I) a Chief Patrol Agent;

22 “(II) the Director of Field Operations;

23 “(III) the Director of Air and Marine
24 Operations; or

1 “(IV) the Internal Affairs Special
2 Agent in Charge; and

3 “(iii) in the case of other Federal, State,
4 or local law enforcement officers, to carry out
5 an enforcement action involving a specific indi-
6 vidual or individuals authorized by—

7 “(I) the head of the Federal agency
8 carrying out the enforcement action; or

9 “(II) the head of the State or local
10 law enforcement agency carrying out the
11 enforcement action.

12 “(E) The term ‘sensitive location’ includes all of
13 the physical space located within 1,000 feet of—

14 “(i) any medical treatment or health care
15 facility, including any hospital, doctor’s office,
16 accredited health clinic, alcohol or drug treat-
17 ment center, or emergent or urgent care facil-
18 ity;

19 “(ii) any public or private school, including
20 any known and licensed day care facility, pre-
21 school, other early learning program facility,
22 primary school, secondary school, postsecondary
23 school (including colleges and universities), or
24 other institution of learning (including voca-
25 tional or trade schools);

1 “(iii) any scholastic or education-related
2 activity or event, including field trips and inter-
3 scholastic events;

4 “(iv) any school bus or school bus stop
5 during periods when school children are present
6 on the bus or at the stop;

7 “(v) any organization that—

8 “(I) assists children, pregnant women,
9 victims of crime or abuse, or individuals
10 with significant mental or physical disabili-
11 ties; or

12 “(II) provides disaster or emergency
13 social services and assistance;

14 “(vi) any church, synagogue, mosque, or
15 other place of worship, including buildings
16 rented for the purpose of religious services, re-
17 treats, counseling, workshops, instruction, and
18 education;

19 “(vii) any Federal, State, or local court-
20 house, including the office of an individual’s
21 legal counsel or representative, and a probation,
22 parole, or supervised release office;

23 “(viii) the site of a funeral, wedding, or
24 other religious ceremony or observance;

1 “(ix) any public demonstration, such as a
2 march, rally, or parade;

3 “(x) any domestic violence shelter, rape
4 crisis center, supervised visitation center, family
5 justice center, or victim services provider; or

6 “(xi) any other location specified by the
7 Secretary of Homeland Security for purposes of
8 this subsection.

9 “(2)(A) An enforcement action may not take place
10 at, or be focused on, a sensitive location unless—

11 “(i) the action involves exigent circumstances;
12 and

13 “(ii) prior approval for the enforcement action
14 was obtained from the appropriate official.

15 “(B) If an enforcement action is initiated pursuant
16 to subparagraph (A) and the exigent circumstances per-
17 mitting the enforcement action cease, the enforcement ac-
18 tion shall be discontinued until such exigent circumstances
19 reemerge.

20 “(C) If an enforcement action is carried out in viola-
21 tion of this subsection—

22 “(i) no information resulting from the enforce-
23 ment action may be entered into the record or re-
24 ceived into evidence in a removal proceeding result-
25 ing from the enforcement action; and

1 “(ii) the alien who is the subject of such re-
2 moval proceeding may file a motion for the imme-
3 diate termination of the removal proceeding.

4 “(3)(A) This subsection shall apply to any enforce-
5 ment action by officers or agents of the Department of
6 Homeland Security, including—

7 “(i) officers or agents of U.S. Immigration and
8 Customs Enforcement;

9 “(ii) officers or agents of U.S. Customs and
10 Border Protection; and

11 “(iii) any individual designated to perform im-
12 migration enforcement functions pursuant to sub-
13 section (g).

14 “(B) While carrying out an enforcement action at a
15 sensitive location, officers and agents referred to in sub-
16 paragraph (A) shall make every effort—

17 “(i) to limit the time spent at the sensitive loca-
18 tion;

19 “(ii) to limit the enforcement action at the sen-
20 sitive location to the person or persons for whom
21 prior approval was obtained; and

22 “(iii) to conduct themselves discreetly.

23 “(C) If, while carrying out an enforcement action
24 that is not initiated at or focused on a sensitive location,
25 officers or agents are led to a sensitive location, and no

1 exigent circumstance and prior approval with respect to
2 the sensitive location exists, such officers or agents shall—

3 “(i) cease before taking any further enforce-
4 ment action;

5 “(ii) conduct themselves in a discreet manner;

6 “(iii) maintain surveillance; and

7 “(iv) immediately consult their supervisor in
8 order to determine whether such enforcement action
9 should be discontinued.

10 “(D) The limitations under this paragraph shall not
11 apply to the transportation of an individual apprehended
12 at or near a land or sea border to a hospital or health
13 care provider for the purpose of providing medical care
14 to such individual.

15 “(4)(A) Each official specified in subparagraph (B)
16 shall ensure that the employees under his or her super-
17 vision receive annual training on compliance with—

18 “(i) the requirements under this subsection in
19 enforcement actions at or focused on sensitive loca-
20 tions and enforcement actions that lead officers or
21 agents to a sensitive location; and

22 “(ii) the requirements under section 239 of this
23 Act and section 384 of the Illegal Immigration Re-
24 form and Immigrant Responsibility Act of 1996 (8
25 U.S.C. 1367).

1 “(B) The officials specified in this subparagraph
2 are—

3 “(i) the Chief Counsel of U.S. Immigration and
4 Customs Enforcement;

5 “(ii) the Field Office Directors of U.S. Immi-
6 gration and Customs Enforcement;

7 “(iii) each Special Agent in Charge of U.S. Im-
8 migration and Customs Enforcement;

9 “(iv) each Chief Patrol Agent of U.S. Customs
10 and Border Protection;

11 “(v) the Director of Field Operations of U.S.
12 Customs and Border Protection;

13 “(vi) the Director of Air and Marine Operations
14 of U.S. Customs and Border Protection;

15 “(vii) the Internal Affairs Special Agent in
16 Charge of U.S. Customs and Border Protection; and

17 “(viii) the chief law enforcement officer of each
18 State or local law enforcement agency that enters
19 into a written agreement with the Department of
20 Homeland Security pursuant to subsection (g).

21 “(5) The Secretary of Homeland Security shall mod-
22 ify the Notice to Appear form (I-862)—

23 “(A) to provide the subjects of an enforcement
24 action with information, written in plain language,
25 summarizing the restrictions against enforcement

1 actions at sensitive locations set forth in this sub-
2 section and the remedies available to the alien if
3 such action violates such restrictions;

4 “(B) so that the information described in sub-
5 paragraph (A) is accessible to individuals with lim-
6 ited-English proficiency; and

7 “(C) so that subjects of an enforcement action
8 are not permitted to verify that the officers or
9 agents that carried out such action complied with
10 the restrictions set forth in this subsection.

11 “(6)(A) The Director of U.S. Immigration and Cus-
12 toms Enforcement and the Commissioner of U.S. Customs
13 and Border Protection shall each submit an annual report
14 to the appropriate committees of Congress that includes
15 the information set forth in subparagraph (B) with respect
16 to the respective agency.

17 “(B) Each report submitted under subparagraph (A)
18 shall include, with respect to the submitting agency during
19 the reporting period—

20 “(i) the number of enforcement actions that
21 were carried out at, or focused on, a sensitive loca-
22 tion;

23 “(ii) the number of enforcement actions in
24 which officers or agents were subsequently led to a
25 sensitive location; and

1 “(iii) for each enforcement action described in
2 clause (i) or (ii)—

3 “(I) the date on which it occurred;

4 “(II) the specific site, city, county, and
5 State in which it occurred;

6 “(III) the components of the agency in-
7 volved in the enforcement action;

8 “(IV) a description of the enforcement ac-
9 tion, including the nature of the criminal activ-
10 ity of its intended target;

11 “(V) the number of individuals, if any, ar-
12 rested or taken into custody;

13 “(VI) the number of collateral arrests, if
14 any, and the reasons for each such arrest;

15 “(VII) a certification whether the location
16 administrator was contacted before, during, or
17 after the enforcement action; and

18 “(VIII) the percentage of all of the staff
19 members and supervisors reporting to the offi-
20 cials listed in paragraph (4)(B) who completed
21 the training required under paragraph (4)(A).

22 “(7) Nothing in the subsection may be construed—

23 “(A) to affect the authority of Federal, State,
24 or local law enforcement agencies—

1 “(i) to enforce generally applicable Federal
2 or State criminal laws unrelated to immigra-
3 tion; or

4 “(ii) to protect residents from imminent
5 threats to public safety; or

6 “(B) to limit or override the protections pro-
7 vided in—

8 “(i) section 239; or

9 “(ii) section 384 of the Illegal Immigration
10 Reform and Immigrant Responsibility Act of
11 1996 (8 U.S.C. 1367).”.

12 **SEC. 411. GRANTS FOR RACIAL AND ETHNIC APPROACHES**
13 **TO COMMUNITY HEALTH.**

14 (a) **PURPOSE.**—It is the purpose of this section to
15 provide for the awarding of grants to assist communities
16 in mobilizing and organizing resources in support of effec-
17 tive and sustainable programs that will reduce or eliminate
18 disparities in health and health care experienced by racial
19 and ethnic minority individuals.

20 (b) **AUTHORITY TO AWARD GRANTS.**—The Secretary
21 of Health and Human Services, acting through the Ad-
22 ministrators of the Health Resources and Services Admin-
23 istration, shall award grants to eligible entities to assist
24 in designing, implementing, and evaluating culturally and
25 linguistically appropriate, science-based, and community-

1 driven sustainable strategies to eliminate racial and ethnic
2 health and health care disparities.

3 (c) ELIGIBLE ENTITIES.—To be eligible to receive a
4 grant under this section, an entity shall—

5 (1) represent a coalition—

6 (A) whose principal purpose is to develop
7 and implement interventions to reduce or elimi-
8 nate a health or health care disparity in a tar-
9 geted racial or ethnic minority group in the
10 community served by the coalition; and

11 (B) that includes—

12 (i) members selected from among—

13 (I) public health departments;

14 (II) community-based organiza-
15 tions;

16 (III) university and research or-
17 ganizations;

18 (IV) American Indian Tribal or-
19 ganizations, national American Indian
20 organizations, Indian Health Service,
21 or organizations serving Alaska Na-
22 tives; and

23 (V) interested public or private
24 health care providers or organizations

1 as deemed appropriate by the Sec-
2 retary; and

3 (ii) at least 1 member from a commu-
4 nity-based organization that represents the
5 targeted racial or ethnic minority group;
6 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, which shall
10 include—

11 (A) a description of the targeted racial or
12 ethnic populations in the community to be
13 served under the grant;

14 (B) a description of at least 1 health dis-
15 parity that exists in the racial or ethnic tar-
16 geted populations, including health issues such
17 as infant mortality, breast and cervical cancer
18 screening and management, musculoskeletal
19 diseases and obesity, prostate cancer screening
20 and management, cardiovascular disease, diabe-
21 tes, child and adult immunization levels, oral
22 disease, or other health priority areas as des-
23 igned by the Secretary; and

24 (C) a demonstration of a proven record of
25 accomplishment of the coalition members in

1 serving and working with the targeted commu-
2 nity.

3 (d) SUSTAINABILITY.—The Secretary shall give pri-
4 ority to an eligible entity under this section if the entity
5 agrees that, with respect to the costs to be incurred by
6 the entity in carrying out the activities for which the grant
7 was awarded, the entity (and each of the participating
8 partners in the coalition represented by the entity) will
9 maintain its expenditures of non-Federal funds for such
10 activities at a level that is not less than the level of such
11 expenditures during the fiscal year immediately preceding
12 the first fiscal year for which the grant is awarded.

13 (e) NONDUPLICATION.—Funds provided through this
14 grant program should supplement, not supplant, existing
15 Federal funding, and the funds should not be used to du-
16 plicate the activities of the other health disparity grant
17 programs in this Act.

18 (f) TECHNICAL ASSISTANCE.—The Secretary may,
19 either directly or by grant or contract, provide any entity
20 that receives a grant under this section with technical and
21 other nonfinancial assistance necessary to meet the re-
22 quirements of this section.

23 (g) DISSEMINATION.—The Secretary shall encourage
24 and enable grantees to share best practices, evaluation re-
25 sults, and reports with communities not affiliated with

1 grantees using the Internet, conferences, and other perti-
2 nent information regarding the projects funded by this
3 section, including the outreach efforts of the Office of Mi-
4 nority Health and Health Disparity Elimination and the
5 Centers for Disease Control and Prevention.

6 (h) ADMINISTRATIVE BURDENS.—The Secretary
7 shall make every effort to minimize duplicative or unneces-
8 sary administrative burdens on grantees.

9 (i) DEFINITION.—In this section, the term “Sec-
10 retary” means the Secretary of Health and Human Serv-
11 ices.

12 (j) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated such sums as may be
14 necessary to carry out this section.

15 **SEC. 412. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.**

16 (a) ELIMINATION OF ISOLATION TEST FOR COST-
17 BASED AMBULANCE REIMBURSEMENT.—

18 (1) IN GENERAL.—Section 1834(l)(8) of the
19 Social Security Act (42 U.S.C. 1395m(l)(8)) is
20 amended—

21 (A) in subparagraph (B)—

22 (i) by striking “owned and”; and

23 (ii) by inserting “(including when
24 such services are provided by the entity

1 under an arrangement with the hospital)”
2 after “hospital”; and

3 (B) by striking the comma at the end of
4 subparagraph (B) and all that follows and in-
5 serting a period.

6 (2) EFFECTIVE DATE.—The amendments made
7 by this subsection shall apply to services furnished
8 on or after January 1, 2015.

9 (b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE
10 TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT
11 REQUIREMENT.—

12 (1) IN GENERAL.—Section 1820(c)(2) of the
13 Social Security Act (42 U.S.C. 1395i–4(c)(2)) is
14 amended—

15 (A) in subparagraph (B)(iii), by striking
16 “provides not more than” and inserting “sub-
17 ject to subparagraph (F), provides not more
18 than”; and

19 (B) by adding at the end the following new
20 subparagraph:

21 “(F) ALTERNATIVE TO 25 INPATIENT BED
22 LIMIT REQUIREMENT.—

23 “(i) IN GENERAL.—A State may elect
24 to treat a facility, with respect to the des-
25 ignation of the facility for a cost-reporting

1 period, as satisfying the requirement of
2 subparagraph (B)(iii) relating to a max-
3 imum number of acute care inpatient beds
4 if the facility elects, in accordance with a
5 method specified by the Secretary and be-
6 fore the beginning of the cost reporting pe-
7 riod, to meet the requirement under clause
8 (ii).

9 “(ii) ALTERNATE REQUIREMENT.—
10 The requirement under this clause, with
11 respect to a facility and a cost-reporting
12 period, is that the total number of inpa-
13 tient bed days described in subparagraph
14 (B)(iii) during such period will not exceed
15 7,300. For purposes of this subparagraph,
16 an individual who is an inpatient in a bed
17 in the facility for a single day shall be
18 counted as one inpatient bed day.

19 “(iii) WITHDRAWAL OF ELECTION.—
20 The option described in clause (i) shall not
21 apply to a facility for a cost-reporting pe-
22 riod if the facility (for any two consecutive
23 cost-reporting periods during the previous
24 5 cost-reporting periods) was treated under
25 such option and had a total number of in-

1 patient bed days for each of such two cost-
2 reporting periods that exceeded the num-
3 ber specified in such clause.”.

4 (2) EFFECTIVE DATE.—The amendments made
5 by paragraph (1) shall apply to cost-reporting peri-
6 ods beginning on or after the date of the enactment
7 of this Act.

8 **SEC. 413. ESTABLISHMENT OF RURAL COMMUNITY HOS-**
9 **PITAL (RCH) PROGRAM.**

10 (a) IN GENERAL.—Section 1861 of the Social Secu-
11 rity Act (42 U.S.C. 1395x), as amended by section
12 205(b)(1), is amended by adding at the end of the fol-
13 lowing new subsection:

14 “Rural Community Hospital; Rural Community Hospital
15 Services

16 “(jjj)(1) The term ‘rural community hospital’ means
17 a hospital (as defined in subsection (e)) that—

18 “(A) is located in a rural area (as defined in
19 section 1886(d)(2)(D)) or treated as being so lo-
20 cated pursuant to section 1886(d)(8)(E);

21 “(B) subject to paragraph (2), has less than 51
22 acute care inpatient beds, as reported in its most re-
23 cent cost report;

24 “(C) makes available 24-hour emergency care
25 services;

1 “(D) subject to paragraph (3), has a provider
2 agreement in effect with the Secretary and is open
3 to the public as of January 1, 2010; and

4 “(E) applies to the Secretary for such designa-
5 tion.

6 “(2) For purposes of paragraph (1)(B), beds in a
7 psychiatric or rehabilitation unit of the hospital which is
8 a distinct part of the hospital shall not be counted.

9 “(3) Paragraph (1)(D) shall not be construed to pro-
10 hibit any of the following from qualifying as a rural com-
11 munity hospital:

12 “(A) A replacement facility (as defined by the
13 Secretary in regulations in effect on January 1,
14 2012) with the same service area (as defined by the
15 Secretary in regulations in effect on such date).

16 “(B) A facility obtaining a new provider num-
17 ber pursuant to a change of ownership.

18 “(C) A facility which has a binding written
19 agreement with an outside, unrelated party for the
20 construction, reconstruction, lease, rental, or financ-
21 ing of a building as of January 1, 2012.

22 “(4) Nothing in this subsection shall be construed as
23 prohibiting a critical access hospital from qualifying as a
24 rural community hospital if the critical access hospital

1 meets the conditions otherwise applicable to hospitals
2 under subsection (e) and section 1866.

3 “(5) Nothing in this subsection shall be construed as
4 prohibiting a rural community hospital participating in
5 the demonstration program under section 410A of the
6 Medicare Prescription Drug, Improvement, and Mod-
7 ernization Act of 2003 (Public Law 108–173; 117 Stat.
8 2313) from qualifying as a rural community hospital if
9 the rural community hospital meets the conditions other-
10 wise applicable to hospitals under subsection (e) and sec-
11 tion 1866.”.

12 (b) PAYMENT.—

13 (1) INPATIENT HOSPITAL SERVICES.—Section
14 1814 of the Social Security Act (42 U.S.C. 1395f)
15 is amended by adding at the end the following new
16 subsection:

17 “Payment for Inpatient Services Furnished in Rural
18 Community Hospitals

19 “(m) The amount of payment under this part for in-
20 patient hospital services furnished in a rural community
21 hospital, other than such services furnished in a psy-
22 chiatric or rehabilitation unit of the hospital which is a
23 distinct part, is, at the election of the hospital in the appli-
24 cation referred to in section 1861(jjj)(1)(E)—

1 “(1) 101 percent of the reasonable costs of pro-
2 viding such services, without regard to the amount
3 of the customary or other charge, or

4 “(2) the amount of payment provided for under
5 the prospective payment system for inpatient hos-
6 pital services under section 1886(d).”.

7 (2) OUTPATIENT SERVICES.—Section 1834 of
8 such Act (42 U.S.C. 1395m) is amended by adding
9 at the end the following new subsection:

10 “(p) PAYMENT FOR OUTPATIENT SERVICES FUR-
11 NISHED IN RURAL COMMUNITY HOSPITALS.—The
12 amount of payment under this part for outpatient services
13 furnished in a rural community hospital is, at the election
14 of the hospital in the application referred to in section
15 1861(jjj)(1)(E)—

16 “(1) 101 percent of the reasonable costs of pro-
17 viding such services, without regard to the amount
18 of the customary or other charge and any limitation
19 under section 1861(v)(1)(U), or

20 “(2) the amount of payment provided for under
21 the prospective payment system for covered OPD
22 services under section 1833(t).”.

23 (3) EXEMPTION FROM 30-PERCENT REDUCTION
24 IN REIMBURSEMENT FOR BAD DEBT.—Section
25 1861(v)(1)(T) of such Act (42 U.S.C.

1 1395x(v)(1)(T)) is amended by inserting “(other
2 than for a rural community hospital)” after “In de-
3 termining such reasonable costs for hospitals”.

4 (c) BENEFICIARY COST-SHARING FOR OUTPATIENT
5 SERVICES.—Section 1834(p) of such Act (as added by
6 subsection (b)(2)) is amended—

7 (1) by redesignating paragraphs (1) and (2) as
8 subparagraphs (A) and (B), respectively;

9 (2) by inserting “(1)” after “(p)”; and

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

11 “(2) The amounts of beneficiary cost-sharing for out-
12 patient services furnished in a rural community hospital
13 under this part shall be as follows:

14 “(A) For items and services that would have
15 been paid under section 1833(t) if provided by a
16 hospital, the amount of cost-sharing determined
17 under paragraph (8) of such section.

18 “(B) For items and services that would have
19 been paid under section 1833(h) if furnished by a
20 provider or supplier, no cost-sharing shall apply.

21 “(C) For all other items and services, the
22 amount of cost-sharing that would apply to the item
23 or service under the methodology that would be used
24 to determine payment for such item or service if pro-

1 vided by a physician, provider, or supplier, as the
2 case may be.”.

3 (d) CONFORMING AMENDMENTS.—

4 (1) PART A PAYMENT.—Section 1814(b) of
5 such Act (42 U.S.C. 1395f(b)) is amended in the
6 matter preceding paragraph (1) by inserting “other
7 than inpatient hospital services furnished by a rural
8 community hospital,” after “critical access hospital
9 services,”.

10 (2) PART B PAYMENT.—Section 1833(a) of
11 such Act (42 U.S.C. 1395l(a)), as amended by sec-
12 tion 205(b)(3), is amended—

13 (A) in paragraph (2), in the matter before
14 subparagraph (A), by striking “and (I)” and in-
15 serting “(I), and (K)”;

16 (B) by striking “and” at the end of para-
17 graph (9);

18 (C) by striking the period at the end of
19 paragraph (10) and inserting “; and”; and

20 (D) by adding at the end the following:

21 “(11) in the case of outpatient services fur-
22 nished by a rural community hospital, the amounts
23 described in section 1834(p).”.

24 (3) TECHNICAL AMENDMENTS.—

1 (A) CONSULTATION WITH STATE AGEN-
2 CIES.—Section 1863 of such Act (42 U.S.C.
3 1395z) is amended by striking “and (dd)(2)”
4 and inserting “(dd)(2), (mm)(1), and (jjj)(1)”.

5 (B) PROVIDER AGREEMENTS.—Section
6 1866(a)(2)(A) of such Act (42 U.S.C.
7 1395cc(a)(2)(A)) is amended by inserting “sec-
8 tion 1834(p)(2),” after “section 1833(b),”.

9 (e) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to items and services furnished on
11 or after October 1, 2016.

12 **SEC. 414. MEDICARE REMOTE MONITORING PILOT**
13 **PROJECTS.**

14 (a) PILOT PROJECTS.—

15 (1) IN GENERAL.—Not later than 9 months
16 after the date of enactment of this Act, the Sec-
17 retary of Health and Human Services (in this sec-
18 tion referred to as the “Secretary”) shall conduct
19 pilot projects under title XVIII of the Social Secu-
20 rity Act for the purpose of providing incentives to
21 home health agencies to utilize home monitoring and
22 communications technologies that—

23 (A) enhance health outcomes for Medicare
24 beneficiaries; and

25 (B) reduce expenditures under such title.

1 (2) SITE REQUIREMENTS.—

2 (A) URBAN AND RURAL.—The Secretary
3 shall conduct the pilot projects under this sec-
4 tion in both urban and rural areas.

5 (B) SITE IN A SMALL STATE.—The Sec-
6 retary shall conduct at least 3 of the pilot
7 projects in a State with a population of less
8 than 1,000,000.

9 (3) DEFINITION OF HOME HEALTH AGENCY.—

10 In this section, the term “home health agency” has
11 the meaning given that term in section 1861(o) of
12 the Social Security Act (42 U.S.C. 1395x(o)).

13 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE
14 OF PROJECTS.—The Secretary shall specify the criteria
15 for identifying those Medicare beneficiaries who shall be
16 considered within the scope of the pilot projects under this
17 section for purposes of the application of subsection (c)
18 and for the assessment of the effectiveness of the home
19 health agency in achieving the objectives of this section.
20 Such criteria may provide for the inclusion in the projects
21 of Medicare beneficiaries who begin receiving home health
22 services under title XVIII of the Social Security Act after
23 the date of the implementation of the projects.

24 (c) INCENTIVES.—

1 (1) PERFORMANCE TARGETS.—The Secretary
2 shall establish for each home health agency partici-
3 pating in a pilot project under this section a per-
4 formance target using one of the following meth-
5 odologies, as determined appropriate by the Sec-
6 retary:

7 (A) ADJUSTED HISTORICAL PERFORMANCE
8 TARGET.—The Secretary shall establish for the
9 agency—

10 (i) a base expenditure amount equal
11 to the average total payments made to the
12 agency under parts A and B of title XVIII
13 of the Social Security Act for Medicare
14 beneficiaries determined to be within the
15 scope of the pilot project in a base period
16 determined by the Secretary; and

17 (ii) an annual per capita expenditure
18 target for such beneficiaries, reflecting the
19 base expenditure amount adjusted for risk
20 and adjusted growth rates.

21 (B) COMPARATIVE PERFORMANCE TAR-
22 GET.—The Secretary shall establish for the
23 agency a comparative performance target equal
24 to the average total payments under such parts
25 A and B during the pilot project for comparable

1 individuals in the same geographic area that
2 are not determined to be within the scope of the
3 pilot project.

4 (2) INCENTIVE.—Subject to paragraph (3), the
5 Secretary shall pay to each participating home care
6 agency an incentive payment for each year under the
7 pilot project equal to a portion of the Medicare sav-
8 ings realized for such year relative to the perform-
9 ance target under paragraph (1).

10 (3) LIMITATION ON EXPENDITURES.—The Sec-
11 retary shall limit incentive payments under this sec-
12 tion in order to ensure that the aggregate expendi-
13 tures under title XVIII of the Social Security Act
14 (including incentive payments under this subsection)
15 do not exceed the amount that the Secretary esti-
16 mates would have been expended if the pilot projects
17 under this section had not been implemented.

18 (d) WAIVER AUTHORITY.—The Secretary may waive
19 such provisions of titles XI and XVIII of the Social Secu-
20 rity Act as the Secretary determines to be appropriate for
21 the conduct of the pilot projects under this section.

22 (e) REPORT TO CONGRESS.—Not later than 5 years
23 after the date that the first pilot project under this section
24 is implemented, the Secretary shall submit to Congress a
25 report on the pilot projects. Such report shall contain a

1 detailed description of issues related to the expansion of
2 the projects under subsection (f) and recommendations for
3 such legislation and administrative actions as the Sec-
4 retary considers appropriate.

5 (f) EXPANSION.—If the Secretary determines that
6 any of the pilot projects under this section enhance health
7 outcomes for Medicare beneficiaries and reduce expendi-
8 tures under title XVIII of the Social Security Act, the Sec-
9 retary may initiate comparable projects in additional
10 areas.

11 (g) INCENTIVE PAYMENTS HAVE NO EFFECT ON
12 OTHER MEDICARE PAYMENTS TO AGENCIES.—An incen-
13 tive payment under this section—

14 (1) shall be in addition to the payments that a
15 home health agency would otherwise receive under
16 title XVIII of the Social Security Act for the provi-
17 sion of home health services; and

18 (2) shall have no effect on the amount of such
19 payments.

20 **SEC. 415. RURAL HEALTH QUALITY ADVISORY COMMISSION**
21 **AND DEMONSTRATION PROJECTS.**

22 (a) RURAL HEALTH QUALITY ADVISORY COMMIS-
23 SION.—

24 (1) ESTABLISHMENT.—Not later than 6
25 months after the date of the enactment of this sec-

1 tion, the Secretary of Health and Human Services
2 (in this section referred to as the “Secretary”) shall
3 establish a commission to be known as the Rural
4 Health Quality Advisory Commission (in this section
5 referred to as the “Commission”).

6 (2) DUTIES OF COMMISSION.—

7 (A) NATIONAL PLAN.—The Commission
8 shall develop, coordinate, and facilitate imple-
9 mentation of a national plan for rural health
10 quality improvement. The national plan shall—

11 (i) identify objectives for rural health
12 quality improvement;

13 (ii) identify strategies to eliminate
14 known gaps in rural health system capacity
15 and improve rural health quality; and

16 (iii) provide for Federal programs to
17 identify opportunities for strengthening
18 and aligning policies and programs to im-
19 prove rural health quality.

20 (B) DEMONSTRATION PROJECTS.—The
21 Commission shall design demonstration projects
22 to test alternative models for rural health qual-
23 ity improvement, including with respect to both
24 personal and population health.

1 (C) MONITORING.—The Commission shall
2 monitor progress toward the objectives identi-
3 fied pursuant to paragraph (1)(A).

4 (3) MEMBERSHIP.—

5 (A) NUMBER.—The Commission shall be
6 composed of 11 members appointed by the Sec-
7 retary.

8 (B) SELECTION.—The Secretary shall se-
9 lect the members of the Commission from
10 among individuals with significant rural health
11 care and health care quality expertise, including
12 expertise in clinical health care, health care
13 quality research, population or public health, or
14 purchaser organizations.

15 (4) CONTRACTING AUTHORITY.—Subject to the
16 availability of funds, the Commission may enter into
17 contracts and make other arrangements, as may be
18 necessary to carry out the duties described in para-
19 graph (2).

20 (5) STAFF.—Upon the request of the Commis-
21 sion, the Secretary may detail, on a reimbursable
22 basis, any of the personnel of the Office of Rural
23 Health Policy of the Health Resources and Services
24 Administration, the Agency for Healthcare Quality
25 and Research, or the Centers for Medicare & Med-

1 icaid Services to the Commission to assist in car-
2 rying out this subsection.

3 (6) REPORTS TO CONGRESS.—Not later than 1
4 year after the establishment of the Commission, and
5 annually thereafter, the Commission shall submit a
6 report to the Congress on rural health quality. Each
7 such report shall include the following:

8 (A) An inventory of relevant programs and
9 recommendations for improved coordination and
10 integration of policy and programs.

11 (B) An assessment of achievement of the
12 objectives identified in the national plan devel-
13 oped under paragraph (2) and recommenda-
14 tions for realizing such objectives.

15 (C) Recommendations on Federal legisla-
16 tion, regulations, or administrative policies to
17 enhance rural health quality and outcomes.

18 (b) RURAL HEALTH QUALITY DEMONSTRATION
19 PROJECTS.—

20 (1) IN GENERAL.—Not later than 270 days
21 after the date of the enactment of this section, the
22 Secretary, in consultation with the Rural Health
23 Quality Advisory Commission, the Office of Rural
24 Health Policy of the Health Resources and Services
25 Administration, the Agency for Healthcare Research

1 and Quality, and the Centers for Medicare & Med-
2 icaid Services, shall make grants to eligible entities
3 for 5 demonstration projects to implement and
4 evaluate methods for improving the quality of health
5 care in rural communities. Each such demonstration
6 project shall include—

7 (A) alternative community models that—

8 (i) will achieve greater integration of
9 personal and population health services;
10 and

11 (ii) address safety, effectiveness,
12 patient- or community-centeredness, timeli-
13 ness, efficiency, and equity (the 6 aims
14 identified by the Institute of Medicine of
15 the National Academies in its report enti-
16 tled “Crossing the Quality Chasm: A New
17 Health System for the 21st Century” re-
18 leased on March 1, 2001);

19 (B) innovative approaches to the financing
20 and delivery of health services to achieve rural
21 health quality goals; and

22 (C) development of quality improvement
23 support structures to assist rural health sys-
24 tems and professionals (such as workforce sup-
25 port structures, quality monitoring and report-

1 ing, clinical care protocols, and information
2 technology applications).

3 (2) ELIGIBLE ENTITIES.—In this subsection,
4 the term “eligible entity” means a consortium
5 that—

6 (A) shall include—

7 (i) at least one health care provider or
8 health care delivery system located in a
9 rural area; and

10 (ii) at least one organization rep-
11 resenting multiple community stakeholders;
12 and

13 (B) may include other partners such as
14 rural research centers.

15 (3) CONSULTATION.—In developing the pro-
16 gram for awarding grants under this subsection, the
17 Secretary shall consult with the Administrator of the
18 Agency for Healthcare Research and Quality, rural
19 health care providers, rural health care researchers,
20 and private and nonprofit groups (including national
21 associations) which are undertaking similar efforts.

22 (4) EXPEDITED WAIVERS.—The Secretary shall
23 expedite the processing of any waiver that—

1 (A) is authorized under title XVIII or XIX
2 of the Social Security Act (42 U.S.C. 1395 et
3 seq.); and

4 (B) is necessary to carry out a demonstra-
5 tion project under this subsection.

6 (5) DEMONSTRATION PROJECT SITES.—The
7 Secretary shall ensure that the 5 demonstration
8 projects funded under this subsection are conducted
9 at a variety of sites representing the diversity of
10 rural communities in the Nation.

11 (6) DURATION.—Each demonstration project
12 under this subsection shall be for a period of 4
13 years.

14 (7) INDEPENDENT EVALUATION.—The Sec-
15 retary shall enter into an arrangement with an enti-
16 ty that has experience working directly with rural
17 health systems for the conduct of an independent
18 evaluation of the program carried out under this
19 subsection.

20 (8) REPORT.—Not later than 1 year after the
21 conclusion of all of the demonstration projects fund-
22 ed under this subsection, the Secretary shall submit
23 a report to the Congress on the results of such
24 projects. The report shall include—

1 (A) an evaluation of patient access to care,
2 patient outcomes, and an analysis of the cost
3 effectiveness of each such project; and

4 (B) recommendations on Federal legisla-
5 tion, regulations, or administrative policies to
6 enhance rural health quality and outcomes.

7 (c) APPROPRIATION.—

8 (1) IN GENERAL.—Out of funds in the Treas-
9 ury not otherwise appropriated, there are appro-
10 priated to the Secretary to carry out this section
11 \$30,000,000 for the period of fiscal years 2019
12 through 2023.

13 (2) AVAILABILITY.—

14 (A) IN GENERAL.—Funds appropriated
15 under paragraph (1) shall remain available for
16 expenditure through fiscal year 2023.

17 (B) REPORT.—For purposes of carrying
18 out subsection (b)(8), funds appropriated under
19 paragraph (1) shall remain available for ex-
20 penditure through fiscal year 2024.

21 (3) RESERVATION.—Of the amount appro-
22 priated under paragraph (1), the Secretary shall re-
23 serve—

24 (A) \$5,000,000 to carry out subsection (a);
25 and

1 (B) \$25,000,000 to carry out subsection
2 (b), of which—

3 (i) 2 percent shall be for the provision
4 of technical assistance to grant recipients;
5 and

6 (ii) 5 percent shall be for independent
7 evaluation under subsection (b)(7).

8 **SEC. 416. RURAL HEALTH CARE SERVICES.**

9 Section 330A of the Public Health Service Act (42
10 U.S.C. 254c) is amended to read as follows:

11 **“SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH,**
12 **RURAL HEALTH NETWORK DEVELOPMENT,**
13 **DELTA RURAL DISPARITIES AND HEALTH**
14 **SYSTEMS DEVELOPMENT, AND SMALL RURAL**
15 **HEALTH CARE PROVIDER QUALITY IMPROVE-**
16 **MENT GRANT PROGRAMS.**

17 “(a) PURPOSE.—The purpose of this section is to
18 provide for grants—

19 “(1) under subsection (b), to promote rural
20 health care services outreach;

21 “(2) under subsection (c), to provide for the
22 planning and implementation of integrated health
23 care networks in rural areas;

24 “(3) under subsection (d), to assist rural com-
25 munities in the Delta Region to reduce health dis-

1 parities and to promote and enhance health system
2 development; and

3 “(4) under subsection (e), to provide for the
4 planning and implementation of small rural health
5 care provider quality improvement activities.

6 “(b) RURAL HEALTH CARE SERVICES OUTREACH
7 GRANTS.—

8 “(1) GRANTS.—The Director of the Office of
9 Rural Health Policy of the Health Resources and
10 Services Administration may award grants to eligible
11 entities to promote rural health care services out-
12 reach by expanding the delivery of health care serv-
13 ices to include new and enhanced services in rural
14 areas. The Director may award the grants for peri-
15 ods of not more than 3 years.

16 “(2) ELIGIBILITY.—To be eligible to receive a
17 grant under this subsection for a project, an enti-
18 ty—

19 “(A) shall be a rural public or rural non-
20 profit private entity, a facility that qualifies as
21 a rural health clinic under title XVIII of the
22 Social Security Act, a public or nonprofit entity
23 existing exclusively to provide services to mi-
24 grant and seasonal farm workers in rural areas,
25 or a Tribal government whose grant-funded ac-

1 activities will be conducted within federally recog-
2 nized Tribal areas;

3 “(B) shall represent a consortium com-
4 posed of members—

5 “(i) that include 3 or more independ-
6 ently owned health care entities; and

7 “(ii) that may be nonprofit or for-
8 profit entities; and

9 “(C) shall not previously have received a
10 grant under this subsection for the same or a
11 similar project, unless the entity is proposing to
12 expand the scope of the project or the area that
13 will be served through the project.

14 “(3) APPLICATIONS.—To be eligible to receive a
15 grant under this subsection, an eligible entity shall
16 prepare and submit to the Director an application at
17 such time, in such manner, and containing such in-
18 formation as the Director may require, including—

19 “(A) a description of the project that the
20 eligible entity will carry out using the funds
21 provided under the grant;

22 “(B) a description of the manner in which
23 the project funded under the grant will meet
24 the health care needs of rural populations in
25 the local community or region to be served;

1 “(C) a plan for quantifying how health
2 care needs will be met through identification of
3 the target population and benchmarks of service
4 delivery or health status, such as—

5 “(i) quantifiable measurements of
6 health status improvement for projects fo-
7 cusing on health promotion; or

8 “(ii) benchmarks of increased access
9 to primary care, including tracking factors
10 such as the number and type of primary
11 care visits, identification of a medical
12 home, or other general measures of such
13 access;

14 “(D) a description of how the local com-
15 munity or region to be served will be involved
16 in the development and ongoing operations of
17 the project;

18 “(E) a plan for sustaining the project after
19 Federal support for the project has ended;

20 “(F) a description of how the project will
21 be evaluated;

22 “(G) the administrative capacity to submit
23 annual performance data electronically as speci-
24 fied by the Director; and

1 “(H) other such information as the Direc-
2 tor determines to be appropriate.

3 “(c) RURAL HEALTH NETWORK DEVELOPMENT
4 GRANTS.—

5 “(1) GRANTS.—

6 “(A) IN GENERAL.—The Director may
7 award rural health network development grants
8 to eligible entities to promote, through planning
9 and implementation, the development of inte-
10 grated health care networks that have combined
11 the functions of the entities participating in the
12 networks in order to—

13 “(i) achieve efficiencies and economies
14 of scale;

15 “(ii) expand access to, coordinate, and
16 improve the quality of the health care de-
17 livery system through development of orga-
18 nizational efficiencies;

19 “(iii) implement health information
20 technology to achieve efficiencies, reduce
21 medical errors, and improve quality;

22 “(iv) coordinate care and manage
23 chronic illness; and

24 “(v) strengthen the rural health care
25 system as a whole in such a manner as to

1 show a quantifiable return on investment
2 to the participants in the network.

3 “(B) GRANT PERIODS.—The Director may
4 award such a rural health network development
5 grant—

6 “(i) for a period of 3 years for imple-
7 mentation activities; or

8 “(ii) for a period of 1 year for plan-
9 ning activities to assist in the initial devel-
10 opment of an integrated health care net-
11 work, if the proposed participants in the
12 network do not have a history of collabo-
13 rative efforts and a 3-year grant would be
14 inappropriate.

15 “(2) ELIGIBILITY.—To be eligible to receive a
16 grant under this subsection, an entity—

17 “(A) shall be a rural public or rural non-
18 profit private entity, a facility that qualifies as
19 a rural health clinic under title XVIII of the
20 Social Security Act, a public or nonprofit entity
21 existing exclusively to provide services to mi-
22 grant and seasonal farm workers in rural areas,
23 or a Tribal government whose grant-funded ac-
24 tivities will be conducted within federally recog-
25 nized Tribal areas;

1 “(B) shall represent a network composed
2 of participants—

3 “(i) that include 3 or more independ-
4 ently owned health care entities; and

5 “(ii) that may be nonprofit or for-
6 profit entities; and

7 “(C) shall not previously have received a
8 grant under this subsection (other than a 1-
9 year grant for planning activities) for the same
10 or a similar project.

11 “(3) APPLICATIONS.—To be eligible to receive a
12 grant under this subsection, an eligible entity, in
13 consultation with the appropriate State office of
14 rural health or another appropriate State entity,
15 shall prepare and submit to the Director an applica-
16 tion at such time, in such manner, and containing
17 such information as the Director may require, in-
18 cluding—

19 “(A) a description of the project that the
20 eligible entity will carry out using the funds
21 provided under the grant;

22 “(B) an explanation of the reasons why
23 Federal assistance is required to carry out the
24 project;

25 “(C) a description of—

1 “(i) the history of collaborative activi-
2 ties carried out by the participants in the
3 network;

4 “(ii) the degree to which the partici-
5 pants are ready to integrate their func-
6 tions; and

7 “(iii) how the local community or re-
8 gion to be served will benefit from and be
9 involved in the activities carried out by the
10 network;

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
14 across the continuum of care as a result of the
15 integration activities carried out by the net-
16 work, including a description of—

17 “(i) return on investment for the com-
18 munity and the network members; and

19 “(ii) other quantifiable performance
20 measures that show the benefit of the net-
21 work activities;

22 “(E) a plan for sustaining the project after
23 Federal support for the project has ended;

24 “(F) a description of how the project will
25 be evaluated;

1 “(G) the administrative capacity to submit
2 annual performance data electronically as speci-
3 fied by the Director; and

4 “(H) other such information as the Direc-
5 tor determines to be appropriate.

6 “(d) DELTA RURAL DISPARITIES AND HEALTH SYS-
7 TEMS DEVELOPMENT GRANTS.—

8 “(1) GRANTS.—The Director may award grants
9 to eligible entities to support reduction of health dis-
10 parities, improve access to health care, and enhance
11 rural health system development in the Delta Re-
12 gion.

13 “(2) ELIGIBILITY.—To be eligible to receive a
14 grant under this subsection, an entity shall be a
15 rural public or rural nonprofit private entity, a facil-
16 ity that qualifies as a rural health clinic under title
17 XVIII of the Social Security Act, a public or non-
18 profit entity existing exclusively to provide services
19 to migrant and seasonal farm workers in rural
20 areas, or a Tribal government whose grant-funded
21 activities will be conducted within federally recog-
22 nized Tribal areas.

23 “(3) APPLICATIONS.—To be eligible to receive a
24 grant under this subsection, an eligible entity shall
25 prepare and submit to the Director an application at

1 such time, in such manner, and containing such in-
2 formation as the Director may require, including—

3 “(A) a description of the project that the
4 eligible entity will carry out using the funds
5 provided under the grant;

6 “(B) an explanation of the reasons why
7 Federal assistance is required to carry out the
8 project;

9 “(C) a description of the manner in which
10 the project funded under the grant will meet
11 the health care needs of the Delta Region;

12 “(D) a description of how the local com-
13 munity or region to be served will experience in-
14 creased access to quality health care services as
15 a result of the activities carried out by the enti-
16 ty;

17 “(E) a description of how health dispari-
18 ties will be reduced or the health system will be
19 improved;

20 “(F) a plan for sustaining the project after
21 Federal support for the project has ended;

22 “(G) a description of how the project will
23 be evaluated including process and outcome
24 measures related to the quality of care provided

1 or how the health care system improves its per-
2 formance;

3 “(H) a description of how the grantee will
4 develop an advisory group made up of rep-
5 resentatives of the communities to be served to
6 provide guidance to the grantee to best meet
7 community need; and

8 “(I) other such information as the Director
9 determines to be appropriate.

10 “(e) SMALL RURAL HEALTH CARE PROVIDER QUAL-
11 ITY IMPROVEMENT GRANTS.—

12 “(1) GRANTS.—The Director may award grants
13 to provide for the planning and implementation of
14 small rural health care provider quality improvement
15 activities. The Director may award the grants for
16 periods of 1 to 3 years.

17 “(2) ELIGIBILITY.—To be eligible for a grant
18 under this subsection, an entity—

19 “(A) shall be—

20 “(i) a rural public or rural nonprofit
21 private health care provider or provider of
22 health care services, such as a rural health
23 clinic; or

24 “(ii) another rural provider or net-
25 work of small rural providers identified by

1 the Director as a key source of local care;
2 and

3 “(B) shall not previously have received a
4 grant under this subsection for the same or a
5 similar project.

6 “(3) PREFERENCE.—In awarding grants under
7 this subsection, the Director shall give preference to
8 facilities that qualify as rural health clinics under
9 title XVIII of the Social Security Act.

10 “(4) APPLICATIONS.—To be eligible to receive a
11 grant under this subsection, an eligible entity shall
12 prepare and submit to the Director an application at
13 such time, in such manner, and containing such in-
14 formation as the Director may require, including—

15 “(A) a description of the project that the
16 eligible entity will carry out using the funds
17 provided under the grant;

18 “(B) an explanation of the reasons why
19 Federal assistance is required to carry out the
20 project;

21 “(C) a description of the manner in which
22 the project funded under the grant will assure
23 continuous quality improvement in the provision
24 of services by the entity;

1 “(D) a description of how the local com-
2 munity or region to be served will experience in-
3 creased access to quality health care services as
4 a result of the activities carried out by the enti-
5 ty;

6 “(E) a plan for sustaining the project after
7 Federal support for the project has ended;

8 “(F) a description of how the project will
9 be evaluated including process and outcome
10 measures related to the quality of care pro-
11 vided; and

12 “(G) other such information as the Direc-
13 tor determines to be appropriate.

14 “(f) GENERAL REQUIREMENTS.—

15 “(1) PROHIBITED USES OF FUNDS.—An entity
16 that receives a grant under this section may not use
17 funds provided through the grant—

18 “(A) to build or acquire real property; or

19 “(B) for construction.

20 “(2) COORDINATION WITH OTHER AGENCIES.—

21 The Director shall coordinate activities carried out
22 under grant programs described in this section, to
23 the extent practicable, with Federal and State agen-
24 cies and nonprofit organizations that are operating

1 similar grant programs, to maximize the effect of
2 public dollars in funding meritorious proposals.

3 “(g) REPORT.—Not later than September 30, 2020,
4 the Secretary shall prepare and submit to the appropriate
5 committees of Congress a report on the progress and ac-
6 complishments of the grant programs described in sub-
7 sections (b), (c), (d), and (e).

8 “(h) DEFINITIONS.—In this section:

9 “(1) The term ‘Delta Region’ has the meaning
10 given to the term ‘region’ in section 382A of the
11 Consolidated Farm and Rural Development Act (7
12 U.S.C. 2009aa).

13 “(2) The term ‘Director’ means the Director of
14 the Office of Rural Health Policy of the Health Re-
15 sources and Services Administration.

16 “(i) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated to carry out this section
18 \$40,000,000 for fiscal year 2019, and such sums as may
19 be necessary for each of fiscal years 2020 through 2023.”.

20 **SEC. 417. COMMUNITY HEALTH CENTER COLLABORATIVE**
21 **ACCESS EXPANSION.**

22 Section 330 of the Public Health Service Act (42
23 U.S.C. 254b) is amended by adding at the end the fol-
24 lowing:

25 “(s) MISCELLANEOUS PROVISIONS.—

1 “(1) RULE OF CONSTRUCTION WITH RESPECT
2 TO RURAL HEALTH CLINICS.—Nothing in this sec-
3 tion shall be construed to prevent a community
4 health center from contracting with a federally cer-
5 tified rural health clinic (as defined by section
6 1861(aa)(2) of the Social Security Act) for the deliv-
7 ery of primary health care and other mental, dental,
8 and physical health services that are available at the
9 rural health clinic to individuals who would other-
10 wise be eligible for free or reduced cost care if that
11 individual were able to obtain that care at the com-
12 munity health center. Such services may be limited
13 in scope to those primary health care and other
14 mental, dental, and physical health services available
15 in that rural health clinic.

16 “(2) ENABLING SERVICES.—To the extent pos-
17 sible, enabling services such as transportation and
18 language assistance (including translation and inter-
19 pretation) shall be provided by rural health clinics
20 described in paragraph (1).

21 “(3) ASSURANCES.—In order for a rural health
22 clinic to receive funds under this section through a
23 contract with a community health center for the de-
24 livery of primary health care and other services de-

1 scribed in paragraph (1), such rural health clinic
2 shall establish policies to ensure—

3 “(A) nondiscrimination based upon the
4 ability of a patient to pay;

5 “(B) the establishment of a sliding fee
6 scale for low-income patients; and

7 “(C) any such services should be subject to
8 full reimbursement according to the Prospective
9 Payment System scale.”.

10 **SEC. 418. 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. 419. SCORING OF PREVENTIVE HEALTH SAVINGS.**

11 Section 202 of the Congressional Budget and Im-
12 poundment Control Act of 1974 (2 U.S.C. 602) is amend-
13 ed by adding at the end the following new subsection:

14 “(h) SCORING OF PREVENTIVE HEALTH SAVINGS.—

15 “(1) DETERMINATION BY THE DIRECTOR.—

16 Upon a request by the chairman or ranking minority
17 member of the Committee on the Budget of the Sen-
18 ate, or by the chairman or ranking minority member
19 of the Committee on the Budget of the House of
20 Representatives, the Director shall determine if a
21 proposed measure would result in reductions in
22 budget outlays in budgetary outyears through the
23 use of preventive health and preventive health serv-
24 ices.

1 “(2) PROJECTIONS.—If the Director determines
2 that a measure would result in substantial reduc-
3 tions in budget outlays as described in paragraph
4 (1), the Director—

5 “(A) shall include, in any projection pre-
6 pared by the Director, a description and esti-
7 mate of the reductions in budget outlays in the
8 budgetary outyears and a description of the
9 basis for such conclusions; and

10 “(B) may prepare a budget projection that
11 includes some or all of the budgetary outyears,
12 notwithstanding the time periods for projections
13 described in subsection (e) and sections 308,
14 402, and 424.

15 “(3) DEFINITIONS.—As used in this sub-
16 section—

17 “(A) the term ‘preventive health’ means an
18 action that focuses on the health of the public,
19 individuals, and defined populations in order to
20 protect, promote, and maintain health, wellness,
21 and functional ability, and prevent disease, dis-
22 ability, and premature death that is dem-
23 onstrated by credible and publicly available epi-
24 demiological projection models, incorporating

1 clinical trials or observational studies in hu-
2 mans, to avoid future health care costs; and

3 “(B) the term ‘budgetary outyears’ means
4 the 2 consecutive 10-year periods beginning
5 with the first fiscal year that is 10 years after
6 the budget year provided for in the most re-
7 cently agreed to concurrent resolution on the
8 budget.”.

9 **SEC. 420. SENSE OF CONGRESS ON MAINTENANCE OF EF-**
10 **FORT PROVISIONS REGARDING CHILDREN’S**
11 **HEALTH.**

12 It is the sense of the Congress that—

13 (1) the maintenance of effort provisions added
14 to sections 1902 and 2105(d) of the Social Security
15 Act by sections 2001(b) and 2101(b) of the Patient
16 Protection and Affordable Care Act were written to
17 maintain the eligibility standards for the Medicaid
18 program under title XIX of the Social Security Act
19 and Children’s Health Insurance Program under
20 title XXI of such Act until the American Health
21 Benefit Exchanges in the States are fully oper-
22 ational;

23 (2) it is imperative that the maintenance of ef-
24 fort provisions are enforced to the strict standard in-

1 tended by the Congress through September 30,
2 2022;

3 (3) waiving the maintenance of effort provisions
4 should not be permitted, except in the case of a re-
5 quest for a waiver that meets the explicit non-
6 application requirements;

7 (4) the maintenance of effort provisions ensure
8 the continued success of the Medicaid program and
9 Children’s Health Insurance Program and were writ-
10 ten deliberately to specifically protect vulnerable and
11 disabled individuals, children, and senior citizens,
12 many of whom are also members of communities of
13 color; and

14 (5) the maintenance of effort provisions must
15 be strictly enforced and proposals to weaken the
16 maintenance of effort provisions must not be consid-
17 ered.

18 **SEC. 421. REPEAL OF REQUIREMENT FOR DOCUMENTA-**
19 **TION EVIDENCING CITIZENSHIP OR NATION-**
20 **ALITY UNDER THE MEDICAID PROGRAM.**

21 (a) REPEAL.—Subsections (i)(22) and (x) of section
22 1903 of the Social Security Act (42 U.S.C. 1396b) are
23 each repealed.

24 (b) CONFORMING AMENDMENTS.—

1 (1) Section 1902 of the Social Security Act (42
2 U.S.C. 1396a) is amended—

3 (A) by amending paragraph (46) of sub-
4 section (a) to read as follows:

5 “(46) provide that information is requested and
6 exchanged for purposes of income and eligibility
7 verification in accordance with a State system which
8 meets the requirements of section 1137 of this
9 Act;”;

10 (B) in subsection (e)(13)(A)(i)—

11 (i) in the matter preceding subclause
12 (I), by striking “sections 1902(a)(46)(B)
13 and 1137(d)” and inserting “section
14 1137(d)”; and

15 (ii) in subclause (IV), by striking
16 “1902(a)(46)(B) or”; and

17 (C) by striking subsection (ee).

18 (2) Section 1903 of the Social Security Act (42
19 U.S.C. 1396b) is amended—

20 (A) in subsection (i), by redesignating
21 paragraphs (23) through (26) as paragraphs
22 (22) through (25), respectively; and

23 (B) by redesignating subsections (y) and
24 (z) as subsections (x) and (y), respectively.

1 (3) Subsection (c) of section 6036 of the Deficit
2 Reduction Act of 2005 (42 U.S.C. 1396b note) is re-
3 pealed.

4 (c) EFFECTIVE DATE.—The repeals and amend-
5 ments made by this section shall take effect as if included
6 in the enactment of the Deficit Reduction Act of 2005.

7 **SEC. 422. PROTECTION OF THE HHS OFFICES OF MINORITY**
8 **HEALTH.**

9 (a) IN GENERAL.—Pursuant to the Patient Protec-
10 tion and Affordable Care Act (Public Law 111–148), the
11 Offices of Minority Health established within the Centers
12 for Disease Control and Prevention, the Health Resources
13 and Services Administration, the Substance Abuse and
14 Mental Health Services Administration, the Agency for
15 Healthcare Research and Quality, the Food and Drug Ad-
16 ministration, and the Centers for Medicare & Medicaid
17 Services, are offices that, regardless of change in the
18 structure of the Department of Health and Human Serv-
19 ices, shall report to the Secretary of Health and Human
20 Services.

21 (b) SENSE OF CONGRESS.—It is the sense of the
22 Congress that any effort to eliminate or consolidate such
23 Offices of Minority Health undermines the progress
24 achieved so far.

1 **SEC. 423. OFFICE OF MINORITY HEALTH IN VETERANS**
2 **HEALTH ADMINISTRATION OF DEPARTMENT**
3 **OF VETERANS AFFAIRS.**

4 (a) ESTABLISHMENT AND FUNCTIONS.—Subchapter
5 I of chapter 73 of title 38, United States Code, is amended
6 by adding at the end the following new section:

7 **“§ 7310. Office of Minority Health**

8 “(a) ESTABLISHMENT.—There is established in the
9 Department within the Office of the Under Secretary for
10 Health an office to be known as the ‘Office of Minority
11 Health’ (in this section referred to as the ‘Office’).

12 “(b) HEAD.—The Director of the Office of Minority
13 Health shall be the head of the Office. The Director of
14 the Office of Minority Health shall be appointed by the
15 Under Secretary of Health from among individuals quali-
16 fied to perform the duties of the position.

17 “(c) FUNCTIONS.—The functions of the Office are as
18 follows:

19 “(1) To establish short-range and long-range
20 goals and objectives and coordinate all other activi-
21 ties within the Veterans Health Administration that
22 relate to disease prevention, health promotion, health
23 care services delivery, and health care research con-
24 cerning veterans who are members of a racial or eth-
25 nic minority group.

1 “(2) To support research, demonstrations, and
2 evaluations to test new and innovative models for
3 the discharge of activities described in paragraph
4 (1).

5 “(3) To increase knowledge and understanding
6 of health risk factors for veterans who are members
7 of a racial or ethnic minority group.

8 “(4) To develop mechanisms that support bet-
9 ter health care information dissemination, education,
10 prevention, and services delivery to veterans from
11 disadvantaged backgrounds, including veterans who
12 are members of a racial or ethnic minority group.

13 “(5) To enter into contracts or agreements with
14 appropriate public and nonprofit private entities to
15 develop and carry out programs to provide bilingual
16 or interpretive services to assist veterans who are
17 members of a racial or ethnic minority group and
18 who lack proficiency in speaking the English lan-
19 guage in accessing and receiving health care services
20 through the Veterans Health Administration.

21 “(6) To carry out programs to improve access
22 to health care services through the Veterans Health
23 Administration for veterans with limited proficiency
24 in speaking the English language, including the de-

1 velopment and evaluation of demonstration and pilot
2 projects for that purpose.

3 “(7) To advise the Under Secretary of Health
4 on matters relating to the development, implementa-
5 tion, and evaluation of health professions education
6 in decreasing disparities in health care outcomes be-
7 tween veterans who are members of a racial or eth-
8 nic minority group and other veterans, including cul-
9 tural competency as a method of eliminating such
10 health disparities.

11 “(8) To perform such other functions and du-
12 ties as the Secretary or the Under Secretary for
13 Health considers appropriate.

14 “(d) DEFINITIONS.—In this section:

15 “(1) The term ‘racial or ethnic minority group’
16 means any of the following:

17 “(A) American Indians (including Alaska
18 Natives, Eskimos, and Aleuts).

19 “(B) Asian Americans.

20 “(C) Native Hawaiians and other Pacific
21 Islanders.

22 “(D) Blacks.

23 “(E) Hispanics.

24 “(2) The term ‘Hispanic’ means individuals
25 whose origin is Mexican, Puerto Rican, Cuban, Cen-

1 tral or South American, or any other Spanish-speak-
2 ing country.”.

3 (b) CLERICAL AMENDMENT.—The table of sections
4 at the beginning of such chapter is amended by inserting
5 after the item relating to section 7309A the following new
6 item:

“7310. Office of Minority Health.”.

7 **SEC. 424. INDIAN DEFINED IN PPACA.**

8 (a) DEFINITION OF INDIAN.—Section 1304 of the
9 Patient Protection and Affordable Care Act (42 U.S.C.
10 18024) is amended by adding at the end the following:

11 “(f) INDIAN.—

12 “(1) IN GENERAL.—In this title, the term ‘In-
13 dian’ means any individual—

14 “(A) described in paragraph (13) or (28)
15 of section 4 of the Indian Health Care Improve-
16 ment Act (25 U.S.C. 1603);

17 “(B) who is eligible for health services pro-
18 vided by the Indian Health Service under sec-
19 tion 809 of the Indian Health Care Improve-
20 ment Act (25 U.S.C. 1679);

21 “(C) who is of Indian descent and belongs
22 to the Indian community served by the local fa-
23 cilities and program of the Indian Health Serv-
24 ice; or

25 “(D) who is described in paragraph (2).

1 “(2) INCLUDED INDIVIDUALS.—The following
2 individuals shall be considered to be an ‘Indian’:

3 “(A) A member of a federally recognized
4 Indian Tribe.

5 “(B) A resident of an urban center who
6 meets 1 or more of the following 4 criteria:

7 “(i) Membership in a Tribe, band, or
8 other organized group of Indians, including
9 those Tribes, bands, or groups terminated
10 since 1940 and those recognized as of the
11 date of enactment of the Health Equity
12 and Accountability Act of 2018 or later by
13 the State in which they reside, or being a
14 descendant, in the first or second degree,
15 of any such member.

16 “(ii) Is an Eskimo or Aleut or other
17 Alaska Native.

18 “(iii) Is considered by the Secretary of
19 the Interior to be an Indian for any pur-
20 pose.

21 “(iv) Is determined to be an Indian
22 under regulations promulgated by the Sec-
23 retary.

1 “(C) An individual who is considered by
2 the Secretary of the Interior to be an Indian for
3 any purpose.

4 “(D) An individual who is considered by
5 the Secretary to be an Indian for purposes of
6 eligibility for Indian health care services, includ-
7 ing as a California Indian, Eskimo, Aleut, or
8 other Alaska Native.”.

9 (b) CONFORMING AMENDMENTS.—

10 (1) AFFORDABLE CHOICES HEALTH BENEFIT
11 PLANS.—Section 1311(c)(6)(D) of the Patient Pro-
12 tection and Affordable Care Act (42 U.S.C.
13 18031(c)(6)(D)) is amended by striking “section 4
14 of the Indian Health Care Improvement Act” and
15 inserting “section 1304(f)”.

16 (2) REDUCED COST-SHARING FOR INDIVIDUALS
17 ENROLLING IN QUALIFIED HEALTH PLANS.—Section
18 1402(d) of the Patient Protection and Affordable
19 Care Act (42 U.S.C. 18071(d)) is amended—

20 (A) in paragraph (1), in the matter pre-
21 ceding subparagraph (A), by striking “section
22 4(d) of the Indian Self-Determination and Edu-
23 cation Assistance Act (25 U.S.C. 450b(d))” and
24 inserting “section 1304(f)”; and

1 (B) in paragraph (2), in the matter pre-
2 ceding subparagraph (A), by striking “(as so
3 defined)” and inserting “(as defined in section
4 1304(f))”.

5 (3) EXEMPTION FROM PENALTY FOR NOT
6 MAINTAINING MINIMUM ESSENTIAL COVERAGE.—
7 Section 5000A(e) of the Internal Revenue Code of
8 1986 is amended by striking paragraph (3) and in-
9 serting the following:

10 “(3) INDIANS.—Any applicable individual who
11 is an Indian (as defined in section 1304(f) of the
12 Patient Protection and Affordable Care Act).”.

13 **SEC. 425. STUDY OF DSH PAYMENTS TO ENSURE HOSPITAL**
14 **ACCESS FOR LOW-INCOME PATIENTS.**

15 (a) IN GENERAL.—Not later than January 1, 2019,
16 the Comptroller General of the United States shall con-
17 duct a study on how certain amendments made by the Pa-
18 tient Protection and Affordable Care Act (Public Law
19 111–148) to titles XVIII and XIX of the Social Security
20 Act affect the timely access to health care services for low-
21 income patients. Such study shall—

22 (1) evaluate and examine whether States elect-
23 ing to make medical assistance available under sec-
24 tion 1902(a)(10)(A)(i)(VIII) of the Social Security
25 Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) (including

1 States making such an election through a waiver of
2 the State plan) to individuals described in such sec-
3 tion mitigates the need for payments to dispropor-
4 tionate share hospitals under section 1886(d)(5)(F)
5 of the Social Security Act (42 U.S.C.
6 1395ww(d)(5)(F)) and section 1923 of such Act (42
7 U.S.C. 1396r-4), including the impact of such
8 States electing to make medical assistance available
9 to such individuals on—

10 (A) the number of individuals in the
11 United States who are without health insurance
12 and the distribution of such individuals in rela-
13 tion to areas primarily served by dispropor-
14 tionate share hospitals; and

15 (B) the low-income utilization rate of such
16 hospitals and the resulting fiscal sustainability
17 of such hospitals;

18 (2) evaluate the appropriate level and distribu-
19 tion of such payments among disproportionate hos-
20 pitals for purposes of—

21 (A) sufficiently accounting for the level of
22 uncompensated care provided by such hospitals
23 to low-income patients; and

1 (B) providing timely access to health serv-
2 ices for individuals in medically underserved
3 areas; and

4 (3) assess, with respect to disproportionate hos-
5 pitals—

6 (A) the role played by such hospitals in
7 providing critical access to emergency, inpa-
8 tient, and outpatient health services, as well as
9 the location of such hospitals in relation to
10 medically underserved areas; and

11 (B) the extent to which such hospitals sat-
12 isfy the requirements established for charitable
13 hospital organizations under section 501(r) of
14 the Internal Revenue Code of 1986 with respect
15 to community health needs assessments, finan-
16 cial assistance policy requirements, limitations
17 on charges, and billing and collection require-
18 ments.

19 (b) REPORTS.—

20 (1) REPORT TO CONGRESS.—Not later than
21 180 days after the date on which the study under
22 subsection (a) is completed, the Comptroller General
23 of the United States shall submit to the Committee
24 on Energy and Commerce of the House of Rep-
25 resentatives and the Committee on Health, Edu-

1 cation, Labor, and Pensions of the Senate a report
2 that contains—

3 (A) the results of the study;

4 (B) recommendations to Congress for any
5 legislative changes to the payments to dis-
6 proportionate share hospitals under section
7 1886(d)(5)(F) of the Social Security Act (42
8 U.S.C. 1395ww(d)(5)(F)) and section 1923 of
9 such Act (42 U.S.C. 1396r-4) that are needed
10 to ensure access to health services for low-in-
11 come patients that—

12 (i) are based on the number of indi-
13 viduals without health insurance, the
14 amount of uncompensated care provided by
15 such hospitals, and the impact of reduced
16 payments levels on low-income commu-
17 nities; and

18 (ii) takes into account any reports
19 submitted by the Secretary of the Treas-
20 ury, in consultation with the Secretary of
21 Health and Human Services, to Congres-
22 sional committees regarding the costs in-
23 curred by charitable hospital organizations
24 for charity care, bad debt, nonreimbursed
25 expenses for services provided to individ-

1 uals under the Medicare Program under
2 title XVIII of the Social Security Act and
3 the Medicaid Program under title XIX of
4 such Act, and any community benefit ac-
5 tivities provided by such organizations.

6 (2) REPORT TO THE SECRETARY OF HEALTH
7 AND HUMAN SERVICES.—Not later than 180 days
8 after the date on which the study under subsection
9 (a) is completed, the Comptroller General of the
10 United States shall submit to the Secretary of
11 Health and Human Services a report that con-
12 tains—

13 (A) the results of the study; and

14 (B) any recommendations for purposes of
15 assisting in the development of the methodology
16 for the adjustment of payments to dispropor-
17 tionate share hospitals, as required under sec-
18 tion 1886(r) of the Social Security Act (42
19 U.S.C. 1395ww(r)) and the reduction of such
20 payments section 1923(f)(7) of such Act (42
21 U.S.C. 1396r-4(f)(7)), taking into account the
22 reports referred to in paragraph (1)(B)(ii).

1 **SEC. 426. ASSISTANT SECRETARY OF THE INDIAN HEALTH**
2 **SERVICE.**

3 (a) REFERENCES.—Any reference in a law, regula-
4 tion, document, paper, or other record of the United
5 States to the Director of the Indian Health Service shall
6 be deemed to be a reference to the Assistant Secretary
7 of the Indian Health Service.

8 (b) EXECUTIVE SCHEDULE.—Section 5315 of title 5,
9 United States Code, is amended in the matter relating to
10 the Assistant Secretaries of Health and Human Services
11 by striking “(6)” and inserting “(7), 1 of whom shall be
12 the Assistant Secretary of the Indian Health Service”.

13 (c) CONFORMING AMENDMENT.—Section 5316 of
14 title 5, United States Code, is amended by striking “Direc-
15 tor, Indian Health Service, Department of Health and
16 Human Services.”.

17 **SEC. 427. REAUTHORIZATION OF THE NATIVE HAWAIIAN**
18 **HEALTH CARE IMPROVEMENT ACT.**

19 (a) NATIVE HAWAIIAN HEALTH CARE SYSTEMS.—
20 Section 6(h)(1) of the Native Hawaiian Health Care Im-
21 provement Act (42 U.S.C. 11705(h)(1)) is amended by
22 striking “may be necessary for fiscal years 1993 through
23 2019” and inserting “are necessary”.

24 (b) ADMINISTRATIVE GRANT FOR PAPA OLA
25 LOKAHI.—Section 7(b) of the Native Hawaiian Health
26 Care Improvement Act (42 U.S.C. 11706(b)) is amended

1 by striking “may be necessary for fiscal years 1993
2 through 2019” and inserting “are necessary”.

3 (c) NATIVE HAWAIIAN HEALTH SCHOLARSHIPS.—
4 Section 10(c) of the Native Hawaiian Health Care Im-
5 provement Act (42 U.S.C. 11709(c)) is amended by strik-
6 ing “may be necessary for fiscal years 1993 through
7 2019” and inserting “are necessary”.

8 **SEC. 428. AVAILABILITY OF NON-ENGLISH LANGUAGE**
9 **SPEAKING PROVIDERS.**

10 (a) IN GENERAL.—Section 1311(c)(1)(B) of the Pa-
11 tient Protection and Affordable Care Act (42 U.S.C.
12 18031(c)(1)(B)) is amended by inserting before the semi-
13 colon the following: “and, with respect to such providers,
14 a provider’s ability to provide care in a language other
15 than English either through the provider speaking such
16 language or by the provider having a trained medical in-
17 terpreter, as defined in subsection (b) of this section, who
18 speaks such language available during office hours”.

19 (b) QUALIFIED INTERPRETER FOR AN INDIVIDUAL
20 WITH LIMITED-ENGLISH PROFICIENCY, DEFINED.—The
21 term “Qualified interpreter for an individual with limited-
22 English proficiency” means an interpreter who via a re-
23 mote interpreting service or an on-site appearance—

24 (1) adheres to generally accepted interpreter
25 ethics principles, including client confidentiality;

1 (2) has demonstrated proficiency in speaking
2 and understanding both spoken English and at least
3 one other spoken language; and

4 (3) is able to interpret effectively, accurately,
5 and impartially, both receptively and expressly, to
6 and from such language(s) and English, using any
7 necessary specialized vocabulary, terminology and
8 phraseology.

9 (c) EFFECTIVE DATE.—The amendment made by
10 subsection (a) shall apply for plan years beginning more
11 than 1 year after the date of the enactment of this Act.

12 **SEC. 429. ACCESS TO ESSENTIAL COMMUNITY PROVIDERS.**

13 (a) ESSENTIAL COMMUNITY PROVIDERS.—Section
14 1311(c)(1)(C) of the Patient Protection and Affordable
15 Care Act (42 U.S.C. 18031(c)(1)(C)) is amended—

16 (1) by inserting “(i)” after “(C)”; and

17 (2) by adding at the end the following new
18 clauses:

19 “(ii) not later than 2018, increase the per-
20 centage of essential community providers in-
21 cluded in its network by 10 percent annually
22 (based on the level in the plan for 2016) until
23 90 percent of all federally qualified health cen-
24 ters and 75 percent of all other essential com-

1 community providers in the contract service area
2 are in-network; and

3 “(iii) include one of each type of essential
4 community provider in network in each county
5 in their service area, where available;”.

6 (b) REPORTING REQUIREMENTS.—Section
7 1311(e)(3) of the Patient Protection and Affordable Care
8 Act (42 U.S.C. 18031(e)(3)(A)) is amended by adding at
9 the end the following new subparagraph:

10 “(E) DATA ON ESSENTIAL COMMUNITY
11 PROVIDERS.—The Secretary shall require quali-
12 fied health plans to submit annually to the Sec-
13 retary data on the percentage of essential com-
14 munity providers, by county, that contract with
15 each qualified health plan offered in that county
16 and the percentage of essential community pro-
17 viders, by type, that contract with each quali-
18 fied health plan offered in that county. Data so
19 submitted shall be made available to the general
20 public”.

21 (c) ESSENTIAL COMMUNITY PROVIDER PROVISIONS
22 APPLIED UNDER MEDICARE AND MEDICAID.—

23 (1) MEDICARE.—Section 1852(d)(1) of the So-
24 cial Security Act (42 U.S.C.1395w-22(d)(1)) is
25 amended—

1 (A) by striking “and” at the end of sub-
2 paragraph (D);

3 (B) by striking the period at the end of
4 subparagraph (E) and inserting “; and”; and

5 (C) by adding at the end the following new
6 subparagraph:

7 “(F) the plan meets the requirements of
8 clauses (ii) and (iii) of section 1311(c)(1)(C) of
9 the Patient Protection and Affordable Care Act
10 (relating to inclusion in networks of essential
11 community providers).”.

12 (2) MEDICAID.—Section 1932(b)(5) of the So-
13 cial Security Act (42 U.S.C. 1396u–2(b)(5)) is
14 amended—

15 (A) by striking “and” at the end of sub-
16 paragraph (A);

17 (B) by striking the period at the end of
18 subparagraph (B) and inserting “; and”; and

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

21 “(C) the plan meets the requirements of
22 clauses (ii) and (iii) of section 1311(c)(1)(C) of
23 the Patient Protection and Affordable Care Act
24 (relating to inclusion in networks of essential

1 community providers) with respect to services
2 offered in the service area involved.”.

3 **SEC. 430. PROVIDER NETWORK ADEQUACY IN COMMU-**
4 **NITIES OF COLOR.**

5 (a) IN GENERAL.—Section 1311(c)(1)(B) of the Pa-
6 tient Protection and Affordable Care Act (42 U.S.C.
7 18031(c)(1)(B)) is amended—

8 (1) by inserting “(i)” after “(B)”; and

9 (2) by adding at the end the following the fol-
10 lowing new clauses:

11 “(ii) meet such network adequacy
12 standards as the Secretary may establish
13 with regard to—

14 “(I) appointment wait time;

15 “(II) travel time and distance to
16 health care provider facilities and pro-
17 viders by public and private transit;

18 “(III) hours of operation to ac-
19 commodate individuals who cannot
20 come to provider appointments during
21 standard business hours; and

22 “(IV) other network adequacy
23 standards to ensure that care through
24 these plans is accessible to diverse

1 communities, including those who are
2 limited-English proficient; and

3 “(iii) provide coverage for services for
4 enrollees through out-of-network providers
5 at no additional cost to the enrollees in
6 cases where in-network providers are un-
7 able to comply with the standards estab-
8 lished under clause subclause (III) or (IV)
9 of clause (ii) for such services and the out-
10 of-network providers can deliver such serv-
11 ices in compliance with such standards.

12 “(b) EFFECTIVE DATE.—The amendments made by
13 subsection (a) shall apply to plan years beginning more
14 than 1 year after the date of the enactment of this Act.”.

15 **SEC. 431. IMPROVING ACCESS TO DENTAL CARE.**

16 (a) REPORTS TO CONGRESS.—

17 (1) GAO REPORT ON DENTAL THERAPIST PRO-
18 GRAMS.—Not later than 1 year after the date of the
19 enactment of this Act, the Comptroller General of
20 the United States shall submit to Congress a report
21 on the Alaska Dental Health Aide Therapists Pro-
22 gram and the Dental Therapist and Advanced Den-
23 tal Therapist programs in Minnesota, to assess den-
24 tal therapists’ effectiveness in—

1 (A) improving access to timely dental care
2 among communities of color;

3 (B) providing high quality care; and

4 (C) providing culturally competent care.

5 (2) GAO REPORT OF EXPANDING SCOPE OF
6 CERTAIN PRACTICES.—The GAO shall also report on
7 state variations in use of dental hygienists and as-
8 sess the effectiveness of expanding the scope of prac-
9 tice for hygienists in—

10 (A) improving access to timely dental care
11 among communities of color;

12 (B) providing high quality care; and

13 (C) providing culturally competent care.

14 (3) HRSA REPORT ON DENTAL SHORTAGE
15 AREAS.—Not later than 1 year after the date of the
16 enactment of this Act, the Secretary, acting through
17 the Administrator of the Health Resources Service
18 Administration, shall submit to Congress a report
19 which details geographic dental access shortages and
20 the preparedness of dental providers to offer cul-
21 turally and linguistically appropriate, affordable, ac-
22 cessible, and timely services.

23 (b) EXPANSION OF DENTAL HEALTH AID THERA-
24 PISTS IN TRIBAL COMMUNITIES.—Section 119(d) of the

1 Indian Health Care Improvement Act (U.S.C. 1616l(d))
2 is amended—

3 (1) in paragraph (2), by striking “Subject to”
4 and all that follows and inserting “Subject to para-
5 graph (3), in establishing a national program under
6 paragraph (1), the Secretary shall not reduce the
7 amounts provided for the Community Health Aide
8 Program described in subsections (a) and (b).”;

9 (2) by striking paragraph (3); and

10 (3) by redesignating paragraph (4) as para-
11 graph (3).

12 (c) COVERAGE OF DENTAL SERVICES UNDER THE
13 MEDICARE PROGRAM.—

14 (1) COVERAGE.—Section 1861(s)(2) of the So-
15 cial Security Act (42 U.S.C. 1395x(s)(2)) is amend-
16 ed—

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

19 (B) in subparagraph (FF), by adding
20 “and” after the semicolon at the end; and

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

23 “(GG) oral health services (as defined in
24 subsection (kkk));”.

1 (2) ORAL HEALTH SERVICES DEFINED.—Sec-
2 tion 1861 of the Social Security Act (42 U.S.C.
3 1395x), as amended by sections 205(b) and 433(a),
4 is amended by adding at the end the following new
5 subsection:

6 “Oral Health Services

7 “(kkk)(1) The term ‘oral health services’ means serv-
8 ices (as defined by the Secretary) that are necessary to
9 prevent disease and promote oral health, restore oral
10 structures to health and function, and treat emergency
11 conditions.

12 “(2) For purposes of paragraph (1), such term shall
13 include mobile and portable oral health services (as de-
14 fined by the Secretary) that—

15 “(A) are provided for the purpose of over-
16 coming mobility, transportation, and access barriers
17 for individuals; and

18 “(B) satisfy the standards and certification re-
19 quirements established under section 1902(a)(82)(B)
20 for the State in which the services are provided.”.

21 (3) PAYMENT AND COINSURANCE.—Section
22 1833(a)(1) of the Social Security Act (42 U.S.C.
23 1395l(a)(1)) is amended—

24 (A) by striking “and” before “(Z)”; and

1 (B) by inserting before the semicolon at
2 the end the following: “, and (AA) with respect
3 to oral health services (as defined in section
4 1861(kkk)), the amount paid shall be (i) in the
5 case of such services that are preventive, 100
6 percent of the lesser of the actual charge for
7 the services or the amount determined under
8 the payment basis determined under section
9 1848, and (ii) in the case of all other such serv-
10 ices, 80 percent of the lesser of the actual
11 charge for the services or the amount deter-
12 mined under the payment basis determined
13 under section 1848”.

14 (4) PAYMENT UNDER PHYSICIAN FEE SCHED-
15 ULE.—Section 1848(j)(3) of the Social Security Act
16 (42 U.S.C. 1395w-4(j)(3)) is amended by inserting
17 “(2)(GG),” after “risk assessment),”.

18 (5) DENTURES.—Section 1861(s)(8) of the So-
19 cial Security Act (42 U.S.C. 1395x(s)(8)) is amend-
20 ed—

21 (A) by striking “(other than dental)” and
22 inserting “(including dentures)”; and

23 (B) by striking “internal body”.

24 (6) REPEAL OF GROUND FOR EXCLUSION.—
25 Section 1862(a) of the Social Security Act (42

1 U.S.C. 1395y) is amended by striking paragraph
2 (12).

3 (7) EFFECTIVE DATE.—The amendments made
4 by this section shall apply to services furnished on
5 or after January 1, 2019.

6 (d) COVERAGE OF DENTAL SERVICES UNDER THE
7 MEDICAID PROGRAM.—

8 (1) IN GENERAL.—Section 1905 of the Social
9 Security Act (42 U.S.C. 1396d) is amended—

10 (A) in subsection (a)(10), by striking “den-
11 tal services” and inserting “oral health services
12 (as defined in subsection (ee)(1))”; and

13 (B) by adding at the end the following new
14 subsection:

15 “(ee)(1) Subject to paragraphs (2) and (3), for pur-
16 poses of this title, the term ‘oral health services’ means
17 services (as defined by the Secretary) that are necessary
18 to prevent disease and promote oral health, restore oral
19 structures to health and function, and treat emergency
20 conditions. These services shall include, in the case of
21 pregnant or postpartum women, such services as are nec-
22 essary to address oral health conditions that exist or are
23 exacerbated by pregnancy or childbirth or which, if left
24 untreated, could adversely affect fetal or child develop-
25 ment.

1 “(2) For purposes of paragraph (1), such term shall
2 include—

3 “(A) dentures; and

4 “(B) mobile and portable oral health services
5 (as defined by the Secretary) that—

6 “(i) are provided for the purpose of over-
7 coming mobility, transportation, and access bar-
8 riers for individuals; and

9 “(ii) satisfy the standards and certification
10 requirements established under section
11 1902(a)(82)(C) for the State in which the serv-
12 ices are provided.

13 “(3) For purposes of paragraph (1), such term shall
14 not apply to dental care or services provided to individuals
15 under the age of 21 under subsection (r)(3).”.

16 (2) CONFORMING AMENDMENTS.—

17 (A) STATE PLAN REQUIREMENTS.—Section
18 1902(a) of the Social Security Act (42 U.S.C.
19 1396a(a)) is amended—

20 (i) in paragraph (10)(A), in the mat-
21 ter preceding clause (i), by inserting
22 “(10),” after “(5),”;

23 (ii) in paragraph (80), by striking
24 “and” at the end;

1 (iii) in paragraph (81), by striking the
2 period at the end and inserting “; and”;
3 and

4 (iv) by inserting after paragraph (81)
5 the following:

6 “(82) provide for—

7 “(A) informing, in writing, all individuals
8 who have been determined to be eligible for
9 medical assistance of the availability of oral
10 health services (as defined in section 1905(ee));

11 “(B) conducting targeted outreach to preg-
12 nant women who have been determined to be el-
13 ible for medical assistance about the avail-
14 ability of medical assistance for such dental
15 services and the importance of receiving dental
16 care while pregnant; and

17 “(C) establishing and maintaining stand-
18 ards for and certification of mobile and portable
19 oral health services (as described in subsections
20 (r)(3)(C) and (ee)(2)(B) of section 1905).”.

21 (B) DEFINITION OF MEDICAL ASSIST-
22 ANCE.—Section 1905(a)(12) of the Social Secu-
23 rity Act (42 U.S.C. 1396d(a)(12)) is amended
24 by striking “, dentures,”.

1 (3) MOBILE AND PORTABLE ORAL HEALTH
2 SERVICES UNDER EPSDT.—Section 1905(r)(3) of the
3 Social Security Act (42 U.S.C. 1396d(r)(3)) is
4 amended—

5 (A) in subparagraph (A)(ii), by striking “;
6 and” and inserting a semicolon;

7 (B) in subparagraph (B), by striking the
8 period at the end and inserting “; and”; and

9 (C) by adding at the end the following new
10 subparagraph:

11 “(C) which shall include mobile and port-
12 able oral health services (as defined by the Sec-
13 retary) that—

14 “(i) are provided for the purpose of
15 overcoming mobility, transportation, or ac-
16 cess barriers for children; and

17 “(ii) satisfy the standards and certifi-
18 cation requirements established under sec-
19 tion 1902(a)(82)(C) for the State in which
20 the services are provided.”.

21 (e) ORAL HEALTH SERVICES AS AN ESSENTIAL
22 HEALTH BENEFIT.—Section 1302(b) of the Patient Pro-
23 tection and Affordable Care Act (42 U.S.C. 18022(b)) is
24 amended—

25 (1) in paragraph (1)—

1 (A) in subparagraph (J), by striking “oral
2 and”; and

3 (B) by adding at the end the following:

4 “(K) Oral health services for children and
5 adults.”; and

6 (2) by adding at the end the following:

7 “(6) ORAL HEALTH SERVICES.—For purposes
8 of paragraph (1)(K), the term ‘oral health services’
9 means services (as defined by the Secretary), that
10 are necessary to prevent disease and promote oral
11 health, restore oral structures to health and func-
12 tion, and treat emergency conditions.”.

13 (f) DEMONSTRATION PROGRAM ON TRAINING AND
14 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
15 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
16 VETERANS IN RURAL AND OTHER UNDERSERVED COM-
17 MUNITIES.—

18 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

19 The Secretary of Veterans Affairs may carry out a
20 demonstration program to establish programs to
21 train and employ alternative dental health care pro-
22 viders in order to increase access to dental health
23 care services for veterans who are entitled to such
24 services from the Department of Veterans Affairs

1 and reside in rural and other underserved commu-
2 nities.

3 (2) TELEHEALTH.—For purposes of alternative
4 dental health care providers and other dental care
5 providers who are licensed to provide clinical care,
6 dental services provided under the demonstration
7 program under this section may be administered by
8 such providers through telehealth-enabled collabora-
9 tion and supervision when appropriate and feasible.

10 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
11 VIDERS DEFINED.—In this section, the term “alter-
12 native dental health care providers” has the meaning
13 given that term in section 340G–1(a)(2) of the Pub-
14 lic Health Service Act (42 U.S.C. 256g–1(a)(2)).

15 (4) AUTHORIZATION OF APPROPRIATIONS.—
16 There are authorized to be appropriated such sums
17 as are necessary to carry out the demonstration pro-
18 gram under this subsection.

19 (g) DEMONSTRATION PROGRAM ON TRAINING AND
20 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
21 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
22 MEMBERS OF THE ARMED FORCES AND DEPENDENTS
23 LACKING READY ACCESS TO SUCH SERVICES.—

24 (1) DEMONSTRATION PROGRAM AUTHORIZED.—
25 The Secretary of Defense may carry out a dem-

1 onstration program to establish programs to train
2 and employ alternative dental health care providers
3 in order to increase access to dental health care
4 services for members of the Armed Forces and their
5 dependents who lack ready access to such services,
6 including the following:

7 (A) Members and dependents who reside in
8 rural areas or areas otherwise underserved by
9 dental health care providers.

10 (B) Members of the National Guard and
11 Reserves in active status who are potentially
12 deployable.

13 (2) TELEHEALTH.—For purposes of alternative
14 dental health care providers and other dental care
15 providers who are licensed to provide clinical care,
16 dental services provided under the demonstration
17 program under this section may be administered by
18 such providers through telehealth-enabled collabora-
19 tion and supervision when appropriate and feasible.

20 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
21 VIDERS DEFINED.—In this section, the term “alter-
22 native dental health care providers” has the meaning
23 given that term in section 340G–1(a)(2) of the Pub-
24 lic Health Service Act (42 U.S.C. 256g–1(a)(2)).

1 (4) AUTHORIZATION OF APPROPRIATIONS.—

2 There are authorized to be appropriated such sums
3 as are necessary to carry out the demonstration pro-
4 gram under this subsection.

5 (h) DEMONSTRATION PROGRAM ON TRAINING AND
6 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
7 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
8 PRISONERS WITHIN THE CUSTODY OF THE BUREAU OF
9 PRISONS.—

10 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

11 The Attorney General, acting through the Director
12 of the Bureau of Prisons, may carry out a dem-
13 onstration program to establish programs to train
14 and employ alternative dental health care providers
15 in order to increase access to dental health services
16 for prisoners within the custody of the Bureau of
17 Prisons.

18 (2) TELEHEALTH.—For purposes of alternative
19 dental health care providers and any other dental
20 care providers who are licensed to provide clinical
21 care, dental services provided under the demonstra-
22 tion program under this section may be administered
23 by such providers through telehealth-enabled collabo-
24 ration and supervision when deemed appropriate and
25 feasible.

1 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
2 VIDERS DEFINED.—In this section, the term “alter-
3 native dental health care providers” has the meaning
4 given that term in section 340G–1(a)(2) of the Pub-
5 lic Health Service Act (42 U.S.C. 256g–1(a)(2)).

6 (4) AUTHORIZATION OF APPROPRIATIONS.—
7 There are authorized to be appropriated such sums
8 as are necessary to carry out the demonstration pro-
9 gram under this subsection.

10 (i) DEMONSTRATION PROGRAM ON TRAINING AND
11 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
12 PROVIDERS FOR DENTAL HEALTH CARE SERVICES
13 UNDER THE INDIAN HEALTH SERVICE.—

14 (1) DEMONSTRATION PROGRAM AUTHORIZED.—
15 The Secretary of Health and Human Services, act-
16 ing through the Indian Health Service, may carry
17 out a demonstration program to establish programs
18 to train and employ alternative dental health care
19 providers in order to help eliminate oral health dis-
20 parities and increase access to dental services
21 through health programs operated by the Indian
22 Health Service, Indian Tribes, Tribal organizations,
23 and urban Indian organizations (as those terms are
24 defined in section 4 of the Indian Health Care Im-
25 provement Act (25 U.S.C. 1603)).

1 (2) TELEHEALTH.—For purposes of alternative
2 dental health care providers and any other dental
3 care providers who are licensed to provide clinical
4 care, dental services provided under the demonstra-
5 tion program under this section may be administered
6 by such providers through telehealth-enabled collabo-
7 ration and supervision when deemed appropriate and
8 feasible.

9 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
10 VIDERS DEFINED.—In this section, the term “alter-
11 native dental health care providers” has the meaning
12 given that term in section 340G–1(a)(2) of the Pub-
13 lic Health Service Act (42 U.S.C. 256g–1(a)(2)).

14 (4) AUTHORIZATION OF APPROPRIATIONS.—
15 There are authorized to be appropriated such sums
16 as are necessary to carry out the demonstration pro-
17 gram under this subsection.

18 **Subtitle C—Advancing Health Eq-**
19 **uity Through Payment and De-**
20 **livery Reform**

21 **SEC. 441. SENSE OF CONGRESS.**

22 It is the Sense of Congress that the sustainability of
23 the U.S. health care system hinges on restructuring how
24 health care is paid for, shifting away from paying for the
25 volume of services provided to the value the services pro-

1 vide. High value care is care that provides higher quality
2 care more efficiently, achieving greater health improve-
3 ment and better health outcomes at lower cost (per patient
4 and overall). A high value health care system must deliver
5 timely, accessible, well-coordinated, high quality, culturally
6 centered, and language appropriate care to everyone.
7 Therefore, eliminating health disparities and achieving
8 health equity must be central to efforts to achieve a high
9 value health care system. This will require tailored inter-
10 ventions and targeted investments to address inequities in
11 health and health care to make sure that health care deliv-
12 ery and payment efforts are responsive to and inclusive
13 of the needs of communities of color and other commu-
14 nities experiencing disparities. New models of value-based
15 payment and care delivery should consider the holistic
16 needs of the patient population, including social deter-
17 minants of health and behavioral health needs.

18 **SEC. 442. CENTERS FOR MEDICARE & MEDICAID SERVICES**

19 **QUALITY PAYMENT PROGRAM.**

20 (a) IN GENERAL.—The Centers for Medicare & Med-
21 icaid Services Quality Payment Program, developed
22 through implementation of the Medicare Access and CHIP
23 Reauthorization Act of 2015, should explicitly integrate
24 “achieving health equity” across all measures and activi-
25 ties, including the Merit-based Payment Incentive System

1 and Alternative Payment Models. In addition, CMS should
2 identify limited-English proficient (LEP) persons as a spe-
3 cific underserved group within the program and give high
4 weight to providing language services for non-English
5 speakers. Clinicians can demonstrate performance in this
6 category by developing language assistance plans, pro-
7 viding oral interpretation services, and providing trans-
8 lated documents for the population served or eligible to
9 be served.

10 (b) STRATIFIED DATA.—CMS should include an ex-
11 plicit reference that data stratification and reporting is
12 one way of working to achieve health equity. CMS should
13 require that in reporting this measure, clinicians should
14 stratify clinical quality measures by disparity variables, in-
15 cluding race, ethnicity, preferred language, disability sta-
16 tus, sexual orientation, and gender identity, psychological
17 and behavioral status. Clinicians can use existing demo-
18 graphic data collection fields in CEHRT to do this. Strati-
19 fied data can help clinicians identify and distinguish ef-
20 forts to improve quality from efforts to reduce disparities,
21 which may not correlate without dedicated work. All par-
22 ticipating entities in the Quality Payment Program should
23 adopt 2015 Certified Electronic Health Records Tech-
24 nology as a condition of participating in the program.

1 (c) QUALITY IMPROVEMENT ACTIVITIES.—Further,
2 CMS, upon yearly review of the Quality Payment Pro-
3 gram, should add quality improvement activities that im-
4 plement the Culturally and Linguistically Accessible
5 Standards (CLAS) standards as Improvement Activities.

6 **SEC. 443. DEVELOPMENT AND TESTING OF DISPARITY RE-**
7 **DUCING DELIVERY AND PAYMENT MODELS.**

8 (a) IN GENERAL.—The Center for Medicaid and
9 Medicare Innovation (CMMI) will establish a dedicated
10 fund to identify, pilot, evaluate and scale delivery and pay-
11 ment models that target health disparities among racial
12 and ethnic minorities, including models that support high-
13 value non-medical services that address socially-deter-
14 mined barriers to health including: English proficiency,
15 health literacy, case management, transportation and en-
16 rollment assistance which will help to reduce disparities
17 and impact the overall cost of care.

18 (b) PILOT PROGRAMS.—Pilot and demonstration pro-
19 grams that include partnerships with entities including
20 community based organizations or other non-profit entities
21 to help address socially determined barriers to health and
22 health care will be given priority.

23 (c) ALTERNATIVES.—Require all CMMI funded alter-
24 native delivery and payment models to include measures
25 to assess and track their impact on health disparities,

1 using existing measures such as, but not limited to, the
2 National Quality Forum Healthcare Disparities and Cul-
3 tural Competency Measures, and stratified by race, eth-
4 nicity, English proficiency, gender identity, sexual orienta-
5 tion, and disability status.

6 **SEC. 444. SUPPORTING SAFETY NET AND COMMUNITY-**
7 **BASED PROVIDERS TO COMPETE IN VALUE-**
8 **BASED PAYMENT SYSTEMS.**

9 (a) IN GENERAL.—All proposed pay for performance
10 and alternative payment models, developed and tested by
11 CMMI, or any other HHS agency should be assessed for
12 potential impact on safety net, community based, and crit-
13 ical access providers, including federally qualified health
14 centers.

15 (b) NEW MODELS.—The rollout of new payment
16 models should include training and additional up front re-
17 sources for community based and safety net providers to
18 enable them to participate in them.

19 **Subtitle D—Health Empowerment**
20 **Zones**

21 **SEC. 451. SHORT TITLE.**

22 This subtitle may be cited as the “Health Empower-
23 ment Zone Act of 2018”.

24 **SEC. 452. FINDINGS.**

25 The Congress finds the following:

1 (1) Numerous studies and reports, including
2 the 2015 National Healthcare Disparities Report of
3 the Administration on Healthcare Research and
4 Quality and the 2002 Unequal Treatment Report of
5 the Institute of Medicine, document the extensive-
6 ness to which health disparities exist across the
7 country.

8 (2) These studies have found that, on average,
9 racial and ethnic minorities are disproportionately
10 afflicted with chronic and acute conditions—such as
11 cancer, diabetes, musculoskeletal disease, obesity,
12 and hypertension—and suffer worse health out-
13 comes, worse health status, and higher mortality
14 rates than their White counterparts.

15 (3) Several recent studies also show that health
16 disparities are a function of not only access to health
17 care, but also the social determinants of health—in-
18 cluding the environment, the physical structure of
19 communities, nutrition and food options, educational
20 attainment and health literacy, employment, race,
21 ethnicity, immigration status, geography, and lan-
22 guage preference—that directly and indirectly affect
23 the health, health care, and wellness of individuals
24 and communities.

1 (4) Integrally involving and fully supporting the
2 communities most affected by health inequities in
3 the assessment, planning, launch, and evaluation of
4 health disparity elimination efforts are among the
5 leading recommendations made to adequately ad-
6 dress and ultimately reduce health disparities.

7 (5) Recommendations also include supporting
8 the efforts of community stakeholders from a broad
9 cross section—including, but not limited to local
10 businesses, local departments of commerce, edu-
11 cation, labor, urban planning, and transportation,
12 and community-based and other nonprofit organiza-
13 tions, including national and regional intermediaries
14 with demonstrated capacity to serve low-income
15 urban communities—to find areas of common
16 ground around health disparity elimination and col-
17 laborate to improve the overall health and wellness
18 of a community and its residents.

19 **SEC. 453. DESIGNATION OF HEALTH EMPOWERMENT**
20 **ZONES.**

21 (a) **IN GENERAL.**—At the request of an eligible com-
22 munity partnership, the Secretary may designate an eligi-
23 ble area as a health empowerment zone.

24 (b) **ELIGIBILITY CRITERIA.**—

1 (1) ELIGIBLE COMMUNITY PARTNERSHIP.—A
2 community partnership is eligible to submit a re-
3 quest under this section if the partnership—

4 (A) demonstrates widespread public sup-
5 port from key individuals and entities in the eli-
6 gible area, including members of the target
7 community, State and local governments, non-
8 profit organizations including national and re-
9 gional intermediaries with demonstrated capac-
10 ity to serve low-income urban communities, and
11 community and industry leaders, for designa-
12 tion of the eligible area as a health empower-
13 ment zone; and

14 (B) includes representatives of—

15 (i) a broad cross section of stake-
16 holders and residents from communities in
17 the eligible area experiencing dispropor-
18 tionate disparities in health status and
19 health care; and

20 (ii) organizations, facilities, and insti-
21 tutions that have a history of working
22 within and serving such communities.

23 (2) ELIGIBLE AREA.—An area is eligible to be
24 designated as a health empowerment zone under this
25 section if one or more communities in the area expe-

1 rience disproportionate disparities in health status
2 and health care. In determining whether a commu-
3 nity experiences such disparities, the Secretary shall
4 consider the data collected by the Department of
5 Health and Human Services focusing on the fol-
6 lowing areas:

7 (A) Access to affordable, high-quality
8 health services.

9 (B) The prevalence of disproportionate
10 rates of certain illnesses or diseases including
11 the following:

12 (i) Arthritis, osteoporosis, chronic
13 back conditions, and other musculoskeletal
14 diseases.

15 (ii) Cancer.

16 (iii) Chronic kidney disease.

17 (iv) Diabetes.

18 (v) Injury (intentional and uninten-
19 tional).

20 (vi) Violence (intimate and non-
21 intimate).

22 (vii) Maternal and paternal illnesses
23 and diseases.

24 (viii) Infant mortality.

1 (ix) Mental illness and other disabil-
2 ities.

3 (x) Substance abuse treatment and
4 prevention, including underage drinking.

5 (xi) Nutrition, obesity, and overweight
6 conditions.

7 (xii) Heart disease.

8 (xiii) Hypertension.

9 (xiv) Cerebrovascular disease or
10 stroke.

11 (xv) Tuberculosis.

12 (xvi) HIV/AIDS and other sexually
13 transmitted infections.

14 (xvii) Viral hepatitis.

15 (xviii) Asthma.

16 (xix) Tooth decay and other oral
17 health issues.

18 (C) Within the target community, the his-
19 torical and persistent presence of conditions
20 that have been found to contribute to health
21 disparities including any such conditions re-
22 specting the following:

23 (i) Poverty.

24 (ii) Educational status and the quality
25 of community schools.

- 1 (iii) Income.
- 2 (iv) Access to high-quality affordable
3 health care.
- 4 (v) Work and work environment.
- 5 (vi) Environmental conditions in the
6 community, including with respect to clean
7 water, clean air, and the presence or ab-
8 sence of pollutants.
- 9 (vii) Language and English pro-
10 ficiency.
- 11 (viii) Access to affordable healthy
12 food.
- 13 (ix) Access to ethnically and culturally
14 diverse health and human service providers
15 and practitioners.
- 16 (x) Access to culturally and linguis-
17 tically competent health and human serv-
18 ices and health and human service pro-
19 viders.
- 20 (xi) Health-supporting infrastructure.
- 21 (xii) Health insurance that is ade-
22 quate and affordable.
- 23 (xiii) Race, racism, and bigotry (con-
24 scious and unconscious).
- 25 (xiv) Sexual orientation.

1 (xv) Health literacy.

2 (xvi) Place of residence (such as
3 urban areas, rural areas, and Tribal res-
4 ervations).

5 (xvii) Stress.

6 (c) PROCEDURE.—

7 (1) REQUEST.—A request under subsection (a)
8 shall—

9 (A) describe the bounds of the area to be
10 designated as a health empowerment zone and
11 the process used to select those bounds;

12 (B) demonstrate that the partnership sub-
13 mitting the request is an eligible community
14 partnership described in subsection (b)(1);

15 (C) demonstrate that the area is an eligible
16 area described in subsection (b)(2);

17 (D) include a comprehensive assessment of
18 disparities in health status and health care ex-
19 perience by one or more communities in the
20 area;

21 (E) set forth—

22 (i) a vision and a set of values for the
23 area; and

24 (ii) a comprehensive and holistic set of
25 goals to be achieved in the area through

1 designation as a health empowerment zone;

2 and

3 (F) include a strategic plan and an action
4 plan for achieving the goals described in sub-
5 paragraph (E)(ii).

6 (2) APPROVAL.—Not later than 60 days after
7 the receipt of a request for designation of an area
8 as a health empowerment zone under this section,
9 the Secretary shall approve or disapprove the re-
10 quest.

11 (d) MINIMUM NUMBER.—The Secretary—

12 (1) shall designate not more than 110 health
13 empowerment zones under this section; and

14 (2) shall designate at least one health empower-
15 ment zone in each of the several States, the District
16 of Columbia, and each territory or possession of the
17 United States.

18 **SEC. 454. ASSISTANCE TO THOSE SEEKING DESIGNATION.**

19 At the request of any organization or entity seeking
20 to submit a request under section 453(a), the Secretary
21 shall provide technical assistance, and may award a grant,
22 to assist such organization or entity—

23 (1) to form an eligible community partnership
24 described in section 453(b)(1);

1 (2) to complete a health assessment, including
2 an assessment of health disparities under section
3 453(c)(1)(D); or

4 (3) to prepare and submit a request, including
5 a strategic plan, in accordance with section 453.

6 **SEC. 455. BENEFITS OF DESIGNATION.**

7 (a) **PRIORITY.**—In awarding any competitive grant,
8 a Federal official shall give priority to any applicant
9 that—

10 (1) meets the eligibility criteria for the grant;

11 (2) proposes to use the grant for activities in a
12 health empowerment zone; and

13 (3) demonstrates that such activities will di-
14 rectly and significantly further the goals of the stra-
15 tegic plan approved for such zone under section 453.

16 (b) **GRANTS FOR INITIAL IMPLEMENTATION OF**
17 **STRATEGIC PLAN.**—

18 (1) **IN GENERAL.**—Upon designating an eligible
19 area as a health empowerment zone at the request
20 of an eligible community partnership, the Secretary
21 shall, subject to the availability of appropriations,
22 make a grant to the community partnership for im-
23 plementation of the strategic plan for such zone.

24 (2) **GRANT PERIOD.**—A grant under paragraph
25 (1) for a health empowerment zone shall be for a pe-

1 riod of 2 years and may be renewed, except that the
2 total period of grants under paragraph (1) for such
3 zone may not exceed 10 years.

4 (3) **LIMITATION.**—In awarding grants under
5 this subsection, the Secretary shall not give less pri-
6 ority to an applicant or reduce the amount of a
7 grant because the Secretary rendered technical as-
8 sistance or made a grant to the same applicant
9 under section 454.

10 (4) **REPORTING.**—The Secretary shall establish
11 metrics for measuring the progress of grantees
12 under this subsection and, based on such metrics,
13 require each such grantee to report to the Secretary
14 not less than every 6 months on the progress in im-
15 plementing the strategic plan for the health em-
16 powerment zone.

17 **SEC. 456. DEFINITION.**

18 In this subtitle, the term “Secretary” means the Sec-
19 retary of Health and Human Services, acting through the
20 Administrator of the Health Resources and Services Ad-
21 ministration and the Deputy Assistant Secretary for Mi-
22 nority Health, and in cooperation with the Director of the
23 Office of Community Services and the Director of the Na-
24 tional Institute for Minority Health and Health Dispari-
25 ties.

1 **SEC. 457. AUTHORIZATION OF APPROPRIATIONS.**

2 To carry out this subtitle, there is authorized to be
3 appropriated \$100,000,000 for fiscal year 2019.

4 **Subtitle E—At-Risk Community**
5 **Coverage**

6 **SEC. 461. MEDICAID COVERAGE FOR CITIZENS OF FREELY**
7 **ASSOCIATED STATES.**

8 (a) IN GENERAL.—Section 402(b)(2) of the Personal
9 Responsibility and Work Opportunity Reconciliation Act
10 of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at
11 the end the following new subparagraph:

12 “(G) MEDICAID EXCEPTION FOR CITIZENS
13 OF FREELY ASSOCIATED STATES.—With respect
14 to eligibility for benefits for the designated Fed-
15 eral program defined in paragraph (3)(C) (re-
16 lating to the Medicaid program), section 401(a)
17 and paragraph (1) shall not apply to any indi-
18 vidual who lawfully resides in 1 of the 50 States
19 or the District of Columbia in accordance with
20 the Compacts of Free Association between the
21 Government of the United States and the Gov-
22 ernments of the Federated States of Micro-
23 nesia, the Republic of the Marshall Islands, and
24 the Republic of Palau and shall not apply, at
25 the option of the Governor of Puerto Rico, the
26 Virgin Islands, Guam, the Northern Mariana

1 Islands, or American Samoa as communicated
2 to the Secretary of Health and Human Services
3 in writing, to any individual who lawfully re-
4 sides in the respective territory in accordance
5 with such Compacts.”.

6 (b) EXCEPTION TO 5-YEAR LIMITED ELIGIBILITY.—
7 Section 403(d) of such Act (8 U.S.C. 1613(d)) is amend-
8 ed—

9 (1) in paragraph (1), by striking “or” at the
10 end;

11 (2) in paragraph (2), by striking the period at
12 the end and inserting “; or”; and

13 (3) by adding at the end the following new
14 paragraph:

15 “(3) an individual described in section
16 402(b)(2)(G), but only with respect to the des-
17 ignated Federal program defined in section
18 402(b)(3)(C).”.

19 (c) DEFINITION OF QUALIFIED ALIEN.—Section
20 431(b) of such Act (8 U.S.C. 1641(b)) is amended—

21 (1) in paragraph (6), by striking “; or” at the
22 end and inserting a comma;

23 (2) in paragraph (7), by striking the period at
24 the end and inserting “, or”; and

1 (3) by adding at the end the following new
2 paragraph:

3 “(8) an individual who lawfully resides in the
4 United States in accordance with a Compact of Free
5 Association referred to in section 402(b)(2)(G), but
6 only with respect to the designated Federal program
7 defined in section 402(b)(3)(C) (relating to the Med-
8 icaid program).”.

9 (d) CONFORMING AMENDMENTS.—Section 1108 of
10 the Social Security Act (42 U.S.C. 1308) is amended—

11 (1) in subsection (f), in the matter preceding
12 paragraph (1), by striking “subsection (g)” and in-
13 serting “subsections (g) and (h)”; and

14 (2) by adding at the end the following:

15 “(h) Expenditures for medical assistance provided to
16 an individual described in section 431(b)(8) of the Per-
17 sonal Responsibility and Work Opportunity Reconciliation
18 Act of 1996 shall not be taken into account for purposes
19 of applying payment limits under subsections (f) and
20 (g).”.

21 (e) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to benefits for items and services
23 furnished on or after the date of the enactment of this
24 Act.

1 **SEC. 462. AT-RISK YOUTH MEDICAID PROTECTION.**

2 (a) IN GENERAL.—Section 1902 of the Social Secu-
3 rity Act (42 U.S.C. 1396a) is amended—

4 (1) in subsection (a)—

5 (A) by striking “and” at the end of para-
6 graph (82);

7 (B) by striking the period at the end of
8 paragraph (83) and inserting “; and”; and

9 (C) by inserting after paragraph (83) the
10 following new paragraph:

11 “(84) provide that—

12 “(A) the State shall not terminate eligi-
13 bility for medical assistance under a State plan
14 for an individual who is an eligible juvenile (as
15 defined in subsection (nn)(2)) because the juve-
16 nile is an inmate of a public institution (as de-
17 fined in subsection (nn)(3)), but may suspend
18 coverage during the period the juvenile is such
19 an inmate;

20 “(B) the State shall restore coverage for
21 such medical assistance to such an individual
22 upon the individual’s release from any such
23 public institution, without requiring a new ap-
24 plication from the individual, unless (and until
25 such date as) there is a determination that the

1 individual no longer meets the eligibility re-
2 quirements for such medical assistance; and

3 “(C) the State shall process any applica-
4 tion for medical assistance submitted by, or on
5 behalf of, a juvenile who is an inmate of a pub-
6 lic institution notwithstanding that the juvenile
7 is such an inmate.”; and

8 (2) by adding at the end the following new sub-
9 section:

10 “(nn) JUVENILE; ELIGIBLE JUVENILE; PUBLIC IN-
11 STITUTION.—For purposes of subsection (a)(84) and this
12 subsection:

13 “(1) JUVENILE.—The term ‘juvenile’ means an
14 individual who is—

15 “(A) under 21 years of age; or

16 “(B) is described in subsection
17 (a)(10)(A)(i)(IX).

18 “(2) ELIGIBLE JUVENILE.—The term ‘eligible
19 juvenile’ means a juvenile who is an inmate of a
20 public institution and was eligible for medical assist-
21 ance under the State plan immediately before be-
22 coming an inmate of such a public institution or who
23 becomes eligible for such medical assistance while an
24 inmate of a public institution.

1 “(3) INMATE OF A PUBLIC INSTITUTION.—The
2 term ‘inmate of a public institution’ has the meaning
3 given such term for purposes of applying the sub-
4 division (A) following paragraph (29) of section
5 1905(a), taking into account the exception in such
6 subdivision for a patient of a medical institution.”.

7 (b) NO CHANGE IN EXCLUSION FROM MEDICAL AS-
8 SISTANCE FOR INMATES OF PUBLIC INSTITUTIONS.—
9 Nothing in this section shall be construed as changing the
10 exclusion from medical assistance under the subdivision
11 (A) following paragraph (29) of section 1905(a) of the So-
12 cial Security Act (42 U.S.C. 1396d(a)), including any ap-
13 plicable restrictions on a State submitting claims for Fed-
14 eral financial participation under title XIX of such Act
15 for such assistance.

16 (c) NO CHANGE IN CONTINUITY OF ELIGIBILITY BE-
17 FORE ADJUDICATION OR SENTENCING.—Nothing in this
18 section shall be construed to mandate, encourage, or sug-
19 gest that a State suspend or terminate coverage for indi-
20 viduals before they have been adjudicated or sentenced.

21 (d) EFFECTIVE DATE.—

22 (1) IN GENERAL.—Except as provided in para-
23 graph (2), the amendments made by subsection (a)
24 shall apply to eligibility of juveniles who become in-

1 mates of public institutions on or after the date that
2 is 1 year after the date of the enactment of this Act.

3 (2) RULE FOR CHANGES REQUIRING STATE
4 LEGISLATION.—In the case of a State plan for med-
5 ical assistance under title XIX of the Social Security
6 Act which the Secretary of Health and Human Serv-
7 ices determines requires State legislation (other than
8 legislation appropriating funds) in order for the plan
9 to meet the additional requirements imposed by the
10 amendments made by subsection (a), the State plan
11 shall not be regarded as failing to comply with the
12 requirements of such title solely on the basis of its
13 failure to meet these additional requirements before
14 the first day of the first calendar quarter beginning
15 after the close of the first regular session of the
16 State legislature that begins after the date of the en-
17 actment of this Act. For purposes of the previous
18 sentence, in the case of a State that has a 2-year
19 legislative session, each year of such session shall be
20 deemed to be a separate regular session of the State
21 legislature.

1 **TITLE V—IMPROVING HEALTH**
2 **OUTCOMES FOR WOMEN,**
3 **CHILDREN, AND FAMILIES**

4 **Subtitle A—In General**

5 **SEC. 501. GRANTS TO PROMOTE HEALTH FOR UNDER-**
6 **SERVED COMMUNITIES.**

7 Part Q of title III of the Public Health Service Act
8 (42 U.S.C. 280g et seq.) is amended by adding at the end
9 the following:

10 **“SEC. 399Z-3. GRANTS TO PROMOTE HEALTH FOR UNDER-**
11 **SERVED COMMUNITIES.**

12 “(a) GRANTS AUTHORIZED.—The Secretary, in col-
13 laboration with the Administrator of the Health Resources
14 and Services Administration and other Federal officials
15 determined appropriate by the Secretary, is authorized to
16 award grants to eligible entities—

17 “(1) to promote health for underserved commu-
18 nities, with preference given to projects that benefit
19 racial and ethnic minority women, racial and ethnic
20 minority children, adolescents, and lesbian, gay, bi-
21 sexual, transgender, queer, or questioning commu-
22 nities; and

23 “(2) to strengthen health outreach initiatives in
24 medically underserved communities, including lin-
25 guistically isolated populations.

1 “(b) USE OF FUNDS.—Grants awarded pursuant to
2 subsection (a) may be used to support the activities of
3 community health workers, including such activities—

4 “(1) to educate and provide outreach regarding
5 enrollment in health insurance including the State
6 Children’s Health Insurance Program under title
7 XXI of the Social Security Act, Medicare under title
8 XVIII of such Act, and Medicaid under title XIX of
9 such Act;

10 “(2) to educate and provide outreach in a com-
11 munity setting regarding health problems prevalent
12 among underserved communities, and especially
13 among racial and ethnic minority women, racial and
14 ethnic minority children, adolescents, and lesbian,
15 gay, bisexual, transgender, queer, or questioning
16 communities;

17 “(3) to educate and provide experiential learn-
18 ing opportunities and target risk factors and healthy
19 behaviors that impede or contribute to achieving
20 positive health outcomes, including—

21 “(A) healthy nutrition;

22 “(B) physical activity;

23 “(C) overweight or obesity;

24 “(D) tobacco use;

25 “(E) alcohol and substance use;

1 “(F) injury and violence;

2 “(G) sexual health;

3 “(H) mental health;

4 “(I) musculoskeletal health and arthritis;

5 “(J) dental and oral health;

6 “(K) understanding informed consent; and

7 “(L) stigma;

8 “(4) to promote community wellness and aware-
9 ness; and

10 “(5) to educate and refer target populations to
11 appropriate health care agencies and community-
12 based programs and organizations in order to in-
13 crease access to quality health care services, includ-
14 ing preventive health services.

15 “(c) APPLICATION.—

16 “(1) IN GENERAL.—Each eligible entity that
17 desires to receive a grant under subsection (a) shall
18 submit an application to the Secretary, at such time,
19 in such manner, and accompanied by such additional
20 information as the Secretary may require.

21 “(2) CONTENTS.—Each application submitted
22 pursuant to paragraph (1) shall—

23 “(A) describe the activities for which as-
24 sistance under this section is sought;

1 “(B) contain an assurance that, with re-
2 spect to each community health worker pro-
3 gram receiving funds under the grant awarded,
4 such program provides in-language training and
5 supervision to community health workers to en-
6 able such workers to provide authorized pro-
7 gram activities in (at least) the most commonly
8 used languages within a particular geographic
9 region;

10 “(C) contain an assurance that the appli-
11 cant will evaluate the effectiveness of commu-
12 nity health worker programs receiving funds
13 under the grant;

14 “(D) contain an assurance that each com-
15 munity health worker program receiving funds
16 under the grant will provide culturally com-
17 petent services in the linguistic context most
18 appropriate for the individuals served by the
19 program;

20 “(E) contain a plan to document and dis-
21 seminate project descriptions and results to
22 other States and organizations as identified by
23 the Secretary; and

24 “(F) describe plans to enhance the capac-
25 ity of individuals to utilize health services and

1 health-related social services under Federal,
2 State, and local programs by—

3 “(i) assisting individuals in estab-
4 lishing eligibility under the programs and
5 in receiving the services or other benefits
6 of the programs; and

7 “(ii) providing other services, as the
8 Secretary determines to be appropriate,
9 which may include transportation and
10 translation services.

11 “(d) PRIORITY.—In awarding grants under sub-
12 section (a), the Secretary shall give priority to those appli-
13 cants—

14 “(1) who propose to target geographic areas
15 that—

16 “(A)(i) have a high percentage of residents
17 who are uninsured or underinsured (if the tar-
18 getted geographic area is located in a State that
19 has elected to make medical assistance available
20 under section 1902(a)(10)(A)(i)(VIII) of the
21 Social Security Act to individuals described in
22 such section);

23 “(ii) have a high percentage of under-
24 insured residents in a particular geographic

1 area (if the targeted geographic area is located
2 in a State that has not so elected); or

3 “(iii) have a high number of households ex-
4 periencing extreme poverty; and

5 “(B) have a high percentage of families for
6 whom English is not their primary language or
7 including smaller limited-English-proficient
8 communities within the region that are not oth-
9 erwise reached by linguistically appropriate
10 health services;

11 “(2) with experience in providing health or
12 health-related social services to individuals who are
13 underserved with respect to such services; and

14 “(3) with documented community activity and
15 experience with community health workers.

16 “(e) COLLABORATION WITH ACADEMIC INSTITU-
17 TIONS.—The Secretary shall encourage community health
18 worker programs receiving funds under this section to col-
19 laborate with academic institutions, including minority-
20 serving institutions. Nothing in this section shall be con-
21 strued to require such collaboration.

22 “(f) QUALITY ASSURANCE AND COST EFFECTIVE-
23 NESS.—The Secretary shall establish guidelines for ensur-
24 ing the quality of the training and supervision of commu-
25 nity health workers under the programs funded under this

1 section and for ensuring the cost effectiveness of such pro-
2 grams.

3 “(g) MONITORING.—The Secretary shall monitor
4 community health worker programs identified in approved
5 applications and shall determine whether such programs
6 are in compliance with the guidelines established under
7 subsection (f).

8 “(h) TECHNICAL ASSISTANCE.—The Secretary may
9 provide technical assistance to community health worker
10 programs identified in approved applications with respect
11 to planning, developing, and operating programs under the
12 grant.

13 “(i) REPORT TO CONGRESS.—

14 “(1) IN GENERAL.—Not later than 4 years
15 after the date on which the Secretary first awards
16 grants under subsection (a), the Secretary shall sub-
17 mit to Congress a report regarding the grant
18 project.

19 “(2) CONTENTS.—The report required under
20 paragraph (1) shall include the following:

21 “(A) A description of the programs for
22 which grant funds were used.

23 “(B) The number of individuals served.

24 “(C) An evaluation of—

1 “(i) the effectiveness of these pro-
2 grams;

3 “(ii) the cost of these programs; and

4 “(iii) the impact of the project on the
5 health outcomes of the community resi-
6 dents.

7 “(D) Recommendations for sustaining the
8 community health worker programs developed
9 or assisted under this section.

10 “(E) Recommendations regarding training
11 to enhance career opportunities for community
12 health workers.

13 “(j) DEFINITIONS.—In this section:

14 “(1) COMMUNITY HEALTH WORKER.—The term
15 ‘community health worker’ means an individual who
16 promotes health or nutrition within the community
17 in which the individual resides—

18 “(A) by serving as a liaison between com-
19 munities and health care agencies;

20 “(B) by providing guidance and social as-
21 sistance to community residents;

22 “(C) by enhancing community residents’
23 ability to effectively communicate with health
24 care providers;

1 “(D) by providing culturally and linguis-
2 tically appropriate health or nutrition edu-
3 cation;

4 “(E) by advocating for individual and com-
5 munity health, including dental, oral, mental,
6 and environmental health, or nutrition needs;

7 “(F) by taking into consideration the
8 needs of the communities served, including the
9 prevalence rates of risk factors that impede
10 achieving positive healthy outcomes among
11 women and children, especially among racial
12 and ethnic minority women and children; and

13 “(G) by providing referral and followup
14 services.

15 “(2) COMMUNITY SETTING.—The term ‘commu-
16 nity setting’ means a home or a community organi-
17 zation that serves a population.

18 “(3) ELIGIBLE ENTITY.—The term ‘eligible en-
19 tity’ means—

20 “(A) a unit of State, territorial, local, or
21 Tribal government (including a federally recog-
22 nized Tribe or Alaska Native village); or

23 “(B) a community-based organization.

1 “(4) MEDICALLY UNDERSERVED COMMUNITY.—
2 The term ‘medically underserved community’ means
3 a community—

4 “(A) that has a substantial number of in-
5 dividuals who are members of a medically un-
6 derserved population, as defined by section
7 330(b)(3);

8 “(B) a significant portion of which is a
9 health professional shortage area as designated
10 under section 332; and

11 “(C) that includes populations that are lin-
12 guistically isolated, such as geographic areas
13 with a shortage of health professionals able to
14 provide linguistically appropriate services.

15 “(5) SUPPORT.—The term ‘support’ means the
16 provision of training, supervision, and materials
17 needed to effectively deliver the services described in
18 subsection (b), reimbursement for services, and
19 other benefits.

20 “(6) TARGET POPULATION.—The term ‘target
21 population means’ women of reproductive age, per-
22 sons who identify as lesbian, gay, bisexual,
23 transgender, and/or queer, and people under age 25.

1 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 \$15,000,000 for each of fiscal years 2019 through 2023.”.

4 **SEC. 502. REMOVING BARRIERS TO HEALTH CARE AND NU-**
5 **TRITION ASSISTANCE FOR CHILDREN, PREG-**
6 **NANT PERSONS, AND LAWFULLY PRESENT IN-**
7 **DIVIDUALS.**

8 (a) MEDICAID.—Section 1903(v) of the Social Secu-
9 rity Act (42 U.S.C. 1396b(v)) is amended by striking
10 paragraph (4) and inserting the following new paragraph:

11 “(4)(A) Notwithstanding sections 401(a), 402(b),
12 403, and 421 of the Personal Responsibility and Work Op-
13 portunity Reconciliation Act of 1996 and paragraph (1),
14 payment shall be made to a State under this section for
15 medical assistance furnished to an alien under this title
16 (including an alien described in such paragraph) who
17 meets any of the following conditions:

18 “(i) The alien is otherwise eligible for such as-
19 sistance under the State plan approved under this
20 title (other than the requirement of the receipt of
21 aid or assistance under title IV, supplemental secu-
22 rity income benefits under title XVI, or a State sup-
23 plementary payment) within either or both of the
24 following eligibility categories:

1 “(I) Children under 21 years of age, in-
2 cluding any optional targeted low-income child
3 (as such term is defined in section
4 1905(u)(2)(B)).

5 “(II) Pregnant persons during pregnancy
6 and during the 60-day period beginning on the
7 last day of the pregnancy.

8 “(ii) The alien is lawfully present in the United
9 States.

10 “(B) No debt shall accrue under an affidavit of sup-
11 port against any sponsor of an alien who meets the condi-
12 tions specified in subparagraph (A) on the basis of the
13 provision of medical assistance to such alien under this
14 paragraph and the cost of such assistance shall not be con-
15 sidered as an unreimbursed cost.”.

16 (b) SCHIP.—Subparagraph (J) of section
17 2107(e)(1) of the Social Security Act (42 U.S.C.
18 1397gg(e)(1)) is amended to read as follows:

19 “(J) Paragraph (4) of section 1903(v) (re-
20 lating to coverage of categories of children,
21 pregnant persons, and other lawfully present in-
22 dividuals).”.

23 (c) SUPPLEMENTAL NUTRITION ASSISTANCE.—Not-
24 withstanding sections 401(a), 402(a), and 403(a) of the
25 Personal Responsibility and Work Opportunity Reconcili-

1 ation Act of 1996 (8 U.S.C. 1611(a); 1612(a); 1613(a))
2 and section 6(f) of the Food and Nutrition Act of 2008
3 (7 U.S.C. 2015(f)), persons who are lawfully present in
4 the United States shall be not be ineligible for benefits
5 under the supplemental nutrition assistance program on
6 the basis of their immigration status or date of entry into
7 the United States.

8 (d) ELIGIBILITY FOR FAMILIES WITH CHILDREN.—
9 Section 421(d)(3) of the Personal Responsibility and
10 Work Opportunity Reconciliation Act of 1996 (8 U.S.C.
11 1631(d)(3)) is amended by striking “to the extent that
12 a qualified alien is eligible under section 402(a)(2)(J)”
13 and inserting, “to the extent that a child is a member of
14 a household under the supplemental nutrition assistance
15 program”.

16 (e) ENSURING PROPER SCREENING.—Section
17 11(e)(2)(B) of the Food and Nutrition Act of 2008 (7
18 U.S.C. 2020(e)(2)(B)) is amended—

19 (1) by redesignating clauses (vi) and (vii) as
20 clauses (vii) and (viii); and

21 (2) by inserting after clause (v) the following:

22 “(vi) shall provide a method for imple-
23 menting section 421 of the Personal Re-
24 sponsibility and Work Opportunity Rec-
25 onciliation Act of 1996 (8 U.S.C. 1631)

1 that does not require any unnecessary in-
2 formation from persons who may be ex-
3 empt from that provision;”.

4 **SEC. 503. REPEAL OF DENIAL OF BENEFITS.**

5 Section 115 of the Personal Responsibility and Work
6 Opportunity Reconciliation Act of 1996 (21 U.S.C. 862a)
7 is amended—

8 (1) in subsection (a), by striking paragraph (2);

9 (2) in subsection (b), by striking paragraph (2);

10 and

11 (3) in subsection (e), by striking paragraph (2).

12 **SEC. 504. BIRTH DEFECTS PREVENTION, RISK REDUCTION,**
13 **AND AWARENESS.**

14 (a) **IN GENERAL.**—The Secretary shall establish and
15 implement a birth defects prevention and public awareness
16 program, consisting of the activities described in sub-
17 sections (c) and (d).

18 (b) **DEFINITIONS.**—In this section:

19 (1) The term “maternal” refers to persons who
20 are pregnant or breastfeeding of all gender identi-
21 ties.

22 (2) The term “pregnancy and breastfeeding in-
23 formation services” includes only—

24 (A) information services to provide accu-
25 rate, evidence-based, clinical information re-

1 garding maternal exposures during pregnancy
2 that may be associated with birth defects or
3 other health risks, such as exposures to medica-
4 tions, chemicals, infections, foodborne patho-
5 gens, illnesses, nutrition, or lifestyle factors;

6 (B) information services to provide accu-
7 rate, evidence-based, clinical information re-
8 garding maternal exposures during breast-
9 feeding that may be associated with health risks
10 to a breast-fed infant, such as exposures to
11 medications, chemicals, infections, foodborne
12 pathogens, illnesses, nutrition, or lifestyle fac-
13 tors;

14 (C) the provision of accurate, evidence-
15 based information weighing risks of exposures
16 during breastfeeding against the benefits of
17 breastfeeding; and

18 (D) the provision of information described
19 in subparagraph (A), (B), or (C) through coun-
20 selors, Web sites, fact sheets, telephonic or elec-
21 tronic communication, community outreach ef-
22 forts, or other appropriate means.

23 (3) The term “Secretary” means the Secretary
24 of Health and Human Services, acting through the

1 Director of the Centers for Disease Control and Pre-
2 vention.

3 (c) NATIONWIDE MEDIA CAMPAIGN.—In carrying out
4 subsection (a), the Secretary shall conduct or support a
5 nationwide media campaign to increase awareness among
6 health care providers and at-risk populations about preg-
7 nancy and breastfeeding information services.

8 (d) GRANTS FOR PREGNANCY AND BREASTFEEDING
9 INFORMATION SERVICES.—

10 (1) IN GENERAL.—In carrying out subsection
11 (a), the Secretary shall award grants to State or re-
12 gional agencies or organizations for any of the fol-
13 lowing:

14 (A) INFORMATION SERVICES.—The provi-
15 sion of, or campaigns to increase awareness
16 about, pregnancy and breastfeeding information
17 services.

18 (B) SURVEILLANCE AND RESEARCH.—The
19 conduct or support of—

20 (i) surveillance of or research on—

21 (I) maternal exposures and ma-
22 ternal health conditions that may in-
23 fluence the risk of birth defects, pre-
24 maturity, or other adverse pregnancy
25 outcomes; and

1 (II) maternal exposures that may
2 influence health risks to a breastfed
3 infant; or

4 (ii) networking to facilitate surveil-
5 lance or research described in this sub-
6 paragraph.

7 (2) PREFERENCE FOR CERTAIN STATES.—The
8 Secretary, in making any grant under this sub-
9 section, shall give preference to States, otherwise
10 equally qualified, that have a pregnancy and
11 breastfeeding information service in place.

12 (3) MATCHING FUNDS.—The Secretary may
13 only award a grant under this subsection to a State
14 or regional agency or organization that agrees, with
15 respect to the costs to be incurred in carrying out
16 the grant activities, to make available (directly or
17 through donations from public or private entities)
18 non-Federal funds toward such costs in an amount
19 equal to not less than 25 percent of the amount of
20 the grant.

21 (4) COORDINATION.—The Secretary shall en-
22 sure that activities funded through a grant under
23 this subsection are coordinated, to the maximum ex-
24 tent practicable, with other birth defects prevention
25 and environmental health activities of the Federal

1 Government, including with respect to pediatric envi-
2 ronmental health specialty units and children’s envi-
3 ronmental health centers.

4 (e) EVALUATION.—In furtherance of the program
5 under subsection (a), the Secretary shall provide for an
6 evaluation of pregnancy and breastfeeding information
7 services to identify efficient and effective models of—

8 (1) providing information;

9 (2) raising awareness and increasing knowledge
10 about birth defects prevention measures and tar-
11 geting education to at-risk groups;

12 (3) modifying risk behaviors; or

13 (4) other outcome measures as determined ap-
14 propriate by the Secretary.

15 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
16 out this section, there are authorized to be appropriated
17 \$5,000,000 for fiscal year 2019, \$6,000,000 for fiscal year
18 2020, \$7,000,000 for fiscal year 2021, \$8,000,000 for fis-
19 cal year 2022, and \$9,000,000 for fiscal year 2023.

20 **SEC. 505. PREVENTING MATERNAL DEATHS.**

21 (a) PROGRAM AUTHORIZED.—

22 (1) IN GENERAL.—The Secretary of Health and
23 Human Services, through the Director of the Cen-
24 ters for Disease Control and Prevention, shall estab-

1 lish a grant program under which the Secretary may
2 make grants to States for the purpose of—

3 (A) carrying out the activities described in
4 subsection (b)(1);

5 (B) establishing and sustaining a State
6 maternal mortality review committee, in accord-
7 ance with subsection (b)(2);

8 (C) ensuring that the State department of
9 health carries out the activities described in
10 subsection (b)(3);

11 (D) disseminating the case abstraction
12 form developed under subsection (c); and

13 (E) providing for the public disclosure of
14 information, in accordance with subsection (d).

15 (2) CRITERIA.—The Secretary shall establish
16 criteria for determining eligibility for, and the
17 amount of a grant awarded to, a State under para-
18 graph (1). Such criteria shall provide that in the
19 case of a State that receives a grant under para-
20 graph (1) for a fiscal year and is determined by the
21 Secretary to have not used such grant in accordance
22 with this section, such State may not be eligible for
23 such a grant for any subsequent fiscal year.

24 (b) USE OF FUNDS.—

1 (1) REVIEW OF PREGNANCY-RELATED AND
2 PREGNANCY-ASSOCIATED DEATHS.—With respect to
3 a State that receives a grant under subsection
4 (a)(1), the following shall apply:

5 (A) PROCESS FOR MANDATORY REPORTING
6 OF PREGNANCY-RELATED AND PREGNANCY-AS-
7 SOCIATED DEATHS.—

8 (i) IN GENERAL.—The State, through
9 the State maternal mortality review com-
10 mittee established under subsection (a)(1),
11 shall develop a process that provides for
12 mandatory and confidential case reporting
13 to the State department of health by indi-
14 viduals and entities described in clause (ii)
15 with respect to pregnancy-related and
16 pregnancy-associated deaths.

17 (ii) INDIVIDUALS AND ENTITIES DE-
18 SCRIBED.—Individuals and entities de-
19 scribed in this clause include each of the
20 following:

21 (I) Health care professionals.

22 (II) Medical examiners.

23 (III) Medical coroners.

24 (IV) Hospitals.

25 (V) Birth centers.

1 (VI) Other health care facilities.

2 (VII) Other individuals respon-
3 sible for completing death records.

4 (VIII) Other appropriate individ-
5 uals or entities specified by the Sec-
6 retary.

7 (B) PROCESS FOR VOLUNTARY REPORTING
8 OF PREGNANCY-RELATED AND PREGNANCY-AS-
9 SOCIATED DEATHS.—The State, through the
10 State maternal mortality review committee es-
11 tablished under subsection (a)(1), shall develop
12 a process that provides for voluntary and con-
13 fidential case reporting to the State department
14 of health by family members of the deceased
15 and other individuals on possible pregnancy-re-
16 lated and pregnancy-associated deaths. Such
17 process shall include—

18 (i) making publicly available on the
19 website of the State department of health
20 a telephone number, Internet web link, and
21 email address for such reporting; and

22 (ii) publicizing to local professional or-
23 ganizations, community organizations, and
24 social services agencies the availability of
25 the telephone number, Internet web link,

1 and email address made available under
2 clause (i).

3 (C) IDENTIFICATION OF PREGNANCY-RE-
4 LATED AND PREGNANCY-ASSOCIATED DEATHS
5 BY STATE VITAL STATISTICS UNIT.—The State,
6 through the vital statistics unit of the State,
7 shall annually identify pregnancy-related and
8 pregnancy-associated deaths occurring in such
9 State in the year involved by—

10 (i) matching each death record of a
11 person in such year to a live birth certifi-
12 cate or an infant death record for the pur-
13 pose of identifying deaths of persons that
14 occurred during pregnancy and within one
15 year after the end of a pregnancy;

16 (ii) identifying each death of a person
17 reported during such year as having an un-
18 derlying or contributing cause of death re-
19 lated to pregnancy, regardless of the time
20 that has passed between the end of the
21 pregnancy and the death;

22 (iii) collecting data from medical ex-
23 aminer and coroner reports; and

24 (iv) using any other method the State
25 may devise to identify maternal deaths

1 such as reviewing a random sample of re-
2 ported deaths of persons who could have
3 been pregnant to ascertain cases of preg-
4 nancy-related and pregnancy-associated
5 deaths that are not discernable from a re-
6 view of death records alone.

7 For purposes of effectively collecting and ob-
8 taining data on pregnancy-related and preg-
9 nancy-associated deaths, the State shall adopt
10 the most recent standardized birth and death
11 records, as issued by the National Center for
12 Vital Health Statistics, including the rec-
13 ommended checkbox section for pregnancy on
14 each death record.

15 (D) CASE INVESTIGATION AND DEVELOP-
16 MENT OF CASE SUMMARIES.—

17 (i) IN GENERAL.—Following the re-
18 ceipt of reports by the State department of
19 health pursuant to subparagraph (A) or
20 (B) and the collection of cases of preg-
21 nancy-related and pregnancy-associated
22 deaths by the vital statistics unit of the
23 State under subparagraph (C), the State,
24 through the State maternal mortality re-
25 view committee established under sub-

1 section (a)(1), shall investigate each case,
2 using the case abstraction form described
3 in subsection (c), and prepare a de-identi-
4 fied case summary for each case, which
5 shall be reviewed by the committee and in-
6 cluded in applicable reports. The State de-
7 partment of health or vital statistics unit
8 of the State, as the case may be, shall pro-
9 vide the State maternal mortality review
10 committee with access to the information
11 collected pursuant to subparagraph (A) or
12 (B), or under subparagraph (C), as nec-
13 essary to carry out this subparagraph.

14 (ii) MANDATORY DATA AND INFORMA-
15 TION.—Each case investigation under this
16 subparagraph shall, subject to availability,
17 include data and information obtained
18 through—

19 (I) medical examiner and autopsy
20 reports of the person involved;

21 (II) medical records of the per-
22 son, including such records related to
23 health care prior to pregnancy, pre-
24 natal and postnatal care, labor and
25 delivery care, emergency room care,

1 hospital discharge records, and any
2 care delivered up until the time of
3 death of the person;

4 (III) oral and written interviews
5 of individuals directly involved in the
6 maternal care of the person during
7 and immediately following the preg-
8 nancy of the person, including health
9 care, mental health, and social service
10 providers, as applicable;

11 (IV) socioeconomic and other rel-
12 evant background information about
13 the person;

14 (V) any information collected
15 under subparagraph (C)(i); and

16 (VI) any other information on
17 the cause of death of the person, such
18 as social services and child welfare re-
19 ports.

20 (iii) DISCRETIONARY DATA AND IN-
21 FORMATION.—Each case investigation
22 under this subparagraph may include data
23 and information obtained through oral or
24 written interviews of the family of the per-
25 son.

1 (2) STATE MATERNAL MORTALITY REVIEW
2 COMMITTEES.—

3 (A) MANDATORY ACTIVITIES.—A State
4 maternal mortality review committee established
5 under subsection (a)(1) shall carry out the fol-
6 lowing activities:

7 (i) Develop the processes described in
8 subparagraphs (A) and (B) of paragraph
9 (1).

10 (ii) Review the data and information
11 collected by the vital statistics unit of the
12 State under paragraph (1)(C) regarding
13 pregnancy-related and pregnancy-associ-
14 ated deaths to identify trends, patterns,
15 and disparities in adverse outcomes and
16 address medical, non-medical, and system-
17 related factors that may have contributed
18 to such pregnancy-related and pregnancy-
19 associated deaths and disparities.

20 (iii) Carry out the activities described
21 in paragraph (1)(D).

22 (iv) Develop recommendations, based
23 on the case summaries prepared under
24 paragraph (1)(D) and the data and infor-
25 mation collected under paragraph (1)(C),

1 to improve maternal care, social and health
2 services, and public health policy and insti-
3 tutions, including improving access to ma-
4 ternal care and social and health services
5 and identifying disparities in maternal care
6 and outcomes.

7 (B) DISCRETIONARY ACTIVITIES.—

8 (i) IN GENERAL.—A State maternal
9 mortality review committee established
10 under subsection (a)(1) may, while subject
11 to confidentiality requirements, present
12 findings and recommendations based on
13 the case summaries prepared under para-
14 graph (1)(D) directly to a health care facil-
15 ity or its local or State professional organi-
16 zation for the purpose of—

17 (I) instituting policy changes,
18 educational activities, and improve-
19 ments in the quality of care provided
20 by the facility; and

21 (II) exploring and forming re-
22 gional collaborations.

23 (ii) INVESTIGATION OF CASES OF SE-
24 VERE MATERNAL MORBIDITY.—A State
25 maternal mortality review committee may

1 investigate cases of severe maternal mor-
2 bidity and any such investigation may in-
3 clude data and information obtained
4 through—

5 (I) identified patient registries;

6 or

7 (II) oral or written interviews of
8 the person concerned and the family
9 of such person.

10 (C) COMPOSITION OF STATE MATERNAL
11 MORTALITY REVIEW COMMITTEES.—

12 (i) IN GENERAL.—A State maternal
13 mortality review committee established
14 under subsection (a)(1) shall be multidisci-
15 plinary and diverse. Membership on the
16 State maternal mortality review committee
17 shall be reviewed annually by the State de-
18 partment of health to ensure that member-
19 ship representation requirements are being
20 fulfilled in accordance with this subpara-
21 graph.

22 (ii) REQUIRED MEMBERSHIP.—Each
23 State maternal mortality review committee
24 shall include—

- 1 (I) representatives from medical
2 specialties providing care to pregnant
3 and postpartum patients, including
4 obstetricians (including generalists
5 and maternal fetal medicine special-
6 ists) and family practice physicians;
- 7 (II) certified nurse midwives, cer-
8 tified midwives, and advanced practice
9 nurses;
- 10 (III) hospital-based registered
11 nurses;
- 12 (IV) representatives of the ma-
13 ternal and child health department of
14 the State department of health;
- 15 (V) social service providers or so-
16 cial workers, including those with ex-
17 perience working with communities di-
18 verse with respect to race, ethnicity,
19 and limited-English proficiency;
- 20 (VI) chief medical examiners or
21 designees;
- 22 (VII) facility representatives,
23 such as from hospitals or birth cen-
24 ters;

1 (VIII) patient advocates, commu-
2 nity maternal health organizations,
3 and minority advocacy groups that
4 represent those diverse racial and eth-
5 nic communities within the State that
6 are the most affected by pregnancy-
7 related or pregnancy-associated deaths
8 and by a lack of access to maternal
9 health care services; and

10 (IX) representatives of the de-
11 partments of health or public health
12 of major cities in the State.

13 (iii) DISCRETIONARY MEMBERSHIP.—
14 Each State maternal mortality review com-
15 mittee may also include representatives
16 from other relevant academic, health, so-
17 cial service, or policy professions or com-
18 munity organizations on an ongoing basis,
19 or as needed, as determined beneficial by
20 the committee, including—

21 (I) anesthesiologists;

22 (II) emergency physicians;

23 (III) pathologists;

24 (IV) epidemiologists;

25 (V) intensivists;

- 1 (VI) nutritionists;
2 (VII) mental health professionals;
3 (VIII) substance use disorder
4 treatment specialists;
5 (IX) representatives of relevant
6 patient and provider advocacy groups;
7 (X) academics;
8 (XI) paramedics; and
9 (XII) risk management special-
10 ists.

11 (iv) STAFF.—Staff of each State ma-
12 ternal mortality review committee shall in-
13 clude—

14 (I) vital health statisticians, ma-
15 ternal child health statisticians, or
16 epidemiologists;

17 (II) a coordinator of the State
18 maternal mortality review committee,
19 to be designated by the State; and

20 (III) administrative staff.

21 (D) OPTION FOR STATES TO ESTABLISH
22 REGIONAL MATERNAL MORTALITY REVIEW COM-
23 MITTEES.—States may choose to partner with
24 one or more neighboring States to carry out the
25 activities required of a State maternal mortality

1 review committee under this section. In such a
2 case, with respect to the States in such a part-
3 nership, any requirement under this section re-
4 lating to the reporting of information related to
5 such activities shall be deemed to be fulfilled by
6 each such State if a single such report is sub-
7 mitted for the partnership.

8 (E) TREATMENT AS PUBLIC HEALTH AU-
9 THORITY FOR PURPOSES OF HIPAA.—For pur-
10 poses of applying HIPAA privacy and security
11 law (as defined in section 3009(a)(2) of the
12 Public Health Service Act (42 U.S.C. 300jj–
13 19)), each State maternal mortality review com-
14 mittee and regional maternal mortality review
15 committee established under subsection (a)(1)
16 or subsection (b)(2)(D), as the case may be,
17 shall be deemed to be a public health authority
18 described in section 164.501 (and referenced in
19 section 164.512(b)(1)(i)) of title 45, Code of
20 Federal Regulations (or any successor regula-
21 tion), carrying out public health activities and
22 purposes described in such section
23 164.512(b)(1)(i) (or any such successor regula-
24 tion).

1 (3) STATE DEPARTMENT OF HEALTH ACTIVI-
2 TIES.—With respect to a State that receives a grant
3 under subsection (a)(1), the State department of
4 health shall—

5 (A) in consultation with the State maternal
6 mortality review committee and in conjunction
7 with relevant professional organizations and pa-
8 tient advocacy organizations, develop a plan for
9 ongoing health care provider education, based
10 on the findings and recommendations of the
11 committee, in order to improve the quality of
12 maternal care; and

13 (B) take steps to widely disseminate the
14 findings and recommendations of the State ma-
15 ternal mortality review committee and imple-
16 ment the recommendations of the committee.

17 (c) CASE ABSTRACTION FORM.—

18 (1) DISSEMINATION.—The Director of the Cen-
19 ters for Disease Control and Prevention shall dis-
20 seminate a uniform case abstraction form to States
21 and State maternal mortality review committees for
22 the purpose of—

23 (A) ensuring that the data and information
24 collected and reviewed by such committees can
25 be pooled for review by the Department of

1 Health and Human Services and its agencies;
2 and

3 (B) preserving the uniformity of the infor-
4 mation collected for Federal public health pur-
5 poses.

6 (2) PERMISSIBLE STATE MODIFICATION.—Each
7 State may modify the form developed under para-
8 graph (1) for implementation and use by such State
9 or by the State maternal mortality review committee
10 of such State by including on such form additional
11 information to be collected, but may not alter the
12 standard questions on such form, in order to ensure
13 that the information can be collected and reviewed
14 centrally at the Federal level.

15 (d) PUBLIC DISCLOSURE OF INFORMATION.—

16 (1) IN GENERAL.—For fiscal year 2019, or a
17 subsequent fiscal year, each State receiving a grant
18 under this section for such year shall, subject to
19 paragraph (3), provide for the public disclosure, and
20 submission to the information clearinghouse estab-
21 lished under paragraph (2), of the information in-
22 cluded in the report of the State under subsection
23 (f)(1) for such year.

24 (2) INFORMATION CLEARINGHOUSE.—The Sec-
25 retary shall establish an information clearinghouse,

1 to be administered by the Director of the Centers for
2 Disease Control and Prevention, that will maintain
3 findings and recommendations submitted pursuant
4 to paragraph (1) and provide such findings and rec-
5 ommendations for public review and research pur-
6 poses by State departments of health, State mater-
7 nal mortality review committees, health providers
8 and institutions, and national patient and provider
9 advocacy groups.

10 (3) CONFIDENTIALITY OF INFORMATION.—In
11 no case may any individually identifiable health in-
12 formation be provided to the public, or submitted to
13 the information clearinghouse, under this subsection.

14 (e) CONFIDENTIALITY OF PROCEEDINGS OF STATE
15 MATERNAL MORTALITY REVIEW COMMITTEES.—

16 (1) IN GENERAL.—All proceedings and activi-
17 ties of a State maternal mortality review committee
18 established under subsection (a)(1), opinions of
19 members of such a committee formed as a result of
20 such proceedings and activities, and records ob-
21 tained, created, or maintained pursuant to this sec-
22 tion, including records of interviews, written reports,
23 and statements procured by the Department of
24 Health and Human Services or by any other person,
25 agency, or organization acting jointly with the De-

1 partment, in connection with morbidity and mor-
2 tality reviews under this section, shall be confidential
3 and may not be subject to discovery, subpoena, or
4 introduction into evidence in any civil, criminal, leg-
5 islative, or other proceeding. Such records shall not
6 be open to public inspection.

7 (2) TESTIMONY OF MEMBERS OF COM-
8 MITTEE.—

9 (A) IN GENERAL.—Members of a State
10 maternal mortality review committee established
11 under subsection (a)(1) may not be questioned
12 in any civil, criminal, legislative, or other pro-
13 ceeding regarding information presented in, or
14 opinions formed as a result of, a meeting or
15 communication of the committee.

16 (B) CLARIFICATION.—Nothing in this sub-
17 section may be construed to prevent a member
18 of a State maternal mortality review committee
19 established under subsection (a)(1) from testi-
20 fying regarding information that was obtained
21 independent of such member's participation on
22 the committee, or public information.

23 (3) AVAILABILITY OF INFORMATION FOR RE-
24 SEARCH PURPOSES.—Nothing in this subsection may
25 prohibit a State maternal mortality review com-

1 mittee established under subsection (a)(1) or the De-
2 partment of Health and Human Services from pub-
3 lishing statistical compilations and research reports
4 that—

5 (A) are based on confidential information,
6 relating to morbidity and mortality reviews
7 under this section; and

8 (B) do not contain identifying information
9 or any other information that could be used to
10 ultimately identify the individuals concerned.

11 (f) REPORTS.—

12 (1) STATE REPORTS.—Not later than one year
13 after the end of fiscal year 2019, and each subse-
14 quent fiscal year, each State maternal mortality re-
15 view committee established under subsection (a)(1)
16 and receiving a grant under this section for such
17 year, shall submit to the Director of the Centers for
18 Disease Control and Prevention a report on the find-
19 ings and recommendations of such committee and
20 information on the implementation of such rec-
21 ommendations during such year.

22 (2) ANNUAL REPORTS TO CONGRESS.—Not
23 later than 60 days after the deadline for State re-
24 ports under paragraph (1) for fiscal year 2019, and
25 each subsequent fiscal year, the Secretary of Health

1 and Human Services shall submit to Congress a re-
2 port on—

3 (A) the findings, recommendations, and
4 implementation information submitted by any
5 State pursuant to paragraph (1); and

6 (B) the status of pregnancy-related and
7 pregnancy-associated deaths in the United
8 States, including recommendations on methods
9 to prevent such deaths in the United States.

10 (g) DEFINITIONS.—In this section:

11 (1) The term “pregnancy-associated death”
12 means the death of a person while pregnant or dur-
13 ing the one-year period following the date of the end
14 of pregnancy, irrespective of the cause of such death.

15 (2) The term “pregnancy-related death” means
16 the death of a person while pregnant or during the
17 one-year period following the date of the end of
18 pregnancy, irrespective of the duration of the preg-
19 nancy, from any cause related to, or aggravated by,
20 the pregnancy or its management, excluding any ac-
21 cidental or incidental cause.

22 (3) The term “severe maternal morbidity”
23 means the physical and psychological conditions that
24 result from, or are aggravated by, pregnancy and
25 have an adverse effect on the health of a person.

1 (4) The term “State” means each of the 50
2 States, the District of Columbia, and each of the
3 territories.

4 (5) The term “vital statistics unit” means the
5 entity that is responsible for maintaining vital
6 records for a State, including official records of live
7 births, deaths, fetal deaths, marriages, divorces, and
8 annulments.

9 (h) AUTHORIZATION OF APPROPRIATIONS.—There is
10 authorized to be appropriated to carry out this section
11 \$7,000,000 for each of fiscal years 2019 through 2023.

12 **SEC. 506. ELIMINATING DISPARITIES IN MATERNITY**
13 **HEALTH OUTCOMES.**

14 Part B of title III of the Public Health Service Act
15 is amended by inserting after section 317V of such Act,
16 as added, the following new section:

17 **“SEC. 317W. ELIMINATING DISPARITIES IN MATERNAL**
18 **HEALTH OUTCOMES.**

19 “(a) IN GENERAL.—The Secretary shall, in consulta-
20 tion with relevant national stakeholder organizations, such
21 as national medical specialty organizations, national ma-
22 ternal child health organizations, national patient advoca-
23 cacy organizations, and national health disparity organiza-
24 tions, carry out the following activities to eliminate dis-
25 parities in maternal health outcomes:

1 “(1) Conduct research into the determinants
2 and the distribution of disparities in maternal care,
3 health risks, and health outcomes, and improve the
4 capacity of the performance measurement infrastruc-
5 ture to measure such disparities.

6 “(2) Expand access to health care services, re-
7 sources, and information that have been dem-
8 onstrated to improve the quality and outcomes of
9 maternity care for vulnerable populations.

10 “(3) Establish a demonstration project to com-
11 pare the effectiveness of interventions to reduce dis-
12 parities in maternity services and outcomes and to
13 implement and assess effective interventions.

14 “(b) SCOPE AND SELECTION OF STATES FOR DEM-
15 ONSTRATION PROJECT.—The demonstration project
16 under subsection (a)(3) shall be conducted in no more
17 than 8 States, which shall be selected by the Secretary
18 based on—

19 “(1) applications submitted by States, which
20 specify which regions and populations the State in-
21 volved will serve under the demonstration project;

22 “(2) criteria designed by the Secretary to en-
23 sure that, as a whole, the demonstration project is,
24 to the greatest extent possible, representative of the

1 demographic and geographic composition of commu-
2 nities most affected by disparities;

3 “(3) criteria designed by the Secretary to en-
4 sure that a variety of models are tested through the
5 demonstration project and that such models include
6 interventions that have an existing evidence base for
7 effectiveness; and

8 “(4) criteria designed by the Secretary to en-
9 sure that the demonstration projects and models will
10 be carried out in consultation with local and regional
11 provider organizations, such as community health
12 centers, hospital systems, and medical societies rep-
13 resenting providers of maternity services.

14 “(c) DURATION OF DEMONSTRATION PROJECT.—
15 The demonstration project under subsection (a)(3) shall
16 begin on January 1, 2019, and end on December 31,
17 2022.

18 “(d) GRANTS FOR EVALUATION AND MONITORING.—
19 The Secretary may make grants to States and health care
20 providers participating in the demonstration project under
21 subsection (a)(3) for the purpose of collecting data nec-
22 essary for the evaluation and monitoring of such project.

23 “(e) REPORTS.—

24 “(1) STATE REPORTS.—Each State that par-
25 ticipates in the demonstration project under sub-

1 section (a)(3) shall report to the Secretary, in a
2 time, form, and manner specified by the Secretary,
3 the data necessary to—

4 “(A) monitor the—

5 “(i) outcomes of the project;

6 “(ii) costs of the project; and

7 “(iii) quality of maternity care pro-
8 vided under the project; and

9 “(B) evaluate the rationale for the selec-
10 tion of the items and services included in any
11 bundled payment made by the State under the
12 project.

13 “(2) FINAL REPORT.—Not later than December
14 31, 2022, the Secretary shall submit to Congress a
15 report on the results of the demonstration project
16 under subsection (a)(3).”.

17 **SEC. 507. DECREASING THE RISK FACTORS FOR SUDDEN**
18 **UNEXPECTED INFANT DEATH AND SUDDEN**
19 **UNEXPLAINED DEATH IN CHILDHOOD.**

20 (a) ESTABLISHMENT.—The Secretary of Health and
21 Human Services, acting through the Administrator of the
22 Health Resources and Services Administration and in con-
23 sultation with the Director of the Centers for Disease Con-
24 trol and Prevention and the Director of the National Insti-
25 tutes of Health (in this section referred to as the “Sec-

1 retary”), shall establish and implement a culturally and
2 linguistically competent public health awareness and edu-
3 cation campaign to provide information that is focused on
4 decreasing the risk factors for sudden unexpected infant
5 death and sudden unexplained death in childhood, includ-
6 ing educating individuals about safe sleep environments,
7 sleep positions, and reducing exposure to smoking during
8 pregnancy and after birth.

9 (b) TARGETED POPULATIONS.—The campaign under
10 subsection (a) shall be designed to reduce health dispari-
11 ties through the targeting of populations with high rates
12 of sudden unexpected infant death and sudden unex-
13 plained death in childhood.

14 (c) CONSULTATION.—In establishing and imple-
15 menting the campaign under subsection (a), the Secretary
16 shall consult with national organizations representing
17 health care providers, including nurses and physicians,
18 parents, child care providers, children’s advocacy and safe-
19 ty organizations, maternal and child health programs, nu-
20 trition professionals focusing on women, infants, and chil-
21 dren, and other individuals and groups determined nec-
22 essary by the Secretary for such establishment and imple-
23 mentation.

24 (d) GRANTS.—

1 (1) IN GENERAL.—In carrying out the cam-
2 paign under subsection (a), the Secretary shall
3 award grants to national organizations, State and
4 local health departments, and community-based or-
5 ganizations for the conduct of education and out-
6 reach programs for nurses, parents, child care pro-
7 viders, public health agencies, and community orga-
8 nizations.

9 (2) APPLICATION.—To be eligible to receive a
10 grant under paragraph (1), an entity shall submit to
11 the Secretary an application at such time, in such
12 manner, and containing such information as the Sec-
13 retary may require.

14 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
15 authorized to be appropriated to carry out this section
16 such sums as may be necessary for each of fiscal years
17 2019 through 2023.

18 **SEC. 508. REDUCING UNINTENDED TEENAGE PREG-**
19 **NANCIES.**

20 Title III of the Public Health Service Act (42 U.S.C.
21 241 et seq.) is amended by adding at the end the following
22 new part:

1 **“PART W—YOUTH ACCESS TO SEXUAL HEALTH**
2 **SERVICES**
3 **“SEC. 39900. AUTHORIZATION OF GRANTS TO SUPPORT**
4 **THE ACCESS OF MARGINALIZED YOUTH TO**
5 **SEXUAL HEALTH SERVICES.**

6 “(a) GRANTS.—The Secretary of Health and Human
7 Services may award grants on a competitive basis to eligi-
8 ble entities to support the access of marginalized youth
9 to sexual health services.

10 “(b) USE OF FUNDS.—An eligible entity that is
11 awarded a grant under subsection (a) may use the funds
12 to—

13 “(1) provide medically accurate and complete
14 and age-, developmentally, and culturally appro-
15 priate sexual health information to marginalized
16 youth, including information on how to access sexual
17 health services;

18 “(2) promote effective communication regarding
19 sexual health among marginalized youth;

20 “(3) promote and support better health, edu-
21 cation, and economic opportunities for school-age
22 parents; and

23 “(4) train individuals who work with
24 marginalized youth to promote—

25 “(A) the prevention of unintended preg-
26 nancy;

1 “(B) the prevention of sexually transmitted
2 infections, including the human immuno-
3 deficiency virus (HIV);

4 “(C) healthy relationships; and

5 “(D) the development of safe and sup-
6 portive environments.

7 “(c) APPLICATION.—To be awarded a grant under
8 subsection (a), an eligible entity shall submit an applica-
9 tion to the Secretary at such time, in such manner, and
10 containing such information as the Secretary may require.

11 “(d) PRIORITY.—In awarding grants under sub-
12 section (a), the Secretary shall give priority to eligible enti-
13 ties—

14 “(1) with a history of supporting the access of
15 marginalized youth to sexuality education or sexual
16 health services; and

17 “(2) that plan to serve marginalized youth that
18 are not served by Federal adolescent programs for
19 the prevention of pregnancy, HIV, and other sexu-
20 ally transmitted infections.

21 “(e) REQUIREMENTS.—The Secretary may not award
22 a grant under subsection (a) to an eligible entity unless—

23 “(1) such eligible entity has formed a partner-
24 ship with a community organization; and

25 “(2) such eligible entity agrees—

1 “(A) to employ a scientifically effective
2 strategy;

3 “(B) that all information provided to
4 marginalized youth will be—

5 “(i) age- and developmentally appro-
6 priate;

7 “(ii) medically accurate and complete;

8 “(iii) scientifically based; and

9 “(iv) provided in the language and
10 cultural context that is most appropriate
11 for the individuals served by the eligible
12 entity; and

13 “(C) that for each year the eligible entity
14 receives grant funds under subsection (a), the
15 eligible entity will submit to the Secretary an
16 annual report that includes—

17 “(i) the use of grant funds by the eli-
18 gible entity;

19 “(ii) how the use of grant funds has
20 increased the access of marginalized youth
21 to sexual health services; and

22 “(iii) such other information as the
23 Secretary may require.

24 “(f) PUBLICATION AND EVALUATIONS.—

1 “(1) EVALUATIONS.—Not less than once every
2 two years after the date of the enactment of this
3 Act, the Secretary shall evaluate the effectiveness of
4 whichever of the following is greater:

5 “(A) Eight grants awarded under sub-
6 section (a).

7 “(B) Ten percent of the grants awarded
8 under subsection (a).

9 “(2) PUBLICATION.—The Secretary shall make
10 available to the public—

11 “(A) the evaluations required under para-
12 graph (1); and

13 “(B) the reports required under subsection
14 (e)(2)(C).

15 “(g) LIMITATIONS.—No funds made available to an
16 eligible entity under this section may be used by such enti-
17 ty to provide access to sexual health services that—

18 “(1) withhold sexual health-promoting or life-
19 saving information;

20 “(2) are medically inaccurate or have been sci-
21 entifically shown to be ineffective;

22 “(3) promote gender stereotypes;

23 “(4) are insensitive or unresponsive to the
24 needs of young people, including—

1 “(A) youth with varying gender identities,
2 gender expressions, and sexual orientations;

3 “(B) sexually active youth;

4 “(C) pregnant or parenting youth;

5 “(D) survivors of sexual abuse or assault;

6 and

7 “(E) youth of all physical, developmental,
8 and mental abilities; or

9 “(5) are inconsistent with the ethical impera-
10 tives of medicine and public health.

11 “(h) TRANSFER OF FUNDS.—Any unobligated bal-
12 ance of funds made available under section 510(d) of the
13 Social Security Act (42 U.S.C. 710(d)) (as in effect on
14 the day before the date of the enactment of this Act) are
15 hereby transferred and made available to the Secretary to
16 carry out this Act. The amounts transferred and made
17 available to carry out this Act shall remain available until
18 expended.

19 “(i) DEFINITIONS.—In this section:

20 “(1) COMMUNITY ORGANIZATION.—The term
21 ‘community organization’ includes a State or local
22 health or education agency, public school, youth-fo-
23 cused organization that is faith-based and commu-
24 nity-based, juvenile justice entity, or other organiza-
25 tion that provides confidential and appropriate sexu-

1 ality education or sexual health services to
2 marginalized youth.

3 “(2) ELIGIBLE ENTITY.—The term ‘eligible en-
4 tity’ includes a State or local health or education
5 agency, public school, nonprofit organization, hos-
6 pital, or an Indian Tribe or Tribal organization (as
7 such terms are defined in section 4 of the Indian
8 Self-Determination and Education Assistance Act
9 (25 U.S.C. 5304)).

10 “(3) MARGINALIZED YOUTH.—The term
11 ‘marginalized youth’ means a person under the age
12 of 26 that is disadvantaged by underlying structural
13 barriers and social inequity.

14 “(4) MEDICALLY ACCURATE AND COMPLETE.—
15 The term ‘medically accurate and complete’, when
16 used with respect to information, means information
17 that—

18 “(A) is supported by research and recog-
19 nized as accurate, objective, and complete by
20 leading medical, psychological, psychiatric, or
21 public health organizations and agencies; and

22 “(B) does not withhold any information re-
23 lating to the effectiveness and benefits of cor-
24 rect and consistent use of condoms or other

1 contraceptives and pregnancy prevention meth-
2 ods.

3 “(5) SCIENTIFICALLY EFFECTIVE STRATEGY.—

4 The term ‘scientifically effective strategy’ means a
5 strategy that—

6 “(A) is widely recognized by leading med-
7 ical and public health agencies as effective in
8 promoting sexual health awareness and healthy
9 behavior; and

10 “(B) either—

11 “(i) has been demonstrated to be ef-
12 fective on the basis of rigorous scientific
13 research; or

14 “(ii) incorporates characteristics of ef-
15 fective programs.

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

18 “(7) SEXUAL HEALTH SERVICES.—The term
19 ‘sexual health services’ includes—

20 “(A) sexual health information, education,
21 and counseling;

22 “(B) contraception;

23 “(C) emergency contraception;

1 “(D) condoms and other barrier methods
2 to prevent pregnancy or sexually transmitted in-
3 fections;

4 “(E) routine gynecological care, including
5 human papillomavirus (HPV) vaccines and can-
6 cer screenings;

7 “(F) pre-exposure prophylaxis or post-ex-
8 posure prophylaxis;

9 “(G) mental health services;

10 “(H) sexual assault survivor services; and

11 “(I) other prevention, care, or treatment.”.

12 **SEC. 509. GESTATIONAL DIABETES.**

13 Part B of title III of the Public Health Service Act
14 (42 U.S.C. 243 et seq.) is amended by adding after section
15 317H the following:

16 **“SEC. 317H-1. GESTATIONAL DIABETES.**

17 “(a) UNDERSTANDING AND MONITORING GESTA-
18 TIONAL DIABETES.—

19 “(1) IN GENERAL.—The Secretary, acting
20 through the Director of the Centers for Disease
21 Control and Prevention, in consultation with the Di-
22 abetes Mellitus Interagency Coordinating Committee
23 established under section 429 and representatives of
24 appropriate national health organizations, shall de-
25 velop a multisite gestational diabetes research

1 project within the diabetes program of the Centers
2 for Disease Control and Prevention to expand and
3 enhance surveillance data and public health research
4 on gestational diabetes.

5 “(2) AREAS TO BE ADDRESSED.—The research
6 project developed under paragraph (1) shall ad-
7 dress—

8 “(A) procedures to establish accurate and
9 efficient systems for the collection of gestational
10 diabetes data within each State and common-
11 wealth, territory, or possession of the United
12 States;

13 “(B) the progress of collaborative activities
14 with the National Vital Statistics System, the
15 National Center for Health Statistics, and
16 State health departments with respect to the
17 standard birth certificate, in order to improve
18 surveillance of gestational diabetes;

19 “(C) postpartum methods of tracking indi-
20 viduals with gestational diabetes after delivery
21 as well as targeted interventions proven to
22 lower the incidence of type 2 diabetes in that
23 population;

24 “(D) variations in the distribution of diag-
25 nosed and undiagnosed gestational diabetes,

1 and of impaired fasting glucose tolerance and
2 impaired fasting glucose, within and among
3 groups of pregnant individuals; and

4 “(E) factors and culturally sensitive inter-
5 ventions that influence risks and reduce the in-
6 cidence of gestational diabetes and related com-
7 plications during childbirth, including cultural,
8 behavioral, racial, ethnic, geographic, demo-
9 graphic, socioeconomic, and genetic factors.

10 “(3) REPORT.—Not later than 2 years after the
11 date of the enactment of this section, and annually
12 thereafter, the Secretary shall generate a report on
13 the findings and recommendations of the research
14 project including prevalence of gestational diabetes
15 in the multisite area and disseminate the report to
16 the appropriate Federal and non-Federal agencies.

17 “(b) EXPANSION OF GESTATIONAL DIABETES RE-
18 SEARCH.—

19 “(1) IN GENERAL.—The Secretary shall expand
20 and intensify public health research regarding gesta-
21 tional diabetes. Such research may include—

22 “(A) developing and testing novel ap-
23 proaches for improving postpartum diabetes
24 testing or screening and for preventing type 2

1 diabetes in individuals who can become preg-
2 nant with a history of gestational diabetes; and

3 “(B) conducting public health research to
4 further understanding of the epidemiologic,
5 socioenvironmental, behavioral, translation, and
6 biomedical factors and health systems that in-
7 fluence the risk of gestational diabetes and the
8 development of type 2 diabetes in individuals
9 who can become pregnant with a history of ges-
10 tational diabetes.

11 “(2) AUTHORIZATION OF APPROPRIATIONS.—

12 There is authorized to be appropriated to carry out
13 this subsection \$5,000,000 for each of fiscal years
14 2019 through 2023.

15 “(c) DEMONSTRATION GRANTS TO LOWER THE
16 RATE OF GESTATIONAL DIABETES.—

17 “(1) IN GENERAL.—The Secretary, acting
18 through the Director of the Centers for Disease
19 Control and Prevention, shall award grants, on a
20 competitive basis, to eligible entities for demonstra-
21 tion projects that implement evidence-based inter-
22 ventions to reduce the incidence of gestational diabe-
23 tes, the recurrence of gestational diabetes in subse-
24 quent pregnancies, and the development of type 2 di-

1 abetes in individuals who can become pregnant with
2 a history of gestational diabetes.

3 “(2) PRIORITY.—In making grants under this
4 subsection, the Secretary shall give priority to
5 projects focusing on—

6 “(A) helping individuals who can become
7 pregnant who have 1 or more risk factors for
8 developing gestational diabetes;

9 “(B) working with individuals who can be-
10 come pregnant with a history of gestational dia-
11 betes during a previous pregnancy;

12 “(C) providing postpartum care for indi-
13 viduals who can become pregnant with gesta-
14 tional diabetes;

15 “(D) tracking cases where individuals who
16 can become pregnant with a history of gesta-
17 tional diabetes developed type 2 diabetes;

18 “(E) educating mothers with a history of
19 gestational diabetes about the increased risk of
20 their child developing diabetes;

21 “(F) working to prevent gestational diabe-
22 tes and prevent or delay the development of
23 type 2 diabetes in individuals who can become
24 pregnant with a history of gestational diabetes;
25 and

1 “(G) achieving outcomes designed to assess
2 the efficacy and cost-effectiveness of interven-
3 tions that can inform decisions on long-term
4 sustainability, including third-party reimburse-
5 ment.

6 “(3) APPLICATION.—An eligible entity desiring
7 to receive a grant under this subsection shall submit
8 to the Secretary—

9 “(A) an application at such time, in such
10 manner, and containing such information as the
11 Secretary may require; and

12 “(B) a plan to—

13 “(i) lower the rate of gestational dia-
14 betes during pregnancy; or

15 “(ii) develop methods of tracking indi-
16 viduals who can become pregnant with a
17 history of gestational diabetes and develop
18 effective interventions to lower the inci-
19 dence of the recurrence of gestational dia-
20 betes in subsequent pregnancies and the
21 development of type 2 diabetes.

22 “(4) USES OF FUNDS.—An eligible entity re-
23 ceiving a grant under this subsection shall use the
24 grant funds to carry out demonstration projects de-
25 scribed in paragraph (1), including—

1 “(A) expanding community-based health
2 promotion education, activities, and incentives
3 focused on the prevention of gestational diabe-
4 tes and development of type 2 diabetes in indi-
5 viduals who can become pregnant with a history
6 of gestational diabetes;

7 “(B) aiding State- and Tribal-based diabe-
8 tes prevention and control programs to collect,
9 analyze, disseminate, and report surveillance
10 data on individuals who can become pregnant
11 with, and at risk for, gestational diabetes, the
12 recurrence of gestational diabetes in subsequent
13 pregnancies, and, for individuals who can be-
14 come pregnant with a history of gestational dia-
15 betes, the development of type 2 diabetes; and

16 “(C) training and encouraging health care
17 providers—

18 “(i) to promote risk assessment, high-
19 quality care, and self-management for ges-
20 tational diabetes and the recurrence of ges-
21 tational diabetes in subsequent preg-
22 nancies; and

23 “(ii) to prevent the development of
24 type 2 diabetes in individuals who can be-
25 come pregnant with a history of gesta-

1 tional diabetes, and its complications in the
2 practice settings of the health care pro-
3 viders.

4 “(5) REPORT.—Not later than 4 years after the
5 date of the enactment of this section, the Secretary
6 shall prepare and submit to the Congress a report
7 concerning the results of the demonstration projects
8 conducted through the grants awarded under this
9 subsection.

10 “(6) DEFINITION OF ELIGIBLE ENTITY.—In
11 this subsection, the term ‘eligible entity’ means a
12 nonprofit organization (such as a nonprofit academic
13 center or community health center) or a State, Trib-
14 al, or local health agency.

15 “(7) AUTHORIZATION OF APPROPRIATIONS.—
16 There is authorized to be appropriated to carry out
17 this subsection \$5,000,000 for each of fiscal years
18 2019 through 2023.

19 “(d) POSTPARTUM FOLLOWUP REGARDING GESTA-
20 TIONAL DIABETES.—The Secretary, acting through the
21 Director of the Centers for Disease Control and Preven-
22 tion, shall work with the State- and Tribal-based diabetes
23 prevention and control programs assisted by the Centers
24 to encourage postpartum followup after gestational diabe-
25 tes, as medically appropriate, for the purpose of reducing

1 the incidence of gestational diabetes, the recurrence of
2 gestational diabetes in subsequent pregnancies, the devel-
3 opment of type 2 diabetes in individuals with a history
4 of gestational diabetes, and related complications.”.

5 **SEC. 510. EMERGENCY CONTRACEPTION EDUCATION AND**
6 **INFORMATION PROGRAMS.**

7 (a) EMERGENCY CONTRACEPTION PUBLIC EDU-
8 CATION PROGRAM.—

9 (1) IN GENERAL.—The Secretary, acting
10 through the Director of the Centers for Disease
11 Control and Prevention, shall develop and dissemi-
12 nate to the public medically accurate and complete
13 information on emergency contraception.

14 (2) DISSEMINATION.—The Secretary may dis-
15 seminate medically accurate and complete informa-
16 tion under paragraph (1) directly or through ar-
17 rangements with nonprofit organizations, community
18 health workers including promotoras, consumer
19 groups, institutions of higher education, clinics, the
20 media, and Federal, State, and local agencies.

21 (3) INFORMATION.—The information dissemi-
22 nated under paragraph (1) shall—

23 (A) include, at a minimum, a description
24 of emergency contraception and an explanation
25 of the use, safety, efficacy, and availability of

1 such contraception and options for no-copay ac-
2 cess through insurance; and

3 (B) be pilot tested for consumer com-
4 prehension, cultural and linguistic appropriate-
5 ness, and acceptance of the messages across
6 geographically, racially, ethnically, and linguis-
7 tically diverse populations.

8 (b) EMERGENCY CONTRACEPTION INFORMATION
9 PROGRAM FOR HEALTH CARE PROVIDERS.—

10 (1) IN GENERAL.—The Secretary, acting
11 through the Administrator of the Health Resources
12 and Services Administration and in consultation
13 with major medical and public health organizations,
14 shall develop and disseminate to health care pro-
15 viders information on emergency contraception.

16 (2) INFORMATION.—The information dissemi-
17 nated under paragraph (1) shall include, at a min-
18 imum—

19 (A) information describing the use, safety,
20 efficacy, availability of emergency contraception,
21 and options for no-copay access through insur-
22 ance;

23 (B) a recommendation regarding the use of
24 such contraception; and

1 (C) information explaining how to obtain
2 copies of the information developed under sub-
3 section (a) for distribution to the patients of
4 the providers.

5 (c) DEFINITIONS.—In this section:

6 (1) EMERGENCY CONTRACEPTION.—The term
7 “emergency contraception” means a drug or device
8 (as the terms are defined in section 201 of the Fed-
9 eral Food, Drug, and Cosmetic Act (21 U.S.C. 321))
10 or a drug regimen that—

11 (A) is used postcoitally;

12 (B) prevents pregnancy primarily by pre-
13 venting or delaying ovulation, and does not ter-
14minate an established pregnancy; and

15 (C) is approved by the Food and Drug Ad-
16ministration.

17 (2) HEALTH CARE PROVIDER.—The term
18 “health care provider” means an individual who is li-
19censed or certified under State law to provide health
20care services and who is operating within the scope
21of such license. Such term shall include a phar-
22macist.

23 (3) INSTITUTION OF HIGHER EDUCATION.—The
24 term “institution of higher education” has the same

1 meaning given such term in section 101(a) of the
2 Higher Education Act of 1965 (20 U.S.C. 1001(a)).

3 (4) **MEDICALLY ACCURATE AND COMPLETE.**—

4 The term “medically accurate and complete” means,
5 with respect to information, activities, or services
6 verified or supported by the weight of research con-
7 ducted in compliance with accepted scientific meth-
8 ods and—

9 (A) published in peer-reviewed journals,
10 where applicable; or

11 (B) comprising information that leading
12 professional organizations and agencies with
13 relevant expertise in the field recognize as accu-
14 rate, objective, and complete.

15 (5) **SECRETARY.**—The term “Secretary” means
16 the Secretary of Health and Human Services.

17 (d) **AUTHORIZATION OF APPROPRIATIONS.**—There
18 are authorized to be appropriated to carry out this section
19 such sums as may be necessary for each of the fiscal years
20 2019 through 2023.

21 **SEC. 511. COMPREHENSIVE SEX EDUCATION PROGRAMS.**

22 (a) **PURPOSES; FINDING; SENSE OF CONGRESS.**—

23 (1) **PURPOSES.**—The purposes of this Act are
24 to provide young people with comprehensive sex edu-
25 cation programs that—

1 (A) promote and uphold the rights of
2 young people to information in order to make
3 healthy decisions about their sexual health;

4 (B) provide the information and skills all
5 young people need to make informed, respon-
6 sible, and healthy decisions in order to become
7 sexually healthy adults and have healthy rela-
8 tionships;

9 (C) provide information about the preven-
10 tion of unintended pregnancy, sexually trans-
11 mitted infections, including HIV, dating vio-
12 lence, sexual assault, bullying, and harassment;
13 and

14 (D) provide resources and information on
15 topics ranging from gender stereotyping and
16 gender roles and stigma and socio-cultural in-
17 fluences surrounding sex and sexuality.

18 (2) FINDING ON REQUIRED RESOURCES.—In
19 order to provide the comprehensive sex education de-
20 scribed in paragraph (1), Congress finds that in-
21 creased resources are required for sex education pro-
22 grams that—

23 (A) substantially incorporate elements of
24 evidence-based programs or characteristics of
25 effective programs;

1 (B) cover a broad range of topics, includ-
2 ing medically accurate and complete informa-
3 tion that is age and developmentally appro-
4 priate about all the aspects of sex, sexual
5 health, and sexuality;

6 (C) are gender and gender identity-sen-
7 sitive, emphasizing the importance of equality
8 and the social environment for achieving sexual
9 and reproductive health and overall well-being;

10 (D) promote educational achievement, crit-
11 ical thinking, decisionmaking, self-esteem, and
12 self-efficacy;

13 (E) help develop healthy attitudes and in-
14 sights necessary for understanding relationships
15 between oneself and others and society;

16 (F) foster leadership skills and community
17 engagement by—

18 (i) promoting principles of fairness,
19 human dignity, and respect; and

20 (ii) engaging young people as partners
21 in their communities; and

22 (G) are culturally and linguistically appro-
23 priate, reflecting the diverse circumstances and
24 realities of young people.

1 (3) SENSE OF CONGRESS.—It is the sense of
2 Congress that—

3 (A) federally funded sex education pro-
4 grams should aim to—

5 (i) provide information about a range
6 of human sexuality topics, including—

7 (I) human development, healthy
8 relationships, personal skills;

9 (II) sexual behavior including ab-
10 stinence;

11 (III) sexual health including pre-
12 venting unintended pregnancy;

13 (IV) sexually transmitted infec-
14 tions including HIV; and

15 (V) society and culture;

16 (ii) promote safe and healthy relation-
17 ships;

18 (iii) promote gender equity;

19 (iv) use, and be informed by, the best
20 scientific information available;

21 (v) be culturally appropriate and in-
22 clusive of youth with varying gender identi-
23 ties, gender expressions, and sexual ori-
24 entations;

1 (vi) be built on characteristics of ef-
2 fective programs;

3 (vii) expand the existing body of re-
4 search on comprehensive sex education
5 programs through program evaluation;

6 (viii) expand training programs for
7 teachers of comprehensive sex education;

8 (ix) build on programs funded under
9 section 513 of the Social Security Act (42
10 U.S.C. 713) and the Office of Adolescent
11 Health’s Teen Pregnancy Prevention Pro-
12 gram, funded under title II of the Consoli-
13 dated Appropriations Act, 2010 (Public
14 Law 111–117; 123 Stat.), and on pro-
15 grams supported through the Centers for
16 Disease Control and Prevention (CDC);
17 and

18 (x) promote and uphold the rights of
19 young people to information in order to
20 make healthy and autonomous decisions
21 about their sexual health; and

22 (B) no Federal funds should be used for
23 health education programs that—

- 1 (i) withhold health-promoting or life-
2 saving information about sexuality-related
3 topics, including HIV;
- 4 (ii) are medically inaccurate or have
5 been scientifically shown to be ineffective;
- 6 (iii) promote gender or racial stereo-
7 types;
- 8 (iv) are insensitive and unresponsive
9 to the needs of sexually active young peo-
10 ple;
- 11 (v) are insensitive and unresponsive to
12 the needs of survivors of sexual violence;
- 13 (vi) are insensitive and unresponsive
14 to the needs of youth of all physical, devel-
15 opmental, and mental abilities;
- 16 (vii) are insensitive and unresponsive
17 to the needs of youth with varying gender
18 identities, gender expressions, and sexual
19 orientations; or
- 20 (viii) are inconsistent with the ethical
21 imperatives of medicine and public health.

22 (b) GRANTS FOR COMPREHENSIVE SEX EDUCATION
23 FOR ADOLESCENTS.—

- 24 (1) PROGRAM AUTHORIZED.—The Secretary of
25 Health and Human Services, in coordination with

1 the Associate Commissioner of the Family and
2 Youth Services Bureau of the Administration on
3 Children, Youth, and Families of the Department of
4 Health and Human Services, the Director of the Of-
5 fice of Adolescent Health, the Director of the Divi-
6 sion of Adolescent and School Health within the
7 Centers for Disease Control and Prevention and the
8 Secretary of Education, shall award grants, on a
9 competitive basis, to eligible entities to enable such
10 eligible entities to carry out programs that provide
11 adolescents with comprehensive sex education, as de-
12 scribed in paragraph (6).

13 (2) DURATION.—Grants awarded under this
14 section shall be for a period of 5 years.

15 (3) ELIGIBLE ENTITY.—In this section, the
16 term “eligible entity” means a public or private enti-
17 ty that focuses on adolescent health and education
18 or has experience working with adolescents.

19 (4) APPLICATIONS.—An eligible entity desiring
20 a grant under this section shall submit an applica-
21 tion to the Secretary at such time, in such manner,
22 and containing such information as the Secretary
23 may require, including an assurance to participate in
24 the evaluation described in subsection (e).

1 (5) PRIORITY.—In awarding grants under this
2 section, the Secretary shall give priority to eligible
3 entities that—

4 (A) are State or local public entities;

5 (B) are entities not currently receiving
6 funds under—

7 (i) section 513 of the Social Security
8 Act (42 U.S.C. 713);

9 (ii) the Office of Adolescent Health’s
10 Teen Pregnancy Prevention Program,
11 funded under title II of the Consolidated
12 Appropriations Act, 2010 (Public Law–
13 117; 123 Stat. 3253), or any substantially
14 similar successive program; or

15 (iii) the Centers for Disease Control
16 and Prevention’s Division of Adolescent
17 and School Health; and

18 (C) address health inequities among young
19 people that face systemic barriers resulting in
20 disproportionate rates of not less than one of
21 the following:

22 (i) Unintended pregnancies.

23 (ii) Sexually transmitted infections,
24 including HIV.

1 (iii) Dating violence and sexual vio-
2 lence.

3 (6) USE OF FUNDS.—

4 (A) IN GENERAL.—Each eligible entity
5 that receives a grant under this section shall
6 use the grant funds to carry out an education
7 program that provides adolescents with com-
8 prehensive sex education that—

9 (i) is age and developmentally appro-
10 priate;

11 (ii) is medically accurate and com-
12 plete;

13 (iii) substantially incorporates ele-
14 ments of evidence-based sex education in-
15 struction; or

16 (iv) creates a demonstration project
17 based on characteristics of effective pro-
18 grams.

19 (B) CONTENTS OF COMPREHENSIVE SEX
20 EDUCATION PROGRAMS.—The comprehensive
21 sex education programs funded under this sec-
22 tion shall include instruction and materials that
23 address—

24 (i) the physical, social, and emotional
25 changes of human development including,

1 human anatomy, reproduction, and sexual
2 development;

3 (ii) healthy relationships, including
4 friendships, within families, and society,
5 that are based on mutual respect, and the
6 ability to distinguish between healthy and
7 unhealthy relationships, including—

8 (I) effective communication, ne-
9 gotiation and refusal skills, including
10 the skills to recognize and report in-
11 appropriate or abusive sexual ad-
12 vances;

13 (II) bodily autonomy, setting and
14 respecting personal boundaries, prac-
15 ticing personal safety, and consent;
16 and

17 (III) the limitations and harm of
18 gender-role stereotypes, violence, coer-
19 cion, bullying, harassment, and intimi-
20 dation in relationships;

21 (iii) healthy decisionmaking skills
22 about sexuality and relationships that in-
23 clude—

- 1 (I) critical thinking, problem
2 solving, self-efficacy, stress-manage-
3 ment, self-care, and decisionmaking;
- 4 (II) individual values and atti-
5 tudes;
- 6 (III) the promotion of positive
7 body images;
- 8 (IV) developing an understanding
9 that there are a range of body types
10 and encouraging positive feeling about
11 students' own body types;
- 12 (V) information on how to re-
13 spect others and ensure safety on the
14 internet and when using other forms
15 of digital communication;
- 16 (VI) information on local services
17 and resources where students can ob-
18 tain additional information related to
19 bullying, harassment, dating violence
20 and sexual assault, suicide prevention,
21 and other related care;
- 22 (VII) encouragement for youth to
23 communicate with their parents or
24 guardians, health and social service
25 professionals, and other trusted adults

1 about sexuality and intimate relation-
2 ships;

3 (VIII) information on how to cre-
4 ate a safe environment for all stu-
5 dents and others in society;

6 (IX) examples of varying types of
7 relationships, couples, and family
8 structures; and

9 (X) affirmative representation of
10 varying gender identities, gender ex-
11 pressions, and sexual orientations, in-
12 cluding individuals and relationships
13 between same sex couples and their
14 families;

15 (iv) abstinence, delaying age of first
16 sexual activity, the use of condoms, preven-
17 tive medication, vaccination, birth control,
18 and other sexually transmitted infection
19 prevention measures, and the options for
20 pregnancy, including parenting, adoption,
21 and abortion, including—

22 (I) the importance of effectively
23 using condoms, preventive medication,
24 and applicable vaccinations to protect

1 against sexually transmitted infec-
2 tions, including HIV;

3 (II) the benefits of effective con-
4 traceptive and condom use in avoiding
5 unintended pregnancy;

6 (III) the relationship between
7 substance use and sexual health and
8 behaviors; and

9 (IV) information about local
10 health services where students can ob-
11 tain additional information and serv-
12 ices related to sexual and reproductive
13 health and other related care;

14 (v) through affirmative recognition,
15 the roles that traditions, values, religion,
16 norms, gender roles, acculturation, family
17 structure, health beliefs, and political
18 power play in how students make decisions
19 that affect their sexual health, using exam-
20 ples of various types of races, ethnicities,
21 cultures, and families, including single-par-
22 ent households and young families;

23 (vi) information about gender identity,
24 gender expression, and sexual orientation
25 for all students, including—

1 (I) affirmative recognition that
2 people have different gender identi-
3 ties, gender expressions, and sexual
4 orientations; and

5 (II) community resources that
6 can provide additional support for in-
7 dividuals with varying gender identi-
8 ties, gender expressions, and sexual
9 orientations; and

10 (vii) opportunities to explore the roles
11 that race, ethnicity, immigration status,
12 disability status, economic status, home-
13 lessness, foster care status, and language
14 within different communities affect sexual
15 attitudes in society and culture and how
16 this may impact student sexual health.

17 (c) GRANTS FOR COMPREHENSIVE SEX EDUCATION
18 AT INSTITUTIONS OF HIGHER EDUCATION.—

19 (1) PROGRAM AUTHORIZED.—The Secretary, in
20 coordination with the Secretary of Education, shall
21 award grants, on a competitive basis, to institutions
22 of higher education or consortia of such institutions
23 to enable such institutions to provide young people
24 with comprehensive sex education, described in para-
25 graph (5)(B).

1 (2) DURATION.—Grants awarded under this
2 section shall be for a period of 5 years.

3 (3) APPLICATIONS.—An institution of higher
4 education or consortia of such institutions desiring a
5 grant under this section shall submit an application
6 to the Secretary at such time, in such manner, and
7 containing such information as the Secretary may
8 require, including an assurance to participate in the
9 evaluation described in subsection (e).

10 (4) PRIORITY.—In awarding grants under this
11 section, the Secretary shall give priority to an insti-
12 tution of higher education that—

13 (A) has an enrollment of needy students as
14 defined in section 318(b) of the Higher Edu-
15 cation Act of 1965 (20 U.S.C. 1059e(b));

16 (B) is a Hispanic-serving institution, as
17 defined in section 502(a) of such Act (20
18 U.S.C. 1101a(a));

19 (C) is a Tribal College or University, as
20 defined in section 316(b) of such Act (20
21 U.S.C. 1059c(b));

22 (D) is an Alaska Native-serving institution,
23 as defined in section 317(b) of such Act (20
24 U.S.C. 1059d(b));

1 (E) is a Native Hawaiian-serving institu-
2 tion, as defined in section 317(b) of such Act
3 (20 U.S.C. 1059d(b));

4 (F) is a Predominately Black Institution,
5 as defined in section 318(b) of such Act (20
6 U.S.C. 1059e(b));

7 (G) is a Native American-serving, non-
8 tribal institution, as defined in section 319(b)
9 of such Act (20 U.S.C. 1059f(b));

10 (H) is an Asian American and Native
11 American Pacific Islander-serving institution, as
12 defined in section 320(b) of such Act (20
13 U.S.C. 1059g(b)); or

14 (I) is a minority institution, as defined in
15 section 365 of such Act (20 U.S.C. 1067k),
16 with an enrollment of needy students, as de-
17 fined in section 312 of such Act (20 U.S.C.
18 1058).

19 (5) USES OF FUNDS.—

20 (A) IN GENERAL.—An institution of higher
21 education receiving a grant under this section
22 shall use grant funds to integrate issues relat-
23 ing to comprehensive sex education into institu-
24 tion of higher education in order to reach a

1 large number of students, by carrying out one
2 or more of the following activities:

3 (i) Developing or adopting educational
4 content for issues relating to comprehen-
5 sive sex education that will be incorporated
6 into student orientation, general education,
7 or core courses.

8 (ii) Developing or adopting, and im-
9 plementing schoolwide educational pro-
10 gramming outside of class that delivers ele-
11 ments of comprehensive sex education pro-
12 grams to students, faculty, and staff.

13 (iii) Developing or adopting innovative
14 technology-based approaches to deliver sex
15 education to students, faculty, and staff.

16 (iv) Developing or adopting, and im-
17 plementing peer-outreach and education
18 programs to generate discussion, educate,
19 and raise awareness among students about
20 issues relating to comprehensive sex edu-
21 cation.

22 (B) CONTENTS OF SEX EDUCATION PRO-
23 GRAMS.—Each institution of higher education’s
24 program of comprehensive sex education funded
25 under this section shall include instruction and

1 materials that address the requirements under
2 paragraph 6.

3 (d) GRANTS FOR PRE-SERVICE AND IN-SERVICE
4 TEACHER TRAINING.—

5 (1) PROGRAM AUTHORIZED.—The Secretary, in
6 coordination with the Director of the Centers for
7 Disease Control and Prevention and the Secretary of
8 Education, shall award grants, on a competitive
9 basis, to eligible entities to enable such eligible enti-
10 ties to carry out the activities described in para-
11 graph (5).

12 (2) DURATION.—Grants awarded under this
13 section shall be for a period of 5 years.

14 (3) ELIGIBLE ENTITY.—In this section, the
15 term “eligible entity” means—

16 (A) a State educational agency, as defined
17 in section 8101 of the Elementary and Sec-
18 ondary Education of 1965 (20 U.S.C. 7801);

19 (B) a local educational agency, as defined
20 in section 8101 of the Elementary and Sec-
21 ondary Education of 1965 (20 U.S.C. 7801);

22 (C) a Tribe or Tribal organization, as de-
23 fined in section 4 of the Indian Self-Determina-
24 tion and Education Assistance Act (25 U.S.C.
25 5304);

1 (D) a State or local department of health;

2 (E) a State or local department of edu-
3 cation;

4 (F) an educational service agency, as de-
5 fined in section 8101 of the Elementary and
6 Secondary Education of 1965 (20 U.S.C.
7 7801);

8 (G) a nonprofit institution of higher edu-
9 cation, as defined in section 101 of the Higher
10 Education Act of 1965 (20 U.S.C. 1001);

11 (H) a national or statewide nonprofit orga-
12 nization that has as its primary purpose the im-
13 provement of provision of comprehensive sex
14 education through training and effective teach-
15 ing of comprehensive sex education; or

16 (I) a consortium of nonprofit organizations
17 that has as its primary purpose the improve-
18 ment of provision of comprehensive sex edu-
19 cation through training and effective teaching
20 of comprehensive sex education.

21 (4) APPLICATION.—An eligible entity desiring a
22 grant under this section shall submit an application
23 to the Secretary at such time, in such manner, and
24 containing such information as the Secretary may

1 require, including an assurance to participate in the
2 evaluation described in subsection (e).

3 (5) AUTHORIZED ACTIVITIES.—

4 (A) REQUIRED ACTIVITY.—Each eligible
5 entity receiving a grant under this section shall
6 use grant funds for professional development
7 and training of relevant faculty, school adminis-
8 trators, teachers, and staff, in order to increase
9 effective teaching of comprehensive sex edu-
10 cation students.

11 (B) PERMISSIBLE ACTIVITIES.—Each eligi-
12 ble entity receiving a grant under this section
13 may use grant funds to—

14 (i) provide research-based training of
15 teachers for comprehensive sex education
16 for adolescents as a means of broadening
17 student knowledge about issues related to
18 human development, healthy relationships,
19 personal skills, and sexual behavior, includ-
20 ing abstinence, sexual health, and society
21 and culture;

22 (ii) support the dissemination of infor-
23 mation on effective practices and research
24 findings concerning the teaching of com-
25 prehensive sex education;

- 1 (iii) support research on—
- 2 (I) effective comprehensive sex
3 education teaching practices; and
- 4 (II) the development of assess-
5 ment instruments and strategies to
6 document—
- 7 (aa) student understanding
8 of comprehensive sex education;
9 and
- 10 (bb) the effects of com-
11 prehensive sex education;
- 12 (iv) convene national conferences on
13 comprehensive sex education, in order to
14 effectively train teachers in the provision of
15 comprehensive sex education; and
- 16 (v) develop and disseminate appro-
17 priate research-based materials to foster
18 comprehensive sex education.
- 19 (C) SUBGRANTS.—Each eligible entity re-
20 ceiving a grant under this section may award
21 subgrants to nonprofit organizations that pos-
22 sess a demonstrated record of providing train-
23 ing to faculty, school administrators, teachers,
24 and staff on comprehensive sex education to—

- 1 (i) train teachers in comprehensive
2 sex education;
- 3 (ii) support Internet or distance learn-
4 ing related to comprehensive sex education;
- 5 (iii) promote rigorous academic stand-
6 ards and assessment techniques to guide
7 and measure student performance in com-
8 prehensive sex education;
- 9 (iv) encourage replication of best
10 practices and model programs to promote
11 comprehensive sex education;
- 12 (v) develop and disseminate effective,
13 research-based comprehensive sex edu-
14 cation learning materials;
- 15 (vi) develop academic courses on the
16 pedagogy of sex education at institutions
17 of higher education; or
- 18 (vii) convene State-based conferences
19 to train teachers in comprehensive sex edu-
20 cation and to identify strategies for im-
21 provement.

22 (e) IMPACT EVALUATION AND REPORTING.—

23 (1) MULTI-YEAR EVALUATION.—

- 24 (A) IN GENERAL.—Not later than 6
25 months after the date of the enactment of this

1 Act, the Secretary shall enter into a contract
2 with a nonprofit organization with experience in
3 conducting impact evaluations, to conduct a
4 multi-year evaluation on the impact of the
5 grants under subsections (b), (c), and (d), and
6 to report to Congress and the Secretary on the
7 findings of such evaluation.

8 (B) EVALUATION.—The evaluation con-
9 ducted under this subsection shall—

10 (i) be conducted in a manner con-
11 sistent with relevant, nationally recognized
12 professional and technical evaluation
13 standards;

14 (ii) use sound statistical methods and
15 techniques relating to the behavioral
16 sciences, including quasi-experimental de-
17 signs, inferential statistics, and other
18 methodologies and techniques that allow
19 for conclusions to be reached;

20 (iii) be carried out by an independent
21 organization that has not received a grant
22 under subsection (b), (c), or (d); and

23 (iv) be designed to provide informa-
24 tion on—

1 (I) output measures, such as the
2 number of individuals served under
3 the grant and the number of hours of
4 instruction;

5 (II) outcome measures, including
6 measures relating to—

7 (aa) the knowledge that in-
8 dividuals participating in the
9 grant program have gained in
10 each of the following age and de-
11 velopmentally appropriate
12 areas—

13 (AA) growth and devel-
14 opment;

15 (BB) relationship dy-
16 namics;

17 (CC) ways to prevent
18 unintended pregnancy and
19 sexually transmitted infec-
20 tions, including HIV; and

21 (DD) sexual health;

22 (bb) the age and develop-
23 mentally appropriate skills that
24 individuals participating in the

1 grant program have gained re-
2 garding—

3 (AA) negotiation and
4 communication;

5 (BB) decisionmaking
6 and goal-setting;

7 (CC) interpersonal
8 skills and healthy relation-
9 ships; and

10 (DD) condom use; and

11 (cc) the behaviors of adoles-
12 cents participating in the grant
13 program, including data about—

14 (AA) age of first inter-
15 course;

16 (BB) condom and con-
17 traceptive use at first inter-
18 course;

19 (CC) recent condom
20 and contraceptive use;

21 (DD) substance use;

22 (EE) dating abuse and
23 lifetime history of sexual as-
24 sult, dating violence, bul-

1 lying, harassment, stalking;
2 and
3 (F) academic per-
4 formance; and
5 (III) other measures necessary to
6 evaluate the impact of the grant pro-
7 gram.

8 (C) REPORT.—Not later than 6 years after
9 the date of enactment of this Act, the organiza-
10 tion conducting the evaluation under this sub-
11 section shall prepare and submit to the appro-
12 priate committees of Congress and the Sec-
13 retary an evaluation report. Such report shall
14 be made publicly available, including on the
15 website of the Department of Health and
16 Human Services.

17 (2) SECRETARY'S REPORT TO CONGRESS.—Not
18 later than 1 year after the date of the enactment of
19 this Act, and annually thereafter for a period of 5
20 years, the Secretary shall prepare and submit to the
21 appropriate committees of Congress a report on the
22 activities to provide adolescents and young people
23 with comprehensive sex education and pre-service
24 and in-service teacher training funded under this

1 Act. The Secretary's report to Congress shall in-
2 clude—

3 (A) a statement of how grants awarded by
4 the Secretary meet the purposes described in
5 subsection (a)(1); and

6 (B) information about—

7 (i) the number of eligible entities and
8 institutions of higher education that are
9 receiving grant funds under subsections
10 (b), (c), and (d);

11 (ii) the specific activities supported by
12 grant funds awarded under subsections
13 (b), (c), and (d);

14 (iii) the number of adolescents served
15 by grant programs funded under sub-
16 section (b);

17 (iv) the number of young people
18 served by grant programs funded under
19 subsection (c);

20 (v) the number of faculty, school ad-
21 ministrators, teachers, and staff trained
22 under subsection (d); and

23 (vi) the status of the evaluation re-
24 quired under paragraph (1).

1 (f) NONDISCRIMINATION.—Programs funded under
2 this Act shall not discriminate on the basis of actual or
3 perceived sex, race, color, ethnicity, national origin, dis-
4 ability, sexual orientation, gender identity, or religion.
5 Nothing in this Act shall be construed to invalidate or
6 limit rights, remedies, procedures, or legal standards avail-
7 able under any other Federal law or any law of a State
8 or a political subdivision of a State, including the Civil
9 Rights Act of 1964 (42 U.S.C. 2000a et seq.), title IX
10 of the Education Amendments of 1972 (20 U.S.C. 1681
11 et seq.), section 504 of the Rehabilitation Act of 1973 (29
12 U.S.C. 794), the Americans with Disabilities Act of 1990
13 (42 U.S.C. 12101 et seq.), and section 1557 of the Patient
14 Protection and Affordable Care Act (42 U.S.C. 18116).

15 (g) LIMITATION.—No Federal funds provided under
16 this Act may be used for health education programs
17 that—

18 (1) withhold health-promoting or life-saving in-
19 formation about sexuality-related topics, including
20 HIV;

21 (2) are medically inaccurate or have been sci-
22 entifically shown to be ineffective;

23 (3) promote gender or racial stereotypes;

24 (4) are insensitive and unresponsive to the
25 needs of sexually active young people;

1 (5) are insensitive and unresponsive to the
2 needs of pregnant or parenting young people;

3 (6) are insensitive and unresponsive to the
4 needs of survivors of sexual abuse or assault;

5 (7) are insensitive and unresponsive to the
6 needs of youth of all physical, developmental, or
7 mental abilities;

8 (8) are insensitive and unresponsive to individ-
9 uals with varying gender identities, gender expres-
10 sions, and sexual orientations; or

11 (9) are inconsistent with the ethical imperatives
12 of medicine and public health.

13 (h) AMENDMENTS TO OTHER LAWS.—

14 (1) AMENDMENT TO THE PUBLIC HEALTH
15 SERVICE ACT.—Section 2500 of the Public Health
16 Service Act (42 U.S.C. 300ee) is amended by strik-
17 ing subsections (b) through (d) and inserting the fol-
18 lowing:

19 “(b) CONTENTS OF PROGRAMS.—All programs of
20 education and information receiving funds under this sub-
21 chapter shall include information about the potential ef-
22 fects of intravenous substance abuse.”.

23 (2) AMENDMENTS TO THE ELEMENTARY AND
24 SECONDARY EDUCATION ACT OF 1965.—Section 8526

1 of the Elementary and Secondary Education Act of
2 (20 U.S.C. 7906) is amended—

3 (A) by striking paragraph (3);

4 (B) by redesignating paragraphs (4) and
5 (5) as paragraphs (3) and (4), respectively;

6 (C) in paragraph (4), by inserting “or”
7 after the semicolon;

8 (D) in paragraph (5), by striking “; or”
9 and inserting a period; and

10 (E) by striking paragraph (6).

11 (i) DEFINITIONS.—In this section:

12 (1) ADOLESCENTS.—The term “adolescents”
13 means individuals who are ages 10 through 19 at
14 the time of commencement of participation in a pro-
15 gram supported under this section.

16 (2) AGE AND DEVELOPMENTALLY APPRO-
17 PRIATE.—The term “age and developmentally appro-
18 priate” means topics, messages, and teaching meth-
19 ods suitable to particular age, age group of children
20 and adolescents, or developmental levels, based on
21 cognitive, emotional, social, and behavioral capacity
22 of most students at that age level.

23 (3) APPROPRIATE COMMITTEES OF CON-
24 GRESS.—The term “appropriate committees of Con-
25 gress” means the Committee on Health, Education,

1 Labor, and Pensions of the Senate, the Committee
2 on Appropriations of the Senate, the Committee on
3 Energy and Commerce of the House of Representa-
4 tives, the Committee on Education and the Work-
5 force of the House of Representatives, and the Com-
6 mittee on Appropriations of the House of Represent-
7 atives.

8 (4) CHARACTERISTICS OF EFFECTIVE PRO-
9 GRAMS.—The term “characteristics of effective pro-
10 grams” means the aspects of evidence-based pro-
11 grams, including development, content, and imple-
12 mentation of such programs, that—

13 (A) have been shown to be effective in
14 terms of increasing knowledge, clarifying values
15 and attitudes, increasing skills, and impacting
16 upon behavior; and

17 (B) are widely recognized by leading med-
18 ical and public health agencies to be effective in
19 changing sexual behaviors that lead to sexually
20 transmitted infections, including HIV, unin-
21 tended pregnancy, and dating violence and sex-
22 ual assault among young people.

23 (5) COMPREHENSIVE SEX EDUCATION.—The
24 term “comprehensive sex education” means instruc-
25 tional part of a comprehensive school health edu-

1 cation approach which addresses the physical, men-
2 tal, emotional, and social dimensions of human sexu-
3 ality; designed to motivate and assist students to
4 maintain and improve their sexual health, prevent
5 disease and reduce sexual health-related risk behav-
6 iors; and enable and empower students to develop
7 and demonstrate age and developmentally appro-
8 priate sexuality and sexual health-related knowledge,
9 attitudes, skills, and practices.

10 (6) CONSENT.—The term “consent” means af-
11 firmative, conscious, and voluntary agreement to en-
12 gage in interpersonal, physical, or sexual activity.

13 (7) CULTURALLY APPROPRIATE.—The term
14 “culturally appropriate” means materials and in-
15 struction that respond to culturally diverse individ-
16 uals, families and communities in an inclusive, re-
17 spectful and effective manner; including materials
18 and instruction that are inclusive of race, ethnicity,
19 languages, cultural background, religion, sex, gender
20 identity, sexual orientation, and different abilities.

21 (8) EVIDENCE-BASED.—The term “evidence-
22 based”, when used with respect to sex education in-
23 struction means a sex education program that has
24 been proven through rigorous evaluation to be effec-
25 tive in changing sexual behavior or incorporates ele-

1 ments of other programs that have been proven to
2 be effective in changing sexual behavior.

3 (9) GENDER EXPRESSION.—The term “gender
4 expression”, when used with respect to a sex edu-
5 cation program, means the expression of one’s gen-
6 der, such as through behavior, clothing, haircut, or
7 voice, and which may or may not conform to socially
8 defined behaviors and characteristics typically asso-
9 ciated with being either masculine or feminine.

10 (10) GENDER IDENTITY.—Except with respect
11 to section 7, the term “gender identity”, when used
12 with respect to a sex education program, means the
13 gender-related identity, appearance, mannerisms, or
14 other gender-related characteristics of an individual,
15 regardless of the individual’s designated sex at birth
16 including a person’s deeply held sense or knowledge
17 of their own gender; such as male, female, both or
18 neither.

19 (11) INCLUSIVE.—The term “inclusive”, when
20 used with respect to a sex education program, means
21 curriculum that ensures that students from histori-
22 cally marginalized communities are reflected in
23 classroom materials and lessons.

24 (12) INSTITUTION OF HIGHER EDUCATION.—
25 The term “institution of higher education” has the

1 meaning given the term in section 101 of the Higher
2 Education Act of 1965 (20 U.S.C. 1001).

3 (13) MEDICALLY ACCURATE AND COMPLETE.—

4 The term “medically accurate and complete”, when
5 used with respect to a sex education program, means
6 that—

7 (A) the information provided through the
8 program is verified or supported by the weight
9 of research conducted in compliance with ac-
10 cepted scientific methods and is published in
11 peer-reviewed journals, where applicable; or

12 (B)(i) the program contains information
13 that leading professional organizations and
14 agencies with relevant expertise in the field rec-
15 ognize as accurate, objective, and complete; and

16 (ii) the program does not withhold infor-
17 mation about the effectiveness and benefits of
18 correct and consistent use of condoms and
19 other contraceptives.

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

22 (15) SEXUAL DEVELOPMENT.—The term “sex-
23 ual development” means the lifelong process of phys-
24 ical, behavioral, cognitive, and emotional growth and
25 change as it relates to an individual’s sexuality and

1 sexual maturation, including puberty, identity devel-
2 opment, socio-cultural influences, and sexual behav-
3 iors.

4 (16) SEXUAL ORIENTATION.—Except with re-
5 spect to subsection (g), the term “sexual orienta-
6 tion”, when used with respect to a sex education
7 program, means an individual’s attraction, including
8 physical or emotional, to the same or different gen-
9 der.

10 (17) YOUNG PEOPLE.—The term “young peo-
11 ple” means individuals who are ages 10 through 24
12 at the time of commencement of participation in a
13 program supported under this Act.

14 (j) FUNDING.—

15 (1) APPROPRIATION.—For the purpose of car-
16 rying out this Act, there is appropriated
17 \$75,000,000 for each of fiscal years 2019 through
18 2024. Amounts appropriated under this subsection
19 shall remain available until expended.

20 (2) RESERVATIONS OF FUNDS.—

21 (A) The Secretary shall reserve 50 percent
22 of the amount appropriated under paragraph
23 (1) for the purposes of awarding grants for
24 comprehensive sex education for adolescents
25 under subsection (c).

1 (B) The Secretary shall reserve 25 percent
2 of the amount appropriated under paragraph
3 (1) for the purposes of awarding grants for
4 comprehensive sex education at institutes of
5 higher education under subsection (d).

6 (C) The Secretary shall reserve 20 percent
7 of the amount appropriated under paragraph
8 (1) for the purposes of awarding grants for pre-
9 service and in-service teacher training under
10 subsection (e).

11 (D) The Secretary shall reserve 2 percent
12 of the amount appropriated under paragraph
13 (1) for the purpose of carrying out the impact
14 evaluation and reporting required under sub-
15 section (a).

16 (3) SECRETARIAL RESPONSIBILITIES.—The
17 Secretary shall reserve 3 percent of the amount ap-
18 propriated under subsection (a) for each fiscal year
19 for expenditures by the Secretary to provide, directly
20 or through a competitive grant process, research,
21 training, and technical assistance, including dissemi-
22 nation of research and information regarding effec-
23 tive and promising practices, providing consultation
24 and resources, and developing resources and mate-
25 rials to support the activities of recipients of grants.

1 In carrying out such functions, the Secretary shall
2 collaborate with a variety of entities that have exper-
3 tise in adolescent sexual health development, edu-
4 cation, and promotion.

5 (4) REPROGRAMMING OF ABSTINENCE ONLY
6 UNTIL MARRIAGE PROGRAM FUNDING.—The unobli-
7 gated balance of funds made available to carry out
8 section 510 of the Social Security Act (42 U.S.C.
9 710) (as in effect on the day before the date of en-
10 actment of this Act) are hereby transferred and shall
11 be used by the Secretary to carry out this Act. The
12 amounts transferred and made available to carry out
13 this Act shall remain available until expended.

14 (5) REPEAL OF ABSTINENCE ONLY UNTIL MAR-
15 RIAGE PROGRAM.—Section 510 of the Social Secu-
16 rity Act (42 U.S.C. 710 et seq.) is repealed.

17 **SEC. 512. COMPASSIONATE ASSISTANCE FOR RAPE EMER-**
18 **GENCIES.**

19 (a) MEDICARE.—

20 (1) LIMITATION ON PAYMENT.—Section
21 1866(a)(1) of the Social Security Act (42 U.S.C.
22 1395cc(a)(1)) is amended—

23 (A) in the subparagraph (W) added by sec-
24 tion 3005(1)(C) of Public Law 111–148—

1 (i) by striking the period at the end
2 and inserting a comma;

3 (ii) by moving the indentation 2 ems
4 to the left; and

5 (iii) by moving such subparagraph to
6 immediately follow subparagraph (V);

7 (B) in the subparagraph (W) added by sec-
8 tion 6406(b)(3) of Public Law 111–148—

9 (i) by striking the period at the end
10 and inserting “, and”;

11 (ii) by moving the indentation 2 ems
12 to the left;

13 (iii) by redesignating such subpara-
14 graph as subparagraph (X); and

15 (iv) by moving such subparagraph to
16 immediately follow subparagraph (W), as
17 moved under paragraph (2)(C); and

18 (C) by inserting after the subparagraph
19 (X), as redesignated and moved under para-
20 graph (3), the following:

21 “(Y) in the case of a hospital or critical ac-
22 cess hospital, to adopt and enforce a policy to
23 ensure compliance with the requirements of
24 subsection (l) and to meet the requirements of
25 such subsection.”.

1 (2) ASSISTANCE TO VICTIMS.—Section 1866 of
2 the Social Security Act (42 U.S.C. 1395cc) is
3 amended by adding at the end the following new
4 subsection:

5 “(1) COMPASSIONATE ASSISTANCE FOR RAPE EMER-
6 GENCIES.—

7 “(1) IN GENERAL.—For purposes of section
8 1866(a)(1)(Y), a hospital meets the requirements of
9 this subsection if the hospital provides each of the
10 services described in paragraph (2) to each indi-
11 vidual, whether or not eligible for benefits under this
12 title or under any other form of health insurance.
13 who comes to the hospital on or after January 1,
14 2019, and—

15 “(A) who states to hospital personnel that
16 they are victims of sexual assault;

17 “(B) who is accompanied by an individual
18 who states to hospital personnel that the indi-
19 vidual is a victim of sexual assault; or

20 “(C) whom hospital personnel, during the
21 course of treatment and care for the individual,
22 have reason to believe is a victim of sexual as-
23 sault.

1 “(2) REQUIRED SERVICES DESCRIBED.—For
2 purposes of paragraph (1), the services described in
3 this subparagraph are the following:

4 “(A) Provision of medically and factually
5 accurate and unbiased written and oral infor-
6 mation about emergency contraception that—

7 “(i) is written in clear and concise
8 language;

9 “(ii) is readily comprehensible;

10 “(iii) includes an explanation that—

11 “(I) emergency contraception has
12 been approved by the Food and Drug
13 Administration as an over-the-counter
14 or prescription medication for individ-
15 uals, and is a safe and effective way
16 to prevent pregnancy after unpro-
17 tected intercourse or contraceptive
18 failure if taken in a timely manner;

19 “(II) emergency contraception is
20 more effective the sooner it is taken;
21 and

22 “(III) emergency contraception
23 does not cause an abortion and cannot
24 interrupt an established pregnancy;

1 “(iv) meets such conditions regarding
2 the provision of such information in lan-
3 guages other than English as the Secretary
4 may establish; and

5 “(v) is provided without regard to the
6 ability of the individual or their family to
7 pay costs associated with the provision of
8 such information to the individual.

9 “(B) Immediate offer to provide emergency
10 contraception to the individual at the hospital
11 and, in the case that the individual accepts such
12 offer, immediate provision to the individual of
13 such contraception on the same day it is re-
14 quested without regard to the inability of the
15 individual or their family to pay costs associ-
16 ated with the offer and provision of such con-
17 traception.

18 “(C) Development and implementation of a
19 written policy to ensure that an individual is
20 present at the hospital, or on-call, who—

21 “(i) has authority to dispense or pre-
22 scribe emergency contraception, independ-
23 ently, or under a protocol prepared by a
24 physician for the administration of emer-

1 gency contraception at the hospital to a
2 victim of sexual assault; and

3 “(ii) is trained to comply with the re-
4 quirements of this section.

5 “(D) Provision of medically and factually
6 accurate and unbiased written and oral infor-
7 mation and counseling about post-exposure pro-
8 phylaxis (PEP) protocol for the prevention of
9 HIV.

10 “(E) Immediately offer to begin PEP to
11 the individual at the hospital except in cases
12 where the medical professional’s best judgement
13 is that further evaluation is required or that
14 such a regimen will be substantially detrimental
15 to the individual’s health. Such provision shall
16 be offered regardless of the individual’s ability
17 to pay. Hospitals shall be responsible for ensur-
18 ing adequate supply of PEP medications to pro-
19 vide to patients.

20 “(3) DEFINITIONS.—For purposes of this para-
21 graph:

22 “(A) The term ‘emergency contraception’
23 means a drug or device (as such terms are de-
24 fined in section 201 of the Federal Food, Drug,

1 and Cosmetic Act (21 U.S.C. 321)) or a drug
2 regimen that—

3 “(i) is used postcoitally;

4 “(ii) prevents pregnancy primarily by
5 preventing or delaying ovulation, and does
6 not terminate an established pregnancy;
7 and

8 “(iii) is approved by the Food and
9 Drug Administration.

10 “(B) The term ‘hospital’ includes a critical
11 access hospital, as defined in section
12 1861(mm)(1).

13 “(C) The term ‘sexual assault’ means co-
14 itus in which the individual involved does not
15 consent or lacks the legal capacity to consent.”.

16 (b) LIMITATION ON PAYMENT UNDER MEDICAID.—
17 Section 1903(i) of the Social Security Act (42 U.S.C.
18 1396b(i)) is amended by inserting after paragraph (11)
19 the following new paragraph:

20 “(12) with respect to any amount expended for
21 care or services furnished under the plan by a hos-
22 pital on or after January 1, 2017, unless such hos-
23 pital meets the requirements specified in section
24 1866(l) for purposes of title XVIII.”.

1 **SEC. 513. ACCESS TO BIRTH CONTROL DUTIES OF PHAR-**
2 **MACIES TO ENSURE PROVISION OF FDA-AP-**
3 **PROVED CONTRACEPTION.**

4 Part B of title II of the Public Health Service Act
5 (42 U.S.C. 238 et seq.) is amended by adding at the end
6 the following:

7 **“SEC. 249. DUTIES OF PHARMACIES TO ENSURE PROVISION**
8 **OF FDA-APPROVED CONTRACEPTION.**

9 “(a) IN GENERAL.—Subject to subsection (c), a
10 pharmacy that receives Food and Drug Administration-
11 approved drugs or devices in interstate commerce shall
12 maintain compliance with the following:

13 “(1) If a customer requests a contraceptive, in-
14 cluding emergency contraception, that is in stock,
15 the pharmacy shall ensure that the contraceptive is
16 provided to the customer—

17 “(A) without delay;

18 “(B) without regard to the customer’s age,
19 gender, gender identity, or sexual orientation;

20 “(C) without a requirement that identifica-
21 tion be presented; and

22 “(D) despite any conflicts of employees to
23 filling a prescription and dispensing a par-
24 ticular prescription drug or device due to sin-
25 cerely held moral, philosophical, or religious be-
26 liefs.

1 “(2) If a customer requests a contraceptive that
2 is not in stock and the pharmacy in the normal
3 course of business stocks contraception, the phar-
4 macy shall immediately inform the customer that the
5 contraceptive is not in stock and without delay offer
6 the customer the following options:

7 “(A) If the customer prefers to obtain the
8 contraceptive through a referral or transfer, the
9 pharmacy shall—

10 “(i) locate a pharmacy of the cus-
11 tomer’s choice or the closest pharmacy
12 confirmed to have the contraceptive in
13 stock; and

14 “(ii) refer the customer or transfer
15 the prescription to that pharmacy.

16 “(B) If the customer prefers for the phar-
17 macy to order the contraceptive, the pharmacy
18 shall obtain the contraceptive under the phar-
19 macy’s standard procedure for expedited order-
20 ing of medication and notify the customer when
21 the contraceptive arrives.

22 “(3) The pharmacy shall ensure that its em-
23 ployees do not—

1 “(A) intimidate, threaten, or harass cus-
2 tomers in the delivery of services relating to a
3 request for contraception;

4 “(B) interfere with or obstruct the delivery
5 of services relating to a request for contracep-
6 tion;

7 “(C) intentionally misrepresent or deceive
8 customers about the availability of contracep-
9 tion or its mechanism of action;

10 “(D) breach medical confidentiality with
11 respect to a request for contraception or threat-
12 en to breach such confidentiality; or

13 “(E) refuse to return a valid, lawful pre-
14 scription for contraception upon customer re-
15 quest.

16 “(b) CONTRACEPTIVES NOT ORDINARILY
17 STOCKED.—Nothing in subsection (a)(2) shall be con-
18 strued to require any pharmacy to comply with such sub-
19 section if the pharmacy does not ordinarily stock contra-
20 ceptives in the normal course of business.

21 “(c) REFUSALS PURSUANT TO STANDARD PHAR-
22 MACY PRACTICE.—This section does not prohibit a phar-
23 macy from refusing to provide a contraceptive to a cus-
24 tomer in accordance with any of the following:

1 “(1) If it is unlawful to dispense the contracep-
2 tive to the customer without a valid, lawful prescrip-
3 tion and no such prescription is presented.

4 “(2) If the customer is unable to pay for the
5 contraceptive.

6 “(3) If the employee of the pharmacy refuses to
7 provide the contraceptive on the basis of a profes-
8 sional clinical judgment.

9 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
10 tion shall be construed to invalidate or limit rights, rem-
11 edies, procedures, or legal standards under title VII of the
12 Civil Rights Act of 1964.

13 “(e) PREEMPTION.—This section does not preempt
14 any provision of State law or any professional obligation
15 made applicable by a State board or other entity respon-
16 sible for licensing or discipline of pharmacies or phar-
17 macists, to the extent that such State law or professional
18 obligation provides protections for customers that are
19 greater than the protections provided by this section.

20 “(f) ENFORCEMENT.—

21 “(1) CIVIL PENALTY.—A pharmacy that vio-
22 lates a requirement of subsection (a) is liable to the
23 United States for a civil penalty in an amount not
24 exceeding \$1,000 per day of violation, not to exceed

1 \$100,000 for all violations adjudicated in a single
2 proceeding.

3 “(2) PRIVATE CAUSE OF ACTION.—Any person
4 aggrieved as a result of a violation of a requirement
5 of subsection (a) may, in any court of competent ju-
6 risdiction, commence a civil action against the phar-
7 macy involved to obtain appropriate relief, including
8 actual and punitive damages, injunctive relief, and a
9 reasonable attorney’s fee and cost.

10 “(3) LIMITATIONS.—A civil action under para-
11 graph (1) or (2) may not be commenced against a
12 pharmacy after the expiration of the 5-year period
13 beginning on the date on which the pharmacy alleg-
14 edly engaged in the violation involved.

15 “(g) DEFINITIONS.—In this section:

16 “(1) The term ‘contraception’ or ‘contraceptive’
17 means any drug or device approved by the Food and
18 Drug Administration to prevent pregnancy.

19 “(2) The term ‘employee’ means a person hired,
20 by contract or any other form of an agreement, by
21 a pharmacy.

22 “(3) The term ‘pharmacy’ means an entity
23 that—

1 “(A) is authorized by a State to engage in
2 the business of selling prescription drugs at re-
3 tail; and

4 “(B) employs one or more employees.

5 “(4) The term ‘product’ means a Food and
6 Drug Administration-approved drug or device.

7 “(5) The term ‘professional clinical judgment’
8 means the use of professional knowledge and skills
9 to form a clinical judgment, in accordance with pre-
10 vailing medical standards.

11 “(6) The term ‘without delay’, with respect to
12 a pharmacy providing, providing a referral for, or
13 ordering contraception, or transferring the prescrip-
14 tion for contraception, means within the usual and
15 customary timeframe at the pharmacy for providing,
16 providing a referral for, or ordering other products,
17 or transferring the prescription for other products,
18 respectively.

19 “(h) EFFECTIVE DATE.—This section shall take ef-
20 fect on the 31st day after the date of the enactment of
21 this section, without regard to whether the Secretary has
22 issued any guidance or final rule regarding this section.”.

1 **SEC. 514. ADDITIONAL FOCUS AREA FOR THE OFFICE ON**
2 **WOMEN'S HEALTH.**

3 Section 229(b) of the Public Health Service Act (42
4 U.S.C. 237a(b)) is amended—

5 (1) in paragraph (6), at the end, by striking
6 “and”;

7 (2) in paragraph (7), at the end, by striking the
8 period and inserting a semicolon; and

9 (3) by adding at the end the following new
10 paragraph:

11 “(8) facilitate policymakers, health system lead-
12 ers and providers, consumers, and other stake-
13 holders in understanding optimal maternity care and
14 support for the provision of such care, including the
15 priorities of—

16 “(A) protecting, promoting, and supporting
17 the innate capacities of childbearing individuals
18 and their newborns for childbirth,
19 breastfeeding, and attachment;

20 “(B) using obstetric interventions only
21 when such interventions are supported by
22 strong, high-quality evidence, and minimizing
23 overuse of maternity practices that have been
24 shown to have benefit in limited situations and
25 that can expose women, infants, or both to risk
26 of harm if used routinely and indiscriminately,

1 including continuous electronic fetal monitoring,
2 labor induction, epidural analgesia, primary ce-
3 sarian section, and routine repeat cesarean
4 birth;

5 “(C) reliably incorporating noninvasive,
6 evidence-based practices that have documented
7 correlation with considerable improvement in
8 outcomes with no detrimental side effects, such
9 as smoking cessation programs in pregnancy
10 and proven models of group prenatal care that
11 integrate health assessment, education, and
12 support into a unified program and supporting
13 evidence-based breastfeeding promotion efforts
14 with respect for a breastfeeding individual’s
15 personal decisionmaking;

16 “(D) a shared understanding of the quali-
17 fications of licensed providers of maternity care
18 and the best evidence about the safety, satisfac-
19 tion, outcomes, and costs of their care, and ap-
20 propriate deployment of such caregivers within
21 the maternity care workforce to address the
22 needs of childbearing individuals and newborns
23 and the growing shortage of maternity care-
24 givers;

1 “(E) a shared understanding of the results
2 of the best available research comparing hos-
3 pital, birth center, and planned home births, in-
4 cluding information about each setting’s safety,
5 satisfaction, outcomes, and costs; and

6 “(F) high-quality, evidence-based child-
7 birth education that promotes a natural,
8 healthy, and safe approach to pregnancy, child-
9 birth, and early parenting; is taught by certified
10 educators, peer counselors, and health profes-
11 sionals; and promotes informed decisionmaking
12 by childbearing individual;”.

13 **SEC. 515. INTERAGENCY COORDINATING COMMITTEE ON**
14 **THE PROMOTION OF OPTIMAL MATERNITY**
15 **OUTCOMES.**

16 (a) IN GENERAL.—Part A of title II of the Public
17 Health Service Act (42 U.S.C. 202 et seq.) is amended
18 by adding at the end the following new section:

19 **“SEC. 229A. INTERAGENCY COORDINATING COMMITTEE ON**
20 **THE PROMOTION OF OPTIMAL MATERNITY**
21 **OUTCOMES.**

22 “(a) IN GENERAL.—The Secretary of Health and
23 Human Services, acting through the Deputy Assistant
24 Secretary for Women’s Health under section 229 and in
25 collaboration with the Federal officials specified in sub-

1 section (b), shall establish the Interagency Coordinating
2 Committee on the Promotion of Optimal Maternity Out-
3 comes (referred to in this subsection as the ‘ICCPOM’).

4 “(b) OTHER AGENCIES.—The officials specified in
5 this subsection are the Secretary of Labor, the Secretary
6 of Defense, the Secretary of Veterans Affairs, the Surgeon
7 General, the Director of the Centers for Disease Control
8 and Prevention, the Administrator of the Health Re-
9 sources and Services Agency, the Administrator of the
10 Centers for Medicare & Medicaid Services, the Director
11 of the Indian Health Service, the Administrator of the
12 Substance Abuse and Mental Health Services Administra-
13 tion, the Director of the National Institute on Child
14 Health and Development, the Director of the Agency for
15 Healthcare Research and Quality, the Assistant Secretary
16 for Children and Families, the Deputy Assistant Secretary
17 for Minority Health, the Director of the Office of Per-
18 sonnel Management, and such other Federal officials as
19 the Secretary of Health and Human Services determines
20 to be appropriate.

21 “(c) CHAIR.—The Deputy Assistant Secretary for
22 Women’s Health shall serve as the chair of the ICCPOM.

23 “(d) DUTIES.—The ICCPOM shall guide policy and
24 program development across the Federal Government with
25 respect to promotion of optimal maternity care, provided,

1 however, that nothing in this section shall be construed
2 as transferring regulatory or program authority from an
3 agency to the ICCPOM.

4 “(e) CONSULTATIONS.—The ICCPOM shall actively
5 seek the input of, and shall consult with, all appropriate
6 and interested stakeholders, including State health depart-
7 ments, public health research and interest groups, founda-
8 tions, childbearing individuals and their advocates, and
9 maternity care professional associations and organiza-
10 tions, reflecting racially, ethnically, demographically, and
11 geographically diverse communities.

12 “(f) ANNUAL REPORT.—

13 “(1) IN GENERAL.—The Secretary, on behalf of
14 the ICCPOM, shall annually submit to Congress a
15 report that summarizes—

16 “(A) all programs and policies of Federal
17 agencies (including the Medicare Program
18 under title XVIII of the Social Security Act and
19 the Medicaid program under title XIX of such
20 Act) designed to promote optimal maternity
21 care, focusing particularly on programs and
22 policies that support the adoption of evidence
23 based maternity care, as defined by timely, sci-
24 entifically sound systematic reviews;

1 “(B) all programs and policies of Federal
2 agencies (including the Medicare Program
3 under title XVIII of the Social Security Act and
4 the Medicaid program under title XIX of such
5 Act) designed to address the problems of mater-
6 nal mortality and morbidity, infant mortality,
7 prematurity, and low birth weight, including
8 such programs and policies designed to address
9 racial and ethnic disparities with respect to
10 each of such problems;

11 “(C) the extent of progress in reducing
12 maternal mortality and infant mortality, low
13 birth weight, and prematurity at State and na-
14 tional levels; and

15 “(D) such other information regarding op-
16 timal maternity care as the Secretary deter-
17 mines to be appropriate.

18 The information specified in subparagraph (C) shall
19 be included in each such report in a manner that
20 disaggregates such information by race, ethnicity,
21 and indigenous status in order to determine the ex-
22 tent of progress in reducing racial and ethnic dis-
23 parities and disparities related to indigenous status.

24 “(2) CERTAIN INFORMATION.—Each report
25 under paragraph (1) shall include information

1 (disaggregated by race, ethnicity, and indigenous
2 status, as applicable) on the following rates and
3 costs by State:

4 “(A) The rate of primary cesarean deliv-
5 eries and repeat cesarean deliveries.

6 “(B) The rate of vaginal births after cesar-
7 ean.

8 “(C) The rate of vaginal breech births.

9 “(D) The rate of induction of labor.

10 “(E) The rate of freestanding birth center
11 births.

12 “(F) The rate of planned and unplanned
13 home birth.

14 “(G) The rate of attended births by pro-
15 vider, including by an obstetrician-gynecologist,
16 family practice physician, obstetrician-gyne-
17 cologist physician assistant, certified nurse-mid-
18 wife, certified midwife, and certified profes-
19 sional midwife.

20 “(H) The cost of maternity care
21 disaggregated by place of birth and provider of
22 care, including—

23 “(i) uncomplicated vaginal birth;

24 “(ii) complicated vaginal birth;

1 “(iii) uncomplicated cesarean birth;

2 and

3 “(iv) complicated cesarean birth.

4 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
5 is authorized to be appropriated, in addition to amounts
6 authorized to be appropriated under section 229(e), to
7 carry out this section \$1,000,000 for each of the fiscal
8 years 2019 through 2023.”.

9 (b) CONFORMING AMENDMENTS.—

10 (1) INCLUSION AS DUTY OF HHS OFFICE ON
11 WOMEN’S HEALTH.—Section 229(b) of such Act (42
12 U.S.C. 237a(b)), as amended by section 514, is fur-
13 ther amended by adding at the end the following
14 new paragraph:

15 “(9) establish the Interagency Coordinating
16 Committee on the Promotion of Optimal Maternity
17 Outcomes in accordance with section 229A; and”.

18 (2) TREATMENT OF BIENNIAL REPORTS.—Sec-
19 tion 229(d) of such Act (42 U.S.C. 237a(d)) is
20 amended by inserting “(other than under subsection
21 (b)(9))” after “under this section”.

22 **SEC. 516. CONSUMER EDUCATION CAMPAIGN.**

23 Section 229(b) of the Public Health Service Act (42
24 U.S.C. 237a(b)), as amended, is further amended by add-
25 ing at the end the following new paragraph:

1 “(10) not later than one year after the date of
2 the enactment of the Health Equity and Account-
3 ability Act of 2018, develop and implement a 4-year
4 culturally and linguistically appropriate multimedia
5 consumer education campaign that is designed to
6 promote understanding and acceptance of evidence-
7 based maternity practices and models of care for op-
8 timal maternity outcomes among individuals of
9 childbearing ages and families of such individuals
10 and that—

11 “(A) highlights the importance of pro-
12 tecting, promoting, and supporting the innate
13 capacities of childbearing individuals and their
14 newborns for childbirth, breastfeeding, and at-
15 tachment;

16 “(B) promotes understanding of the impor-
17 tance of using obstetric interventions when
18 medically necessary and when supported by
19 strong, high-quality evidence;

20 “(C) highlights the widespread overuse of
21 maternity practices that have been shown to
22 have benefit when used appropriately in situa-
23 tions of medical necessity, but which can expose
24 pregnant individuals, infants, or both to risk of
25 harm if used routinely and indiscriminately, in-

1 including continuous fetal monitoring, labor in-
2 duction, epidural anesthesia, elective primary
3 cesarean section, and repeat cesarean delivery;

4 “(D) emphasizes the noninvasive maternity
5 practices that have strong proven correlation or
6 may be associated with considerable improve-
7 ment in outcomes with no detrimental side ef-
8 fects, and are significantly underused in the
9 United States, including smoking cessation pro-
10 grams in pregnancy, group model prenatal care,
11 continuous labor support, nonsupine positions
12 for birth, and external version to turn breech
13 babies at term;

14 “(E) educates consumers about the quali-
15 fications of licensed providers of maternity care
16 and the best evidence about their safety, satis-
17 faction, outcomes, and costs;

18 “(F) informs consumers about the best
19 available research comparing birth center
20 births, planned home births, and hospital
21 births, including information about each set-
22 ting’s safety, satisfaction, outcomes, and costs;

23 “(G) fosters participation in high-quality,
24 evidence-based childbirth education that pro-
25 motes a natural, healthy, and safe approach to

1 pregnancy, childbirth, and early parenting; is
2 taught by certified educators, peer counselors,
3 and health professionals; and promotes in-
4 formed decisionmaking by childbearing individ-
5 uals; and

6 “(H) is pilot tested for consumer com-
7 prehension, cultural sensitivity, and acceptance
8 of the messages across geographically, racially,
9 ethnically, and linguistically diverse popu-
10 lations.”.

11 **SEC. 517. BIBLIOGRAPHIC DATABASE OF SYSTEMATIC RE-**
12 **VIEWS FOR CARE OF CHILDBEARING INDI-**
13 **VIDUALS AND NEWBORNS.**

14 (a) IN GENERAL.—Not later than one year after the
15 date of the enactment of this Act, the Secretary of Health
16 and Human Services, through the Agency for Healthcare
17 Research and Quality, shall—

18 (1) make publicly available an online biblio-
19 graphic database identifying systematic reviews, in-
20 cluding an explanation of the level and quality of
21 evidence, for care of childbearing individuals and
22 newborns; and

23 (2) initiate regular updates that incorporate
24 newly issued and updated systematic reviews.

1 (b) SOURCES.—To aim for a comprehensive inventory
2 of systematic reviews relevant to maternal and newborn
3 care, the database shall identify reviews from diverse
4 sources, including—

5 (1) scientific peer-reviewed journals;

6 (2) databases, including Cochrane Database of
7 Systematic Reviews, Clinical Evidence, and Data-
8 base of Abstracts of Reviews of Effects; and

9 (3) Internet Web sites of agencies and organi-
10 zations throughout the world that produce such sys-
11 tematic reviews.

12 (c) FEATURES.—The database shall—

13 (1) provide bibliographic citations for each
14 record within the database, and for each such cita-
15 tion include an explanation of the level and quality
16 of evidence;

17 (2) include abstracts, as available;

18 (3) provide reference to companion documents
19 as may exist for each review, such as evidence tables
20 and guidelines or consumer educational materials de-
21 veloped from the review;

22 (4) provide links to the source of the full review
23 and to any companion documents;

24 (5) provide links to the source of a previous
25 version or update of the review;

1 (6) be searchable by intervention or other topic
2 of the review, reported outcomes, author, title, and
3 source; and

4 (7) offer to users periodic electronic notification
5 of database updates relating to users' topics of inter-
6 est.

7 (d) OUTREACH.—Not later than the first date the
8 database is made publicly available and periodically there-
9 after, the Secretary of Health and Human Services shall
10 publicize the availability, features, and uses of the data-
11 base under this section to the stakeholders described in
12 subsection (e).

13 (e) CONSULTATION.—For purposes of developing the
14 database under this section and maintaining and updating
15 such database, the Secretary of Health and Human Serv-
16 ices shall convene and consult with an advisory committee
17 composed of relevant stakeholders, including—

18 (1) Federal Medicaid administrators and State
19 agencies administering State plans under title XIX
20 of the Social Security Act pursuant to section
21 1902(a)(5) of such Act (42 U.S.C. 1396a(a)(5));

22 (2) providers of maternity and newborn care
23 from both academic and community-based settings,
24 including obstetrician-gynecologists, family physi-
25 cians, certified nurse midwives, certified midwives,

1 certified professional midwives, physician assistants,
2 perinatal nurses, pediatricians, and nurse practi-
3 tioners;

4 (3) maternal-fetal medicine specialists;

5 (4) neonatologists;

6 (5) childbearing individuals and advocates for
7 such individuals, including childbirth educators cer-
8 tified by a nationally accredited program, rep-
9 resenting communities that are diverse in terms of
10 race, ethnicity, indigenous status, and geographic
11 area;

12 (6) employers and purchasers;

13 (7) health facility and system leaders, including
14 both hospital and birth center facilities;

15 (8) journalists; and

16 (9) bibliographic informatics specialists.

17 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
18 authorized to be appropriated \$2,500,000 for each of the
19 fiscal years 2019 through 2021 for the purpose of devel-
20 oping the database and such sums as may be necessary
21 for each subsequent fiscal year for updating the database
22 and providing outreach and notification to users, as de-
23 scribed in this section.

1 **SEC. 518. MATERNITY CARE HEALTH PROFESSIONAL**
2 **SHORTAGE AREAS.**

3 Section 332 of the Public Health Service Act (42
4 U.S.C. 254e) is amended by adding at the end the fol-
5 lowing new subsection:

6 “(k)(1) The Secretary, acting through the Adminis-
7 trator of the Health Resources and Services Administra-
8 tion, shall designate maternity care health professional
9 shortage areas in the States, publish a descriptive list of
10 the area’s population groups, medical facilities, and other
11 public facilities so designated, and at least annually review
12 and, as necessary, revise such designations.

13 “(2) For purposes of paragraph (1), a complete de-
14 scriptive list shall be published in the Federal Register not
15 later than one year after the date of the enactment of the
16 Health Equity and Accountability Act of 2018 and annu-
17 ally thereafter.

18 “(3) The provisions of subsections (b), (c), (e), (f),
19 (g), (h), (i), and (j) (other than (j)(1)(B)) of this section
20 shall apply to the designation of a maternity care health
21 professional shortage area in a similar manner and extent
22 as such provisions apply to the designation of health pro-
23 fessional shortage areas, except in applying subsection
24 (b)(3), the reference in such subsection to ‘physicians’
25 shall be deemed to be a reference to nationally certified
26 and State licensed obstetricians, family practice physicians

1 who practice full-scope maternity care, certified nurse
2 midwives, certified midwives, certified professional mid-
3 wives, and physician’s assistants who practice full scope
4 maternity care.

5 “(4) For purposes of this subsection, the term ‘ma-
6 ternity care health professional shortage area’ means—

7 “(A) an area in an urban or rural area (which
8 need not conform to the geographic boundaries of a
9 political subdivision and which is a rational area for
10 the delivery of health services) which the Secretary
11 determines has a shortage of providers of maternity
12 care health services including those referenced in
13 paragraph (3) or an urban or rural area that the
14 Secretary determines has lost a significant number
15 of such providers during the 10-year period begin-
16 ning with 2004 or has no obstetrical providers li-
17 censed to provide operative obstetrical services;

18 “(B) an area in an urban or rural area (which
19 need not conform to the geographic boundaries of a
20 political subdivision and which is a rational area for
21 the delivery of health services) which the Secretary
22 determines has a shortage of hospital or labor and
23 delivery units, hospital birth center units, or free-
24 standing birth centers or an area that lost a signifi-

1 cant number of these units during the 10-year pe-
2 riod beginning with 2004; or

3 “(C) a population group which the Secretary
4 determines has such a shortage of providers or fa-
5 cilities.”.

6 **SEC. 519. EXPANSION OF CDC PREVENTION RESEARCH**
7 **CENTERS PROGRAM TO INCLUDE CENTERS**
8 **ON OPTIMAL MATERNITY OUTCOMES.**

9 (a) **IN GENERAL.**—Not later than one year after the
10 date of the enactment of this Act, the Secretary of Health
11 and Human Services, shall support the establishment of
12 additional Prevention Research Centers under the Preven-
13 tion Research Center Program administered by the Cen-
14 ters for Disease Control and Prevention. Such additional
15 centers shall each be known as a Center for Excellence
16 on Optimal Maternity Outcomes.

17 (b) **RESEARCH.**—Each Center for Excellence on Opti-
18 mal Maternity Outcomes shall—

19 (1) conduct at least one focused program of re-
20 search to improve maternity outcomes, including the
21 reduction of cesarean birth rates, elective inductions,
22 prematurity rates, and low birth weight rates within
23 an underserved population that has a disproportion-
24 ately large burden of suboptimal maternity out-

1 comes, including maternal mortality and morbidity,
2 infant mortality, prematurity, or low birth weight;

3 (2) work with partners on special interest
4 projects, as specified by the Centers for Disease
5 Control and Prevention and other relevant agencies
6 within the Department of Health and Human Serv-
7 ices, and on projects funded by other sources; and

8 (3) involve a minimum of two distinct birth set-
9 ting models, such as a hospital labor and delivery
10 model and freestanding birth center model; or a hos-
11 pital labor and delivery model and planned home
12 birth model.

13 (c) INTERDISCIPLINARY PROVIDERS.—Each Center
14 for Excellence on Optimal Maternity Outcomes shall in-
15 clude the following interdisciplinary providers of maternity
16 care:

17 (1) Obstetrician-gynecologists.

18 (2) At least two of the following providers:

19 (A) Family practice physicians.

20 (B) Nurse practitioners.

21 (C) Physician assistants.

22 (D) Certified professional midwives.

23 (d) SERVICES.—Research conducted by each Center
24 for Excellence on Optimal Maternity Outcomes shall in-

1 clude at least 2 (and preferably more) of the following sup-
2 portive provider services:

3 (1) Mental health.

4 (2) Doula labor support.

5 (3) Nutrition education.

6 (4) Childbirth education.

7 (5) Social work.

8 (6) Physical therapy or occupation therapy.

9 (7) Substance abuse services.

10 (8) Home visiting.

11 (e) COORDINATION.—The programs of research at
12 each of the two Centers of Excellence on Optimal Mater-
13 nity Outcomes shall compliment and not replicate the
14 work of the other.

15 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
16 authorized to be appropriated to carry out this section
17 \$2,000,000 for each of the fiscal years 2019 through
18 2023.

19 **SEC. 520. EXPANDING MODELS ALLOWED TO BE TESTED BY**
20 **CENTER FOR MEDICARE & MEDICAID INNO-**
21 **VATION TO INCLUDE MATERNITY CARE MOD-**
22 **ELS.**

23 Section 1115A(b)(2)(B) of the Social Security Act
24 (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the
25 end the following new clause:

1 “(xxv) Promoting evidence-based mod-
2 els of care that have been associated with
3 reductions in maternal and infant health
4 disparities, including incorporating the use
5 of doula and promotoras support for preg-
6 nant and childbearing individuals into evi-
7 dence-based models of prenatal care, labor
8 and delivery, and postpartum care, and
9 supporting the appropriate use of out-of-
10 hospital birth models, including births at
11 home and in freestanding birth centers.”.

12 **SEC. 521. DEVELOPMENT OF INTERPROFESSIONAL MATER-**
13 **NITY CARE EDUCATIONAL MODELS AND**
14 **TOOLS.**

15 (a) IN GENERAL.—Not later than 6 months after the
16 date of the enactment of this Act, the Secretary of Health
17 and Human Services, acting in conjunction with the Ad-
18 ministrator of Health Resources and Services Administra-
19 tion, shall convene, for a 1-year period, an Interprofes-
20 sional Maternity Provider Education Commission to dis-
21 cuss and make recommendations for—

22 (1) a consensus standard physiologic maternity
23 care curriculum that takes into account the core
24 competencies for basic midwifery practice such as
25 those developed by the American College of Nurse

1 Midwives and the North American Registry of Mid-
2 wives, and the educational objectives for physicians
3 practicing in obstetrics and gynecology as deter-
4 mined by the Council on Resident Education in Ob-
5 stetrics and Gynecology;

6 (2) suggestions for multidisciplinary use of the
7 consensus physiologic curriculum;

8 (3) strategies to integrate and coordinate edu-
9 cation across maternity care disciplines, including
10 recommendations to increase medical and midwifery
11 student exposure to out-of-hospital birth; and

12 (4) pilot demonstrations of interprofessional
13 educational models.

14 (b) PARTICIPANTS.—The Commission shall include
15 maternity care educators, curriculum developers, service
16 leaders, certification leaders, and accreditation leaders
17 from the various professions that provide maternity care
18 in this country. Such professions shall include obstetrician
19 gynecologists, certified nurse midwives or certified mid-
20 wives, family practice physicians, nurse practitioners, phy-
21 sician assistants, certified professional midwives, and
22 perinatal nurses. Additionally, the Commission shall in-
23 clude representation from maternity care consumer advo-
24 cates.

1 (c) CURRICULUM.—The consensus standard physio-
2 logic maternity care curriculum described in subsection
3 (a)(1) shall—

4 (1) have a public health focus with a foundation
5 in health promotion and disease prevention;

6 (2) foster physiologic childbearing and woman
7 and family centered care;

8 (3) integrate strategies to reduce maternal and
9 infant morbidity and mortality;

10 (4) incorporate recommendations to ensure re-
11 spectful, safe, and seamless consultation, referral,
12 transport, and transfer of care when necessary; and

13 (5) include cultural sensitivity and strategies to
14 decrease disparities in maternity outcomes.

15 (d) REPORT.—Not later than 6 months after the final
16 meeting of the Commission, the Secretary of Health and
17 Human Services shall—

18 (1) submit to Congress a report containing the
19 recommendations made by the Commission under
20 this section; and

21 (2) make such report publicly available.

22 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
23 authorized to be appropriated to carry out this section
24 \$1,000,000 for each of the fiscal years 2019 and 2020,

1 and such sums as are necessary for each of the fiscal years
2 2021 through 2023.

3 **SEC. 522. INCLUDING WITHIN INPATIENT HOSPITAL SERV-**
4 **ICES UNDER MEDICARE SERVICES FUR-**
5 **NISHED BY CERTAIN STUDENTS, INTERNS,**
6 **AND RESIDENTS SUPERVISED BY CERTIFIED**
7 **NURSE MIDWIVES.**

8 (a) IN GENERAL.—Section 1861(b) of the Social Se-
9 curity Act (42 U.S.C. 1395x(b)) is amended—

10 (1) in paragraph (6), by striking “; or” and in-
11 sserting “, or in the case of services in a hospital or
12 osteopathic hospital by a student midwife or an in-
13 tern or resident-in-training under a teaching pro-
14 gram previously described in this paragraph who is
15 in the field of obstetrics and gynecology, if such stu-
16 dent midwife, intern, or resident-in-training is super-
17 vised by a certified nurse-midwife to the extent per-
18 mitted under applicable State law and as may be au-
19 thorized by the hospital;”;

20 (2) in paragraph (7), by striking the period at
21 the end and inserting “; or”; and

22 (3) by adding at the end the following new
23 paragraph:

1 “(8) a certified nurse-midwife where the hos-
2 pital has a teaching program approved as specified
3 in paragraph (6), if—

4 “(A) the hospital elects to receive any pay-
5 ment due under this title for reasonable costs of
6 such services; and

7 “(B) all certified nurse-midwives in such
8 hospital agree not to bill charges for profes-
9 sional services rendered in such hospital to indi-
10 viduals covered under the insurance program
11 established by this title.”.

12 (b) EFFECTIVE DATE.—The amendments made by
13 subsection (a) shall apply to services furnished on or after
14 the date of the enactment of this Act.

15 **SEC. 523. GRANTS TO PROFESSIONAL ORGANIZATIONS TO**
16 **INCREASE DIVERSITY IN MATERNAL, REPRO-**
17 **DUCTIVE, AND SEXUAL HEALTH PROFES-**
18 **SIONALS.**

19 (a) IN GENERAL.—The Secretary of Health and
20 Human Services, through the Administrator of the Health
21 Resources and Services Administration, shall carry out a
22 grant program under which the Secretary may make to
23 eligible health professional organizations—

24 (1) for fiscal year 2019, planning grants de-
25 scribed in subsection (b); and

1 (2) for the subsequent 4-year period, implemen-
2 tation grants described in subsection (c).

3 (b) PLANNING GRANTS.—

4 (1) IN GENERAL.—Planning grants described in
5 this subsection are grants for the following purposes:

6 (A) To collect data and identify any work-
7 force disparities, with respect to a health pro-
8 fession, at each of the following areas along the
9 health professional continuum:

10 (i) Pipeline availability with respect to
11 students at the high school and college or
12 university levels considering and working
13 toward entrance in the profession.

14 (ii) Entrance into the training pro-
15 gram for the profession.

16 (iii) Graduation from such training
17 program.

18 (iv) Entrance into practice.

19 (v) Retention in practice for more
20 than a 5-year period.

21 (B) To develop one or more strategies to
22 address the workforce disparities within the
23 health profession, as identified under (and in
24 response to the findings pursuant to) subpara-
25 graph (A).

1 (2) APPLICATION.—To be eligible to receive a
2 grant under this subsection, an eligible health pro-
3 fessional organization shall submit to the Secretary
4 of Health and Human Services an application in
5 such form and manner and containing such informa-
6 tion as specified by the Secretary.

7 (3) AMOUNT.—Each grant awarded under this
8 subsection shall be for an amount not to exceed
9 \$300,000.

10 (4) REPORT.—Each recipient of a grant under
11 this subsection shall submit to the Secretary of
12 Health and Human Services a report containing—

13 (A) information on the extent and distribu-
14 tion of workforce disparities identified through
15 the grant; and

16 (B) reasonable objectives and strategies
17 developed to address such disparities within a
18 5-, 10-, and 25-year period.

19 (c) IMPLEMENTATION GRANTS.—

20 (1) IN GENERAL.—Implementation grants de-
21 scribed in this subsection are grants to implement
22 one or more of the strategies developed pursuant to
23 a planning grant awarded under subsection (b).

24 (2) APPLICATION.—To be eligible to receive a
25 grant under this subsection, an eligible health pro-

1 fessional organization shall submit to the Secretary
2 of Health and Human Services an application in
3 such form and manner as specified by the Secretary.
4 Each such application shall contain information on
5 the capability of the organization to carry out a
6 strategy described in paragraph (1), involvement of
7 partners or coalitions, plans for developing sustain-
8 ability of the efforts after the culmination of the
9 grant cycle, and any other information specified by
10 the Secretary.

11 (3) AMOUNT.—Each grant awarded under this
12 subsection shall be for an amount not to exceed
13 \$500,000 each year during the 4-year period of the
14 grant.

15 (4) REPORTS.—For each of the first 3 years for
16 which an eligible health professional organization is
17 awarded a grant under this subsection, the organiza-
18 tion shall submit to the Secretary of Health and
19 Human Services a report on the activities carried
20 out by such organization through the grant during
21 such year and objectives for the subsequent year.
22 For the fourth year for which an eligible health pro-
23 fessional organization is awarded a grant under this
24 subsection, the organization shall submit to the Sec-
25 retary a report that includes an analysis of all the

1 activities carried out by the organization through the
2 grant and a detailed plan for continuation of out-
3 reach efforts.

4 (d) ELIGIBLE HEALTH PROFESSIONAL ORGANIZA-
5 TION DEFINED.—For purposes of this section, the term
6 “eligible health professional organization” means a profes-
7 sional organization representing obstetrician-gyne-
8 cologists, certified nurse midwives, certified midwives,
9 family practice physicians, nurse practitioners whose scope
10 of practice includes maternity or sexual and reproductive
11 health care, physician assistants whose scope of practice
12 includes obstetrical or sexual and reproductive health care,
13 or certified professional midwives adolescent medicine spe-
14 cialists, and pediatricians who provide sexual and repro-
15 ductive health care.

16 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
17 authorized to be appropriated to carry out this section
18 \$2,000,000 for fiscal year 2019 and \$3,000,000 for each
19 of the fiscal years 2020 through 2023.

20 **SEC. 524. INTERAGENCY UPDATE TO THE QUALITY FAMILY**
21 **PLANNING GUIDELINES.**

22 (a) IN GENERAL.—Not later than six months after
23 the date of enactment of this Act, the Director of the Cen-
24 ters for Disease Control and Prevention and the Office

1 of Population Affairs shall review and expand the 2014
2 Quality Family Planning Guidelines to address—

3 (1) health disparities; and

4 (2) the importance of patient-directed contra-
5 ceptive decisionmaking.

6 (b) CONSULTATION.—In carrying out subsection (a),
7 the Director of the Centers for Disease Control and Pre-
8 vention and the Office of Population Affairs shall convene
9 a meeting, and solicit the views of, stakeholders including
10 experts on health disparities, experts on reproductive coer-
11 cion, representatives of provider organizations, patient ad-
12 vocates, reproductive justice organizations, organizations
13 that represent racial and ethnic minority communities, or-
14 ganizations that represent people with disabilities, organi-
15 zations that represent LGBTQ persons, and organizations
16 that represent people with limited-English proficiency.

17 **SEC. 525. DISSEMINATION OF THE QUALITY FAMILY PLAN-**
18 **NING GUIDELINES.**

19 (a) IN GENERAL.—Not later than six months after
20 the date of enactment of this Act, the Secretary of Health
21 and Human Services and the Director of the Centers for
22 Disease Control and Prevention shall—

23 (1) develop a plan for outreach to publicly fund-
24 ed health care providers, including federally qualified
25 health centers and branches of the Indian Health

1 Service, about the quality family planning guidelines
2 referred to in section 524; and

3 (2) award grants to eligible entities to imple-
4 ment these guidelines for all patients seeking family
5 planning services.

6 (b) DEFINITION.—In this section, the term “eligible
7 entity” means a publicly funded health care provider that
8 serves persons of reproductive age.

9 **Subtitle B—Pregnancy Screening**

10 **SEC. 531. PREGNANCY INTENTION SCREENING INITIATIVE**

11 **DEMONSTRATION PROGRAM.**

12 Part P of title III of the Public Health Service Act
13 (42 U.S.C. 280g et seq.) is amended by adding at the end
14 the following new sections:

15 **“SEC. 399V-7. PREGNANCY INTENTION SCREENING INITIA-**

16 **TIVE DEMONSTRATION PROGRAM.**

17 “(a) PROGRAM ESTABLISHMENT.—The Secretary,
18 acting through the Director of the Centers for Disease
19 Control and Prevention, shall establish a demonstration
20 program to facilitate the clinical adoption of pregnancy in-
21 tention screening initiatives by health care providers.

22 “(b) GRANTS.—The Secretary may carry out the
23 demonstration program through awarding grants to eligi-
24 ble entities to implement pregnancy intention screening
25 initiatives, collect data, and evaluate such initiatives.

1 “(c) ELIGIBLE ENTITIES.—

2 “(1) IN GENERAL.—An eligible entity under
3 this section is an entity described in paragraph (2)
4 that provides non-directive, comprehensive, medically
5 accurate information.

6 “(2) ENTITIES DESCRIBED.—For purposes of
7 paragraph (1), an entity described in this paragraph
8 is a community-based organization, voluntary health
9 organization, public health department, community
10 health center, or other interested public or private
11 health care provider or organization.

12 “(d) PREGNANCY INTENTION SCREENING INITIA-
13 TIVE.—For purposes of this section, the term ‘pregnancy
14 intention screening initiative’ means any initiative by a
15 health care provider to routinely screen women with re-
16 spect to their pregnancy intentions and goals to either pre-
17 vent unintended pregnancies or improve the likelihood of
18 healthy pregnancies, in order to better provide health care
19 that meets the contraceptive or pre-pregnancy needs of
20 such women.

21 “(e) EVALUATION.—

22 “(1) IN GENERAL.—The Secretary, acting
23 through the Director of the Centers for Disease
24 Control and Prevention, shall, by grant or contract,
25 and after consultation as described in paragraph (2),

1 conduct an evaluation of the demonstration pro-
2 gram, with respect to pregnancy intention screening
3 initiatives, conducted under this section. The evalua-
4 tion shall include:

5 “(A) Assessment of the implementation of
6 pregnancy intention screening protocols among
7 a diverse group of patients and providers, in-
8 cluding collecting data on the experiences and
9 outcomes for diverse patient populations in a
10 variety of clinical settings.

11 “(B) Analysis of outcome measures that
12 will facilitate effective and widespread adoption
13 of such protocols by health care providers for
14 inquiring about and responding to pregnancy
15 intentions of women with both contraceptive
16 and pre-pregnancy care.

17 “(C) Consideration of health disparities
18 among the population served.

19 “(D) Assessment of the equitable and vol-
20 untary application of such initiatives to minor-
21 ity and medically underserved communities.

22 “(E) Assessment of the training, capacity,
23 and ongoing technical assistance needed for
24 providers to effectively implement such preg-
25 nancy intention screening protocols.

1 “(F) Assessment of whether referral sys-
2 tems for selected protocols follow evidence-based
3 standards that ensure access to comprehensive
4 health services and appropriate follow-up care.

5 “(2) INDEPENDENT, EXPERT ADVISORY
6 PANEL.—In conducting the evaluation under para-
7 graph (1), the Director of the Centers for Disease
8 Control and Prevention shall consult with physi-
9 cians, physician assistants, and nurses who spe-
10 cialize in women’s health, and other experts in clin-
11 ical practice, program evaluation, and research.

12 “(3) REPORT.—Not later than one year after
13 the last day of the demonstration program under
14 this section, the Director of the Centers for Disease
15 Control and Prevention shall submit to Congress a
16 report on the results of the evaluation conducted
17 under paragraph (1) and shall make the report pub-
18 licly available.

19 “(f) FUNDING.—

20 “(1) AUTHORIZATION OF APPROPRIATIONS.—
21 To carry out this section, there is authorized to be
22 appropriated \$5,000,000 for each of fiscal years
23 2019 through 2021.

24 “(2) LIMITATION.—Not more than 25 percent
25 of funds appropriated to carry out this section pur-

1 suant to paragraph (1) for a fiscal year may be used
2 for purposes of the evaluation under subsection
3 (e).”.

4 **TITLE VI—MENTAL HEALTH**

5 **SEC. 601. MENTAL HEALTH FINDINGS.**

6 Congress finds the following:

7 (1) Despite the existence of effective treat-
8 ments, disparities lie in the availability, accessibility,
9 and quality of mental health services for racial and
10 ethnic minorities.

11 (2) These disparities have powerful significance
12 for minority groups and for society as a whole.

13 (3) Racial and ethnic minorities bear a greater
14 burden from unmet mental health needs and thus
15 suffer a greater loss to their overall health and pro-
16 ductivity.

17 (4) The foremost barriers include the cost of
18 care, societal stigma, and the fragmented organiza-
19 tion of services.

20 (5) African American attitudes toward mental
21 illness are another barrier to seeking mental health
22 care.

23 (6) Mental illness retains considerable stigma,
24 and seeking treatment is not always encouraged.

1 (7) Mental illness is highly stigmatizing in
2 many Asian cultures.

3 (8) Addressing mental health stigma in commu-
4 nities will help increase utilization of mental health
5 services and reduce the burden of mental illness

6 **SEC. 602. COVERAGE OF MARRIAGE AND FAMILY THERA-**
7 **PIST SERVICES, MENTAL HEALTH COUN-**
8 **SELOR SERVICES, AND SUBSTANCE ABUSE**
9 **COUNSELOR SERVICES UNDER PART B OF**
10 **THE MEDICARE PROGRAM.**

11 (a) COVERAGE OF SERVICES.—

12 (1) IN GENERAL.—Section 1861(s)(2) of the
13 Social Security Act (42 U.S.C. 1395x(s)(2)), as
14 amended by section 450, is amended—

15 (A) in subparagraph (FF), by striking
16 “and” at the end;

17 (B) in subparagraph (GG), by inserting
18 “and” at the end; and

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

21 “(HH) marriage and family therapist services
22 (as defined in subsection (lll)(1)) and mental health
23 counselor services (as defined in subsection (lll)(3))
24 and substance abuse counselor services (as defined
25 in subsection (lll)(5));”.

1 (2) DEFINITIONS.—Section 1861 of such Act
2 (42 U.S.C. 1395x), as amended by sections 413(a)
3 and 470(a), is amended by adding at the end the
4 following new subsection:

5 “Marriage and Family Therapist Services; Marriage and
6 Family Therapist; Mental Health Counselor Serv-
7 ices; Mental Health Counselor

8 “(III)(1) The term ‘marriage and family therapist
9 services’ means services performed by a marriage and
10 family therapist (as defined in paragraph (2)) for the diag-
11 nosis and treatment of mental illnesses, which the mar-
12 riage and family therapist is legally authorized to perform
13 under State law (or the State regulatory mechanism pro-
14 vided by State law) of the State in which such services
15 are performed, as would otherwise be covered if furnished
16 by a physician or as an incident to a physician’s profes-
17 sional service, but only if no facility or other provider
18 charges or is paid any amounts with respect to the fur-
19 nishing of such services.

20 “(2) The term ‘marriage and family therapist’ means
21 an individual who—

22 “(A) possesses a master’s or doctoral degree
23 which qualifies for licensure or certification as a
24 marriage and family therapist pursuant to State
25 law;

1 “(B) after obtaining such degree has performed
2 at least 2 years of clinical supervised experience in
3 marriage and family therapy; and

4 “(C) in the case of an individual performing
5 services in a State that provides for licensure or cer-
6 tification of marriage and family therapists, is li-
7 censed or certified as a marriage and family thera-
8 pist in such State.

9 “(3) The term ‘mental health counselor services’
10 means services performed by a mental health counselor (as
11 defined in paragraph (4)) for the diagnosis and treatment
12 of mental illnesses which the mental health counselor is
13 legally authorized to perform under State law (or the
14 State regulatory mechanism provided by the State law) of
15 the State in which such services are performed, as would
16 otherwise be covered if furnished by a physician or as inci-
17 dent to a physician’s professional service, but only if no
18 facility or other provider charges or is paid any amounts
19 with respect to the furnishing of such services.

20 “(4) The term ‘mental health counselor’ means an
21 individual who—

22 “(A) possesses a master’s or doctor’s degree in
23 mental health counseling or a related field;

1 “(B) after obtaining such a degree has per-
2 formed at least 2 years of supervised mental health
3 counselor practice; and

4 “(C) in the case of an individual performing
5 services in a State that provides for licensure or cer-
6 tification of mental health counselors or professional
7 counselors, is licensed or certified as a mental health
8 counselor or professional counselor in such State.

9 “(5) The term ‘substance abuse counselor services’
10 means services performed by a substance abuse counselor
11 (as defined in paragraph (6)) for the diagnosis and treat-
12 ment of substance abuse and addiction which the sub-
13 stance abuse counselor is legally authorized to perform
14 under State law (or the State regulatory mechanism pro-
15 vided by the State law) of the State in which such services
16 are performed, as would otherwise be covered if furnished
17 by a physician or as incident to a physician’s professional
18 service, but only if no facility or other provider charges
19 or is paid any amounts with respect to the furnishing of
20 such services.

21 “(6) The term ‘substance abuse counselor’ means an
22 individual who—

23 “(A) has performed at least 2 years of super-
24 vised substance abuse counselor practice;

1 “(B) in the case of an individual performing
2 services in a State that provides for licensure or cer-
3 tification of substance abuse counselors or profes-
4 sional counselors, is licensed or certified as a sub-
5 stance abuse counselor or professional counselor in
6 such State; or

7 “(C) is a drug and alcohol counselor as defined
8 in section 40.281 of title 49, Code of Federal Regu-
9 lations.”.

10 (3) PROVISION FOR PAYMENT UNDER PART
11 B.—Section 1832(a)(2)(B) of such Act (42 U.S.C.
12 1395k(a)(2)(B)) is amended—

13 (A) by striking “and” at the end of clause
14 (iv); and

15 (B) by adding at the end the following new
16 clause:

17 “(v) marriage and family therapist
18 services, mental health counselor services,
19 and substance abuse counselor services;
20 and”.

21 (4) AMOUNT OF PAYMENT.—Section 1833(a)(1)
22 of such Act (42 U.S.C. 1395l(a)(1)), as amended by
23 section 431(c)(3), is amended—

24 (A) by striking “and (AA)” and inserting
25 “(AA)”; and

1 (B) by inserting before the semicolon at
2 the end the following: “, and (BB) with respect
3 to marriage and family therapist services, men-
4 tal health counselor services, and substance
5 abuse counselor services under section
6 1861(s)(2)(HH), the amounts paid shall be 80
7 percent of the lesser of the actual charge for
8 the services or 75 percent of the amount deter-
9 mined for payment of a psychologist under sub-
10 paragraph (L)”.

11 (5) EXCLUSION OF MARRIAGE AND FAMILY
12 THERAPIST SERVICES AND MENTAL HEALTH COUN-
13 SELOR SERVICES FROM SKILLED NURSING FACILITY
14 PROSPECTIVE PAYMENT SYSTEM.—Section
15 1888(e)(2)(A)(ii) of such Act (42 U.S.C.
16 1395yy(e)(2)(A)(ii)) is amended by inserting “mar-
17 riage and family therapist services (as defined in
18 section 1861(lll)(1)), mental health counselor serv-
19 ices (as defined in section 1861(lll)(3)),” after
20 “qualified psychologist services”.

21 (6) INCLUSION OF MARRIAGE AND FAMILY
22 THERAPISTS, MENTAL HEALTH COUNSELORS, AND
23 SUBSTANCE ABUSE COUNSELORS AS PRACTITIONERS
24 FOR ASSIGNMENT OF CLAIMS.—Section
25 1842(b)(18)(C) of such Act (42 U.S.C.

1 1395u(b)(18)(C)) is amended by adding at the end
2 the following new clauses:

3 “(vii) A marriage and family therapist (as de-
4 fined in section 1861(lll)(2)).

5 “(viii) A mental health counselor (as defined in
6 section 1861(lll)(4)).

7 “(ix) A substance abuse counselor (as defined
8 in section 1861 (lll)(6)).”.

9 (b) COVERAGE OF CERTAIN MENTAL HEALTH SERV-
10 ICES PROVIDED IN CERTAIN SETTINGS.—

11 (1) RURAL HEALTH CLINICS AND FEDERALLY
12 QUALIFIED HEALTH CENTERS.—Section
13 1861(aa)(1)(B) of the Social Security Act (42
14 U.S.C. 1395x(aa)(1)(B)) is amended by striking “or
15 by a clinical social worker (as defined in subsection
16 (hh)(1)),” and inserting “, by a clinical social worker
17 (as defined in subsection (hh)(1)), by a marriage
18 and family therapist (as defined in subsection
19 (lll)(2)), or by a mental health counselor (as defined
20 in subsection (lll)(4)), or by a substance abuse coun-
21 selor (as defined in section 1861 (lll)(6)).”.

22 (2) HOSPICE PROGRAMS.—Section
23 1861(dd)(2)(B)(i)(III) of such Act (42 U.S.C.
24 1395x(dd)(2)(B)(i)(III)) is amended by inserting “or

1 one marriage and family therapist (as defined in
2 subsection (lll)(2))” after “social worker”.

3 (c) AUTHORIZATION OF MARRIAGE AND FAMILY
4 THERAPISTS TO DEVELOP DISCHARGE PLANS FOR
5 POSTHOSPITAL SERVICES.—Section 1861(ee)(2)(G) of
6 the Social Security Act (42 U.S.C. 1395x(ee)(2)(G)) is
7 amended by inserting “marriage and family therapist (as
8 defined in subsection (lll)(2)),” after “social worker,”.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply with respect to services furnished
11 on or after January 1, 2019.

12 **SEC. 603. INTEGRATED HEALTH CARE DEMONSTRATION**
13 **PROGRAM.**

14 Part D of title V of the Public Health Service Act
15 (42 U.S.C. 290dd et seq.) is amended by adding at the
16 end the following:

17 **“SEC. 550. INTERPROFESSIONAL HEALTH CARE TEAMS FOR**
18 **PROVISION OF BEHAVIORAL HEALTH CARE**
19 **IN PRIMARY CARE SETTINGS.**

20 “(a) GRANTS.—The Secretary, acting through the
21 Assistant Secretary for Mental Health and Substance
22 Abuse, shall award grants to eligible entities for the pur-
23 pose of establishing interprofessional health care teams
24 that provide behavioral health care.

1 “(b) **ELIGIBLE ENTITIES.**—To be eligible to receive
2 a grant under this section, an entity shall be a federally
3 qualified health center (as defined in section 1861(aa) of
4 the Social Security Act), rural health clinic, or behavioral
5 health program, serving a high proportion of individuals
6 from racial and ethnic minority groups (as defined in sec-
7 tion 1707(g)).

8 “(c) **SCIENTIFICALLY BASED.**—Integrated health
9 care funded through this section shall be scientifically
10 based, taking into consideration the results of the most
11 recent peer-reviewed research available.

12 “(d) **AUTHORIZATION OF APPROPRIATIONS.**—To
13 carry out this section, there is authorized to be appro-
14 priated \$20,000,000 for each of fiscal years 2019 through
15 2024.”.

16 **SEC. 604. ADDRESSING RACIAL AND ETHNIC MINORITY**
17 **MENTAL HEALTH DISPARITIES RESEARCH**
18 **GAPS.**

19 Not later than 6 months after the date of the enact-
20 ment of this Act, the Director of the National Institute
21 on Minority Health and Health Disparities shall enter into
22 an arrangement with the National Academy of Sciences
23 (or, if the National Academy of Sciences declines to enter
24 into such an arrangement, an arrangement with the Insti-
25 tute of Medicine, the Patient Centered Outcomes Research

1 Institute, the Agency for Healthcare Quality, or another
2 appropriate entity)—

3 (1) to conduct a study with respect to mental
4 health disparities in racial and ethnic minority
5 groups (as defined in section 1707(g) of the Public
6 Health Service Act (42 U.S.C. 300u–6(g)); and

7 (2) to submit to the Congress a report on the
8 results of such study, including—

9 (A) a compilation of information on the dy-
10 namics of mental disorders in such racial and
11 ethnic minority groups; and

12 (B) a compilation of information on the
13 impact of exposure to community violence, ad-
14 verse childhood experiences, and other psycho-
15 logical traumas on mental disorders in such ra-
16 cial and minority groups.

17 **SEC. 605. HEALTH PROFESSIONS COMPETENCIES TO AD-**
18 **DRESS RACIAL AND ETHNIC MINORITY MEN-**
19 **TAL HEALTH DISPARITIES.**

20 (a) IN GENERAL.—The Secretary of Health and
21 Human Services, acting through the Assistant Secretary
22 for Mental Health and Substance Use, shall award grants
23 to qualified national organizations for the purposes of—

24 (1) developing, and disseminating to health pro-
25 fessional educational programs curricula or core

1 competencies addressing mental health disparities
2 among racial and ethnic minority groups for use in
3 the training of students in the professions of social
4 work, psychology, psychiatry, marriage and family
5 therapy, mental health counseling, and substance
6 abuse counseling; and

7 (2) certifying community health workers and
8 peer wellness specialists with respect to such cur-
9 ricula and core competencies and integrating and ex-
10 panding the use of such workers and specialists into
11 health care to address mental health disparities
12 among racial and ethnic minority groups.

13 (b) CURRICULA; CORE COMPETENCIES.—Organiza-
14 tions receiving funds under subsection (a) may use the
15 funds to engage in the following activities related to the
16 development and dissemination of curricula or core com-
17 petencies described in subsection (a)(1):

18 (1) Formation of committees or working groups
19 comprised of experts from accredited health profes-
20 sions schools to identify core competencies relating
21 to mental health disparities among racial and ethnic
22 minority groups.

23 (2) Planning of workshops in national fora to
24 allow for public input into the educational needs as-

1 sociated with mental health disparities among racial
2 and ethnic minority groups.

3 (3) Dissemination and promotion of the use of
4 curricula or core competencies in undergraduate and
5 graduate health professions training programs na-
6 tionwide.

7 (4) Establishing external stakeholder advisory
8 boards to provide meaningful input into policy and
9 program development and best practices to reduce
10 mental health disparities among racial and ethnic
11 minority groups.

12 (c) DEFINITIONS.—In this section:

13 (1) QUALIFIED NATIONAL ORGANIZATION.—The
14 term “qualified national organization” means a na-
15 tional organization that focuses on the education of
16 students in programs of social work, psychology,
17 psychiatry, and marriage and family therapy.

18 (2) RACIAL AND ETHNIC MINORITY GROUP.—
19 The term “racial and ethnic minority group” has the
20 meaning given to such term in section 1707(g) of
21 the Public Health Service Act (42 U.S.C. 300u-
22 6(g)).

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 2019 through 2024.

3 **SEC. 606. ASIAN AMERICAN, NATIVE HAWAIIAN, AND PA-**
4 **CIFIC ISLANDER BEHAVIORAL AND MENTAL**
5 **HEALTH OUTREACH AND EDUCATION STRAT-**
6 **EGIES.**

7 Part D of title V of the Public Health Service Act
8 (42 U.S.C. 290dd et seq.) is amended by adding at the
9 end the following new section:

10 **“SEC. 544. BEHAVIORAL AND MENTAL HEALTH OUTREACH**
11 **AND EDUCATION STRATEGIES.**

12 “(a) IN GENERAL.—The Secretary, acting through
13 the Administrator of the Substance Abuse and Mental
14 Health Services Administration, shall, in coordination with
15 advocacy and behavioral and mental health organizations
16 serving populations of Asian American, Native Hawaiian,
17 and Pacific Islander individuals or communities, develop
18 and implement an outreach and education strategy to pro-
19 mote behavioral and mental health and reduce stigma as-
20 sociated with mental health conditions and substance
21 abuse among the Asian American, Native Hawaiian, and
22 Pacific Islander populations. Such strategy shall—

23 “(1) be designed to—

24 “(A) meet the diverse cultural and lan-
25 guage needs of the various Asian American,

1 Native Hawaiian, and Pacific Islander popu-
2 lations; and

3 “(B) ensure such strategies are develop-
4 mentally and age appropriate;

5 “(2) increase awareness of symptoms of mental
6 illnesses common among such populations, taking
7 into account differences within subgroups, such as
8 gender, gender identity, age, sexual orientation, or
9 ethnicity, of such populations;

10 “(3) provide information on evidence-based, cul-
11 turally and linguistically appropriate and adapted
12 interventions and treatments;

13 “(4) ensure full participation of, and engage,
14 both consumers and community members in the de-
15 velopment and implementation of materials; and

16 “(5) seek to broaden the perspective among
17 both individuals in these communities and stake-
18 holders serving these communities to use a com-
19 prehensive public health approach to promoting be-
20 havioral health that addresses a holistic view of
21 health by focusing on the intersection between be-
22 havioral and physical health.

23 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
24 is authorized to be appropriated to carry out this section
25 \$300,000 for fiscal year 2019.”.

1 **SEC. 607. MENTAL HEALTH IN SCHOOLS.**

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

3 (1) revise, increase funding for, and expand the
4 scope of the Project AWARE State Educational
5 Agency Grant Program carried out by the Secretary
6 of Health and Human Services, in order to provide
7 access to more comprehensive school-based mental
8 health services and supports;

9 (2) provide for comprehensive staff development
10 for school and community service personnel working
11 in the school; and

12 (3) provide for comprehensive training for chil-
13 dren with mental health disorders, for parents, sib-
14 lings, and other family members of such children,
15 and for concerned members of the community.

16 (b) TECHNICAL AMENDMENTS.—The second part G
17 (relating to services provided through religious organiza-
18 tions) of title V of the Public Health Service Act (42
19 U.S.C. 290kk et seq.) is amended—

20 (1) by redesignating such part as part J; and

21 (2) by redesignating sections 581 through 584
22 as sections 596 through 596C, respectively.

23 (c) SCHOOL-BASED MENTAL HEALTH AND CHIL-
24 DREN AND VIOLENCE.—Section 581 of the Public Health
25 Service Act (42 U.S.C. 290hh) is amended to read as fol-
26 lows:

1 **“SEC. 581. SCHOOL-BASED MENTAL HEALTH AND CHIL-**
2 **DREN AND VIOLENCE.**

3 “(a) IN GENERAL.—The Secretary, in collaboration
4 with the Secretary of Education and in consultation with
5 the Attorney General, shall, directly or through grants,
6 contracts, or cooperative agreements awarded to eligible
7 entities described in subsection (c), assist local commu-
8 nities and schools (including schools funded by the Bureau
9 of Indian Education) in applying a public health approach
10 to mental health services both in schools and in the com-
11 munity. Such approach should provide comprehensive age
12 appropriate services and supports, be linguistically and
13 culturally appropriate, be trauma-informed, and incor-
14 porate age appropriate strategies of positive behavioral
15 interventions and supports. A comprehensive school men-
16 tal health program funded under this section shall assist
17 children in dealing with trauma and violence.

18 “(b) ACTIVITIES.—Under the program under sub-
19 section (a), the Secretary may—

20 “(1) provide financial support to enable local
21 communities to implement a comprehensive cul-
22 turally and linguistically appropriate, trauma-in-
23 formed, and age-appropriate, school-based mental
24 health program that—

25 “(A) builds awareness of trauma;

1 “(B) trains appropriate staff to identify
2 signs of trauma or mental health disorders; and

3 “(C) incorporates positive behavioral inter-
4 ventions, family engagement, student treatment,
5 and multi-generational supports to foster the
6 health and development of children;

7 “(2) provide technical assistance to local com-
8 munities with respect to the development of pro-
9 grams described in paragraph (1);

10 “(3) provide assistance to local communities in
11 the development of policies to address child and ado-
12 lescent trauma and mental health issues and violence
13 when and if it occurs;

14 “(4) facilitate community partnerships among
15 families, students, law enforcement agencies, edu-
16 cation systems, mental health and substance use dis-
17 order service systems, family-based mental health
18 service systems, child welfare agencies, health care
19 service systems (including primary care physicians),
20 faith-based programs, trauma networks, and other
21 community-based systems; and

22 “(5) establish mechanisms for children and ado-
23 lescents to report incidents of violence or plans by
24 other children, adolescents, or adults to commit vio-
25 lence.

1 “(c) REQUIREMENTS.—

2 “(1) IN GENERAL.—To be eligible for a grant,
3 contract, or cooperative agreement under subsection
4 (a), an entity shall—

5 “(A) be a partnership that—

6 “(i) shall include a State educational
7 agency and one or more local educational
8 agencies, with a local educational agency
9 serving as the lead partner; and

10 “(ii) may include, in accordance with
11 paragraph (2)(A)(i), appropriate public or
12 private entities that use evidence-based
13 interventions, as defined in section 8101 of
14 the Elementary and Secondary Education
15 Act of 1965 (20 U.S.C. 7801); and

16 “(B) submit an application, that is en-
17 dorsed by all members of the partnership, that
18 contains the assurances described in paragraph
19 (2).

20 “(2) REQUIRED ASSURANCES.—An application
21 under paragraph (1) shall contain assurances as fol-
22 lows:

23 “(A) That the eligible entity will ensure
24 that, in carrying out activities under this sec-

1 tion, the eligible entity will enter into a memo-
2 randum of understanding—

3 “(i) with at least 1 public or private
4 mental health entity, health care entity,
5 law enforcement or juvenile justice entity,
6 child welfare agency, family-based mental
7 health entity, trauma network, or other
8 community-based entity; and

9 “(ii) that clearly states—

10 “(I) the responsibilities of each
11 partner with respect to the activities
12 to be carried out, including how fam-
13 ily engagement will be incorporated in
14 the activities;

15 “(II) how school-employed and
16 school-based mental health profes-
17 sionals will be utilized for carrying out
18 such responsibilities;

19 “(III) how each such partner will
20 be accountable for carrying out such
21 responsibilities; and

22 “(IV) the amount of non-Federal
23 funding or in-kind contributions that
24 each such partner will contribute in
25 order to sustain the program.

1 “(B) That the comprehensive school-based
2 mental health program carried out under this
3 section supports the flexible use of funds to ad-
4 dress—

5 “(i) the promotion of the social, emo-
6 tional, and behavioral health of all students
7 in an environment that is conducive to
8 learning;

9 “(ii) the reduction in the likelihood of
10 at risk students developing social, emo-
11 tional, behavioral health problems, or sub-
12 stance use disorders;

13 “(iii) the early identification of social,
14 emotional, behavioral problems, or sub-
15 stance use disorders and the provision of
16 early intervention services;

17 “(iv) the treatment or referral for
18 treatment of students with existing social,
19 emotional, behavioral health problems, or
20 substance use disorders; and

21 “(v) the development and implementa-
22 tion of programs to assist children in deal-
23 ing with trauma and violence, including
24 program curricula, school supports, and
25 after-school programs.

1 “(C) That the comprehensive school-based
2 mental health program carried out under this
3 section will provide for in-service training of all
4 school personnel, including ancillary staff and
5 volunteers, in—

6 “(i) the techniques and supports need-
7 ed to identify early children with trauma
8 histories and children with, or at risk of,
9 mental illness;

10 “(ii) the use of referral mechanisms
11 that effectively link such children to appro-
12 priate treatment and intervention services
13 in the school and in the community and to
14 follow-up when services are not available;

15 “(iii) strategies that promote a school-
16 wide positive environment;

17 “(iv) strategies for promoting the so-
18 cial, emotional, mental, and behavioral
19 health of all students; and

20 “(v) strategies to increase the knowl-
21 edge and skills of school and community
22 leaders about the impact of trauma and vi-
23 olence and on the application of a public
24 health approach to comprehensive school-
25 based mental health programs.

1 “(D) That the comprehensive school-based
2 mental health program carried out under this
3 section will include comprehensive training for
4 parents, siblings, and other family members of
5 children with mental health disorders, and for
6 concerned members of the community in—

7 “(i) the techniques and supports need-
8 ed to identify early children with trauma
9 histories, and children with, or at risk of,
10 mental illness;

11 “(ii) the use of referral mechanisms
12 that effectively link such children to appro-
13 priate treatment and intervention services
14 in the school and in the community and
15 follow-up when such services are not avail-
16 able; and

17 “(iii) strategies that promote a school-
18 wide positive environment.

19 “(E) That the comprehensive school-based
20 mental health program carried out under this
21 section will demonstrate the measures to be
22 taken to sustain the program after funding
23 under this section terminates (which may in-
24 clude seeking funding for the program under a
25 State Medicaid plan under title XIX of the So-

1 cial Security Act (42 U.S.C. 1396 et seq.) or a
2 waiver of such a plan).

3 “(F) That the eligible entity is supported
4 by the State agency with primary responsibility
5 for behavioral health to ensure that the sustain-
6 ability of the programs is established after
7 funding under this section terminates.

8 “(G) That the comprehensive school-based
9 mental health program carried out under this
10 section will be based on trauma-informed and
11 evidence-based practices.

12 “(H) That the comprehensive school-based
13 mental health program carried out under this
14 section will be coordinated with early inter-
15 vening activities carried out under the Individ-
16 uals with Disabilities Education Act.

17 “(I) That the comprehensive school-based
18 mental health program carried out under this
19 section will be trauma-informed and culturally
20 and linguistically appropriate.

21 “(J) That the comprehensive school-based
22 mental health program carried out under this
23 section will include a broad needs assessment of
24 youth who drop out of school due to policies of
25 ‘zero tolerance’ with respect to drugs, alcohol,

1 or weapons and an inability to obtain appro-
2 priate services.

3 “(K) That the mental health services pro-
4 vided through the comprehensive school-based
5 mental health program carried out under this
6 section will be provided by qualified mental and
7 behavioral health professionals who are certified
8 or licensed by the State involved and practicing
9 within their area of expertise.

10 “(3) COORDINATOR.—Any entity that is a
11 member of a partnership described in paragraph
12 (1)(A) may serve as the coordinator of funding and
13 activities under the grant if all members of the part-
14 nership agree.

15 “(4) COMPLIANCE WITH HIPAA.—A grantee
16 under this section shall be deemed to be a covered
17 entity for purposes of compliance with the regula-
18 tions promulgated under section 264(c) of the
19 Health Insurance Portability and Accountability Act
20 of 1996 with respect to any patient records devel-
21 oped through activities under the grant.

22 “(d) GEOGRAPHICAL DISTRIBUTION.—The Secretary
23 shall ensure that grants, contracts, or cooperative agree-
24 ments under subsection (a) will be distributed equitably

1 among the regions of the country and among urban and
2 rural areas.

3 “(e) DURATION OF AWARDS.—With respect to a
4 grant, contract, or cooperative agreement under sub-
5 section (a), the period during which payments under such
6 an award will be made to the recipient shall be 5 years.
7 An eligible entity described in subsection (c) may receive
8 only one award under this section, except that an eligible
9 entity that is providing services and supports on a regional
10 basis may receive additional funding after the expiration
11 of the preceding grant period.

12 “(f) EVALUATION AND MEASURES OF OUTCOMES.—

13 “(1) DEVELOPMENT OF PROCESS.—The Ad-
14 ministrators shall develop a fiscally appropriate pro-
15 cess for evaluating activities carried out under this
16 section. Such process shall include—

17 “(A) the development of guidelines for the
18 submission of program data by grant, contract,
19 or cooperative agreement recipients;

20 “(B) the development of measures of out-
21 comes (in accordance with paragraph (2)) to be
22 applied by such recipients in evaluating pro-
23 grams carried out under this section; and

1 “(C) the submission of annual reports by
2 such recipients concerning the effectiveness of
3 programs carried out under this section.

4 “(2) MEASURES OF OUTCOMES.—

5 “(A) IN GENERAL.—The Administrator
6 shall develop measures of outcomes to be ap-
7 plied by recipients of assistance under this sec-
8 tion, and the Administrator, in evaluating the
9 effectiveness of programs carried out under this
10 section. Such measures shall include student
11 and family measures as provided for in sub-
12 paragraph (B) and local educational measures
13 as provided for under subparagraph (C).

14 “(B) STUDENT AND FAMILY MEASURES OF
15 OUTCOMES.—The measures of outcomes devel-
16 oped under paragraph (1)(B) relating to stu-
17 dents and families shall, with respect to activi-
18 ties carried out under a program under this
19 section, at a minimum include provisions to
20 evaluate whether the program is effective in—

21 “(i) increasing social and emotional
22 competency;

23 “(ii) increasing academic competency
24 (as defined by the Secretary);

1 “(iii) reducing disruptive and aggres-
2 sive behaviors;

3 “(iv) improving child functioning;

4 “(v) reducing substance use disorders;

5 “(vi) reducing suspensions, truancy,
6 expulsions, and violence;

7 “(vii) increasing high school gradua-
8 tion rates, calculated using the four-year
9 adjusted cohort graduation rate or the ex-
10 tended-year adjusted cohort graduation
11 rate (as such terms are defined in section
12 8101 of the Elementary and Secondary
13 Education Act of 1965 (20 U.S.C. 7801));
14 and

15 “(viii) improving access to care for
16 mental health disorders.

17 “(C) LOCAL EDUCATIONAL OUTCOMES.—

18 The outcome measures developed under para-
19 graph (1)(B) relating to local educational sys-
20 tems shall, with respect to activities carried out
21 under a program under this section, at a min-
22 imum include provisions to evaluate—

23 “(i) the effectiveness of comprehensive
24 school mental health programs established
25 under this section;

1 “(ii) the effectiveness of formal part-
2 nership linkages among child and family
3 serving institutions, community support
4 systems, and the educational system;

5 “(iii) the progress made in sustaining
6 the program once funding under the grant
7 has expired;

8 “(iv) the effectiveness of training and
9 professional development programs for all
10 school personnel that incorporate indica-
11 tors that measure cultural and linguistic
12 competencies under the program in a man-
13 ner that incorporates appropriate cultural
14 and linguistic training;

15 “(v) the improvement in perception of
16 a safe and supportive learning environment
17 among school staff, students, and parents;

18 “(vi) the improvement in case-finding
19 of students in need of more intensive serv-
20 ices and referral of identified students to
21 early intervention and clinical services;

22 “(vii) the improvement in the imme-
23 diate availability of clinical assessment and
24 treatment services within the context of

1 the local community to students posing a
2 danger to themselves or others;

3 “(viii) the increased successful matric-
4 ulation to postsecondary school; and

5 “(ix) reduced referrals to juvenile jus-
6 tice.

7 “(3) SUBMISSION OF ANNUAL DATA.—An eligi-
8 ble entity described in subsection (c) that receives a
9 grant, contract, or cooperative agreement under this
10 section shall annually submit to the Administrator a
11 report that includes data to evaluate the success of
12 the program carried out by the entity based on
13 whether such program is achieving the purposes of
14 the program. Such reports shall utilize the measures
15 of outcomes under paragraph (2) in a reasonable
16 manner to demonstrate the progress of the program
17 in achieving such purposes.

18 “(4) EVALUATION BY ADMINISTRATOR.—Based
19 on the data submitted under paragraph (3), the Ad-
20 ministrator shall annually submit to Congress a re-
21 port concerning the results and effectiveness of the
22 programs carried out with assistance received under
23 this section.

24 “(5) LIMITATION.—An eligible entity shall use
25 not more than 10 percent of amounts received under

1 a grant under this section to carry out evaluation
2 activities under this subsection.

3 “(g) INFORMATION AND EDUCATION.—The Sec-
4 retary shall establish comprehensive information and edu-
5 cation programs to disseminate the findings of the knowl-
6 edge development and application under this section to the
7 general public and to health care professionals.

8 “(h) AMOUNT OF GRANTS AND AUTHORIZATION OF
9 APPROPRIATIONS.—

10 “(1) AMOUNT OF GRANTS.—A grant under this
11 section shall be in an amount that is not more than
12 \$2,000,000 for each of fiscal years 2019 through
13 2023. The Secretary shall determine the amount of
14 each such grant based on the population of children
15 up to age 21 of the area to be served under the
16 grant.

17 “(2) AUTHORIZATION OF APPROPRIATIONS.—
18 There is authorized to be appropriated to carry out
19 this section, \$200,000,000 for each of fiscal years
20 2019 through 2023.”.

21 (d) CONFORMING AMENDMENT.—Part G of title V
22 of the Public Health Service Act (42 U.S.C. 290hh et
23 seq.), as amended by this section, is further amended by
24 striking the part heading and inserting the following:

1 **“PART G—SCHOOL-BASED MENTAL HEALTH”.**

2 **SEC. 608. GEO-ACCESS STUDY.**

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

5 (1) conduct a study to—

6 (A) determine which geographic areas of
7 the United States have shortages of specialty
8 mental health providers; and

9 (B) assess the preparedness of speciality
10 mental health providers to deliver culturally and
11 linguistically appropriate, affordable, and acces-
12 sible services; and

13 (2) submit a report to the Congress on the re-
14 sults of such study.

15 **TITLE VII—ADDRESSING HIGH**
16 **IMPACT MINORITY DISEASES**
17 **Subtitle A—Cancer**

18 **SEC. 701. LUNG CANCER MORTALITY REDUCTION.**

19 (a) **SHORT TITLE.**—This section may be cited as the
20 “Lung Cancer Mortality Reduction Act of 2018”.

21 (b) **FINDINGS.**—Congress makes the following find-
22 ings:

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) The 5-year survival rate for lung cancer is
11 still only 15 percent, and a similar coordinated and
12 comprehensive research effort is required to achieve
13 increases in lung cancer survivability rates.

14 (5) Sixty percent of lung cancer cases are now
15 diagnosed as nonsmokers or former smokers.

16 (6) Two-thirds of nonsmokers diagnosed with
17 lung cancer are women.

18 (7) Certain minority populations, such as Afri-
19 can American males, have disproportionately high
20 rates of lung cancer incidence and mortality, not-
21 withstanding their similar smoking rate.

22 (8) Members of the baby boomer generation are
23 entering their sixties, the most common age at which
24 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) Recent research has shown that screening
11 with low-dose computed tomography (CT) scan im-
12 proved lung cancer death mortality by 20 percent for
13 those with a high risk of lung cancer through early
14 detection. The Centers for Medicare & Medicaid
15 Services supports annual lung cancer screening for
16 high-risk patients with low-dose computed tomog-
17 raphy.

18 (12) Additional strategies are necessary to fur-
19 ther enhance the existing tests and therapies avail-
20 able to diagnose and treat lung cancer in the future.

21 (13) The August 2001 Report of the Lung
22 Cancer Progress Review Group of the National Can-
23 cer Institute stated that funding for lung cancer re-
24 search was “far below the levels characterized for

1 other common malignancies and far out of propor-
2 tion to its massive health impact”.

3 (14) The Report of the Lung Cancer Progress
4 Review Group identified as its “highest priority” the
5 creation of integrated, multidisciplinary, multi-insti-
6 tutional research consortia organized around the
7 problem of lung cancer rather than around specific
8 research disciplines.

9 (15) The United States must enhance its re-
10 sponse to the issues raised in the Report of the
11 Lung Cancer Progress Review Group, and this can
12 be accomplished through the establishment of a co-
13 ordinated effort designed to reduce the lung cancer
14 mortality rate by 50 percent by 2020 and targeted
15 funding to support this coordinated effort.

16 (c) SENSE OF CONGRESS CONCERNING INVESTMENT
17 IN LUNG CANCER RESEARCH.—It is the sense of the Con-
18 gress that—

19 (1) lung cancer mortality reduction should be
20 made a national public health priority; and

21 (2) a comprehensive mortality reduction pro-
22 gram coordinated by the Secretary of Health and
23 Human Services is justified and necessary to ade-
24 quately address and reduce lung cancer mortality.

1 (d) LUNG CANCER MORTALITY REDUCTION PRO-
2 GRAM.—

3 (1) IN GENERAL.—Subpart 1 of part C of title
4 IV of the Public Health Service Act (42 U.S.C. 285
5 et seq.) is amended by adding at the end the fol-
6 lowing:

7 **“SEC. 417H. LUNG CANCER MORTALITY REDUCTION PRO-**
8 **GRAM.**

9 “(a) IN GENERAL.—Not later than 6 months after
10 the date of the enactment of this section, the Secretary,
11 in consultation with the Secretary of Defense, the Sec-
12 retary of Veterans Affairs, the Director of the National
13 Institutes of Health, the Director of the Centers for Dis-
14 ease Control and Prevention, the Commissioner of Food
15 and Drugs, the Administrator of the Centers for Medicare
16 & Medicaid Services, the Director of the National Institute
17 on Minority Health and Health Disparities, and other
18 members of the Lung Cancer Advisory Board established
19 under section 701 of the Health Equity and Accountability
20 Act of 2018, shall implement a comprehensive program,
21 to be known as the Lung Cancer Mortality Reduction Pro-
22 gram, to achieve a reduction of at least 25 percent in the
23 mortality rate of lung cancer by 2020.

24 “(b) REQUIREMENTS.—The Program shall include at
25 least the following:

1 “(1) With respect to the National Institutes of
2 Health—

3 “(A) a strategic review and prioritization
4 by the National Cancer Institute of research
5 grants to achieve the goal of the Lung Cancer
6 Mortality Reduction Program in reducing lung
7 cancer mortality;

8 “(B) the provision of funds to enable the
9 Airway Biology and Disease Branch of the Na-
10 tional Heart, Lung, and Blood Institute to ex-
11 pand its research programs to include pre-
12 dispositions to lung cancer, the interrelationship
13 between lung cancer and other pulmonary and
14 cardiac disease, and the diagnosis and treat-
15 ment of these interrelationships;

16 “(C) the provision of funds to enable the
17 National Institute of Biomedical Imaging and
18 Bioengineering to expedite the development of
19 computer-assisted diagnostic, surgical, treat-
20 ment, and drug-testing innovations to reduce
21 lung cancer mortality, such as through expan-
22 sion of the Institute’s Quantum Grant Program
23 and Image-Guided Interventions programs; and

24 “(D) the provision of funds to enable the
25 National Institute of Environmental Health

1 Sciences to implement research programs rel-
2 ative to the lung cancer incidence.

3 “(2) With respect to the Food and Drug Ad-
4 ministration—

5 “(A) activities under section 530 of the
6 Federal Food, Drug, and Cosmetic Act; and

7 “(B) activities under section 561 of the
8 Federal Food, Drug, and Cosmetic Act to ex-
9 pand access to investigational drugs and devices
10 for the diagnosis, monitoring, or treatment of
11 lung cancer.

12 “(3) With respect to the Centers for Disease
13 Control and Prevention, the establishment of an
14 early disease research and management program
15 under section 1511.

16 “(4) With respect to the Agency for Healthcare
17 Research and Quality, the conduct of a biannual re-
18 view of lung cancer screening, diagnostic, and treat-
19 ment protocols, and the issuance of updated guide-
20 lines.

21 “(5) The promotion (including education) of
22 lung cancer screening within minority and rural pop-
23 ulations and the study of the effectiveness of efforts
24 to increase such screening.

1 “(6) The cooperation and coordination of all
2 minority and health disparity programs within the
3 Department of Health and Human Services to en-
4 sure that all aspects of the Lung Cancer Mortality
5 Reduction Program under this section adequately
6 address the burden of lung cancer on minority and
7 rural populations.

8 “(7) The cooperation and coordination of all to-
9 bacco control and cessation programs within agen-
10 cies of the Department of Health and Human Serv-
11 ices to achieve the goals of the Lung Cancer Mor-
12 tality Reduction Program under this section with
13 particular emphasis on the coordination of drug and
14 other cessation treatments with early detection pro-
15 tocols.”.

16 (2) FEDERAL FOOD, DRUG, AND COSMETIC
17 ACT.—Subchapter B of chapter V of the Federal
18 Food, Drug, and Cosmetic Act (21 U.S.C. 360aaa et
19 seq.) is amended by adding at the end the following:

20 “DRUGS RELATING TO LUNG CANCER

21 “SEC. 530. (a) IN GENERAL.—The provisions of this
22 subchapter shall apply to a drug described in subsection
23 (b) to the same extent and in the same manner as such
24 provisions apply to a drug for a rare disease or condition.

25 “(b) QUALIFIED DRUGS.—A drug described in this
26 subsection is—

1 “(1) a chemoprevention drug for precancerous
2 conditions of the lung;

3 “(2) a drug for targeted therapeutic treat-
4 ments, including any vaccine, for lung cancer; and

5 “(3) a drug to curtail or prevent nicotine addic-
6 tion.

7 “(c) BOARD.—The Board established under the
8 Health Equity and Accountability Act of 2018 shall mon-
9 itor the program implemented under this section.”.

10 (3) ACCESS TO UNAPPROVED THERAPIES.—Sec-
11 tion 561(e) of the Federal Food, Drug, and Cos-
12 metic Act (21 U.S.C. 360bbb(e)) is amended by in-
13 sserting before the period the following: “and shall
14 include expanding access to drugs under section
15 530, with substantial consideration being given to
16 whether the totality of information available to the
17 Secretary regarding the safety and effectiveness of
18 an investigational drug, as compared to the risk of
19 morbidity and death from the disease, indicates that
20 a patient may obtain more benefit than risk if treat-
21 ed with the drug”.

22 (4) CDC.—Title XV of the Public Health Serv-
23 ice Act (42 U.S.C. 300k et seq.) is amended by add-
24 ing at the end the following:

1 **“SEC. 1511. EARLY DISEASE RESEARCH AND MANAGEMENT**
2 **PROGRAM.**

3 “The Secretary shall establish and implement an
4 early disease research and management program targeted
5 at the high incidence and mortality rates of lung cancer
6 among minority and low-income populations.”.

7 (e) DEPARTMENT OF DEFENSE AND THE DEPART-
8 MENT OF VETERANS AFFAIRS.—The Secretary of Defense
9 and the Secretary of Veterans Affairs shall coordinate
10 with the Secretary of Health and Human Services—

11 (1) in the development of the Lung Cancer
12 Mortality Reduction Program under section 417H;

13 (2) in the implementation within the Depart-
14 ment of Defense and the Department of Veterans
15 Affairs of an early detection and disease manage-
16 ment research program for military personnel and
17 veterans whose smoking history and exposure to car-
18 cinogens during active duty service has increased
19 their risk for lung cancer; and

20 (3) in the implementation of coordinated care
21 programs for military personnel and veterans diag-
22 nosed with lung cancer.

23 (f) LUNG CANCER ADVISORY BOARD.—

24 (1) IN GENERAL.—The Secretary of Health and
25 Human Services shall convene a Lung Cancer Advi-

1 sory Board (referred to in this section as the
2 “Board”)—

3 (A) to monitor the programs established
4 under this section (and the amendments made
5 by this section); and

6 (B) to provide annual reports to the Con-
7 gress concerning benchmarks, expenditures,
8 lung cancer statistics, and the public health im-
9 pact of such programs.

10 (2) COMPOSITION.—The Board shall be com-
11 posed of—

12 (A) the Secretary of Health and Human
13 Services;

14 (B) the Secretary of Defense;

15 (C) the Secretary of Veterans Affairs; and

16 (D) two representatives each from the
17 fields of clinical medicine focused on lung can-
18 cer, lung cancer research, imaging, drug devel-
19 opment, and lung cancer advocacy, to be ap-
20 pointed by the Secretary of Health and Human
21 Services.

22 (g) AUTHORIZATION OF APPROPRIATIONS.—

23 (1) IN GENERAL.—To carry out this section
24 (and the amendments made by this section), there
25 are authorized to be appropriated such sums as may

1 be necessary for each of fiscal years 2019 through
2 2023.

3 (2) LUNG CANCER MORTALITY REDUCTION PRO-
4 GRAM.—Of the amounts authorized to be appro-
5 priated by subsection (a), there are authorized to be
6 appropriated—

7 (A) \$25,000,000 for fiscal year 2019, and
8 such sums as may be necessary for each of fis-
9 cal years 2020 through 2023, for the activities
10 described in section 417H(b)(1)(B) of the Pub-
11 lic Health Service Act, as added by subsection
12 (d)(1);

13 (B) \$25,000,000 for fiscal year 2019, and
14 such sums as may be necessary for each of fis-
15 cal years 2020 through 2023, for the activities
16 described in section 417H(b)(1)(C) of such Act;

17 (C) \$10,000,000 for fiscal year 2019, and
18 such sums as may be necessary for each of fis-
19 cal years 2020 through 2023, for the activities
20 described in section 417H(b)(1)(D) of such Act;
21 and

22 (D) \$15,000,000 for fiscal year 2019, and
23 such sums as may be necessary for each of fis-
24 cal years 2020 through 2023, for the activities
25 described in section 417H(b)(3) of such Act.

1 **SEC. 702. EXPANDING PROSTATE CANCER RESEARCH, OUT-**
2 **REACH, SCREENING, TESTING, ACCESS, AND**
3 **TREATMENT EFFECTIVENESS.**

4 (a) **SHORT TITLE.**—This section may be cited as the
5 “Prostate Research, Outreach, Screening, Testing, Access,
6 and Treatment Effectiveness Act of 2018” or the “PROS-
7 TATE Act”.

8 (b) **FINDINGS.**—Congress makes the following find-
9 ings:

10 (1) Prostate cancer is the second leading cause
11 of cancer death among men.

12 (2) In 2010, more than 217,730 new patients
13 were diagnosed with prostate cancer and more than
14 32,000 men died from this disease.

15 (3) Roughly 2,000,000 Americans are living
16 with a diagnosis of prostate cancer and its con-
17 sequences.

18 (4) While prostate cancer generally affects older
19 individuals, younger men are also at risk for the dis-
20 ease, and when prostate cancer appears in early
21 middle age, it frequently takes on a more aggressive
22 form.

23 (5) There are significant racial and ethnic dis-
24 parities that demand attention, namely African
25 Americans have prostate cancer mortality rates that
26 are more than double those in the White population.

1 (6) Underserved rural populations have higher
2 rates of mortality compared to their urban counter-
3 parts, and innovative and cost-efficient methods to
4 improve rural access to high-quality care should take
5 advantage of advances in telehealth to diagnose and
6 treat prostate cancer when appropriate.

7 (7) Certain veterans populations may have
8 nearly twice the incidence of prostate cancer as the
9 general population of the United States.

10 (8) Urologists may constitute the specialists
11 who diagnose and treat the vast majority of prostate
12 cancer patients.

13 (9) Although much basic and translational re-
14 search has been completed and much is currently
15 known, there are still many unanswered questions.
16 For example, it is not fully understood how much of
17 known disparities are attributable to disease eti-
18 ology, access to care, or education and awareness in
19 the community.

20 (10) Causes of prostate cancer are not known.
21 There is not good information regarding how to dif-
22 ferentiate accurately, early on, between aggressive
23 and indolent forms of the disease. As a result, there
24 is significant overtreatment in prostate cancer.
25 There are no treatments that can durably arrest

1 growth or cure prostate cancer once it has metasta-
2 sized.

3 (11) A significant proportion (roughly 23 to 54
4 percent) of cases may be clinically indolent and
5 “overdiagnosed”, resulting in significant overtreat-
6 ment. More accurate tests will allow men and their
7 families to face less physical, psychological, financial,
8 and emotional trauma, and billions of dollars could
9 be saved in private and public health care systems
10 in an area that has been identified by the Medicare
11 Program as one of eight high-volume, high-cost
12 areas in the Resource Utilization Report Program
13 authorized by Congress under the Medicare Im-
14 provements for Patients and Providers Act of 2008.

15 (12) Prostate cancer research and health care
16 programs across Federal agencies should be coordi-
17 nated to improve accountability and actively encour-
18 age the translation of research into practice, to iden-
19 tify and implement best practices, in order to foster
20 an integrated and consistent focus on effective pre-
21 vention, diagnosis, and treatment of this disease.

22 (c) PROSTATE CANCER COORDINATION AND EDU-
23 CATION.—

24 (1) INTERAGENCY PROSTATE CANCER COORDI-
25 NATION AND EDUCATION TASK FORCE.—Not later

1 than 180 days after the date of the enactment of
2 this section, the Secretary of Veterans Affairs, in co-
3 operation with the Secretary of Defense and the Sec-
4 retary of Health and Human Services, shall estab-
5 lish an Interagency Prostate Cancer Coordination
6 and Education Task Force (in this section referred
7 to as the “Prostate Cancer Task Force”).

8 (2) DUTIES.—The Prostate Cancer Task Force
9 shall—

10 (A) develop a summary of advances in
11 prostate cancer research supported or con-
12 ducted by Federal agencies relevant to the diag-
13 nosis, prevention, and treatment of prostate
14 cancer, including psychosocial impairments re-
15 lated to prostate cancer treatment, and compile
16 a list of best practices that warrant broader
17 adoption in health care programs;

18 (B) consider establishing, and advocating
19 for, a guidance to enable physicians to allow
20 screening of men who are over age 74, on a
21 case-by-case basis, taking into account quality
22 of life and family history of prostate cancer;

23 (C) share and coordinate information on
24 Federal research and health care program ac-
25 tivities, including activities related to—

1 (i) determining how to improve re-
2 search and health care programs, including
3 psychosocial impairments related to pros-
4 tate cancer treatment;

5 (ii) identifying any gaps in the overall
6 research inventory and in health care pro-
7 grams;

8 (iii) identifying opportunities to pro-
9 mote translation of research into practice;
10 and

11 (iv) maximizing the effects of Federal
12 efforts by identifying opportunities for col-
13 laboration and leveraging of resources in
14 research and health care programs that
15 serve those susceptible to or diagnosed
16 with prostate cancer;

17 (D) develop a comprehensive interagency
18 strategy and advise relevant Federal agencies in
19 the solicitation of proposals for collaborative,
20 multidisciplinary research and health care pro-
21 grams, including proposals to evaluate factors
22 that may be related to the etiology of prostate
23 cancer, that would—

24 (i) result in innovative approaches to
25 study emerging scientific opportunities or

1 eliminate knowledge gaps in research to
2 improve the prostate cancer research port-
3 folio of the Federal Government;

4 (ii) outline key research questions,
5 methodologies, and knowledge gaps; and

6 (iii) ensure consistent action, as out-
7 lined by section 402(b) of the Public
8 Health Service Act;

9 (E) develop a coordinated message related
10 to screening and treatment for prostate cancer
11 to be reflected in educational and beneficiary
12 materials for Federal health programs as such
13 documents are updated; and

14 (F) not later than 2 years after the date
15 of the establishment of the Prostate Cancer
16 Task Force, submit to the Expert Advisory
17 Panel to be reviewed and returned within 30
18 days, and then within 90 days submitted to
19 Congress recommendations—

20 (i) regarding any appropriate changes
21 to research and health care programs, in-
22 cluding recommendations to improve the
23 research portfolio of the Department of
24 Veterans Affairs, the Department of De-
25 fense, National Institutes of Health, and

1 other Federal agencies to ensure that sci-
2 entifically based strategic planning is im-
3 plemented in support of research and
4 health care program priorities;

5 (ii) designed to ensure that the re-
6 search and health care programs and ac-
7 tivities of the Department of Veterans Af-
8 fairs, the Department of Defense, the De-
9 partment of Health and Human Services,
10 and other Federal agencies are free of un-
11 necessary duplication;

12 (iii) regarding public participation in
13 decisions relating to prostate cancer re-
14 search and health care programs to in-
15 crease the involvement of patient advo-
16 cates, community organizations, and med-
17 ical associations representing a broad geo-
18 graphical area;

19 (iv) on how to best disseminate infor-
20 mation on prostate cancer research and
21 progress achieved by health care programs;

22 (v) about how to expand partnerships
23 between public entities, including Federal
24 agencies, and private entities to encourage

1 collaborative, cross-cutting research and
2 health care delivery;

3 (vi) assessing any cost savings and ef-
4 ficiencies realized through the efforts iden-
5 tified and supported in this section and
6 recommending expansion of those efforts
7 that have proved most promising while also
8 ensuring against any conflicts in directives
9 from other congressional or statutory man-
10 dates or enabling statutes;

11 (vii) identifying key priority action
12 items from among the recommendations;
13 and

14 (viii) with respect to the level of fund-
15 ing needed by each agency to implement
16 the recommendations contained in the re-
17 port.

18 (3) MEMBERS OF THE PROSTATE CANCER TASK
19 FORCE.—The Prostate Cancer Task Force described
20 in this subsection shall be composed of representa-
21 tives from such Federal agencies, as each Secretary
22 determines necessary, to coordinate a uniform mes-
23 sage relating to prostate cancer screening and treat-
24 ment where appropriate, including representatives of
25 the following:

1 (A) The Department of Veterans Affairs,
2 including representatives of each relevant pro-
3 gram area of the Department of Veterans Af-
4 fairs.

5 (B) The Prostate Cancer Research Pro-
6 gram of the Congressionally Directed Medical
7 Research Program of the Department of De-
8 fense.

9 (C) The Department of Health and
10 Human Services, including at a minimum rep-
11 resentatives of the following:

12 (i) The National Institutes of Health.

13 (ii) National research institutes and
14 centers, including the National Cancer In-
15 stitute, the National Institute of Allergy
16 and Infectious Diseases, and the Office of
17 Minority Health.

18 (iii) The Centers for Medicare & Med-
19 icaid Services.

20 (iv) The Food and Drug Administra-
21 tion.

22 (v) The Centers for Disease Control
23 and Prevention.

24 (vi) The Agency for Healthcare Re-
25 search and Quality.

1 (vii) The Health Resources and Serv-
2 ices Administration.

3 (4) APPOINTING EXPERT ADVISORY PANELS.—

4 The Prostate Cancer Task Force shall appoint ex-
5 pert advisory panels, as determined appropriate, to
6 provide input and concurrence from individuals and
7 organizations from the medical, prostate cancer pa-
8 tient and advocate, research, and delivery commu-
9 nities with expertise in prostate cancer diagnosis,
10 treatment, and research, including practicing urolo-
11 gists, primary care providers, and others and indi-
12 viduals with expertise in education and outreach to
13 underserved populations affected by prostate cancer.

14 (5) MEETINGS.—The Prostate Cancer Task
15 Force shall convene not less than twice a year, or
16 more frequently as the Secretary determines to be
17 appropriate.

18 (6) FEDERAL ADVISORY COMMITTEE ACT.—

19 (A) IN GENERAL.—Except as provided in
20 subparagraph (B), the Federal Advisory Com-
21 mittee Act (5 U.S.C. App.) shall apply to the
22 Prostate Cancer Task Force.

23 (B) EXCEPTION.—Section 14(a)(2)(B) of
24 such Act (relating to the termination of advi-

1 sory committees) shall not apply to the Prostate
2 Cancer Task Force.

3 (7) SUNSET DATE.—The Prostate Cancer Task
4 Force shall terminate at the end of fiscal year 2021.

5 (d) PROSTATE CANCER RESEARCH.—

6 (1) RESEARCH COORDINATION.—The Secretary
7 of Veterans Affairs, in coordination with the Secre-
8 taries of Defense and of Health and Human Serv-
9 ices, shall establish and carry out a program to co-
10 ordinate and intensify prostate cancer research as
11 needed. Specifically, such research program shall—

12 (A) develop advances in diagnostic and
13 prognostic methods and tests, including bio-
14 markers and an improved prostate cancer
15 screening blood test, including improvements or
16 alternatives to the prostate specific antigen test
17 and additional tests to distinguish indolent from
18 aggressive disease;

19 (B) better understand the etiology of the
20 disease (including an analysis of lifestyle factors
21 proven to be involved in higher rates of prostate
22 cancer, such as obesity and diet, and in dif-
23 ferent ethnic, racial, and socioeconomic groups,
24 such as the African-American, Latino or His-
25 panic, and American Indian populations and

1 men with a family history of prostate cancer) to
2 improve prevention efforts;

3 (C) expand basic research into prostate
4 cancer, including studies of fundamental molec-
5 ular and cellular mechanisms;

6 (D) identify and provide clinical testing of
7 novel agents for the prevention and treatment
8 of prostate cancer;

9 (E) establish clinical registries for prostate
10 cancer;

11 (F) use the National Institute of Bio-
12 medical Imaging and Bioengineering and the
13 National Cancer Institute for assessment of ap-
14 propriate imaging modalities; and

15 (G) address such other matters relating to
16 prostate cancer research as may be identified by
17 the Federal agencies participating in the pro-
18 gram under this section.

19 (2) PROSTATE CANCER ADVISORY BOARD.—

20 There is established in the Office of the Chief Sci-
21 entist of the Food and Drug Administration a Pros-
22 tate Cancer Scientific Advisory Board. Such board
23 shall be responsible for accelerating real-time shar-
24 ing of the latest research data and accelerating
25 movement of new medicines to patients.

1 (3) UNDERSERVED MINORITY GRANT PRO-
2 GRAM.—In carrying out such program, the Secretary
3 shall—

4 (A) award grants to eligible entities to
5 carry out components of the research outlined
6 in paragraph (1);

7 (B) integrate and build upon existing
8 knowledge gained from comparative effective-
9 ness research; and

10 (C) recognize and address—

11 (i) the racial and ethnic disparities in
12 the incidence and mortality rates of pros-
13 tate cancer and men with a family history
14 of prostate cancer;

15 (ii) any barriers in access to care and
16 participation in clinical trials that are spe-
17 cific to racial, ethnic, and other under-
18 served minorities and men with a family
19 history of prostate cancer;

20 (iii) needed outreach and educational
21 efforts to raise awareness in these commu-
22 nities; and

23 (iv) appropriate access and utilization
24 of imaging modalities.

1 (e) TELEHEALTH AND RURAL ACCESS PILOT
2 PROJECTS.—

3 (1) IN GENERAL.—The Secretary of Veterans
4 Affairs, the Secretary of Defense, and the Secretary
5 of Health and Human Services (in this section re-
6 ferred to as the “Secretaries”) shall establish 4-year
7 telehealth pilot projects for the purpose of analyzing
8 the clinical outcomes and cost-effectiveness associ-
9 ated with telehealth services in a variety of geo-
10 graphic areas that contain high proportions of medi-
11 cally underserved populations, including African
12 Americans, Latinos or Hispanics, American Indians
13 or Alaska Natives, and those in rural areas. Such
14 projects shall promote efficient use of specialist care
15 through better coordination of primary care and
16 physician extender teams in underserved areas and
17 more effectively employ tumor boards to better coun-
18 sel patients.

19 (2) ELIGIBLE ENTITIES.—

20 (A) IN GENERAL.—The Secretaries shall
21 select eligible entities to participate in the pilot
22 projects under this section.

23 (B) PRIORITY.—In selecting eligible enti-
24 ties to participate in the pilot projects under
25 this section, the Secretaries shall give priority

1 to such entities located in medically under-
2 served areas, particularly those that include Af-
3 rican Americans, Latinos and Hispanics, and
4 facilities of the Indian Health Service, including
5 Indian Health Service-operated facilities, trib-
6 ally operated facilities, and Urban Indian Clin-
7 ics, and those in rural areas.

8 (3) EVALUATION.—The Secretaries shall,
9 through the pilot projects, evaluate—

10 (A) the effective and economic delivery of
11 care in diagnosing and treating prostate cancer
12 with the use of telehealth services in medically
13 underserved and Tribal areas including collabo-
14 rative uses of health professionals and integra-
15 tion of the range of telehealth and other tech-
16 nologies;

17 (B) the effectiveness of improving the ca-
18 pacity of nonmedical providers and nonspecial-
19 ized medical providers to provide health services
20 for prostate cancer in medically underserved
21 and Tribal areas, including the exploration of
22 innovative medical home models with collabora-
23 tion between urologists, other relevant medical
24 specialists, including oncologists, radiologists,
25 and primary care teams and coordination of

1 care through the efficient use of primary care
2 teams and physician extenders; and

3 (C) the effectiveness of using telehealth
4 services to provide prostate cancer treatment in
5 medically underserved areas, including the use
6 of tumor boards to facilitate better patient
7 counseling.

8 (4) REPORT.—Not later than 12 months after
9 the completion of the pilot projects under this sub-
10 section, the Secretaries shall submit to Congress a
11 report describing the outcomes of such pilot projects,
12 including any cost savings and efficiencies realized,
13 and providing recommendations, if any, for expand-
14 ing the use of telehealth services.

15 (f) EDUCATION AND AWARENESS.—

16 (1) IN GENERAL.—The Secretary of Veterans
17 Affairs shall develop a national education campaign
18 for prostate cancer. Such campaign shall involve the
19 use of written educational materials and public serv-
20 ice announcements consistent with the findings of
21 the Prostate Cancer Task Force under subsection
22 (c), that are intended to encourage men to seek
23 prostate cancer screening when appropriate.

24 (2) RACIAL DISPARITIES AND THE POPULATION
25 OF MEN WITH A FAMILY HISTORY OF PROSTATE

1 CANCER.—In developing the national campaign
2 under paragraph (1), the Secretary shall ensure that
3 such educational materials and public service an-
4 nouncements are more readily available in commu-
5 nities experiencing racial disparities in the incidence
6 and mortality rates of prostate cancer and by men
7 of any race classification with a family history of
8 prostate cancer.

9 (3) GRANTS.—In carrying out the national
10 campaign under this section, the Secretary shall
11 award grants to nonprofit private entities to enable
12 such entities to test alternative outreach and edu-
13 cation strategies.

14 (g) AUTHORIZATION OF APPROPRIATIONS.—

15 (1) IN GENERAL.—There is authorized to be
16 appropriated to carry out this section for the period
17 of fiscal years 2019 through 2023 an amount equal
18 to the savings described in paragraph (2).

19 (2) CORRESPONDING REDUCTION.—The
20 amount authorized to be appropriated by provisions
21 of law other than this section for the period of fiscal
22 years 2019 through 2023 for Federal research and
23 health care program activities related to prostate
24 cancer is reduced by the amount of Federal savings

1 projected to be achieved over such period by imple-
2 mentation of this section.

3 **SEC. 703. IMPROVED MEDICAID COVERAGE FOR CERTAIN**
4 **BREAST AND CERVICAL CANCER PATIENTS**
5 **IN THE TERRITORIES.**

6 (a) ELIMINATION OF FUNDING LIMITATIONS.—

7 (1) IN GENERAL.—Section 1108(g)(4) of the
8 Social Security Act (42 U.S.C. 1308(g)(4)) is
9 amended by adding at the end the following: “With
10 respect to fiscal years beginning with fiscal year
11 2019, payment for medical assistance for individuals
12 who are eligible for such assistance only on the basis
13 of section 1902(a)(10)(A)(ii)(XVIII) shall not be
14 taken into account in applying subsection (f) (as in-
15 creased in accordance with paragraphs (1), (2), (3),
16 and (5) of this subsection) to such commonwealth or
17 territory for such fiscal year.”.

18 (2) TECHNICAL AMENDMENT.—Such section is
19 further amended by striking “(3), and (4)” and in-
20 serting “(3), and (5)”.

21 (b) APPLICATION OF ENHANCED FMAP FOR HIGH-
22 EST STATE.—Section 1905(b) of such Act (42 U.S.C.
23 1396d(b)) is amended by adding at the end the following:
24 “Notwithstanding the first sentence of this subsection,
25 with respect to medical assistance described in clause (4)

1 of such sentence that is furnished in Puerto Rico, the
2 United States Virgin Islands, Guam, the Commonwealth
3 of the Northern Mariana Islands, or American Samoa in
4 a fiscal year, the Federal medical assistance percentage
5 is equal to the highest such percentage applied under such
6 clause for such fiscal year for any of the 50 States or the
7 District of Columbia that provides such medical assistance
8 for any portion of such fiscal year.”

9 (c) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to payment for medical assistance
11 for items and services furnished on or after October 1,
12 2016.

13 **SEC. 704. CANCER PREVENTION AND TREATMENT DEM-**
14 **ONSTRATION FOR ETHNIC AND RACIAL MI-**
15 **NORITIES.**

16 (a) DEMONSTRATION.—

17 (1) IN GENERAL.—The Secretary of Health and
18 Human Services (in this section referred to as the
19 “Secretary”) shall conduct demonstration projects
20 (in this section referred to as “demonstration
21 projects”) for the purpose of developing models and
22 evaluating methods that—

23 (A) improve the quality of items and serv-
24 ices provided to target individuals in order to

1 facilitate reduced disparities in early detection
2 and treatment of cancer;

3 (B) improve clinical outcomes, satisfaction,
4 quality of life, appropriate use of items and
5 services covered under the Medicare Program
6 under title XVIII of the Social Security Act (42
7 U.S.C. 1395 et seq.), and referral patterns with
8 respect to target individuals with cancer;

9 (C) eliminate disparities in the rate of pre-
10 ventive cancer screening measures, such as Pap
11 smears, prostate cancer screenings, colon cancer
12 screenings, breast cancer screenings, and com-
13 puted tomography (CT) scans, for lung cancer
14 among target individuals;

15 (D) promote collaboration with community-
16 based organizations to ensure cultural com-
17 petency of health care professionals and lin-
18 guistic access for target individuals who are
19 persons with limited-English proficiency; and

20 (E) encourage the incorporation of commu-
21 nity health workers to increase the efficiency
22 and appropriateness of cancer screening pro-
23 grams.

24 (2) COMMUNITY HEALTH WORKER DEFINED.—

25 In this section, the term “community health worker”

1 includes a community health advocate, a lay health
2 worker, a community health representative, a peer
3 health promoter, a community health outreach work-
4 er, and a promotore de salud, who promotes health
5 or nutrition within the community in which the indi-
6 vidual resides.

7 (3) TARGET INDIVIDUAL DEFINED.—In this
8 section, the term “target individual” means an indi-
9 vidual of a racial and ethnic minority group, as de-
10 fined in section 1707(g)(1) of the Public Health
11 Service Act (42 U.S.C. 300u–6(g)(1)), who is enti-
12 tled to benefits under part A, and enrolled under
13 part B, of title XVIII of the Social Security Act.

14 (b) PROGRAM DESIGN.—

15 (1) INITIAL DESIGN.—Not later than 1 year
16 after the date of the enactment of this Act, the Sec-
17 retary shall evaluate best practices in the private
18 sector, community programs, and academic research
19 of methods that reduce disparities among individuals
20 of racial and ethnic minority groups in the preven-
21 tion and treatment of cancer and shall design the
22 demonstration projects based on such evaluation.

23 (2) NUMBER AND PROJECT AREAS.—Not later
24 than 2 years after the date of the enactment of this

1 Act, the Secretary shall implement at least nine
2 demonstration projects, including the following:

3 (A) Two projects, each of which shall tar-
4 get different ethnic subpopulations, for each of
5 the four following major racial and ethnic mi-
6 nority groups:

7 (i) American Indians and Alaska Na-
8 tives, Eskimos and Aleuts.

9 (ii) Asian Americans.

10 (iii) Blacks/African Americans.

11 (iv) Latinos or Hispanics.

12 (v) Native Hawaiians and other Pa-
13 cific Islanders.

14 (B) One project within the Pacific Islands
15 or United States insular areas.

16 (C) At least one project each in a rural
17 area and inner-city area.

18 (3) EXPANSION OF PROJECTS; IMPLEMENTA-
19 TION OF DEMONSTRATION PROJECT RESULTS.—If
20 the initial report under subsection (c) contains an
21 evaluation that demonstration projects—

22 (A) reduce expenditures under the Medi-
23 care Program under title XVIII of the Social
24 Security Act (42 U.S.C. 1395 et seq.); or

1 (B) do not increase expenditures under the
2 Medicare Program and reduce racial and ethnic
3 health disparities in the quality of health care
4 services provided to target individuals and in-
5 crease satisfaction of Medicare beneficiaries and
6 health care providers;

7 the Secretary shall continue the existing demonstra-
8 tion projects and may expand the number of dem-
9 onstration projects.

10 (c) REPORT TO CONGRESS.—

11 (1) IN GENERAL.—Not later than 2 years after
12 the date the Secretary implements the initial dem-
13 onstration projects, and biannually thereafter, the
14 Secretary shall submit to Congress a report regard-
15 ing the demonstration projects.

16 (2) CONTENTS OF REPORT.—Each report under
17 paragraph (1) shall include the following:

18 (A) A description of the demonstration
19 projects.

20 (B) An evaluation of—

21 (i) the cost-effectiveness of the dem-
22 onstration projects;

23 (ii) the quality of the health care serv-
24 ices provided to target individuals under
25 the demonstration projects; and

1 (iii) beneficiary and health care pro-
2 vider satisfaction under the demonstration
3 projects.

4 (C) Any other information regarding the
5 demonstration projects that the Secretary de-
6 termines to be appropriate.

7 (d) WAIVER AUTHORITY.—The Secretary shall waive
8 compliance with the requirements of title XVIII of the So-
9 cial Security Act (42 U.S.C. 1395 et seq.) to such extent
10 and for such period as the Secretary determines is nec-
11 essary to conduct demonstration projects.

12 **SEC. 705. REDUCING CANCER DISPARITIES WITHIN MEDI-**
13 **CARE.**

14 (a) DEVELOPMENT OF MEASURES OF DISPARITIES
15 IN QUALITY OF CANCER CARE.—

16 (1) DEVELOPMENT OF MEASURES.—The Sec-
17 retary of Health and Human Services (in this sec-
18 tion referred to as the “Secretary”) shall enter into
19 an agreement with an entity that specializes in de-
20 veloping quality measures for cancer care under
21 which the entity shall develop a uniform set of meas-
22 ures to evaluate disparities in the quality of cancer
23 care and annually update such set of measures.

24 (2) MEASURES TO BE INCLUDED.—Such set of
25 measures shall include, with respect to the treatment

1 of cancer, measures of patient outcomes, the process
2 for delivering medical care related to such treat-
3 ment, patient counseling and engagement in deci-
4 sionmaking, patient experience of care, resource use,
5 and practice capabilities, such as care coordination.

6 (b) ESTABLISHMENT OF REPORTING PROCESS.—

7 (1) IN GENERAL.—The Secretary shall establish
8 a reporting process that requires and provides for a
9 method for health care providers specified under
10 paragraph (2) to submit to the Secretary and make
11 public data on the performance of such providers
12 during each reporting period through use of the
13 measures developed pursuant to subsection (a). Such
14 data shall be submitted in a form and manner and
15 at a time specified by the Secretary.

16 (2) SPECIFICATION OF PROVIDERS TO REPORT
17 ON MEASURES.—The Secretary shall specify the
18 classes of Medicare providers of services and sup-
19 pliers, including hospitals, cancer centers, physi-
20 cians, primary care providers, and specialty pro-
21 viders, that will be required under such process to
22 publicly report on the measures specified under sub-
23 section (a).

24 (3) ASSESSMENT OF CHANGES.—Under such
25 reporting process, the Secretary shall establish a for-

1 mat that assesses changes in both the absolute and
2 relative disparities in cancer care over time. These
3 measures shall be presented in an easily comprehen-
4 sible format, such as those presented in the final
5 publications relating to Healthy People 2010 or the
6 National Healthcare Disparities Report.

7 (4) INITIAL IMPLEMENTATION.—The Secretary
8 shall implement the reporting process under this
9 subsection for reporting periods beginning not later
10 than 6 months after the date that measures are first
11 established under subsection (a).

12 **Subtitle B—Viral Hepatitis and**
13 **Liver Cancer Control and Pre-**
14 **vention**

15 **SEC. 711. VIRAL HEPATITIS AND LIVER CANCER CONTROL**
16 **AND PREVENTION.**

17 (a) SHORT TITLE.—This subtitle may be cited as the
18 “Viral Hepatitis and Liver Cancer Control and Prevention
19 Act of 2018”.

20 (b) FINDINGS.—Congress finds the following:

21 (1) In the United States, as many as 4,400,000
22 persons are living with the hepatitis B virus (re-
23 ferred to in this section as “HBV”) or the hepatitis
24 C virus (referred to in this section as “HCV”).

1 (2) In the United States, chronic HBV and
2 HCV are the most common cause of liver cancer,
3 one of the most lethal and fastest growing cancers
4 in this country. It is the most common cause of
5 chronic liver disease, liver cirrhosis, and the most
6 common indication for liver transplantation. At least
7 21,000 deaths per year in the United States can be
8 attributed to chronic HBV and HCV. Chronic HCV
9 is also a leading cause of death in Americans living
10 with HIV/AIDS; many of those living with HIV/
11 AIDS are coinfectd with chronic HBV, chronic
12 HCV, or both.

13 (3) According to the Centers for Disease Con-
14 trol and Prevention (referred to in this section as
15 the “CDC”), approximately 2 percent of the popu-
16 lation of the United States is living with chronic
17 HBV, chronic HCV, or both. The CDC has recog-
18 nized HCV as the Nation’s most common chronic
19 bloodborne virus infection and HBV as the deadliest
20 vaccine-preventable disease.

21 (4) HBV is easily transmitted and is 100 times
22 more infectious than HIV. According to the CDC,
23 HBV is transmitted through contact with infectious
24 blood, semen, or other body fluids. HCV is trans-
25 mitted by contact with infectious blood, particularly

1 through percutaneous exposures (i.e. puncture
2 through the skin).

3 (5) The CDC estimates that in 2015, approxi-
4 mately 33,900 Americans were newly infected with
5 HCV and approximately 21,900 Americans were
6 newly infected with HBV. These estimates could be
7 much higher due to many reasons, including lack of
8 screening education and awareness, and perceived
9 marginalization of the populations at risk.

10 (6) In 2012, CDC released new guidelines rec-
11 ommending every person born between 1945 and
12 1965 receive a one-time test. Among the estimated
13 102 million (1.6 million chronically HCV-infected)
14 eligible for screening, birth-cohort screening leads to
15 84,000 fewer cases of decompensated cirrhosis,
16 46,000 fewer cases of hepatocellular carcinoma,
17 10,000 fewer liver transplants, and 78,000 fewer
18 HCV-related deaths gained versus risk-based screen-
19 ing.

20 (7) In 2013, the United States Preventive Serv-
21 ices Task Force (USPSTF) issued a Grade B rating
22 for screening for the hepatitis C virus (HCV) infec-
23 tion in persons at high risk for infection and adults
24 born between 1945 and 1965. In 2014, the
25 USPSTF issued a Grade B for screening for the

1 hepatitis B virus (HBV) in persons at high-risk of
2 hepatitis B infection. In 2009, the USPSTF issued
3 a Grade A for screening pregnant women for the
4 hepatitis B virus (HBV) during their first prenatal
5 visit.

6 (8) There were 59 outbreaks (24 of HBV and
7 36 of HCV, including one of both HBV and HCV)
8 reported to CDC for investigation from 2008
9 through 2016 related to healthcare-associated infec-
10 tion of HBV and HCV, 56 of which occurred in non-
11 hospital settings. There were more than 115,983 pa-
12 tients potentially exposed to one of the viruses.

13 (9) Chronic HBV and chronic HCV usually do
14 not cause symptoms early in the course of the dis-
15 ease, but after many years of a clinically “silent”
16 phase, CDC estimates show more than 33 percent of
17 infected individuals will develop cirrhosis, end-stage
18 liver disease, or liver cancer. Since most individuals
19 with chronic HBV, HCV, or both are unaware of
20 their infection, they do not know to take precautions
21 to prevent the spread of their infection and can un-
22 knowingly exacerbate their own disease progression.

23 (10) HBV and HCV disproportionately affect
24 certain populations in the United States. Although
25 representing only about 5 percent of the population,

1 Asian Americans and Pacific Islanders account for
2 over half of all chronic HBV cases in the United
3 States. Baby boomers (those born between 1945 and
4 1965) account for approximately 75 percent of do-
5 mestic chronic hepatitis C cases. In addition, African
6 Americans, Latinos (Latinas), and American Indian/
7 Native Alaskans are among the groups which have
8 disproportionately high rates of HBV and/or HCV
9 infections in the United States.

10 (11) For both chronic HBV and chronic HCV,
11 behavioral changes can slow disease progression if
12 diagnosis is made early. Early diagnosis, which is
13 determined through simple blood tests, can reduce
14 the risk of transmission and disease progression
15 through education and vaccination of household
16 members and other susceptible persons at risk.

17 (12) Advancements have led to the development
18 of improved diagnostic tests for viral hepatitis.
19 These tests, including rapid, point of care testing
20 and others in development, can facilitate testing, no-
21 tification of results and post-test counseling, and re-
22 ferral to care at the time of the testing visit. In par-
23 ticular, these tests are also advantageous because
24 they can be used simultaneously with HIV rapid

1 testing for persons at risk for both HCV and HIV
2 infections.

3 (13) For those chronically infected with HBV
4 or HCV, regular monitoring can lead to the early de-
5 tection of liver cancer at a stage where a cure is still
6 possible. Liver cancer is the second deadliest cancer
7 in the United States; however, liver cancer has re-
8 ceived little funding for research, prevention, or
9 treatment.

10 (14) Treatment for chronic HCV can eradicate
11 the disease in approximately 90 percent of those cur-
12 rently treated. The treatment of chronic HBV can
13 effectively suppress viral replication in the over-
14 whelming majority (over 80 percent) of those treat-
15 ed, thereby reducing the risk of transmission and
16 progression to liver scarring or liver cancer, even
17 though a complete cure is much less common than
18 for HCV.

19 (15) To combat the viral hepatitis epidemic in
20 the United States, in February 2017, the Depart-
21 ment of Health and Human Services released its
22 “National Viral Hepatitis Action Plan 2017–2020”
23 (hereafter referred to as the “HHS Action Plan”).
24 In March 2017, the National Academies of Sciences,
25 Engineering, and Medicine (NASEM) released “A

1 National Strategy for the Elimination of Hepatitis B
2 and C: Phase Two Report”, recommending specific
3 actions to eliminate viral hepatitis as public health
4 problems in the United States by 2030.

5 (16) The annual health care costs attributable
6 to HBV and HCV in the United States are signifi-
7 cant. For HBV, it is estimated to be approximately
8 \$2,500,000,000 (\$2,000 per infected person). In
9 2000, the lifetime cost of HBV—before the avail-
10 ability of most current therapies—was approximately
11 \$80,000 per chronically infected person, totaling
12 more than \$100,000,000,000. For HCV, medical
13 costs for patients are expected to increase from
14 \$30,000,000,000 in 2009 to over \$85,000,000,000
15 in 2024. Avoiding these costs by screening and diag-
16 nosing individuals earlier—and connecting them to
17 appropriate treatment and care, will save lives and
18 critical health care dollars. Currently, without a
19 comprehensive screening, testing, and diagnosis pro-
20 gram, most patients are diagnosed too late when
21 they need a liver transplant costing at least
22 \$314,000 for uncomplicated cases or when they have
23 liver cancer or end-stage liver disease which costs
24 \$30,980 to \$110,576 per hospital admission. As
25 health care costs continue to grow, it is critical that

1 the Federal Government invests in effective mecha-
2 nisms to avoid documented cost drivers.

3 (17) According to the IOM report in 2010,
4 chronic HBV and HCV infections cause substantial
5 morbidity and mortality despite being preventable
6 and treatable. Deficiencies in the implementation of
7 established guidelines for the prevention, diagnosis,
8 and medical management of chronic HBV and HCV
9 infections perpetuate personal and economic bur-
10 dens. Existing grants are not sufficient for the scale
11 of the health burden presented by HBV and HCV.

12 (18) Screening and testing for HBV and HCV
13 is aligned with the Healthy People 2020 goal to in-
14 crease immunization rates and reduce preventable
15 infectious diseases. Awareness of disease and access
16 to prevention and treatment remain essential compo-
17 nents for reducing infectious disease transmission.

18 (19) Federal support is necessary to increase
19 knowledge and awareness of HBV and HCV and to
20 assist State and local prevention and control efforts
21 in reducing the morbidity and mortality of these
22 epidemics.

23 (20) The Secretary of Health and Human Serv-
24 ices has the discretion to carry out this Act directly
25 and through whichever of the agencies of the Public

1 Health Service the Secretary determines to be ap-
2 propriate, which may (in the Secretary’s discretion)
3 include the Centers for Disease Control and Preven-
4 tion, the Health Resources and Services Administra-
5 tion, the Substance Abuse and Mental Health Serv-
6 ices Administration, the National Institutes of
7 Health (including the National Institute on Minority
8 Health and Health Disparities), and other agencies
9 of such Service.

10 (21) The Centers for Disease Control and Pre-
11 vention reported a 151 percent increase in hepatitis
12 C cases from 2010–2013, stemming from the opioid,
13 heroin, and overdose epidemics affecting commu-
14 nities nationwide. For the first time since 2006, the
15 number of reported cases of acute hepatitis B infec-
16 tion in the United States is rising; it increased by
17 20.7 percent in 2015 alone, which is also largely due
18 to the opioid epidemic.

19 (c) BIENNIAL ASSESSMENT OF HHS HEPATITIS B
20 AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH,
21 AND MEDICAL MANAGEMENT PLAN.—Title III of the
22 Public Health Service Act (42 U.S.C. 241 et seq.) is
23 amended—

24 (1) by striking section 317N (42 U.S.C. 247b–
25 15); and

1 (2) by adding at the end the following:

2 **“PART X—BIENNIAL ASSESSMENT OF HHS HEPA-**
3 **TITIS B AND HEPATITIS C PREVENTION, EDU-**
4 **CATION, RESEARCH, AND MEDICAL MANAGE-**
5 **MENT PLAN**

6 **“SEC. 399PP. BIENNIAL UPDATE OF THE PLAN.**

7 “(a) IN GENERAL.—The Secretary shall conduct a bi-
8 ennial assessment of the Secretary’s plan for the preven-
9 tion, control, and medical management of, and education
10 and research relating to, hepatitis B and hepatitis C, for
11 the purposes of—

12 “(1) incorporating into such plan new knowl-
13 edge or observations relating to hepatitis B and hep-
14 atitis C (such as knowledge and observations that
15 may be derived from clinical, laboratory, and epide-
16 miological research and disease detection, preven-
17 tion, and surveillance outcomes);

18 “(2) addressing gaps in the coverage or effec-
19 tiveness of the plan; and

20 “(3) evaluating and, if appropriate, updating
21 recommendations, guidelines, or educational mate-
22 rials of the Centers for Disease Control and Preven-
23 tion or the National Institutes of Health for health
24 care providers or the public on viral hepatitis in
25 order to be consistent with the plan.

1 “(b) PUBLICATION OF NOTICE OF ASSESSMENTS.—
2 Not later than October 1 of the first even-numbered year
3 beginning after the date of the enactment of this part,
4 and October 1 of each even-numbered year thereafter, the
5 Secretary shall publish in the Federal Register a notice
6 of the results of the assessments conducted under para-
7 graph (1). Such notice shall include—

8 “(1) a description of any revisions to the plan
9 referred to in subsection (a) as a result of the as-
10 sessment;

11 “(2) an explanation of the basis for any such
12 revisions, including the ways in which such revisions
13 can reasonably be expected to further promote the
14 original goals and objectives of the plan; and

15 “(3) in the case of a determination by the Sec-
16 retary that the plan does not need revision, an expla-
17 nation of the basis for such determination.

18 **“SEC. 399PP-1. ELEMENTS OF PROGRAM.**

19 “(a) EDUCATION AND AWARENESS PROGRAMS.—The
20 Secretary, acting through the Director of the Centers for
21 Disease Control and Prevention, the Administrator of the
22 Health Resources and Services Administration, and the
23 Administrator of the Substance Abuse and Mental Health
24 Services Administration, and in accordance with the plan
25 referred to in section 399PP(a), shall implement programs

1 to increase awareness and enhance knowledge and under-
2 standing of hepatitis B and hepatitis C. Such programs
3 shall include—

4 “(1) the conduct of culturally and language ap-
5 propriate health education in primary and secondary
6 schools, college campuses, public awareness cam-
7 paigns, and community outreach activities (especially
8 to the ethnic communities with high rates of chronic
9 hepatitis B and chronic hepatitis C and other high-
10 risk groups) to promote public awareness and knowl-
11 edge about the value of hepatitis A and hepatitis B
12 immunization, risk factors, the transmission and
13 prevention of hepatitis B and hepatitis C, the value
14 of screening for the early detection of hepatitis B
15 and hepatitis C, and options available for the treat-
16 ment of chronic hepatitis B and chronic hepatitis C;

17 “(2) the promotion of immunization programs
18 that increase awareness and access to hepatitis A
19 and hepatitis B vaccines for susceptible adults and
20 children;

21 “(3) the training of health care professionals
22 regarding the importance of vaccinating individuals
23 infected with hepatitis C and individuals who are at
24 risk for hepatitis C infection against hepatitis A and
25 hepatitis B;

1 “(4) the training of health care professionals
2 regarding the importance of vaccinating individuals
3 chronically infected with hepatitis B and individuals
4 who are at risk for chronic hepatitis B infection
5 against the hepatitis A virus;

6 “(5) the training of health care professionals
7 and health educators to make them aware of the
8 high rates of chronic hepatitis B and chronic hepa-
9 titis C in certain adult ethnic populations, and the
10 importance of prevention, detection, and medical
11 management of hepatitis B and hepatitis C and of
12 liver cancer screening;

13 “(6) the development and distribution of health
14 education curricula (including information relating
15 to the special needs of individuals infected with hep-
16 atitis B and hepatitis C, such as the importance of
17 prevention and early intervention, regular moni-
18 toring, the recognition of psychosocial needs, appro-
19 priate treatment, and liver cancer screening) for in-
20 dividuals providing hepatitis B and hepatitis C coun-
21 seling; and

22 “(7) support for the implementation curricula
23 described in paragraph (6) by State and local public
24 health agencies.

1 “(b) IMMUNIZATION, PREVENTION, AND CONTROL
2 PROGRAMS.—

3 “(1) IN GENERAL.—The Secretary, acting
4 through the Director of the Centers for Disease
5 Control and Prevention, shall support the integra-
6 tion of activities described in paragraph (3) into ex-
7 isting clinical and public health programs at State,
8 local, territorial, and Tribal levels (including commu-
9 nity health clinics, programs for the prevention and
10 treatment of HIV/AIDS, sexually transmitted infec-
11 tions, and substance abuse, and programs for indi-
12 viduals in correctional settings).

13 “(2) COORDINATION OF DEVELOPMENT OF
14 FEDERAL SCREENING GUIDELINES.—

15 “(A) REFERENCES.—For purposes of this
16 subsection, the term ‘CDC Director’ means the
17 Director of the Centers for Disease Control and
18 Prevention, and the term ‘AHRQ Director’
19 means the Director of the Agency for
20 Healthcare Research and Quality.

21 “(B) AGENCY FOR HEALTHCARE RE-
22 SEARCH AND QUALITY.—Due to the rapidly
23 evolving standard of care associated with diag-
24 nosing and treating viral hepatitis infection, the
25 AHRQ Director shall convene the Preventive

1 Services Task Force under section 915(a) of
2 the Public Health Service Act to review its rec-
3 ommendation for screening for HBV and HCV
4 infection every 3 years.

5 “(3) ACTIVITIES.—

6 “(A) VOLUNTARY TESTING PROGRAMS.—

7 “(i) IN GENERAL.—The Secretary
8 shall establish a mechanism by which to
9 support and promote the development of
10 State, local, territorial, and Tribal vol-
11 untary hepatitis B and hepatitis C testing
12 programs to screen the high-prevalence
13 populations to aid in the early identifica-
14 tion of chronically infected individuals.

15 “(ii) CONFIDENTIALITY OF THE TEST
16 RESULTS.—The Secretary shall prohibit
17 the use of the results of a hepatitis B or
18 hepatitis C test conducted by a testing pro-
19 gram developed or supported under this
20 subparagraph for any of the following:

21 “(I) Issues relating to health in-
22 surance.

23 “(II) To screen or determine
24 suitability for employment.

1 “(III) To discharge a person
2 from employment.

3 “(B) COUNSELING REGARDING VIRAL HEP-
4 ATITIS.—The Secretary shall support State,
5 local, territorial, and Tribal programs in a wide
6 variety of settings, including those providing
7 primary and specialty health care services in
8 nonprofit private and public sectors, to—

9 “(i) provide individuals with ongoing
10 risk factors for hepatitis B and hepatitis C
11 infection with client-centered education
12 and counseling which concentrates on—

13 “(I) promoting testing of individ-
14 uals that have been exposed to their
15 blood, family members, and their sex-
16 ual partners; and

17 “(II) changing behaviors that
18 place individuals at risk for infection;

19 “(ii) provide individuals chronically in-
20 fected with hepatitis B or hepatitis C with
21 education, health information, and coun-
22 seling to reduce their risk of—

23 “(I) dying from end-stage liver
24 disease and liver cancer; and

1 “(II) transmitting viral hepatitis
2 to others; and

3 “(iii) provide women chronically in-
4 fected with hepatitis B or hepatitis C who
5 are pregnant or of childbearing age with
6 culturally and linguistically appropriate
7 health information, such as how to prevent
8 hepatitis B perinatal infection, and to al-
9 leviate fears associated with pregnancy or
10 raising a family.

11 “(C) IMMUNIZATION.—The Secretary shall
12 support State, local, territorial, and Tribal ef-
13 forts to expand the current vaccination pro-
14 grams to protect every child in the country and
15 all susceptible adults, particularly those infected
16 with hepatitis C and high-prevalence ethnic
17 populations and other high-risk groups, from
18 the risks of acute and chronic hepatitis B infec-
19 tion by—

20 “(i) ensuring continued funding for
21 hepatitis B vaccination for all children 19
22 years of age or younger through the Vac-
23 cines for Children Program;

24 “(ii) ensuring that the recommenda-
25 tions of the Advisory Committee on Immu-

1 nization Practices are followed regarding
2 the birth dose of hepatitis B vaccinations
3 for newborns;

4 “(iii) requiring proof of hepatitis B
5 vaccination for entry into public or private
6 daycare, preschool, elementary school, sec-
7 ondary school, and institutions of higher
8 education;

9 “(iv) expanding the availability of
10 hepatitis B vaccination for all susceptible
11 adults to protect them from becoming
12 acutely or chronically infected, including
13 ethnic and other populations with high
14 prevalence rates of chronic hepatitis B in-
15 fection;

16 “(v) expanding the availability of hep-
17 atitis B vaccination for all susceptible
18 adults, particularly those in their reproduc-
19 tive age (women and men less than 45
20 years of age), to protect them from the
21 risk of hepatitis B infection;

22 “(vi) ensuring the vaccination of indi-
23 viduals infected, or at risk for infection,
24 with hepatitis C against hepatitis A, hepa-
25 titis B, and other infectious diseases, as

1 appropriate, for which such individuals
2 may be at increased risk; and

3 “(vii) ensuring the vaccination of indi-
4 viduals infected, or at risk for infection,
5 with hepatitis B against hepatitis A virus
6 and other infectious diseases, as appro-
7 priate, for which such individuals may be
8 at increased risk.

9 “(D) MEDICAL REFERRAL.—The Secretary
10 shall support State, local, territorial, and Tribal
11 programs that support—

12 “(i) referral of persons chronically in-
13 fected with hepatitis B or hepatitis C—

14 “(I) for medical evaluation to de-
15 termine the appropriateness for
16 antiviral treatment to reduce the risk
17 of progression to cirrhosis and liver
18 cancer; and

19 “(II) for ongoing medical man-
20 agement including regular monitoring
21 of liver function and screening for
22 liver cancer; and

23 “(ii) referral of persons infected with
24 acute or chronic hepatitis B infection or
25 acute or chronic hepatitis C infection for

1 drug and alcohol abuse treatment where
2 appropriate.

3 “(4) INCREASED SUPPORT FOR ADULT VIRAL
4 HEPATITIS PREVENTION COORDINATORS.—The Sec-
5 retary, acting through the Director of the Centers
6 for Disease Control and Prevention, shall provide in-
7 creased support to adult viral hepatitis prevention
8 coordinators in State, local, territorial, and Tribal
9 health departments in order to enhance the addi-
10 tional management, networking, and technical exper-
11 tise needed to ensure successful integration of hepa-
12 titis B and hepatitis C prevention and control activi-
13 ties into existing public health programs.

14 “(c) EPIDEMIOLOGICAL SURVEILLANCE.—

15 “(1) IN GENERAL.—The Secretary, acting
16 through the Director of the Centers for Disease
17 Control and Prevention, shall support the establish-
18 ment and maintenance of a national chronic and
19 acute hepatitis B and hepatitis C surveillance pro-
20 gram, in order to identify—

21 “(A) trends in the incidence of acute and
22 chronic hepatitis B and acute and chronic hepa-
23 titis C;

24 “(B) trends in the prevalence of acute and
25 chronic hepatitis B and acute and chronic hepa-

1 titis C infection among groups that may be dis-
2 proportionately affected; and

3 “(C) trends in liver cancer and end-stage
4 liver disease incidence and deaths, caused by
5 chronic hepatitis B and chronic hepatitis C in
6 the high-risk ethnic populations.

7 “(2) SEROPREVALENCE AND LIVER CANCER
8 STUDIES.—The Secretary, acting through the Direc-
9 tor of the Centers for Disease Control and Preven-
10 tion, shall prepare a report outlining the population-
11 based seroprevalence studies currently underway, fu-
12 ture planned studies, the criteria involved in deter-
13 mining which seroprevalence studies to conduct,
14 defer, or suspend, and the scope of those studies, the
15 economic and clinical impact of hepatitis B and hep-
16 atitis C, and the impact of chronic hepatitis B and
17 chronic hepatitis C infections on the quality of life.
18 Not later than one year after the date of the enact-
19 ment of this part, the Secretary shall submit the re-
20 port to the Committee on Energy and Commerce of
21 the House of Representatives and the Committee on
22 Health, Education, Labor, and Pensions of the Sen-
23 ate.

24 “(3) CONFIDENTIALITY.—The Secretary shall
25 not disclose any individually identifiable information

1 identified under paragraph (1) or derived through
2 studies under paragraph (2).

3 “(d) RESEARCH.—The Secretary, acting through the
4 Director of the Centers for Disease Control and Preven-
5 tion, the Director of the National Cancer Institute, and
6 the Director of the National Institutes of Health, shall—

7 “(1) conduct epidemiologic and community-
8 based research to develop, implement, and evaluate
9 best practices for hepatitis B and hepatitis C pre-
10 vention especially in the ethnic populations with high
11 rates of chronic hepatitis B and chronic hepatitis C
12 and other high-risk groups;

13 “(2) conduct research on hepatitis B and hepa-
14 titis C natural history, pathophysiology, improved
15 treatments and prevention (such as the hepatitis C
16 vaccine), and noninvasive tests that help to predict
17 the risk of progression to liver cirrhosis and liver
18 cancer;

19 “(3) conduct research that will lead to better
20 noninvasive or blood tests to screen for liver cancer,
21 and more effective treatments of liver cancer caused
22 by chronic hepatitis B and chronic hepatitis C; and

23 “(4) conduct research comparing the effective-
24 ness of screening, diagnostic, management, and
25 treatment approaches for chronic hepatitis B, chron-

1 ic hepatitis C, and liver cancer in the affected com-
2 munities.

3 “(e) **UNDERSERVED AND DISPROPORTIONATELY AF-**
4 **FECTED POPULATIONS.**—In carrying out this section, the
5 Secretary shall provide expanded support for individuals
6 with limited access to health education, testing, and health
7 care services and groups that may be disproportionately
8 affected by hepatitis B and hepatitis C.

9 “(f) **EVALUATION OF PROGRAM.**—The Secretary
10 shall develop benchmarks for evaluating the effectiveness
11 of the programs and activities conducted under this sec-
12 tion and make determinations as to whether such bench-
13 marks have been achieved.

14 **“SEC. 399PP-2. GRANTS.**

15 “(a) **IN GENERAL.**—The Secretary may award grants
16 to, or enter into contracts or cooperative agreements with,
17 States, political subdivisions of States, territories, Indian
18 Tribes, or nonprofit entities that have special expertise re-
19 lating to hepatitis B, hepatitis C, or both, to carry out
20 activities under this part.

21 “(b) **APPLICATION.**—To be eligible for a grant, con-
22 tract, or cooperative agreement under subsection (a), an
23 entity shall prepare and submit to the Secretary an appli-
24 cation at such time, in such manner, and containing such
25 information as the Secretary may require.

1 **“SEC. 399PP-3. AUTHORIZATION OF APPROPRIATIONS.**

2 “There are authorized to be appropriated to carry out
3 this part \$90,000,000 for fiscal year 2019, \$90,000,000
4 for fiscal year 2020, \$110,000,000 for fiscal year 2021,
5 \$130,000,000 for fiscal year 2022, and \$150,000,000 for
6 fiscal year 2023.”.

7 **Subtitle C—Acquired Bone Marrow**
8 **Failure Diseases**

9 **SEC. 721. ACQUIRED BONE MARROW FAILURE DISEASES.**

10 (a) **SHORT TITLE.**—This subtitle may be cited as the
11 “Bone Marrow Failure Disease Research and Treatment
12 Act of 2018”.

13 (b) **FINDINGS.**—The Congress finds the following:

14 (1) Between 20,000 and 30,000 Americans are
15 diagnosed each year with myelodysplastic syndromes,
16 aplastic anemia, paroxysmal nocturnal hemo-
17 globinuria, and other acquired bone marrow failure
18 diseases.

19 (2) Acquired bone marrow failure diseases have
20 a debilitating and often fatal impact on those diag-
21 nosed with these diseases.

22 (3) While some treatments for acquired bone
23 marrow failure diseases can prolong and improve the
24 quality of patients’ lives, there is no single cure for
25 these diseases.

1 (4) The prevalence of acquired bone marrow
2 failure diseases in the United States will continue to
3 grow as the general public ages.

4 (5) Evidence exists suggesting that acquired
5 bone marrow failure diseases occur more often in
6 minority populations, particularly in Asian-American
7 and Latino or Hispanic populations.

8 (6) The National Heart, Lung, and Blood Insti-
9 tute and the National Cancer Institute have con-
10 ducted important research into the causes of and
11 treatments for acquired bone marrow failure dis-
12 eases.

13 (7) The National Marrow Donor Program Reg-
14 istry has made significant contributions to the fight
15 against bone marrow failure diseases by connecting
16 millions of potential marrow donors with individuals
17 and families suffering from these conditions.

18 (8) Despite these advances, a more comprehen-
19 sive Federal strategic effort among numerous Fed-
20 eral agencies is needed to discover a cure for ac-
21 quired bone marrow failure disorders.

22 (9) Greater Federal surveillance of acquired
23 bone marrow failure diseases is needed to gain a bet-
24 ter understanding of the causes of acquired bone
25 marrow failure diseases.

1 (10) The Federal Government should increase
2 its research support for and engage with public and
3 private organizations in developing a comprehensive
4 approach to combat and cure acquired bone marrow
5 failure diseases.

6 (c) NATIONAL ACQUIRED BONE MARROW FAILURE
7 DISEASE REGISTRY.—Part B of the Public Health Service
8 Act (42 U.S.C. 311 et seq.) is amended by inserting after
9 section 317W, as added, the following:

10 **“SEC. 317X. NATIONAL ACQUIRED BONE MARROW FAILURE**
11 **DISEASE REGISTRY.**

12 “(a) ESTABLISHMENT OF REGISTRY.—

13 “(1) IN GENERAL.—Not later than 6 months
14 after the date of the enactment of this section, the
15 Secretary, acting through the Director of the Cen-
16 ters for Disease Control and Prevention, shall—

17 “(A) develop a system to collect data on
18 acquired bone marrow failure diseases; and

19 “(B) establish and maintain a national and
20 publicly available registry, to be known as the
21 National Acquired Bone Marrow Failure Dis-
22 ease Registry, in accordance with paragraph
23 (3).

24 “(2) RECOMMENDATIONS OF ADVISORY COM-
25 MITTEE.—In carrying out this subsection, the Sec-

1 retary shall take into consideration the recommenda-
2 tions of the Advisory Committee on Acquired Bone
3 Marrow Failure Diseases established under sub-
4 section (b).

5 “(3) PURPOSES OF REGISTRY.—The National
6 Acquired Bone Marrow Failure Disease Registry—

7 “(A) shall identify the incidence and preva-
8 lence of acquired bone marrow failure diseases
9 in the United States;

10 “(B) shall be used to collect and store data
11 on acquired bone marrow failure diseases, in-
12 cluding data concerning—

13 “(i) the age, race or ethnicity, general
14 geographic location, sex, and family history
15 of individuals who are diagnosed with ac-
16 quired bone marrow failure diseases, and
17 any other characteristics of such individ-
18 uals determined appropriate by the Sec-
19 retary;

20 “(ii) the genetic and environmental
21 factors that may be associated with devel-
22 oping acquired bone marrow failure dis-
23 eases;

1 “(iii) treatment approaches for deal-
2 ing with acquired bone marrow failure dis-
3 eases;

4 “(iv) outcomes for individuals treated
5 for acquired bone marrow failure diseases,
6 including outcomes for recipients of stem
7 cell therapeutic products as contained in
8 the database established pursuant to sec-
9 tion 379A; and

10 “(v) any other factors pertaining to
11 acquired bone marrow failure diseases de-
12 termined appropriate by the Secretary; and
13 “(C) shall be made available—

14 “(i) to the general public; and

15 “(ii) to researchers to facilitate fur-
16 ther research into the causes of, and treat-
17 ments for, acquired bone marrow failure
18 diseases in accordance with standard prac-
19 tices of the Centers for Disease Control
20 and Preventions.

21 “(b) ADVISORY COMMITTEE.—

22 “(1) ESTABLISHMENT.—Not later than 6
23 months after the date of the enactment of this sec-
24 tion, the Secretary, acting through the Director of
25 the Centers for Disease Control and Prevention,

1 shall establish an advisory committee, to be known
2 as the Advisory Committee on Acquired Bone Mar-
3 row Failure Diseases.

4 “(2) MEMBERS.—The members of the Advisory
5 Committee on Acquired Bone Marrow Failure Dis-
6 eases shall be appointed by the Secretary, acting
7 through the Director of the Centers for Disease
8 Control and Prevention, and shall include at least
9 one representative from each of the following:

10 “(A) A national patient advocacy organiza-
11 tion with experience advocating on behalf of pa-
12 tients suffering from acquired bone marrow
13 failure diseases.

14 “(B) The National Institutes of Health, in-
15 cluding at least one representative from each
16 of—

17 “(i) the National Cancer Institute;

18 “(ii) the National Heart, Lung, and
19 Blood Institute; and

20 “(iii) the Office of Rare Diseases.

21 “(C) The Centers for Disease Control and
22 Prevention.

23 “(D) Clinicians with experience in—

24 “(i) diagnosing or treating acquired
25 bone marrow failure diseases; and

1 “(ii) medical data registries.

2 “(E) Epidemiologists who have experience
3 with data registries.

4 “(F) Publicly or privately funded research-
5 ers who have experience researching acquired
6 bone marrow failure diseases.

7 “(G) The entity operating the C.W. Bill
8 Young Cell Transplantation Program estab-
9 lished pursuant to section 379 and the entity
10 operating the C.W. Bill Young Cell Transplan-
11 tation Program Outcomes Database.

12 “(3) RESPONSIBILITIES.—The Advisory Com-
13 mittee on Acquired Bone Marrow Failure Diseases
14 shall provide recommendations to the Secretary on
15 the establishment and maintenance of the National
16 Acquired Bone Marrow Failure Disease Registry, in-
17 cluding recommendations on the collection, mainte-
18 nance, and dissemination of data.

19 “(4) PUBLIC AVAILABILITY.—The Secretary
20 shall make the recommendations of the Advisory
21 Committee on Acquired Bone Marrow Failure Dis-
22 ease publicly available.

23 “(c) GRANTS.—The Secretary, acting through the
24 Director of the Centers for Disease Control and Preven-
25 tion, may award grants to, and enter into contracts and

1 cooperative agreements with, public or private nonprofit
2 entities for the management of, as well as the collection,
3 analysis, and reporting of data to be included in, the Na-
4 tional Acquired Bone Marrow Failure Disease Registry.

5 “(d) DEFINITION.—In this section, the term ‘ac-
6 quired bone marrow failure disease’ means—

7 “(1) myelodysplastic syndromes (MDS);

8 “(2) aplastic anemia;

9 “(3) paroxysmal nocturnal hemoglobinuria
10 (PNH);

11 “(4) pure red cell aplasia;

12 “(5) acute myeloid leukemia that has pro-
13 gressed from myelodysplastic syndromes; or

14 “(6) large granular lymphocytic leukemia.

15 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
16 is authorized to be appropriated to carry out this section
17 \$3,000,000 for each of fiscal years 2019 through 2023.”.

18 (d) PILOT STUDIES THROUGH THE AGENCY FOR
19 TOXIC SUBSTANCES AND DISEASE REGISTRY.—

20 (1) PILOT STUDIES.—The Secretary of Health
21 and Human Services, acting through the Adminis-
22 trator of the Agency for Toxic Substances and Dis-
23 ease Registry, shall conduct pilot studies to deter-
24 mine which environmental factors, including expo-

1 sure to toxins, may cause acquired bone marrow fail-
2 ure diseases.

3 (2) COLLABORATION WITH THE RADIATION IN-
4 JURY TREATMENT NETWORK.—In carrying out the
5 directives of this section, the Secretary may collabo-
6 rate with the Radiation Injury Treatment Network
7 of the C.W. Bill Young Cell Transplantation Pro-
8 gram established pursuant to section 379 of the
9 Public Health Service Act (42 U.S.C. 274j) to—

10 (A) augment data for the pilot studies au-
11 thorized by this section;

12 (B) access technical assistance that may be
13 provided by the Radiation Injury Treatment
14 Network; or

15 (C) perform joint research projects.

16 (3) AUTHORIZATION OF APPROPRIATIONS.—
17 There is authorized to be appropriated to carry out
18 this section \$1,000,000 for each of fiscal years 2019
19 through 2023.

20 (e) MINORITY-FOCUSED PROGRAMS ON ACQUIRED
21 BONE MARROW FAILURE DISEASES.—Title XVII of the
22 Public Health Service Act (42 U.S.C. 300u et seq.) is
23 amended by inserting after section 1707A the following:

1 “MINORITY-FOCUSED PROGRAMS ON ACQUIRED BONE
2 MARROW FAILURE DISEASES

3 “SEC. 1707B. (a) INFORMATION AND REFERRAL
4 SERVICES.—

5 “(1) IN GENERAL.—Not later than 6 months
6 after the date of the enactment of this section, the
7 Secretary, acting through the Deputy Assistant Sec-
8 retary for Minority Health, shall establish and co-
9 ordinate outreach and informational programs tar-
10 geted to minority populations affected by acquired
11 bone marrow failure diseases.

12 “(2) PROGRAM REQUIREMENTS.—Minority-fo-
13 cused outreach and informational programs author-
14 ized by this section—

15 “(A) shall make information about treat-
16 ment options and clinical trials for acquired
17 bone marrow failure diseases publicly available;
18 and

19 “(B) shall provide referral services for
20 treatment options and clinical trials;
21 at the National Minority Health Resource Center
22 supported under section 1707(b)(8) (including by
23 means of the Center’s website, through appropriate
24 locations such as the Center’s knowledge center, and
25 through appropriate programs such as the Center’s

1 resource persons network) and through minority
2 health consultants located at each Department of
3 Health and Human Services regional office.

4 “(b) HISPANIC AND ASIAN-AMERICAN AND PACIFIC
5 ISLANDER OUTREACH.—

6 “(1) IN GENERAL.—The Secretary, acting
7 through the Deputy Assistant Secretary for Minority
8 Health, shall undertake a coordinated outreach ef-
9 fort to connect Hispanic, Asian-American, and Pa-
10 cific Islander communities with comprehensive serv-
11 ices focused on treatment of, and information about,
12 acquired bone marrow failure diseases.

13 “(2) COLLABORATION.—In carrying out this
14 subsection, the Secretary may collaborate with public
15 health agencies, nonprofit organizations, community
16 groups, and online entities to disseminate informa-
17 tion about treatment options and clinical trials for
18 acquired bone marrow failure diseases.

19 “(c) GRANTS AND COOPERATIVE AGREEMENTS.—

20 “(1) IN GENERAL.—Not later than 6 months
21 after the date of the enactment of this section, the
22 Secretary, acting through the Deputy Assistant Sec-
23 retary for Minority Health, shall award grants to, or
24 enter into cooperative agreements with, entities to

1 perform research on acquired bone marrow failure
2 diseases.

3 “(2) REQUIREMENT.—Grants and cooperative
4 agreements authorized by this subsection shall be
5 awarded or entered into on a competitive, peer-re-
6 viewed basis.

7 “(3) SCOPE OF RESEARCH.—Research funded
8 under this section shall examine factors affecting the
9 incidence of acquired bone marrow failure diseases
10 in minority populations.

11 “(d) DEFINITION.—In this section, the term ‘ac-
12 quired bone marrow failure disease’ has the meaning given
13 to such term in section 317X(d).

14 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
15 is authorized to be appropriated to carry out this section
16 \$2,000,000 for each of fiscal years 2019 through 2023.”.

17 (f) DIAGNOSIS AND QUALITY OF CARE FOR AC-
18 QUIRED BONE MARROW FAILURE DISEASES.—

19 (1) GRANTS.—The Secretary of Health and
20 Human Services, acting through the Director of the
21 Agency for Healthcare Research and Quality, shall
22 award grants to entities to improve diagnostic prac-
23 tices and quality of care with respect to patients
24 with acquired bone marrow failure diseases.

1 (2) AUTHORIZATION OF APPROPRIATIONS.—

2 There is authorized to be appropriated to carry out
3 this section \$2,000,000 for each of fiscal years 2019
4 through 2023.

5 (g) DEFINITION.—In this section, the term “acquired
6 bone marrow failure disease” means—

7 (1) myelodysplastic syndromes (MDS);

8 (2) aplastic anemia;

9 (3) paroxysmal nocturnal hemoglobinuria
10 (PNH);

11 (4) pure red cell aplasia;

12 (5) acute myeloid leukemia that progressed
13 from myelodysplastic syndromes; or

14 (6) large granular lymphocytic leukemia.

15 **Subtitle D—Cardiovascular Dis-**
16 **ease, Chronic Disease, and**
17 **Other Disease Issues**

18 **SEC. 731. GUIDELINES FOR DISEASE SCREENING FOR MI-**
19 **NORITY PATIENTS.**

20 (a) IN GENERAL.—The Secretary, acting through the
21 Director of the Agency for Healthcare Research and Qual-
22 ity, shall convene a series of meetings to develop guidelines
23 for disease screening for minority patient populations
24 which have a higher than average risk for many chronic
25 diseases and cancers.

1 (b) PARTICIPANTS.—In convening meetings under
2 subsection (a), the Secretary shall ensure that meeting
3 participants include representatives of—

4 (1) professional societies and associations;

5 (2) minority health organizations;

6 (3) health care researchers and providers, in-
7 cluding those with expertise in minority health;

8 (4) Federal health agencies, including the Of-
9 fice of Minority Health, the National Institute on
10 Minority Health and Health Disparities, and the
11 National Institutes of Health; and

12 (5) other experts determined appropriate by the
13 Secretary.

14 (c) DISEASES.—Screening guidelines for minority
15 populations shall be developed as appropriate under sub-
16 section (a) for—

17 (1) hypertension;

18 (2) hypercholesterolemia;

19 (3) diabetes;

20 (4) cardiovascular disease;

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

23 (6) other pulmonary problems including sleep
24 apnea;

25 (7) asthma;

- 1 (8) diabetes;
- 2 (9) kidney diseases;
- 3 (10) eye diseases and disorders, including glau-
- 4 coma;
- 5 (11) HIV/AIDS and sexually transmitted infec-
- 6 tions;
- 7 (12) uterine fibroids;
- 8 (13) autoimmune disease;
- 9 (14) mental health conditions;
- 10 (15) dental health conditions and oral diseases,
- 11 including oral cancer;
- 12 (16) environmental and related health illnesses
- 13 and conditions;
- 14 (17) sickle cell disease and sickle cell trait;
- 15 (18) violence and injury prevention and control;
- 16 (19) genetic and related conditions;
- 17 (20) heart disease and stroke;
- 18 (21) tuberculosis;
- 19 (22) chronic obstructive pulmonary disease;
- 20 (23) musculoskeletal diseases, arthritis, and
- 21 obesity; and
- 22 (24) other diseases determined appropriate by
- 23 the Secretary.
- 24 (d) DISSEMINATION.—Not later than 24 months
- 25 after the date of enactment of this title, the Secretary

1 shall publish and disseminate to health care provider orga-
2 nizations the guidelines developed under subsection (a).

3 (e) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section
5 such sums as may be necessary for each of fiscal years
6 2019 through 2023.

7 **SEC. 732. CDC WISEWOMAN SCREENING PROGRAM.**

8 Section 1509 of the Public Health Service Act (42
9 U.S.C. 300n–4a) is amended—

10 (1) in subsection (a)—

11 (A) by striking the heading and inserting
12 “IN GENERAL.—”; and

13 (B) in the matter preceding paragraph (1),
14 by striking “may make grants” and all that fol-
15 lows through “purpose” and inserting the fol-
16 lowing: “may make grants to such States for
17 the purpose”; and

18 (2) in subsection (d)(1), by striking “there are
19 authorized” and all that follows through the period
20 and inserting “there are authorized to be appro-
21 priated \$23,000,000 for fiscal year 2019,
22 \$25,300,000 for fiscal year 2020, \$27,800,000 for
23 fiscal year 2021, \$30,800,000 for fiscal year 2022,
24 and \$34,000,000 for fiscal year 2023.”.

1 **SEC. 733. REPORT ON CARDIOVASCULAR CARE FOR WOMEN**
2 **AND MINORITIES.**

3 Part P of title III of the Public Health Service Act
4 (42 U.S.C. 280g et seq.), as amended, is further amended
5 by adding at the end the following:

6 **“SEC. 399V-8. REPORT ON CARDIOVASCULAR CARE FOR**
7 **WOMEN AND MINORITIES.**

8 “Not later than September 30, 2019, and annually
9 thereafter, the Secretary shall prepare and submit to the
10 Congress a report on the quality of and access to care
11 for women and minorities with heart disease, stroke, and
12 other cardiovascular diseases. The report shall contain rec-
13 ommendations for eliminating disparities in, and improv-
14 ing the treatment of, heart disease, stroke, and other car-
15 diovascular diseases in women, racial and ethnic minori-
16 ties, those for whom English is not their primary lan-
17 guage, and individuals with disabilities.”.

18 **SEC. 734. COVERAGE OF COMPREHENSIVE TOBACCO CES-**
19 **SATION SERVICES IN MEDICAID AND PRI-**
20 **VATE HEALTH INSURANCE.**

21 (a) REQUIRING MEDICAID COVERAGE OF COUN-
22 SELING AND PHARMACOTHERAPY FOR CESSATION OF TO-
23 BACCO USE.—Section 1905 of the Social Security Act (42
24 U.S.C. 1396d) is amended—

25 (1) in subsection (a)(4)(D), by striking “by
26 pregnant women”; and

1 (2) in subsection (bb)—

2 (A) by striking “by pregnant women” each
3 place it appears;

4 (B) in paragraph (1), in the matter before
5 subparagraph (A), by inserting “by individuals”
6 before “who use tobacco”; and

7 (C) in paragraph (2)(A), by striking “with
8 respect to pregnant women”.

9 (b) EXCEPTION FROM OPTIONAL RESTRICTION
10 UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—
11 Section 1927(d)(2)(F) of the Social Security Act (42
12 U.S.C. 1396r–8(d)(2)(F)) is amended—

13 (1) by striking “in the case of pregnant
14 women”; and

15 (2) by striking “under the over-the-counter
16 monograph process”.

17 (c) STATE MONITORING AND PROMOTING OF COM-
18 PREHENSIVE TOBACCO CESSATION SERVICES UNDER
19 MEDICAID.—Section 1902(a) of the Social Security Act
20 (42 U.S.C. 1396a(a)), as amended by section 450(c), is
21 amended—

22 (1) by striking “and” at the end of paragraph
23 (82);

24 (2) by striking the period at the end of para-
25 graph (83) and inserting “; and”; and

1 (3) by inserting after paragraph (83) the fol-
2 lowing new paragraph:

3 “(84) provide for the State to monitor and pro-
4 mote the use of comprehensive tobacco cessation
5 services under the State plan, including conducting
6 an outreach campaign to increase awareness of, and
7 the benefits of using, such services among—

8 “(A) individuals entitled to medical assist-
9 ance under the State plan who use tobacco
10 products; and

11 “(B) clinicians and others who provide
12 services to individuals entitled to medical assist-
13 ance under the State plan.”.

14 (d) FEDERAL REIMBURSEMENT FOR MEDICAID OUT-
15 REACH CAMPAIGN TO INCREASE AWARENESS.—Section
16 1903(a) of the Social Security Act (42 U.S.C. 1396b(a))
17 is amended—

18 (1) by striking the period at the end of para-
19 graph (7) and inserting “; plus”; and

20 (2) by inserting after paragraph (7) the fol-
21 lowing new paragraph:

22 “(8) an amount equal to 90 percent of the
23 sums expended during each quarter which are attrib-
24 utable to the development, implementation, and eval-
25 uation of an outreach campaign to—

1 “(A) increase awareness of comprehensive
2 tobacco cessation services covered in the State
3 plan among—

4 “(i) individuals who are likely to be el-
5 igible for medical assistance under the
6 State plan; and

7 “(ii) clinicians and others who provide
8 services to individuals who are likely to be
9 eligible for medical assistance under the
10 State plan; and

11 “(B) increase awareness of the benefits of
12 using comprehensive tobacco cessation services
13 covered in the State plan among—

14 “(i) individuals who are likely to be el-
15 igible for medical assistance under the
16 State plan; and

17 “(ii) clinicians and others who provide
18 services to individuals who are likely to be
19 eligible for medical assistance under the
20 State plan about the benefits of using com-
21 prehensive tobacco cessation services.”.

22 (e) REMOVAL OF COST SHARING FOR COUNSELING
23 AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO
24 USE UNDER MEDICAID.—

1 (1) GENERAL COST SHARING LIMITATIONS.—
2 Section 1916 of the Social Security Act (42 U.S.C.
3 1396o) is amended—

4 (A) in subsections (a)(2)(B) and (b)(2)(B),
5 by striking “and counseling and
6 pharmacotherapy for cessation of tobacco use
7 by pregnant women (as defined in section
8 1396d(bb) of this title) and covered outpatient
9 drugs (as defined in subsection (k)(2) of section
10 1396r–8 of this title and including nonprescrip-
11 tion drugs described in subsection (d)(2) of
12 such section) that are prescribed for purposes
13 of promoting, and when used to promote, to-
14 bacco cessation by pregnant women in accord-
15 ance with the Guideline referred to in section
16 1396d(bb)(2)(A) of this title” each place it ap-
17 pears; and

18 (B) in each of subsections (a)(2)(D) and
19 (b)(2)(D) by inserting “and counseling and
20 pharmacotherapy for cessation of tobacco use
21 (as defined in section 1396d(bb) of this title)
22 and covered outpatient drugs (as defined in
23 subsection (k)(2) of section 1396r–8 of this
24 title and including nonprescription drugs de-
25 scribed in subsection (d)(2) of such section)

1 that are prescribed for purposes of promoting,
2 and when used to promote, tobacco cessation in
3 accordance with the Guideline referred to in
4 section 1396d(bb)(2)(A) of this title,” after
5 “(or at the option of the State, any services fur-
6 nished to pregnant women”.

7 (2) APPLICATION TO ALTERNATIVE COST SHAR-
8 ING.—Section 1916A(b)(3)(B) of such Act (42
9 U.S.C. 1396o–1(b)(3)(B)) is amended—

10 (A) in clause (iii), by striking “, and coun-
11 seling and pharmacotherapy for cessation of to-
12 bacco use by pregnant women (as defined in
13 section 1396d of this title)”; and

14 (B) by adding at the end the following:

15 “(xi) Counseling and
16 pharmacotherapy for cessation of tobacco
17 use (as defined in section 1905(bb)) and
18 covered outpatient drugs (as defined in
19 subsection (k)(2) of section 1396r–8 of
20 this title and including nonprescription
21 drugs described in subsection (d)(2) of
22 such section) that are prescribed for pur-
23 poses of promoting, and when used to pro-
24 mote, tobacco cessation in accordance with

1 the Guideline referred to in section 1396d
2 (bb)(2)(A) of this title.”.

3 (f) NO PRIOR AUTHORIZATION FOR TOBACCO CES-
4 SATION DRUGS UNDER MEDICAID.—Section 1927(d) of
5 the Social Security Act (42 U.S.C. 1396r–8) is amended—

6 (1) by striking in paragraph (1)(A) “A State”
7 and inserting “Except as otherwise provided in para-
8 graph (6), a State”;

9 (2) by inserting after paragraph (5) the fol-
10 lowing new paragraph:

11 “(6) NO PRIOR AUTHORIZATION PROGRAMS FOR
12 TOBACCO CESSATION DRUGS.—A State plan under
13 this subchapter shall not require, as a condition of
14 coverage or payment for a covered outpatient drug
15 for which Federal financial participation is available
16 in accordance with this section, the approval of an
17 agent when used to promote smoking cessation, in-
18 cluding agents approved by the Food and Drug Ad-
19 ministration for the purposes of promoting, and
20 when used to promote, tobacco cessation.”.

21 (3) by redesignating paragraphs (6) and (7) as
22 paragraphs (7) and (8).

23 (g) COMPREHENSIVE COVERAGE OF TOBACCO CES-
24 SATION COVERAGE IN PRIVATE HEALTH INSURANCE.—

1 (1) NO PRIOR AUTHORIZATION FOR TOBACCO
2 CESSATION COVERAGE.—Section 2713 of the Public
3 Health Service Act (42 U.S.C. 300gg–3) is amended
4 by inserting after subsection (c) a new subsection:

5 “(d) NO PRIOR AUTHORIZATION.—A group health
6 plan and a health insurance issuer offering group or indi-
7 vidual health insurance coverage shall not impose any
8 prior authorization requirement for tobacco cessation
9 counseling and pharmacotherapy that has in effect a rat-
10 ing of ‘A’ or ‘B’ in the current recommendations of the
11 United States Preventive Services Task Force.”.

12 (2) NO COST SHARING.—Section 1302(c) of the
13 Patient Protection and Affordable Care Act (42
14 U.S.C. 18022(c)) is amended by inserting after
15 paragraph (1) the following new paragraph:

16 “(2) NO COST SHARING OR PRIOR AUTHORIZA-
17 TION FOR COMPREHENSIVE TOBACCO CESSATION
18 COVERAGE.—There shall be no cost sharing or prior
19 authorization requirement imposed with respect to
20 services described in subsection (b)(1)(K).”.

21 (h) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to items and services furnished on
23 or after January 1, 2019.

1 **SEC. 735. CLINICAL RESEARCH FUNDING FOR ORAL**
2 **HEALTH.**

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services shall expand and intensify the conduct
5 and support of the research activities of the National In-
6 stitutes of Health and the National Institute of Dental
7 and Craniofacial Research to improve the oral health of
8 the population through the prevention and management
9 of oral diseases and conditions.

10 (b) INCLUDED RESEARCH ACTIVITIES.—Research
11 activities under subsection (a) shall include—

12 (1) comparative effectiveness research and clin-
13 ical disease management research addressing early
14 childhood caries and oral cancer; and

15 (2) awarding of grants and contracts to support
16 the training and development of health services re-
17 searchers, comparative effectiveness researchers, and
18 clinical researchers whose research improves the oral
19 health of the population.

20 **SEC. 736. PARTICIPATION BY MEDICAID BENEFICIARIES IN**
21 **APPROVED CLINICAL TRIALS.**

22 (a) IN GENERAL.—Title XIX of the Social Security
23 Act (42 U.S.C. 1396 et seq.) is amended by inserting after
24 section 1943 the following new section:

1 **“SEC. 1944. PARTICIPATION IN AN APPROVED CLINICAL**
2 **TRIAL.**

3 “(a) **COVERAGE OF ROUTINE PATIENT COSTS ASSO-**
4 **CIATED WITH APPROVED CLINICAL TRIALS.—**

5 “(1) **INCLUSION.—**Subject to paragraph (2),
6 routine patient costs shall include all items and serv-
7 ices consistent with the medical assistance provided
8 under the State plan that would otherwise be pro-
9 vided to the individual under such State plan if such
10 individual was not enrolled in an approved clinical
11 trial, including any items or services related to the
12 prevention, detection, and treatment of any medical
13 complications that arise as a result of participation
14 in the approved clinical trial.

15 “(2) **EXCLUSION.—**For purposes of paragraph
16 (1), routine patient costs does not include—

17 “(A) the investigational item, device, or
18 service itself;

19 “(B) items and services that are provided
20 solely to satisfy data collection and analysis
21 needs and that are not used in the direct clin-
22 ical management of the patient; or

23 “(C) a service that is clearly inconsistent
24 with widely accepted and established standards
25 of care for a particular diagnosis.

1 “(3) INFORMATION CONCERNING CLINICAL
2 TRIALS.—

3 “(A) IN GENERAL.—Subject to subpara-
4 graph (B), the Secretary, in consultation with
5 relevant stakeholders, shall develop a single
6 standardized electronic form for use by the indi-
7 vidual or the referring health care provider to
8 submit to the State agency administering the
9 State plan in order to verify that the clinical
10 trial meets the conditions established for an ap-
11 proved clinical trial (as defined in subsection
12 (c)).

13 “(B) EXCLUDED INFORMATION.—For pur-
14 poses of subparagraph (A) or any such request
15 by the State agency for information regarding
16 a clinical trial, an individual or referring health
17 care provider shall not be required to submit—

18 “(i) the clinical protocol document for
19 the clinical trial; or

20 “(ii) subject to subparagraph (C), any
21 additional information other than such in-
22 formation as is required pursuant to the
23 form described in subparagraph (A).

24 “(C) OPTIONAL INFORMATION.—For pur-
25 poses of subparagraphs (A) and (B)(ii), the

1 form may include a requirement that the refer-
2 ring health care provider attest that the indi-
3 vidual is eligible to participate in the clinical
4 trial pursuant to the trial protocol and that in-
5 dividual participation in such trial would be ap-
6 propriate.

7 “(D) REVIEW OF INFORMATION.—

8 “(i) IN GENERAL.—A State plan
9 under this title shall establish a process for
10 timely review by the State agency of the
11 form and information submitted pursuant
12 to subparagraph (A) and, not later than
13 48 hours after receipt of such form, con-
14 firmation that the information provided in
15 such form satisfies the requirements estab-
16 lished under such subparagraph, with such
17 process to include establishment and oper-
18 ation of a 24-hour, toll-free telephone num-
19 ber and email address to provide for expe-
20 dited communication.

21 “(ii) FAILURE TO RESPOND.—If an
22 individual or the referring health care pro-
23 vider does not receive a response or re-
24 quest for additional information from the
25 State agency following the 48-hour period

1 described in clause (i), the information
2 provided in the form may be presumed to
3 satisfy the requirements established under
4 this paragraph.

5 “(b) ENCOURAGEMENT OF PARTICIPATION IN AP-
6 PROVED CLINICAL TRIALS.—

7 “(1) REASONABLY ACCESSIBLE PROVIDER.—

8 For purposes of participation in an approved clinical
9 trial by an individual eligible for medical assistance
10 under this title, the State agency administering the
11 State plan shall make reasonable efforts to ensure
12 that the individual is provided with access to a pro-
13 vider who is—

14 “(A) participating in the approved clinical
15 trial;

16 “(B) located not more than 25 miles from
17 the residence of the individual (or, if no such
18 provider is available, as close as possible to the
19 residence of the individual); and

20 “(C) a participating provider under the
21 State plan or has been deemed to be a partici-
22 pating provider under the State plan for pur-
23 poses of providing medical assistance to the in-
24 dividual during their participation in the ap-
25 proved clinical trial.

1 “(2) INFORMATIONAL MATERIALS.—The State
2 agency administering the plan approved under this
3 title shall develop informational materials and pro-
4 grams to encourage participating providers to make
5 appropriate referrals to physicians and other appro-
6 priate health care professionals who can provide in-
7 dividuals with access to approved clinical trials.

8 “(c) DEFINITION OF APPROVED CLINICAL TRIAL.—
9 The term ‘approved clinical trial’ has the same meaning
10 as provided under section 2709(d) of the Public Health
11 Service Act.”.

12 (b) CONFORMING AMENDMENT.—Section 1902(a) of
13 the Social Security Act (42 U.S.C. 1396a(a)) is amended
14 by inserting after paragraph (77) the following new para-
15 graph:

16 “(78) provide that participation in an approved
17 clinical trial and coverage of routine patient costs
18 associated with such trial for an individual eligible
19 for medical assistance under this title is conducted
20 in accordance with the requirements under section
21 1944;”.

22 (c) EFFECTIVE DATE.—

23 (1) IN GENERAL.—Except as provided in para-
24 graph (2), the amendments made by this section

1 shall apply to calendar quarters beginning on or
2 after October 1, 2018.

3 (2) DELAY PERMITTED FOR STATE PLAN
4 AMENDMENT.—In the case of a State plan for med-
5 ical assistance under title XIX of the Social Security
6 Act which the Secretary of Health and Human Serv-
7 ices determines requires State legislation (other than
8 legislation appropriating funds) in order for the plan
9 to meet the additional requirements imposed by the
10 amendments made by this section, the State plan
11 shall not be regarded as failing to comply with the
12 requirements of such title solely on the basis of its
13 failure to meet these additional requirements before
14 the first day of the first calendar quarter beginning
15 after the close of the first regular session of the
16 State legislature that begins after the date of enact-
17 ment of this Act. For purposes of the previous sen-
18 tence, in the case of a State that has a 2-year legis-
19 lative session, each year of such session shall be
20 deemed to be a separate regular session of the State
21 legislature.

22 **Subtitle E—HIV/AIDS**

23 **SEC. 741. STATEMENT OF POLICY.**

24 It is the policy of the United States to achieve an
25 AIDS-free generation, and to—

1 (1) expand access to lifesaving antiretroviral
2 therapy for people living with HIV/AIDS and imme-
3 diately link people to continuous and coordinated
4 high-quality care when they learn they are infected
5 with HIV;

6 (2) expand targeted efforts to prevent HIV in-
7 fection using a combination of effective, evidence-
8 based approaches, including routine HIV screening,
9 and universal access to HIV prevention tools in the
10 communities where HIV/AIDS is most heavily con-
11 centrated, particularly communities of color;

12 (3) ensure laws, policies, and regulations do not
13 impede access to prevention, treatment, and care for
14 people living with HIV/AIDS or at risk for acquiring
15 HIV;

16 (4) accelerate research for more efficacious HIV
17 prevention and treatments tools, a cure, and a vac-
18 cine; and

19 (5) respect the human rights and dignity of
20 persons living with HIV/AIDS.

21 **SEC. 742. FINDINGS.**

22 The Congress finds the following:

23 (1) Over one million people are estimated to be
24 living with HIV in the United States according to
25 the Centers for Disease Control and Prevention, 15

1 percent of whom are unaware of their HIV-positive
2 status.

3 (2) Annually there are about 37,600 new HIV
4 infections and 20,000 deaths in people with an HIV
5 diagnoses in 50 States and 6 dependent areas of the
6 United States.

7 (3) The Centers for Disease Control and Pre-
8 vention estimates that, in 2015, there were approxi-
9 mately 37,600 people newly diagnosed with HIV.
10 The estimated number of annual new HIV infections
11 declined 10 percent from 2010 to 2014. However,
12 the number of new infections is increasing among
13 certain populations, such as Latino gay and bisexual
14 men, where annual infections increase 14 percent.
15 New infections among Black gay or bisexual men
16 are remaining stable.

17 (4) HIV disproportionately affects certain popu-
18 lations in the United States. Though African Ameri-
19 cans represent approximately 12 percent of the pop-
20 ulation, African Americans account for almost half
21 (45 percent) of all people living with HIV in the
22 United States. Men who have sex with men (MSM)
23 account for 67 percent of all new HIV infections and
24 are the only risk group in which HIV infections con-
25 tinue to increase.

1 (5) Disparities exist among Latinos/Hispanics;
2 they make up 18 percent of the United States popu-
3 lation and 24 percent of new infections (2015).

4 (6) Though the rate of new infections among
5 American Indians/Alaska Native (AI/AN) is propor-
6 tional to their population size, from 2005 to 2014,
7 the annual number of HIV diagnoses increased 19
8 percent among AIs/ANs overall and 63 percent
9 among AI/AN gay and bisexual men.

10 (7) Asian Americans account for about 2 per-
11 cent of new HIV infections, but in 2013, 22 percent
12 were undiagnosed, the highest rate of undiagnosed
13 HIV among any race/ethnicity.

14 (8) The latest data from the CDC (2015) indi-
15 cate that new infections among women declined 20
16 percent.

17 (9) The history of HIV shows that culturally
18 relevant and gender-responsive supportive services,
19 including psychosocial support, treatment literacy,
20 case management, and transportation are necessary
21 strategies to reach and engage women and girls in
22 medical care.

23 (10) The limited data available on transgender
24 individuals point to a disproportionate burden of
25 HIV infection.

1 (11) Stigma and discrimination contribute to
2 these disparities.

3 (12) The Centers for Disease Control and Pre-
4 vention has determined that increasing the propor-
5 tion of people who know their HIV status is an es-
6 sential component of comprehensive HIV/AIDS
7 treatment and prevention efforts and that early di-
8 agnosis is critical in order for people with HIV/
9 AIDS to receive life-extending therapy. Additionally,
10 the Centers for Disease Control and Prevention rec-
11 ommend routine HIV screening in health care set-
12 tings for all patients aged 13 to 64, regardless of
13 risk.

14 (13) In 1998, Congress created the National
15 Minority AIDS Initiative to provide technical assist-
16 ance, build capacity, and strengthen outreach efforts
17 among local institutions and community-based orga-
18 nizations that serve racial and ethnic minorities liv-
19 ing with or vulnerable to HIV/AIDS.

20 (14) To combat the HIV epidemic in the United
21 States, the National HIV/AIDS Strategy (NHAS)
22 provides a framework of increasing access to care,
23 reducing new infections, and eliminating HIV-re-
24 lated health disparities. The vision of NHAS is “The
25 United States will become a place where new HIV

1 infections are rare and when they do occur, every
2 person, regardless of age, gender, race/ethnicity,
3 gender identity, or socioeconomic circumstance, will
4 have unfettered access to high quality, life-extending
5 care, free from stigma and discrimination.”.

6 (15) At present, many States and United
7 States territories have criminal statutes based on
8 “exposure” to HIV. Most of these laws were adopted
9 before the availability of effective antiretroviral
10 treatment for HIV/AIDS.

11 (16) Research shows that stable housing leads
12 to better health outcomes for those living with HIV.
13 Inadequate or unstable housing is not only a barrier
14 to effective treatment, but also increases the likeli-
15 hood of engaging in risky behaviors leading to HIV
16 infection. Insecure housing puts people with HIV/
17 AIDS at risk of premature death from exposure to
18 other diseases, poor nutrition, and lack of medical
19 care.

20 (17) Due to advances in treatment, many peo-
21 ple living with HIV/AIDS (PLWHA) today are liv-
22 ing healthy lives and have the ability and desire to
23 fully participate in all aspects of community life, in-
24 cluding employment. Research associates being em-

1 employed with tremendous economic, social, and health
2 benefits for many people living with HIV/AIDS.

3 (18) The common benefits associated with em-
4 ployment include income, autonomy, productivity,
5 and status within society, daily structure, making a
6 contribution to one's community, and increased skills
7 and self-esteem. Research also indicates that many
8 people with disabilities, including PLWHA, report
9 perceiving themselves as being less disabled or not
10 disabled at all, when working. Furthermore, some
11 studies link working with better physical and mental
12 health outcomes for PLWHA when compared to
13 those who are not working. Preliminary data also
14 suggest that transitioning to employment is associ-
15 ated with reduced HIV-related health risk behavior
16 for many people.

17 (19) On July 16, 2012, the Food and Drug Ad-
18 ministration approved the first drug to reduce the
19 risk of HIV infection in uninfected individuals who
20 are at high risk of HIV infection and who may en-
21 gage in sexual activity with HIV-infected partners.

22 (20) Syringe service programs (SSPs) have
23 been associated with lowered HIV infections, lower
24 hepatitis C infections, and increased linkage to sub-
25 stance use treatment.

1 (21) There is now conclusive scientific evidence
2 that a person living with HIV who is on
3 antiretroviral therapy (ART) and is durably virally
4 suppressed (defined as having a consistent viral load
5 of less than 200 copies/ml) does not sexually trans-
6 mit HIV. The conclusive evidence about the highly
7 effective preventative benefits of ART provides an
8 unprecedented opportunity to improve the lives of
9 people living with HIV, improve treatment uptake
10 and adherence, and advocate for expanded access to
11 treatment and care.

12 **SEC. 743. ADDITIONAL FUNDING FOR AIDS DRUG ASSIST-**
13 **ANCE PROGRAM TREATMENTS.**

14 Section 2623 of the Public Health Service Act (42
15 U.S.C. 300ff–31b) is amended by adding at the end the
16 following:

17 “(c) **ADDITIONAL FUNDING FOR AIDS DRUG AS-**
18 **SISTANCE PROGRAM TREATMENTS.**—In addition to
19 amounts otherwise authorized to be appropriated for car-
20 rying out this subpart, there are authorized to be appro-
21 priated such sums as may be necessary to carry out sec-
22 tions 2612(b)(3)(B) and 2616 for each of fiscal years
23 2019 through 2022.”.

1 **SEC. 744. ENHANCING THE NATIONAL HIV SURVEILLANCE**
2 **SYSTEM.**

3 (a) GRANTS.—The Secretary of Health and Human
4 Services, acting through the Director of the Centers for
5 Disease Control and Prevention, shall make grants to
6 States to support integration of public health surveillance
7 systems into all electronic health records in order to allow
8 rapid communications between the clinical setting and
9 health departments, by means that include—

10 (1) providing technical assistance and policy
11 guidance to State and local health departments, clin-
12 ical providers, and other agencies serving individuals
13 with HIV to improve the interoperability of data sys-
14 tems relevant to monitoring HIV care and sup-
15 portive services;

16 (2) capturing longitudinal data pertaining to
17 the initiation and ongoing prescription or dispensing
18 of antiretroviral therapy for individuals diagnosed
19 with HIV (such as through pharmacy-based report-
20 ing);

21 (3) obtaining information—

22 (A) on a voluntary basis, on sexual orienta-
23 tion and gender identity; and

24 (B) on sources of coverage (or the lack
25 thereof) for medical treatment (including cov-
26 erage through Medicaid, Medicare, the program

1 under title XXVI of the Public Health Service
2 Act (42 U.S.C. 300ff–11 et seq.; commonly re-
3 ferred to as the “Ryan White HIV/AIDS Pro-
4 gram”), other public funding, private insurance,
5 and health maintenance organizations); and

6 (4) obtaining and using current geographic
7 markers of residence (such as current address, zip
8 code, partial zip code, and census block).

9 (b) PRIVACY AND SECURITY SAFEGUARDS.—In car-
10 rying out this section, the Secretary of Health and Human
11 Services shall ensure that appropriate privacy and security
12 safeguards are met to prevent unauthorized disclosure of
13 protected health information and compliance with the
14 HIPAA privacy and security law (as defined in section
15 3009 of the Public Health Service Act (42 U.S.C. 300jj–
16 19)) and other relevant laws and regulations.

17 (c) PROHIBITION AGAINST IMPROPER USE OF
18 DATA.—No grant under this section may be used to allow
19 or facilitate the collection or use of surveillance or clinical
20 data or records—

21 (1) for punitive measures of any kind, civil or
22 criminal, against the subject of such data or records;
23 or

1 (2) for imposing any requirement or restriction
2 with respect to an individual without the individual's
3 written consent.

4 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
5 out this section, there are authorized to be appropriated
6 such sums as may be necessary for each of fiscal years
7 2019 through 2023.

8 **SEC. 745. EVIDENCE-BASED STRATEGIES FOR IMPROVING**
9 **LINKAGE TO AND RETENTION IN APPRO-**
10 **PRIATE CARE.**

11 (a) STRATEGIES.—The Secretary of Health and
12 Human Services, in collaboration with the Director of the
13 Centers for Disease Control and Prevention, the Adminis-
14 trator of the Substance Abuse and Mental Health Services
15 Administration, the Director of the Office of AIDS Re-
16 search, the Administrator of the Health Resources and
17 Services Administration, and the Administrator of the
18 Centers for Medicare & Medicaid Services, shall—

19 (1) identify evidence-based strategies most ef-
20 fective at addressing the multifaceted issues that im-
21 pede disease status awareness and linkage to and re-
22 tention in appropriate care, taking into consideration
23 health care systems issues, clinic and provider
24 issues, and individual psychosocial, environmental,
25 and other contextual factors;

1 (2) support the wide-scale implementation of
2 the evidence-based strategies identified pursuant to
3 paragraph (1), including through incorporating such
4 strategies into health care coverage supported by the
5 Medicaid program under title XIX of the Social Se-
6 curity Act (42 U.S.C. 1396 et seq.), the program
7 under title XXVI of the Public Health Service Act
8 (42 U.S.C. 300ff–11 et seq.; commonly referred to
9 as the “Ryan White HIV/AIDS Program”), and
10 health plans purchased through an American Health
11 Benefit Exchange established pursuant to section
12 1311 of the Patient Protection and Affordable Care
13 Act (42 U.S.C. 18031); and

14 (3) not later than 12 months after the date of
15 the enactment of this Act, submit a report to the
16 Congress on the status of activities under para-
17 graphs (1) and (2).

18 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
19 out this section, there are authorized to be appropriated
20 such sums as may be necessary for fiscal years 2019
21 through 2023.

1 **SEC. 746. IMPROVING ENTRY INTO AND RETENTION IN**
2 **CARE AND ANTIRETROVIRAL ADHERENCE**
3 **FOR PERSONS WITH HIV.**

4 (a) SENSE OF CONGRESS.—It is the sense of the Con-
5 gress that AIDS research has led to scientific advance-
6 ments that have—

7 (1) saved the lives of millions of people with
8 HIV/AIDS;

9 (2) prevented millions of people from being in-
10 fected; and

11 (3) had broad benefits that extend far beyond
12 helping people at risk for or living with HIV.

13 (b) IN GENERAL.—The Secretary of Health and
14 Human Services, acting through the Director of the Na-
15 tional Institutes of Health, shall expand, intensify, and co-
16 ordinate operational and translational research and other
17 activities of the National Institutes of Health regarding
18 methods—

19 (1) to increase adoption of evidence-based ad-
20 herence strategies within HIV care and treatment
21 programs;

22 (2) to increase HIV testing and case detection
23 rates;

24 (3) to reduce HIV-related health disparities;

1 (4) to ensure that research to improve adher-
2 ence to HIV care and treatment programs address
3 the unique concerns of women;

4 (5) to integrate HIV/AIDS prevention and care
5 services with mental health and substance use pre-
6 vention and treatment delivery systems;

7 (6) to increase knowledge on the implementa-
8 tion of preexposure prophylaxis (PrEP), including
9 with respect to—

10 (A) who can benefit most from PrEP;

11 (B) how to provide PrEP safely and effi-
12 ciently;

13 (C) how to integrate PrEP with other es-
14 sential prevention methods such as condoms;
15 and

16 (D) how to ensure high levels of adherence;
17 and

18 (7) to increase knowledge of Undetectable =
19 Untransmittable (U=U) a person living with HIV
20 who is on antiretroviral therapy (ART) and is dura-
21 bly virally suppressed (defined as having a consistent
22 viral load of less than 200 copies/ml) cannot sexually
23 transmit HIV.

24 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
25 out this section, there are authorized to be appropriated

1 such sums as may be necessary for fiscal years 2019
2 through 2023.

3 **SEC. 747. SERVICES TO REDUCE HIV/AIDS IN RACIAL AND**
4 **ETHNIC MINORITY COMMUNITIES.**

5 (a) IN GENERAL.—For the purpose of reducing HIV/
6 AIDS in racial and ethnic minority communities, the Sec-
7 retary, acting through the Deputy Assistant Secretary for
8 Minority Health, may make grants to public health agen-
9 cies and faith-based organizations to conduct—

10 (1) outreach activities related to HIV/AIDS
11 prevention and testing activities;

12 (2) HIV/AIDS prevention activities; and

13 (3) HIV/AIDS testing activities.

14 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
15 out this section, there are authorized to be appropriated
16 such sums as may be necessary for fiscal years 2019
17 through 2023.

18 **SEC. 748. MINORITY AIDS INITIATIVE.**

19 (a) EXPANDED FUNDING.—The Secretary, in col-
20 laboration with the Deputy Assistant Secretary for Minor-
21 ity Health, the Director of the Centers for Disease Control
22 and Prevention, the Administrator of the Health Re-
23 sources and Services Administration, and the Adminis-
24 trator of the Substance Abuse and Mental Health Services

1 Administration, shall provide funds and carry out activi-
2 ties to expand the Minority HIV/AIDS Initiative.

3 (b) USE OF FUNDS.—The additional funds made
4 available under this section may be used, through the Mi-
5 nority AIDS Initiative, to support the following activities:

6 (1) Providing technical assistance and infra-
7 structure support to reduce HIV/AIDS in minority
8 populations.

9 (2) Increasing minority populations' access to
10 HIV/AIDS prevention and care services.

11 (3) Building strong community programs and
12 partnerships to address HIV prevention and the
13 health care needs of specific racial and ethnic minor-
14 ity populations.

15 (c) PRIORITY INTERVENTIONS.—Within the racial
16 and ethnic minority populations referred to in subsection
17 (b), priority in conducting intervention services shall be
18 given to—

19 (1) men who have sex with men;

20 (2) youth;

21 (3) persons who engage in intravenous drug
22 abuse;

23 (4) women;

24 (5) homeless individuals; and

1 (6) individuals incarcerated or in the penal sys-
2 tem.

3 (d) AUTHORIZATION OF APPROPRIATIONS.—For car-
4 rying out this section, there are authorized to be appro-
5 priated \$610,000,000 for fiscal year 2019 and such sums
6 as may be necessary for each of fiscal years 2020 through
7 2023.

8 **SEC. 749. HEALTH CARE PROFESSIONALS TREATING INDI-**
9 **VIDUALS WITH HIV/AIDS.**

10 (a) IN GENERAL.—The Secretary of Health and
11 Human Services, acting through the Administrator of the
12 Health Resources and Services Administration, shall ex-
13 pand, intensify, and coordinate workforce initiatives of the
14 Health Resources and Services Administration to increase
15 the capacity of the health workforce focusing primarily on
16 HIV/AIDS to meet the demand for culturally competent
17 care, and may award grants for any of the following:

18 (1) Development of curricula for training pri-
19 mary care providers in HIV/AIDS prevention and
20 care, including routine HIV testing.

21 (2) Support to expand access to culturally and
22 linguistically accessible benefits counselors, trained
23 peer navigators, and mental and behavioral health
24 professionals with expertise in HIV/AIDS.

1 (3) Training health care professionals to pro-
2 vide care to individuals with HIV/AIDS.

3 (4) Development by grant recipients under title
4 XXVI of the Public Health Service Act (42 U.S.C.
5 300ff–11 et seq.; commonly referred to as the “Ryan
6 White HIV/AIDS Program”) and other persons, of
7 policies for providing culturally relevant and sen-
8 sitive treatment to individuals with HIV/AIDS, with
9 particular emphasis on treatment to racial and eth-
10 nic minorities, men who have sex with men, and
11 women, young people, and children with HIV/AIDS.

12 (5) Development and implementation of pro-
13 grams to increase the use of telehealth to respond to
14 HIV/AIDS-specific health care needs in rural and
15 minority communities, with particular emphasis
16 given to medically underserved communities and in-
17 sular areas.

18 (6) Evaluating interdisciplinary medical pro-
19 vider care team models that promote high-quality
20 care, with particular emphasis on care to racial and
21 ethnic minorities.

22 (7) Training health care professionals to make
23 them aware of the high rates of chronic hepatitis B
24 and chronic hepatitis C in adult racial and ethnic
25 populations, and the importance of prevention, de-

1 (2) the Secretary agrees to make payments in
2 accordance with subsection (b) on the professional
3 education loans of the physician, nurse practitioner,
4 or physician assistant.

5 (b) MANNER OF PAYMENTS.—The payments de-
6 scribed in subsection (a) shall be made by the Secretary
7 as follows:

8 (1) Upon completion by the physician, nurse
9 practitioner, or physician assistant for whom the
10 payments are to be made of the first year of the
11 service specified in the agreement entered into with
12 the Secretary under subsection (a), the Secretary
13 shall pay 30 percent of the principal of and the in-
14 terest on the individual's professional education
15 loans.

16 (2) Upon completion by the physician, nurse
17 practitioner, or physician assistant of the second
18 year of such service, the Secretary shall pay another
19 30 percent of the principal of and the interest on
20 such loans.

21 (3) Upon completion by that individual of a
22 third year of such service, the Secretary shall pay
23 another 25 percent of the principal of and the inter-
24 est on such loans.

1 (c) APPLICABILITY OF CERTAIN PROVISIONS.—The
2 provisions of subpart III of part D of title III of the Public
3 Health Service Act (42 U.S.C. 254l et seq.) shall, except
4 as inconsistent with this section, apply to the program car-
5 ried out under this section in the same manner and to
6 the same extent as such provisions apply to the National
7 Health Service Corps Loan Repayment Program.

8 (d) REPORTS.—Not later than 18 months after the
9 date of the enactment of this Act, and annually thereafter,
10 the Secretary shall prepare and submit to the Congress
11 a report describing the program carried out under this sec-
12 tion, including statements regarding the following:

13 (1) The number of physicians, nurse practi-
14 tioners, and physician assistants enrolled in the pro-
15 gram.

16 (2) The number and amount of loan repay-
17 ments.

18 (3) The placement location of loan repayment
19 recipients at facilities described in subsection (a)(1).

20 (4) The default rate and actions required.

21 (5) The amount of outstanding default funds.

22 (6) To the extent that it can be determined, the
23 reason for the default.

24 (7) The demographics of individuals partici-
25 pating in the program.

1 (8) An evaluation of the overall costs and bene-
2 fits of the program.

3 (e) DEFINITIONS.—In this section:

4 (1) HIV/AIDS.—The term “HIV/AIDS” means
5 human immunodeficiency virus and acquired im-
6 mune deficiency syndrome.

7 (2) NURSE PRACTITIONER.—The term “nurse
8 practitioner” means a registered nurse who has com-
9 pleted an accredited graduate degree program in ad-
10 vanced nurse practice and has successfully passed a
11 national certification exam.

12 (3) PHYSICIAN.—The term “physician” means
13 a graduate of a school of medicine who has com-
14 pleted postgraduate training in general or pediatric
15 medicine.

16 (4) PHYSICIAN ASSISTANT.—The term “physi-
17 cian assistant” means a medical provider who com-
18 pleted an accredited physician assistant training pro-
19 gram and successfully passed the Physician Assist-
20 ant National Certifying Examination.

21 (5) PROFESSIONAL EDUCATION LOAN.—The
22 term “professional education loan”—

23 (A) means a loan that is incurred for the
24 cost of attendance (including tuition, other rea-
25 sonable educational expenses, and reasonable

1 living costs) at a school of medicine, nursing, or
2 physician assistant training program; and

3 (B) includes only the portion of the loan
4 that is outstanding on the date the physician,
5 nurse practitioner, or physician assistant in-
6 volved begins the service specified in the agree-
7 ment under subsection (a).

8 (6) RYAN WHITE-FUNDED.—The term “Ryan
9 White-funded” means, with respect to a facility, re-
10 ceiving funds under title XXVI of the Public Health
11 Service Act (42 U.S.C. 300ff–11 et seq.).

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

14 (8) SCHOOL OF MEDICINE.—The term “school
15 of medicine” has the meaning given to that term in
16 section 799B of the Public Health Service Act (42
17 U.S.C. 295p).

18 (9) TITLE X-FUNDED.—The term “title X-fund-
19 ed” means, with respect to a facility, receiving funds
20 under title X of the Public Health Service Act (42
21 U.S.C. 300 et seq.).

22 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
23 out this section, there are authorized to be appropriated
24 such sums as may be necessary for fiscal years 2019
25 through 2023.

1 **SEC. 751. DENTAL EDUCATION LOAN REPAYMENT PRO-**
2 **GRAM.**

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services may enter into an agreement with any
5 dentist under which—

6 (1) the dentist agrees to serve as a dentist for
7 a period of not less than 2 years at a facility with
8 a critical shortage of dentists (as determined by the
9 Secretary) in an area with a high incidence of HIV/
10 AIDS; and

11 (2) the Secretary agrees to make payments in
12 accordance with subsection (b) on the dental edu-
13 cation loans of the dentist.

14 (b) MANNER OF PAYMENTS.—The payments de-
15 scribed in subsection (a) shall be made by the Secretary
16 as follows:

17 (1) Upon completion by the dentist for whom
18 the payments are to be made of the first year of the
19 service specified in the agreement entered into with
20 the Secretary under subsection (a), the Secretary
21 shall pay 30 percent of the principal of and the in-
22 terest on the dental education loans of the dentist.

23 (2) Upon completion by the dentist of the sec-
24 ond year of such service, the Secretary shall pay an-
25 other 30 percent of the principal of and the interest
26 on such loans.

1 (3) Upon completion by that individual of a
2 third year of such service, the Secretary shall pay
3 another 25 percent of the principal of and the inter-
4 est on such loans.

5 (c) APPLICABILITY OF CERTAIN PROVISIONS.—The
6 provisions of subpart III of part D of title III of the Public
7 Health Service Act (42 U.S.C. 2541 et seq.) shall, except
8 as inconsistent with this section, apply to the program car-
9 ried out under this section in the same manner and to
10 the same extent as such provisions apply to the National
11 Health Service Corps Loan Repayment Program.

12 (d) REPORTS.—Not later than 18 months after the
13 date of the enactment of this Act, and annually thereafter,
14 the Secretary shall prepare and submit to the Congress
15 a report describing the program carried out under this sec-
16 tion, including statements regarding the following:

17 (1) The number of dentists enrolled in the pro-
18 gram.

19 (2) The number and amount of loan repay-
20 ments.

21 (3) The placement location of loan repayment
22 recipients at facilities described in subsection (a)(1).

23 (4) The default rate and actions required.

24 (5) The amount of outstanding default funds.

1 (6) To the extent that it can be determined, the
2 reason for the default.

3 (7) The demographics of individuals partici-
4 pating in the program.

5 (8) An evaluation of the overall costs and bene-
6 fits of the program.

7 (e) DEFINITIONS.—In this section:

8 (1) DENTAL EDUCATION LOAN.—The term
9 “dental education loan”—

10 (A) means a loan that is incurred for the
11 cost of attendance (including tuition, other rea-
12 sonable educational expenses, and reasonable
13 living costs) at a school of dentistry; and

14 (B) includes only the portion of the loan
15 that is outstanding on the date the dentist in-
16 volved begins the service specified in the agree-
17 ment under subsection (a).

18 (2) DENTIST.—The term “dentist” means a
19 graduate of a school of dentistry who has completed
20 postgraduate training in general or pediatric den-
21 tistry.

22 (3) HIV/AIDS.—The term “HIV/AIDS” means
23 human immunodeficiency virus and acquired im-
24 mune deficiency syndrome.

1 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section, there are authorized to be appropriated
3 such sums as may be necessary for fiscal years 2019
4 through 2023.

5 **SEC. 753. REPORT ON IMPACT OF HIV/AIDS IN VULNERABLE**
6 **POPULATIONS.**

7 (a) IN GENERAL.—The Secretary shall submit to the
8 Congress and the President an annual report on the im-
9 pact of HIV/AIDS for racial and ethnic minority commu-
10 nities, women, and youth aged 24 and younger.

11 (b) CONTENTS.—The report under subsection (a)
12 shall include information on the—

13 (1) progress that has been made in reducing
14 the impact of HIV/AIDS in such communities;

15 (2) opportunities that exist to make additional
16 progress in reducing the impact of HIV/AIDS in
17 such communities;

18 (3) challenges that may impede such additional
19 progress; and

20 (4) Federal funding necessary to achieve sub-
21 stantial reductions in HIV/AIDS in racial and ethnic
22 minority communities.

23 **SEC. 754. NATIONAL HIV/AIDS OBSERVANCE DAYS.**

24 (a) NATIONAL OBSERVANCE DAYS.—It is the sense
25 of the Congress that national observance days highlighting

1 the impact of HIV/AIDS on communities of color include
2 the following:

3 (1) National Black HIV/AIDS Awareness Day.

4 (2) National Latino AIDS Awareness Day.

5 (3) National Asian and Pacific Islander HIV/
6 AIDS Awareness Day.

7 (4) National Native American HIV/AIDS
8 Awareness Day.

9 (5) National Youth HIV/AIDS Awareness Day.

10 (b) CALL TO ACTION.—It is the sense of the Con-
11 gress that the President should call on members of com-
12 munities of color—

13 (1) to become involved at the local community
14 level in HIV/AIDS testing, policy, and advocacy;

15 (2) to become aware, engaged, and empowered
16 on the HIV/AIDS epidemic within their commu-
17 nities; and

18 (3) to urge members of their communities to re-
19 duce risk factors, practice safe sex and other preven-
20 tive measures, be tested for HIV/AIDS, and seek
21 care when appropriate.

1 **SEC. 755. REVIEW OF ALL FEDERAL AND STATE LAWS,**
2 **POLICIES, AND REGULATIONS REGARDING**
3 **THE CRIMINAL PROSECUTION OF INDIVID-**
4 **UALS FOR HIV-RELATED OFFENSES.**

5 (a) DEFINITIONS.—

6 (1) HIV AND HIV/AIDS.—The terms “HIV” and
7 “HIV/AIDS” have the meanings given to such terms
8 in section 2689 of the Public Health Service Act (42
9 U.S.C. 300ff–88).

10 (2) STATE.—The term “State” includes the
11 District of Columbia, American Samoa, the Com-
12 monwealth of the Northern Mariana Islands, Guam,
13 Puerto Rico, and the United States Virgin Islands.

14 (b) SENSE OF CONGRESS REGARDING LAWS OR REG-
15 ULATIONS DIRECTED AT PEOPLE LIVING WITH HIV/
16 AIDS.—It is the sense of the Congress that Federal and
17 State laws, policies, and regulations regarding people liv-
18 ing with HIV/AIDS—

19 (1) should not place unique or additional bur-
20 dens on such individuals solely as a result of their
21 HIV status; and

22 (2) should instead demonstrate a public health-
23 oriented, evidence-based, medically accurate, and
24 contemporary understanding of—

25 (A) the multiple factors that lead to HIV
26 transmission;

1 (B) the relative risk of HIV transmission
2 routes;

3 (C) the current health implications of liv-
4 ing with HIV;

5 (D) the associated benefits of treatment
6 and support services for people living with HIV;
7 and

8 (E) the impact of punitive HIV-specific
9 laws and policies on public health, on people liv-
10 ing with or affected by HIV, and on their fami-
11 lies and communities.

12 (c) REVIEW OF ALL FEDERAL AND STATE LAWS,
13 POLICIES, AND REGULATIONS REGARDING THE CRIMINAL
14 PROSECUTION OF INDIVIDUALS FOR HIV-RELATED OF-
15 FENSES.—

16 (1) REVIEW OF FEDERAL AND STATE LAWS.—

17 (A) IN GENERAL.—No later than 90 days
18 after the date of the enactment of this Act, the
19 Attorney General, the Secretary of Health and
20 Human Services, and the Secretary of Defense
21 acting jointly (in this paragraph and paragraph
22 (2) referred to as the “designated officials”) shall
23 initiate a national review of Federal and
24 State laws, policies, regulations, and judicial
25 precedents and decisions regarding criminal and

1 related civil commitment cases involving people
2 living with HIV/AIDS, including in regards to
3 the Uniform Code of Military Justice.

4 (B) CONSULTATION.—In carrying out the
5 review under subparagraph (A), the designated
6 officials shall ensure diverse participation and
7 consultation from each State, including with—

8 (i) State attorneys general (or their
9 representatives);

10 (ii) State public health officials (or
11 their representatives);

12 (iii) State judicial and court system
13 officers, including judges, district attor-
14 neys, prosecutors, defense attorneys, law
15 enforcement, and correctional officers;

16 (iv) members of the United States
17 Armed Forces, including members of other
18 Federal services subject to the Uniform
19 Code of Military Justice;

20 (v) people living with HIV/AIDS, par-
21 ticularly those who have been subject to
22 HIV-related prosecution or who are from
23 communities whose members have been
24 disproportionately subject to HIV-specific
25 arrests and prosecutions;

1 (vi) legal advocacy and HIV/AIDS
2 service organizations that work with people
3 living with HIV/AIDS;

4 (vii) nongovernmental health organi-
5 zations that work on behalf of people living
6 with HIV/AIDS; and

7 (viii) trade organizations or associa-
8 tions representing persons or entities de-
9 scribed in clauses (i) through (vii).

10 (C) RELATION TO OTHER REVIEWS.—In
11 carrying out the review under subparagraph
12 (A), the designated officials may utilize other
13 existing reviews of criminal and related civil
14 commitment cases involving people living with
15 HIV/AIDS, including any such review con-
16 ducted by any Federal or State agency or any
17 public health, legal advocacy, or trade organiza-
18 tion or association if the designated officials de-
19 termine that such reviews were conducted in ac-
20 cordance with the principles set forth in sub-
21 section (b).

22 (2) REPORT.—No later than 180 days after ini-
23 tiating the review required by paragraph (1), the At-
24 torney General shall transmit to the Congress and

1 make publicly available a report containing the re-
2 sults of the review, which includes the following:

3 (A) For each State and for the Uniform
4 Code of Military Justice, a summary of the rel-
5 evant laws, policies, regulations, and judicial
6 precedents and decisions regarding criminal
7 cases involving people living with HIV/AIDS,
8 including, if applicable, the following:

9 (i) A determination of whether such
10 laws, policies, regulations, and judicial
11 precedents and decisions place any unique
12 or additional burdens upon people living
13 with HIV/AIDS.

14 (ii) A determination of whether such
15 laws, policies, regulations, and judicial
16 precedents and decisions demonstrate a
17 public health-oriented, evidence-based,
18 medically accurate, and contemporary un-
19 derstanding of—

20 (I) the multiple factors that lead
21 to HIV transmission;

22 (II) the relative risk of HIV
23 transmission routes;

24 (III) the current health implica-
25 tions of living with HIV;

1 (IV) the associated benefits of
2 treatment and support services for
3 people living with HIV; and

4 (V) the impact of punitive HIV-
5 specific laws and policies on public
6 health, on people living with or af-
7 fected by HIV, and on their families
8 and communities.

9 (iii) An analysis of the public health
10 and legal implications of such laws, poli-
11 cies, regulations, and judicial precedents,
12 including an analysis of the consequences
13 of having a similar penal scheme applied to
14 comparable situations involving other com-
15 municable diseases.

16 (iv) An analysis of the proportionality
17 of punishments imposed under HIV-spe-
18 cific laws, policies, regulations, and judicial
19 precedents, taking into consideration pen-
20 alties attached to violation of State laws
21 against similar degrees of endangerment or
22 harm, such as driving while intoxicated
23 (DWI) or transmission of other commu-
24 nicable diseases, or more serious harms,
25 such as vehicular manslaughter offenses.

1 (B) An analysis of common elements
2 shared among State laws, policies, regulations,
3 and judicial precedents.

4 (C) A set of best practice recommendations
5 directed to State governments, including State
6 attorneys general, public health officials, and
7 judicial officers, in order to ensure that laws,
8 policies, regulations, and judicial precedents re-
9 garding people living with HIV/AIDS are in ac-
10 cordance with the principles set forth in sub-
11 section (b).

12 (D) Recommendations for adjustments to
13 the Uniform Code of Military Justice, as may
14 be necessary, in order to ensure that laws, poli-
15 cies, regulations, and judicial precedents re-
16 garding people living with HIV/AIDS are in ac-
17 cordance with the principles set forth in sub-
18 section (b).

19 (3) GUIDANCE.—Within 90 days of the release
20 of the report required by paragraph (2), the Attor-
21 ney General and the Secretary of Health and
22 Human Services, acting jointly, shall develop and
23 publicly release updated guidance for States based
24 on the set of best practice recommendations required
25 by paragraph (2)(C) in order to assist States dealing

1 with criminal and related civil commitment cases re-
2 garding people living with HIV/AIDS.

3 (4) MONITORING AND EVALUATION SYSTEM.—

4 Within 60 days of the release of the guidance re-
5 quired by paragraph (3), the Attorney General and
6 the Secretary of Health and Human Services, acting
7 jointly, shall establish an integrated monitoring and
8 evaluation system which includes, where appropriate,
9 objective and quantifiable performance goals and in-
10 dicators to measure progress toward statewide im-
11 plementation in each State of the best practice rec-
12 ommendations required in paragraph (2)(C), includ-
13 ing to monitor, track, and evaluate the effectiveness
14 of assistance provided pursuant to subsection (d).

15 (5) ADJUSTMENTS TO FEDERAL LAWS, POLI-
16 CIES, OR REGULATIONS.—Within 90 days of the re-
17 lease of the report required by paragraph (2), the
18 Attorney General, the Secretary of Health and
19 Human Services, and the Secretary of Defense, act-
20 ing jointly, shall develop and transmit to the Presi-
21 dent and the Congress, and make publicly available,
22 such proposals as may be necessary to implement
23 adjustments to Federal laws, policies, or regulations,
24 including to the Uniform Code of Military Justice,
25 based on the recommendations required by para-

1 graph (2)(D), either through Executive order or
2 through changes to statutory law.

3 (6) AUTHORIZATION OF APPROPRIATIONS.—

4 (A) IN GENERAL.—There are authorized to
5 be appropriated such sums as may be necessary
6 for the purpose of carrying out this subsection.
7 Amounts authorized to be appropriated by the
8 preceding sentence are in addition to amounts
9 otherwise authorized to be appropriated for
10 such purpose.

11 (B) AVAILABILITY OF FUNDS.—Amounts
12 appropriated pursuant to the authorization of
13 appropriations in subparagraph (A) are author-
14 ized to remain available until expended.

15 (d) AUTHORIZATION TO PROVIDE GRANTS.—

16 (1) GRANTS BY ATTORNEY GENERAL.—

17 (A) IN GENERAL.—The Attorney General
18 may provide assistance to eligible State and
19 local entities and eligible nongovernmental orga-
20 nizations for the purpose of incorporating the
21 best practice recommendations developed under
22 subsection (c)(2)(C) within relevant State laws,
23 policies, regulations, and judicial decisions re-
24 garding people living with HIV/AIDS.

1 (B) AUTHORIZED ACTIVITIES.—The assist-
2 ance authorized by subparagraph (A) may in-
3 clude—

4 (i) direct technical assistance to eligi-
5 ble State and local entities in order to de-
6 velop, disseminate, or implement State
7 laws, policies, regulations, or judicial deci-
8 sions that conform with the best practice
9 recommendations developed under sub-
10 section (c)(2)(C);

11 (ii) direct technical assistance to eligi-
12 ble nongovernmental organizations in order
13 to provide education and training, includ-
14 ing through classes, conferences, meetings,
15 and other educational activities, to eligible
16 State and local entities; and

17 (iii) subcontracting authority to allow
18 eligible State and local entities and eligible
19 nongovernmental organizations to seek
20 technical assistance from legal and public
21 health experts with a demonstrated under-
22 standing of the principles underlying the
23 best practice recommendations developed
24 under subsection (c)(2)(C).

1 (2) GRANTS BY SECRETARY OF HEALTH AND
2 HUMAN SERVICES.—

3 (A) IN GENERAL.—The Secretary of
4 Health and Human Services, acting through the
5 Director of the Centers for Disease Control and
6 Prevention, may provide assistance to State and
7 local public health departments and eligible
8 nongovernmental organizations for the purpose
9 of supporting eligible State and local entities to
10 incorporate the best practice recommendations
11 developed under subsection (c)(2)(C) within rel-
12 evant State laws, policies, regulations, and judi-
13 cial decisions regarding people living with HIV/
14 AIDS.

15 (B) AUTHORIZED ACTIVITIES.—The assist-
16 ance authorized by subparagraph (A) may in-
17 clude—

18 (i) direct technical assistance to State
19 and local public health departments in
20 order to support the development, dissemi-
21 nation, or implementation of State laws,
22 policies, regulations, or judicial decisions
23 that conform with the set of best practice
24 recommendations developed under sub-
25 section (c)(2)(C);

1 (ii) direct technical assistance to eligi-
2 ble nongovernmental organizations in order
3 to provide education and training, includ-
4 ing through classes, conferences, meetings,
5 and other educational activities, to State
6 and local public health departments; and

7 (iii) subcontracting authority to allow
8 State and local public health departments
9 and eligible nongovernmental organizations
10 to seek technical assistance from legal and
11 public health experts with a demonstrated
12 understanding of the principles underlying
13 the best practice recommendations devel-
14 oped under subsection (c)(2)(C).

15 (3) LIMITATION.—As a condition of receiving
16 assistance through this subsection, eligible State and
17 local entities, State and local public health depart-
18 ments, and eligible nongovernmental organizations
19 shall agree—

20 (A) not to place any unique or additional
21 burdens on people living with HIV/AIDS solely
22 as a result of their HIV status; and

23 (B) that if the entity, department, or orga-
24 nization promulgates any laws, policies, regula-
25 tions, or judicial decisions regarding people liv-

1 ing with HIV/AIDS, such actions shall dem-
2 onstrate a public health-oriented, evidence-
3 based, medically accurate, and contemporary
4 understanding of—

5 (i) the multiple factors that lead to
6 HIV transmission;

7 (ii) the relative risk of HIV trans-
8 mission routes;

9 (iii) the current health implications of
10 living with HIV;

11 (iv) the associated benefits of treat-
12 ment and support services for people living
13 with HIV; and

14 (v) the impact of punitive HIV-spe-
15 cific laws and policies on public health, on
16 people living with or affected by HIV, and
17 on their families and communities.

18 (4) REPORT.—No later than 1 year after the
19 date of the enactment of this Act, and annually
20 thereafter, the Attorney General and the Secretary
21 of Health and Human Services, acting jointly, shall
22 transmit to Congress and make publicly available a
23 report describing, for each State, the impact and ef-
24 fectiveness of the assistance provided through this
25 Act. Each such report shall include—

1 (A) a detailed description of the progress
2 each State has made, if any, in implementing
3 the best practice recommendations developed
4 under subsection (c)(2)(C) as a result of the as-
5 sistance provided under this subsection, and
6 based on the performance goals and indicators
7 established as part of the monitoring and eval-
8 uation system in subsection (c)(4);

9 (B) a brief summary of any outreach ef-
10 forts undertaken during the prior year by the
11 Attorney General and the Secretary of Health
12 and Human Services to encourage States to
13 seek assistance under this subsection in order
14 to implement the best practice recommenda-
15 tions developed under subsection (c)(2)(C);

16 (C) a summary of how assistance provided
17 through this subsection is being utilized by eli-
18 gible State and local entities, State and local
19 public health departments, and eligible non-
20 governmental organizations and, if applicable,
21 any contractors, including with respect to non-
22 governmental organizations, the type of tech-
23 nical assistance provided, and an evaluation of
24 the impact of such assistance on eligible State
25 and local entities; and

1 (D) a summary and description of eligible
2 State and local entities, State and local public
3 health departments, and eligible nongovern-
4 mental organizations receiving assistance
5 through this subsection, including if applicable,
6 a summary and description of any contractors
7 selected to assist in implementing such assist-
8 ance.

9 (5) DEFINITIONS.—For the purposes of this
10 subsection:

11 (A) ELIGIBLE STATE AND LOCAL ENTI-
12 TIES.—The term “eligible State and local enti-
13 ties” means the relevant individuals, offices, or
14 organizations that directly participate in the de-
15 velopment, dissemination, or implementation of
16 State laws, policies, regulations, or judicial deci-
17 sions, including—

18 (i) State governments, including State
19 attorneys general, State departments of
20 justice, and State National Guards, or
21 their equivalents;

22 (ii) State judicial and court systems,
23 including trial courts, appellate courts,
24 State supreme courts and courts of appeal,

1 and State correctional facilities, or their
2 equivalents; and

3 (iii) local governments, including city
4 and county governments, district attorneys,
5 and local law enforcement departments, or
6 their equivalents.

7 (B) STATE AND LOCAL PUBLIC HEALTH
8 DEPARTMENTS.—The term “State and local
9 public health departments” means the fol-
10 lowing:

11 (i) State public health departments, or
12 their equivalents, including the chief officer
13 of such departments and infectious disease
14 and communicable disease specialists with-
15 in such departments.

16 (ii) Local public health departments,
17 or their equivalents, including city and
18 county public health departments, the chief
19 officer of such departments, and infectious
20 disease and communicable disease special-
21 ists within such departments.

22 (iii) Public health departments or offi-
23 cials, or their equivalents, within State or
24 local correctional facilities.

1 (iv) Public health departments or offi-
2 cials, or their equivalents, within State Na-
3 tional Guards.

4 (v) Any other recognized State or
5 local public health organization or entity
6 charged with carrying out official State or
7 local public health duties.

8 (C) ELIGIBLE NONGOVERNMENTAL ORGA-
9 NIZATIONS.—The term “eligible nongovern-
10 mental organizations” means the following:

11 (i) Nongovernmental organizations,
12 including trade organizations or associa-
13 tions that represent—

14 (I) State attorneys general, or
15 their equivalents;

16 (II) State public health officials,
17 or their equivalents;

18 (III) State judicial and court offi-
19 cers, including judges, district attor-
20 neys, prosecutors, defense attorneys,
21 law enforcement, and correctional offi-
22 cers;

23 (IV) State National Guards;

24 (V) people living with HIV/AIDS;

1 (VI) legal advocacy and HIV/
2 AIDS service organizations that work
3 with people living with HIV/AIDS;
4 and

5 (VII) nongovernmental health or-
6 ganizations that work on behalf of
7 people living with HIV/AIDS.

8 (ii) Nongovernmental organizations,
9 including trade organizations or associa-
10 tions that demonstrate a public-health ori-
11 ented, evidence-based, medically accurate,
12 and contemporary understanding of—

13 (I) the multiple factors that lead
14 to HIV transmission;

15 (II) the relative risk of HIV
16 transmission routes;

17 (III) the current health implica-
18 tions of living with HIV;

19 (IV) the associated benefits of
20 treatment and support services for
21 people living with HIV; and

22 (V) the impact of punitive HIV-
23 specific laws and policies on public
24 health, on people living with or af-

1 fected by HIV, and on their families
2 and communities.

3 (6) AUTHORIZATION OF APPROPRIATIONS.—

4 (A) IN GENERAL.—In addition to amounts
5 otherwise made available, there are authorized
6 to be appropriated to the Attorney General and
7 the Secretary of Health and Human Services
8 such sums as may be necessary to carry out
9 this subsection for each of the fiscal years 2019
10 through 2023.

11 (B) AVAILABILITY OF FUNDS.—Amounts
12 appropriated pursuant to the authorizations of
13 appropriations in subparagraph (A) are author-
14 ized to remain available until expended.

15 **SEC. 756. EXPANDING SUPPORT FOR CONDOMS IN PRIS-**
16 **ONS.**

17 (a) AUTHORITY TO ALLOW COMMUNITY ORGANIZA-
18 TIONS TO PROVIDE STI COUNSELING, STI PREVENTION
19 EDUCATION, AND SEXUAL BARRIER PROTECTION DE-
20 VICES IN FEDERAL CORRECTIONAL FACILITIES.—

21 (1) DIRECTIVE TO ATTORNEY GENERAL.—Not
22 later than 30 days after the date of enactment of
23 this Act, the Attorney General shall direct the Bu-
24 reau of Prisons to allow community organizations to
25 distribute sexual barrier protection devices and to

1 engage in STI counseling and STI prevention edu-
2 cation in Federal correctional facilities. These activi-
3 ties shall be subject to all relevant Federal laws and
4 regulations which govern visitation in correctional
5 facilities.

6 (2) INFORMATION REQUIREMENT.—Any com-
7 munity organization permitted to distribute sexual
8 barrier protection devices under paragraph (1) shall
9 ensure that the persons to whom the devices are dis-
10 tributed are informed about the proper use and dis-
11 posal of sexual barrier protection devices in accord-
12 ance with established public health practices. Any
13 community organization conducting STI counseling
14 or STI prevention education under paragraph (1)
15 shall offer comprehensive sexuality education.

16 (3) POSSESSION OF DEVICE PROTECTED.—No
17 Federal correctional facility may, because of the pos-
18 session or use of a sexual barrier protection device—

19 (A) take adverse action against an incar-
20 cerated person; or

21 (B) consider possession or use as evidence
22 of prohibited activity for the purpose of any
23 Federal correctional facility administrative pro-
24 ceeding.

1 (4) IMPLEMENTATION.—The Attorney General
2 and Bureau of Prisons shall implement this section
3 according to established public health practices in a
4 manner that protects the health, safety, and privacy
5 of incarcerated persons and of correctional facility
6 staff.

7 (b) SENSE OF CONGRESS REGARDING DISTRIBUTION
8 OF SEXUAL BARRIER PROTECTION DEVICES IN STATE
9 PRISON SYSTEMS.—It is the sense of the Congress that
10 States should allow for the legal distribution of sexual bar-
11 rier protection devices in State correctional facilities to re-
12 duce the prevalence and spread of STIs in those facilities.

13 (c) SURVEY OF AND REPORT ON CORRECTIONAL FA-
14 CILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF
15 STIs.—

16 (1) SURVEY.—The Attorney General, after con-
17 sulting with the Secretary of Health and Human
18 Services, State officials, and community organiza-
19 tions, shall, to the maximum extent practicable, con-
20 duct a survey of all Federal and State correctional
21 facilities, not later than 180 days after the date of
22 enactment of this Act and annually thereafter for 5
23 years, to determine the following:

24 (A) COUNSELING, TREATMENT, AND SUP-
25 PORTIVE SERVICES.—Whether the correctional

1 facility requires incarcerated persons to partici-
2 pate in counseling, treatment, and supportive
3 services related to STIs, or whether it offers
4 such programs to incarcerated persons.

5 (B) ACCESS TO SEXUAL BARRIER PROTEC-
6 TION DEVICES.—Whether incarcerated persons
7 can—

8 (i) possess sexual barrier protection
9 devices;

10 (ii) purchase sexual barrier protection
11 devices;

12 (iii) purchase sexual barrier protection
13 devices at a reduced cost; and

14 (iv) obtain sexual barrier protection
15 devices without cost.

16 (C) INCIDENCE OF SEXUAL VIOLENCE.—
17 The incidence of sexual violence and assault
18 committed by incarcerated persons and by cor-
19 rectional facility staff.

20 (D) PREVENTION EDUCATION OFFERED.—
21 The type of prevention education, information,
22 or training offered to incarcerated persons and
23 correctional facility staff regarding sexual vio-
24 lence and the spread of STIs, including whether
25 such education, information, or training—

- 1 (i) constitutes comprehensive sexuality
2 education;
- 3 (ii) is compulsory for new incarcerated
4 persons and for new staff; and
- 5 (iii) is offered on an ongoing basis.

6 (E) STI TESTING.—Whether the correc-
7 tional facility tests incarcerated persons for
8 STIs or gives them the option to undergo such
9 testing—

- 10 (i) at intake;
- 11 (ii) on a regular basis; and
- 12 (iii) prior to release.

13 (F) STI TEST RESULTS.—The number of
14 incarcerated persons who are tested for STIs
15 and the outcome of such tests at each correc-
16 tional facility, disaggregated to include results
17 for—

- 18 (i) the type of sexually transmitted in-
19 fection tested for;
- 20 (ii) the race and/or ethnicity of indi-
21 viduals tested;
- 22 (iii) the age of individuals tested; and
- 23 (iv) the gender of individuals tested.

24 (G) PRERELEASE REFERRAL POLICY.—
25 Whether incarcerated persons are informed

1 prior to release about STI-related services or
2 other health services in their communities, in-
3 cluding free and low-cost counseling and treat-
4 ment options.

5 (H) PRERELEASE REFERRALS MADE.—

6 The number of referrals to community-based
7 organizations or public health facilities offering
8 STI-related or other health services provided to
9 incarcerated persons prior to release, and the
10 type of counseling or treatment for which the
11 referral was made.

12 (I) REINSTATEMENT OF MEDICAID BENE-

13 FITS.—Whether the correctional facility assists
14 incarcerated persons that were enrolled in the
15 State Medicaid program prior to their incarcer-
16 ation, in reinstating their enrollment upon re-
17 lease and whether such individuals receive refer-
18 rals as provided by subparagraph (G) to entities
19 that accept the State Medicaid program, includ-
20 ing if applicable—

21 (i) the number of such individuals, in-
22 cluding those diagnosed with the human
23 immunodeficiency virus, that have been re-
24 instated;

1 (ii) a list of obstacles to reinstating
2 enrollment or to making determinations of
3 eligibility for reinstatement, if any; and

4 (iii) the number of individuals denied
5 enrollment.

6 (J) OTHER ACTIONS TAKEN.—Whether the
7 correctional facility has taken any other action,
8 in conjunction with community organizations or
9 otherwise, to reduce the prevalence and spread
10 of STIs in that facility.

11 (2) PRIVACY.—In conducting the survey, the
12 Attorney General shall not request or retain the
13 identity of any person who has sought or been of-
14 fered counseling, treatment, testing, or prevention
15 education information regarding an STI (including
16 information about sexual barrier protection devices),
17 or who has tested positive for an STI.

18 (3) REPORT.—The Attorney General shall
19 transmit to Congress and make publicly available
20 the results of the survey required under paragraph
21 (1), both for the Nation as a whole and
22 disaggregated as to each State and each correctional
23 facility. To the maximum extent possible, the Attor-
24 ney General shall issue the first report no later than

1 1 year after the date of enactment of this Act and
2 shall issue reports annually thereafter for 5 years.

3 (d) STRATEGY.—

4 (1) DIRECTIVE TO ATTORNEY GENERAL.—The
5 Attorney General, in consultation with the Secretary
6 of Health and Human Services, State officials, and
7 community organizations, shall develop and imple-
8 ment a 5-year strategy to reduce the prevalence and
9 spread of STIs in Federal and State correctional fa-
10 cilities. To the maximum extent possible, the strat-
11 egy shall be developed, transmitted to Congress, and
12 made publicly available no later than 180 days after
13 the transmission of the first report required under
14 subsection (c)(3).

15 (2) CONTENTS OF STRATEGY.—The strategy
16 shall include the following:

17 (A) PREVENTION EDUCATION.—A plan for
18 improving prevention education, information,
19 and training offered to incarcerated persons
20 and correctional facility staff, including infor-
21 mation and training on sexual violence and the
22 spread of STIs, and comprehensive sexuality
23 education.

24 (B) SEXUAL BARRIER PROTECTION DEVICE
25 ACCESS.—A plan for expanding access to sexual

1 barrier protection devices in correctional facili-
2 ties.

3 (C) SEXUAL VIOLENCE REDUCTION.—A
4 plan for reducing the incidence of sexual vio-
5 lence among incarcerated persons and correc-
6 tional facility staff, developed in consultation
7 with the National Prison Rape Elimination
8 Commission.

9 (D) COUNSELING AND SUPPORTIVE SERV-
10 ICES.—A plan for expanding access to coun-
11 seling and supportive services related to STIs in
12 correctional facilities.

13 (E) TESTING.—A plan for testing incarcer-
14 ated persons for STIs during intake, during
15 regular health exams, and prior to release, and
16 that—

17 (i) is conducted in accordance with
18 guidelines established by the Centers for
19 Disease Control and Prevention;

20 (ii) includes pretest counseling;

21 (iii) requires that incarcerated persons
22 are notified of their option to decline test-
23 ing at any time;

1 (iv) requires that incarcerated persons
2 are confidentially notified of their test re-
3 sults in a timely manner; and

4 (v) ensures that incarcerated persons
5 testing positive for STIs receive post-test
6 counseling, care, treatment, and supportive
7 services.

8 (F) TREATMENT.—A plan for ensuring
9 that correctional facilities have the necessary
10 medicine and equipment to treat and monitor
11 STIs and for ensuring that incarcerated per-
12 sons living with or testing positive for STIs re-
13 ceive and have access to care and treatment
14 services.

15 (G) STRATEGIES FOR DEMOGRAPHIC
16 GROUPS.—A plan for developing and imple-
17 menting culturally appropriate, sensitive, and
18 specific strategies to reduce the spread of STIs
19 among demographic groups heavily impacted by
20 STIs.

21 (H) LINKAGES WITH COMMUNITIES AND
22 FACILITIES.—A plan for establishing and
23 strengthening linkages to local communities and
24 health facilities that—

1 (i) provide counseling, testing, care,
2 and treatment services;

3 (ii) may receive persons recently re-
4 leased from incarceration who are living
5 with STIs; and

6 (iii) accept payment through the State
7 Medicaid program.

8 (I) ENROLLMENT IN STATE MEDICAID
9 PROGRAMS.—Plans to ensure that incarcerated
10 persons who were—

11 (i) enrolled in their State Medicaid
12 program prior to incarceration in a correc-
13 tional facility are automatically reenrolled
14 in such program upon their release; and

15 (ii) not enrolled in their State Med-
16 icaid program prior to incarceration, but
17 who are diagnosed with the human im-
18 munodeficiency virus while incarcerated in
19 a correctional facility, are automatically
20 enrolled in such program upon their re-
21 lease.

22 (J) OTHER PLANS.—Any other plans de-
23 veloped by the Attorney General for reducing
24 the spread of STIs or improving the quality of
25 health care in correctional facilities.

1 (K) MONITORING SYSTEM.—A monitoring
2 system that establishes performance goals re-
3 lated to reducing the prevalence and spread of
4 STIs in correctional facilities and which, where
5 feasible, expresses such goals in quantifiable
6 form.

7 (L) MONITORING SYSTEM PERFORMANCE
8 INDICATORS.—Performance indicators that
9 measure or assess the achievement of the per-
10 formance goals described in subparagraph (K).

11 (M) COST ESTIMATE.—A detailed estimate
12 of the funding necessary to implement the
13 strategy at the Federal and State levels for all
14 5 years, including the amount of funds required
15 by community organizations to implement the
16 parts of the strategy in which they take part.

17 (3) REPORT.—The Attorney General shall
18 transmit to Congress and make publicly available an
19 annual progress report regarding the implementation
20 and effectiveness of the strategy described in para-
21 graph (1). The progress report shall include an eval-
22 uation of the implementation of the strategy using
23 the monitoring system and performance indicators
24 provided for in subparagraphs (K) and (L) of para-
25 graph (2).

1 (e) AUTHORIZATION OF APPROPRIATIONS.—

2 (1) IN GENERAL.—There are authorized to be
3 appropriated such sums as may be necessary to
4 carry out this section for each of fiscal years 2019
5 through 2023.

6 (2) AVAILABILITY OF FUNDS.—Amounts made
7 available under paragraph (1) are authorized to re-
8 main available until expended.

9 (f) DEFINITIONS.—For the purposes of this section:

10 (1) COMMUNITY ORGANIZATION.—The term
11 “community organization” means a public health
12 care facility or a nonprofit organization which pro-
13 vides health- or STI-related services according to es-
14 tablished public health standards.

15 (2) COMPREHENSIVE SEXUALITY EDUCATION.—
16 The term “comprehensive sexuality education”
17 means sexuality education that includes information
18 about abstinence and about the proper use and dis-
19 posal of sexual barrier protection devices and which
20 is—

21 (A) evidence-based;

22 (B) medically accurate;

23 (C) age and developmentally appropriate;

24 (D) gender and identity sensitive;

1 (E) culturally and linguistically appro-
2 priate; and

3 (F) structured to promote critical thinking,
4 self-esteem, respect for others, and the develop-
5 ment of healthy attitudes and relationships.

6 (3) CORRECTIONAL FACILITY.—The term “cor-
7 rectional facility” means any prison, penitentiary,
8 adult detention facility, juvenile detention facility,
9 jail, or other facility to which persons may be sent
10 after conviction of a crime or act of juvenile delin-
11 quency within the United States.

12 (4) INCARCERATED PERSON.—The term “incar-
13 cerated person” means any person who is serving a
14 sentence in a correctional facility after conviction of
15 a crime.

16 (5) SEXUALLY TRANSMITTED INFECTION.—The
17 term “sexually transmitted infection” or “STI”
18 means any disease or infection that is commonly
19 transmitted through sexual activity, including HIV/
20 AIDS, gonorrhea, chlamydia, syphilis, genital her-
21 pes, viral hepatitis, and human papillomavirus.

22 (6) SEXUAL BARRIER PROTECTION DEVICE.—
23 The term “sexual barrier protection device” means
24 any FDA-approved physical device which has not
25 been tampered with and which reduces the prob-

1 ability of STI transmission or infection between sex-
 2 ual partners, including female condoms, male
 3 condoms, and dental dams.

4 (7) STATE.—The term “State” includes the
 5 District of Columbia, American Samoa, the Com-
 6 monwealth of the Northern Mariana Islands, Guam,
 7 Puerto Rico, and the United States Virgin Islands.

8 **SEC. 757. AUTOMATIC REINSTATEMENT OR ENROLLMENT**
 9 **IN MEDICAID FOR PEOPLE WHO TEST POSI-**
 10 **TIVE FOR HIV BEFORE REENTERING COMMU-**
 11 **NITIES.**

12 (a) IN GENERAL.—Section 1902(e) of the Social Se-
 13 curity Act (42 U.S.C. 1396a(e)) is amended by adding at
 14 the end the following:

15 “(15) ENROLLMENT OF EX-OFFENDERS.—

16 “(A) AUTOMATIC ENROLLMENT OR REIN-
 17 STATEMENT.—

18 “(i) IN GENERAL.—The State plan
 19 shall provide for the automatic enrollment
 20 or reinstatement of enrollment of an eligi-
 21 ble individual—

22 “(I) if such individual is sched-
 23 uled to be released from a public insti-
 24 tution due to the completion of sen-

1 tence, not less than 30 days prior to
2 the scheduled date of the release; and

3 “(II) if such individual is to be
4 released from a public institution on
5 parole or on probation, as soon as
6 possible after the date on which the
7 determination to release such indi-
8 vidual was made, and before the date
9 such individual is released.

10 “(ii) EXCEPTION.—If a State makes a
11 determination that an individual is not eli-
12 gible to be enrolled under the State plan—

13 “(I) on or before the date by
14 which the individual would be enrolled
15 under clause (i), such clause shall not
16 apply to such individual; or

17 “(II) after such date, the State
18 may terminate the enrollment of such
19 individual.

20 “(B) RELATIONSHIP OF ENROLLMENT TO
21 PAYMENT FOR SERVICES.—

22 “(i) IN GENERAL.—Subject to sub-
23 paragraph (A)(ii), an eligible individual
24 who is enrolled, or whose enrollment is re-
25 instated, under subparagraph (A) shall be

1 eligible for medical assistance that is pro-
2 vided after the date that the eligible indi-
3 vidual is released from the public institu-
4 tion.

5 “(ii) RELATIONSHIP TO PAYMENT
6 PROHIBITION FOR INMATES.—No provision
7 of this paragraph may be construed to per-
8 mit payment for care or services for which
9 payment is excluded under section
10 1905(a)(3)(A).

11 “(C) TREATMENT OF CONTINUOUS ELIGI-
12 BILITY.—

13 “(i) SUSPENSION FOR INMATES.—Any
14 period of continuous eligibility under this
15 title shall be suspended on the date an in-
16 dividual enrolled under this title becomes
17 an inmate of a public institution (except as
18 a patient of a medical institution).

19 “(ii) DETERMINATION OF REMAINING
20 PERIOD.—Notwithstanding any changes to
21 State law related to continuous eligibility
22 during the time that an individual is an in-
23 mate of a public institution (except as a
24 patient of a medical institution), subject to
25 clause (iii), with respect to an eligible indi-

1 vidual who was subject to a suspension
2 under clause (i), on the date that such in-
3 dividual is released from a public institu-
4 tion the suspension of continuous eligibility
5 under such clause shall be lifted for a pe-
6 riod that is equal to the time remaining in
7 the period of continuous eligibility for such
8 individual on the date that such period was
9 suspended under such clause.

10 “(iii) EXCEPTION.—If a State makes
11 a determination that an individual is not
12 eligible to be enrolled under the State
13 plan—

14 “(I) on or before the date that
15 the suspension of continuous eligibility
16 is lifted under clause (ii), such clause
17 shall not apply to such individual; or

18 “(II) after such date, the State
19 may terminate the enrollment of such
20 individual.

21 “(D) AUTOMATIC ENROLLMENT OR REIN-
22 STATEMENT OF ENROLLMENT DEFINED.—For
23 purposes of this paragraph, the term ‘automatic
24 enrollment or reinstatement of enrollment’
25 means that the State determines eligibility for

1 medical assistance under the State plan without
2 a program application from, or on behalf of, the
3 eligible individual, but an individual can only be
4 automatically enrolled in the State Medicaid
5 plan if the individual affirmatively consents to
6 being enrolled through affirmation in writing,
7 by telephone, orally, through electronic signa-
8 ture, or through any other means specified by
9 the Secretary.

10 “(E) ELIGIBLE INDIVIDUAL DEFINED.—

11 For purposes of this paragraph, the term ‘eligi-
12 ble individual’ means an individual who is an
13 inmate of a public institution (except as a pa-
14 tient in a medical institution)—

15 “(i) who was enrolled under the State
16 plan for medical assistance immediately be-
17 fore becoming an inmate of such an insti-
18 tution; or

19 “(ii) who is diagnosed with human im-
20 munodeficiency virus.”.

21 (b) SUPPLEMENTAL FUNDING FOR STATE IMPLE-
22 MENTATION OF AUTOMATIC REINSTATEMENT OF MED-
23 ICAID BENEFITS.—

24 (1) IN GENERAL.—Subject to paragraph (6),
25 for each State for which the Secretary of Health and

1 Human Services has approved an application under
2 paragraph (3), the Federal matching payments (in-
3 cluding payments based on the Federal medical as-
4 sistance percentage) made to such State under sec-
5 tion 1903 of the Social Security Act (42 U.S.C.
6 1396b) shall be increased by 5.0 percentage points
7 for payments to the State for the activities per-
8 mitted under paragraph (2) or a period of one year.

9 (2) USE OF FUNDS.—A State may only use in-
10 creased matching payments authorized under para-
11 graph (1)—

12 (A) to strengthen the State’s enrollment
13 and administrative resources for the purpose of
14 improving processes for enrolling (or reinstating
15 the enrollment of) eligible individuals (as such
16 term is defined in subparagraph (E) of para-
17 graph (15) of section 1902(e) of the Social Se-
18 curity Act (as amended by subsection (a))); and

19 (B) for medical assistance (as such term is
20 defined in section 1905(a) of the Social Secu-
21 rity Act) provided to such eligible individuals.

22 (3) APPLICATION AND AGREEMENT.—The Sec-
23 retary may only make payments to a State in the in-
24 creased amount if—

1 (A) the State has amended the State plan
2 under section 1902(e) of the Social Security
3 Act to incorporate the requirements of para-
4 graph (15) of such section (as added by sub-
5 section (a));

6 (B) the State has submitted an application
7 to the Secretary that includes a plan for imple-
8 menting the requirements of section
9 1902(e)(15) of the Social Security Act under
10 the State's amended State plan before the end
11 of the 90-day period beginning on the date that
12 the State receives increased matching payments
13 under paragraph (1);

14 (C) the State's application meets the satis-
15 faction of the Secretary; and

16 (D) the State enters an agreement with
17 the Secretary that states that—

18 (i) the State will only use the in-
19 creased matching funds for the uses per-
20 mitted under paragraph (2); and

21 (ii) at the end of the period under
22 paragraph (1), the State will submit to the
23 Secretary, and make publicly available, a
24 report that contains the information re-
25 quired under paragraph (4).

1 (4) REQUIRED REPORT INFORMATION.—The in-
2 formation that is required in the report under para-
3 graph (3)(D)(ii) includes—

4 (A) the results of an evaluation of the im-
5 pact of the implementation of the requirements
6 of section 1902(e)(15) of the Social Security
7 Act on improving the State’s processes for en-
8 rolling of individuals who are released from
9 public institutions into the Medicaid program;

10 (B) the number of individuals who were
11 automatically enrolled (or whose enrollment is
12 reinstated) under such section 1902(e)(15) dur-
13 ing the period under paragraph (1); and

14 (C) any other information that is required
15 by the Secretary.

16 (5) INCREASE IN CAP ON MEDICAID PAYMENTS
17 TO TERRITORIES.—Subject to paragraph (6), the
18 amounts otherwise determined for Puerto Rico, the
19 United States Virgin Islands, Guam, the Northern
20 Mariana Islands, and American Samoa under sub-
21 sections (f) and (g) of section 1108 of the Social Se-
22 curity Act (42 U.S.C. 1308) shall each be increased
23 by the necessary amount to allow for the increase in
24 the Federal matching payments under paragraph
25 (1), but only for the period under such paragraph

1 for such State. In the case of such an increase for
2 a territory, subsection (a)(1) of such section 1108
3 shall be applied without regard to any increase in
4 payment made to the territory under part E of title
5 IV of such Act that is attributable to the increase
6 in Federal medical assistance percentage effected
7 under paragraph (1) for the territory.

8 (6) LIMITATIONS.—

9 (A) TIMING.—With respect to a State, at
10 the end of the period under paragraph (1), no
11 increased matching payments may be made to
12 such State under this subsection.

13 (B) MAINTENANCE OF ELIGIBILITY.—

14 (i) IN GENERAL.—Subject to clause
15 (ii), a State is not eligible for an increase
16 in its Federal matching payments under
17 paragraph (1), or an increase in a cap
18 amount under paragraph (5), if eligibility
19 standards, methodologies, or procedures
20 under its State plan under title XIX of the
21 Social Security Act (including any waiver
22 under such title or under section 1115 of
23 such Act (42 U.S.C. 1315)) are more re-
24 strictive than the eligibility standards,
25 methodologies, or procedures, respectively,

1 under such plan (or waiver) as in effect on
2 the date of enactment of this Act.

3 (ii) STATE REINSTATEMENT OF ELIGI-
4 BILITY PERMITTED.—A State that has re-
5 stricted eligibility standards, methodolo-
6 gies, or procedures under its State plan
7 under title XIX of the Social Security Act
8 (including any waiver under such title or
9 under section 1115 of such Act (42 U.S.C.
10 1315)) after the date of enactment of this
11 Act, is no longer ineligible under subpara-
12 graph (A) beginning with the first calendar
13 quarter in which the State has reinstated
14 eligibility standards, methodologies, or pro-
15 cedures that are no more restrictive than
16 the eligibility standards, methodologies, or
17 procedures, respectively, under such plan
18 (or waiver) as in effect on such date.

19 (C) NO WAIVER AUTHORITY.—The Sec-
20 retary may not waive the application of this
21 subsection under section 1115 of the Social Se-
22 curity Act or otherwise.

23 (D) LIMITATION OF MATCHING PAYMENTS
24 TO 100 PERCENT.—In no case shall an increase
25 in Federal matching payments under this sub-

1 section result in Federal matching payments
2 that exceed 100 percent.

3 (c) EFFECTIVE DATE.—

4 (1) IN GENERAL.—Except as provided in para-
5 graph (2), the amendments made by subsection (a)
6 shall take effect 180 days after the date of the en-
7 actment of this Act and shall apply to services fur-
8 nished on or after such date.

9 (2) RULE FOR CHANGES REQUIRING STATE
10 LEGISLATION.—In the case of a State plan for med-
11 ical assistance under title XIX of the Social Security
12 Act which the Secretary of Health and Human Serv-
13 ices determines requires State legislation (other than
14 legislation appropriating funds) in order for the plan
15 to meet the additional requirement imposed by the
16 amendments made by this section, the State plan
17 shall not be regarded as failing to comply with the
18 requirements of such title solely on the basis of its
19 failure to meet this additional requirement before
20 the first day of the first calendar quarter beginning
21 after the close of the first regular session of the
22 State legislature that begins after the date of the en-
23 actment of this Act. For purposes of the previous
24 sentence, in the case of a State that has a 2-year
25 legislative session, each year of such session shall be

1 deemed to be a separate regular session of the State
2 legislature.

3 **SEC. 758. STOP AIDS IN PRISON.**

4 (a) **SHORT TITLE.**—This section may be cited as the
5 “Stop AIDS in Prison Act”.

6 (b) **IN GENERAL.**—The Bureau of Prisons (herein-
7 after in this section referred to as the “Bureau”) shall
8 develop a comprehensive policy to provide HIV testing,
9 treatment, and prevention for inmates within the correc-
10 tional setting and upon reentry.

11 (c) **PURPOSE.**—The purposes of this policy shall be
12 as follows:

13 (1) To stop the spread of HIV/AIDS among in-
14 mates.

15 (2) To protect prison guards and other per-
16 sonnel from HIV/AIDS infection.

17 (3) To provide comprehensive medical treat-
18 ment to inmates who are living with HIV/AIDS.

19 (4) To promote HIV/AIDS awareness and pre-
20 vention among inmates.

21 (5) To encourage inmates to take personal re-
22 sponsibility for their health.

23 (6) To reduce the risk that inmates will trans-
24 mit HIV/AIDS to other persons in the community
25 following their release from prison.

1 (d) CONSULTATION.—The Bureau shall consult with
2 appropriate officials of the Department of Health and
3 Human Services, the Office of National Drug Control Pol-
4 icy, the Office of National AIDS Policy, and the Centers
5 for Disease Control and Prevention regarding the develop-
6 ment of this policy.

7 (e) TIME LIMIT.—The Bureau shall draft appro-
8 priate regulations to implement this policy not later than
9 1 year after the date of the enactment of this Act.

10 (f) REQUIREMENTS FOR POLICY.—The policy created
11 under subsection (b) shall provide for the following:

12 (1) TESTING AND COUNSELING UPON IN-
13 TAKE.—

14 (A) Health care personnel shall provide
15 routine HIV testing to all inmates as a part of
16 a comprehensive medical examination imme-
17 diately following admission to a facility. Health
18 care personnel need not provide routine HIV
19 testing to an inmate who is transferred to a fa-
20 cility from another facility if the inmate's med-
21 ical records are transferred with the inmate and
22 indicate that the inmate has been tested pre-
23 viously.

24 (B) To all inmates admitted to a facility
25 prior to the effective date of this policy, health

1 care personnel shall provide routine HIV testing
2 within no more than 6 months. HIV testing for
3 these inmates may be performed in conjunction
4 with other health services provided to these in-
5 mates by health care personnel.

6 (C) All HIV tests under this paragraph
7 shall comply with the opt-out provision.

8 (2) PRE-TEST AND POST-TEST COUNSELING.—
9 Health care personnel shall provide confidential pre-
10 test and post-test counseling to all inmates who are
11 tested for HIV. Counseling may be included with
12 other general health counseling provided to inmates
13 by health care personnel.

14 (3) HIV/AIDS PREVENTION EDUCATION.—

15 (A) Health care personnel shall improve
16 HIV/AIDS awareness through frequent edu-
17 cational programs for all inmates. HIV/AIDS
18 educational programs may be provided by com-
19 munity-based organizations, local health depart-
20 ments, and inmate peer educators.

21 (B) HIV/AIDS educational materials shall
22 be made available to all inmates at orientation,
23 at health care clinics, at regular educational
24 programs, and prior to release. Both written

1 and audiovisual materials shall be made avail-
2 able to all inmates.

3 (C)(i) The HIV/AIDS educational pro-
4 grams and materials under this paragraph shall
5 include information on—

6 (I) modes of transmission, including
7 transmission through tattooing, sexual con-
8 tact, and intravenous drug use;

9 (II) prevention methods;

10 (III) treatment; and

11 (IV) disease progression.

12 (ii) The programs and materials shall be
13 culturally sensitive, written or designed for low-
14 literacy levels, available in a variety of lan-
15 guages, and present scientifically accurate in-
16 formation in a clear and understandable man-
17 ner.

18 (4) HIV TESTING UPON REQUEST.—

19 (A) Health care personnel shall allow in-
20 mates to obtain HIV tests upon request once
21 per year or whenever an inmate has a reason to
22 believe the inmate may have been exposed to
23 HIV. Health care personnel shall, both orally
24 and in writing, inform inmates, during orienta-

1 tion and periodically throughout incarceration,
2 of their right to obtain HIV tests.

3 (B) Health care personnel shall encourage
4 inmates to request HIV tests if the inmate is
5 sexually active, has been raped, uses intra-
6 venous drugs, receives a tattoo, or if the inmate
7 is concerned that the inmate may have been ex-
8 posed to HIV/AIDS.

9 (C) An inmate's request for an HIV test
10 shall not be considered an indication that the
11 inmate has put him/herself at risk of infection
12 and/or committed a violation of prison rules.

13 (5) HIV TESTING OF PREGNANT WOMAN.—

14 (A) Health care personnel shall provide
15 routine HIV testing to all inmates who become
16 pregnant.

17 (B) All HIV tests under this paragraph
18 shall comply with the opt-out provision.

19 (6) COMPREHENSIVE TREATMENT.—

20 (A) Health care personnel shall provide all
21 inmates who test positive for HIV—

22 (i) timely, comprehensive medical
23 treatment;

24 (ii) confidential counseling on man-
25 aging their medical condition and pre-

1 venting its transmission to other persons;
2 and
3 (iii) voluntary partner notification
4 services.

5 (B) Health care provided under this para-
6 graph shall be consistent with current Depart-
7 ment of Health and Human Services guidelines
8 and standard medical practice. Health care per-
9 sonnel shall discuss treatment options, the im-
10 portance of adherence to antiretroviral therapy,
11 and the side effects of medications with inmates
12 receiving treatment.

13 (C) Health care personnel and pharmacy
14 personnel shall ensure that the facility for-
15 mulary contains all Food and Drug Administra-
16 tion-approved medications necessary to provide
17 comprehensive treatment for inmates living with
18 HIV/AIDS, and that the facility maintains ade-
19 quate supplies of such medications to meet in-
20 mates' medical needs. Health care personnel
21 and pharmacy personnel shall also develop and
22 implement automatic renewal systems for these
23 medications to prevent interruptions in care.

24 (D) Correctional staff, health care per-
25 sonnel, and pharmacy personnel shall develop

1 and implement distribution procedures to en-
2 sure timely and confidential access to medica-
3 tions.

4 (7) PROTECTION OF CONFIDENTIALITY.—

5 (A) Health care personnel shall develop
6 and implement procedures to ensure the con-
7 fidentiality of inmate tests, diagnoses, and
8 treatment. Health care personnel and correc-
9 tional staff shall receive regular training on the
10 implementation of these procedures. Penalties
11 for violations of inmate confidentiality by health
12 care personnel or correctional staff shall be
13 specified and strictly enforced.

14 (B) HIV testing, counseling, and treat-
15 ment shall be provided in a confidential setting
16 where other routine health services are provided
17 and in a manner that allows the inmate to re-
18 quest and obtain these services as routine med-
19 ical services.

20 (8) TESTING, COUNSELING, AND REFERRAL
21 PRIOR TO REENTRY.—

22 (A) Health care personnel shall provide
23 routine HIV testing to all inmates no more
24 than 3 months prior to their release and re-
25 entry into the community. Inmates who are al-

1 ready known to be infected need not be tested
2 again. This requirement may be waived if an in-
3 mate's release occurs without sufficient notice
4 to the Bureau to allow health care personnel to
5 perform a routine HIV test and notify the in-
6 mate of the results.

7 (B) All HIV tests under this paragraph
8 shall comply with the opt-out provision.

9 (C) To all inmates who test positive for
10 HIV and all inmates who already are known to
11 have HIV/AIDS, health care personnel shall
12 provide—

13 (i) confidential prerelease counseling
14 on managing their medical condition in the
15 community, accessing appropriate treat-
16 ment and services in the community, and
17 preventing the transmission of their condi-
18 tion to family members and other persons
19 in the community;

20 (ii) referrals to appropriate health
21 care providers and social service agencies
22 in the community that meet the inmate's
23 individual needs, including voluntary part-
24 ner notification services and prevention

1 counseling services for people living with
2 HIV/AIDS; and

3 (iii) a 30-day supply of any medically
4 necessary medications the inmate is cur-
5 rently receiving.

6 (9) OPT-OUT PROVISION.—Inmates shall have
7 the right to refuse routine HIV testing. Inmates
8 shall be informed both orally and in writing of this
9 right. Oral and written disclosure of this right may
10 be included with other general health information
11 and counseling provided to inmates by health care
12 personnel. If an inmate refuses a routine test for
13 HIV, health care personnel shall make a note of the
14 inmate’s refusal in the inmate’s confidential medical
15 records. However, the inmate’s refusal shall not be
16 considered a violation of prison rules or result in dis-
17 ciplinary action. Any reference in this section to the
18 “opt-out provision” shall be deemed a reference to
19 the requirement of this paragraph.

20 (10) EXCLUSION OF TESTS PERFORMED UNDER
21 SECTION 4014(b) FROM THE DEFINITION OF ROU-
22 TINE HIV TESTING.—HIV testing of an inmate
23 under section 4014(b) of title 18, United States
24 Code, is not routine HIV testing for the purposes of
25 the opt-out provision. Health care personnel shall

1 document the reason for testing under section
2 4014(b) of title 18, United States Code, in the in-
3 mate’s confidential medical records.

4 (11) TIMELY NOTIFICATION OF TEST RE-
5 SULTS.—Health care personnel shall provide timely
6 notification to inmates of the results of HIV tests.

7 (g) CHANGES IN EXISTING LAW.—

8 (1) SCREENING IN GENERAL.—Section 4014(a)
9 of title 18, United States Code, is amended—

10 (A) by striking “for a period of 6 months
11 or more”;

12 (B) by striking “, as appropriate,”; and

13 (C) by striking “if such individual is deter-
14 mined to be at risk for infection with such virus
15 in accordance with the guidelines issued by the
16 Bureau of Prisons relating to infectious disease
17 management” and inserting “unless the indi-
18 vidual declines. The Attorney General shall also
19 cause such individual to be so tested before re-
20 lease unless the individual declines.”.

21 (2) INADMISSIBILITY OF HIV TEST RESULTS IN
22 CIVIL AND CRIMINAL PROCEEDINGS.—Section
23 4014(d) of title 18, United States Code, is amended
24 by inserting “or under the Stop AIDS in Prison
25 Act” after “under this section”.

1 (3) SCREENING AS PART OF ROUTINE SCREEN-
2 ING.—Section 4014(e) of title 18, United States
3 Code, is amended by adding at the end the fol-
4 lowing: “Such rules shall also provide that the initial
5 test under this section be performed as part of the
6 routine health screening conducted at intake.”.

7 (h) REPORTING REQUIREMENTS.—

8 (1) REPORT ON HEPATITIS, LIVER, AND OTHER
9 DISEASES.—Not later than 1 year after the date of
10 the enactment of this Act, the Bureau shall provide
11 a report to the Congress on Bureau policies and pro-
12 cedures to provide testing, treatment, and prevention
13 education programs for hepatitis, liver failure, and
14 other liver-related diseases transmitted through sex-
15 ual activity, intravenous drug use, or other means.
16 The Bureau shall consult with appropriate officials
17 of the Department of Health and Human Services,
18 the Office of National Drug Control Policy, the Of-
19 fice of National AIDS Policy, and the Centers for
20 Disease Control and Prevention regarding the devel-
21 opment of this report.

22 (2) ANNUAL REPORTS.—

23 (A) GENERALLY.—Not later than 2 years
24 after the date of the enactment of this Act, and
25 then annually thereafter, the Bureau shall re-

1 port to Congress on the incidence among in-
2 mates of diseases transmitted through sexual
3 activity and intravenous drug use.

4 (B) MATTERS PERTAINING TO VARIOUS
5 DISEASES.—Reports under paragraph (1) shall
6 discuss—

7 (i) the incidence among inmates of
8 HIV/AIDS, hepatitis, and other diseases
9 transmitted through sexual activity and in-
10 travenous drug use; and

11 (ii) updates on Bureau testing, treat-
12 ment, and prevention education programs
13 for these diseases.

14 (C) MATTERS PERTAINING TO HIV/AIDS
15 ONLY.—Reports under paragraph (1) shall also
16 include—

17 (i) the number of inmates who tested
18 positive for HIV upon intake;

19 (ii) the number of inmates who tested
20 positive prior to reentry;

21 (iii) the number of inmates who were
22 not tested prior to reentry because they
23 were released without sufficient notice;

24 (iv) the number of inmates who opted-
25 out of taking the test;

1 (v) the number of inmates who were
2 tested under section 4014(b) of title 18,
3 United States Code; and

4 (vi) the number of inmates under
5 treatment for HIV/AIDS.

6 (D) CONSULTATION.—The Bureau shall
7 consult with appropriate officials of the Depart-
8 ment of Health and Human Services, the Office
9 of National Drug Control Policy, the Office of
10 National AIDS Policy, and the Centers for Dis-
11 ease Control and Prevention regarding the de-
12 velopment of reports under paragraph (1).

13 **SEC. 759. SUPPORT DATA SYSTEM REVIEW AND INDICA-**
14 **TORS FOR MONITORING HIV CARE.**

15 The Secretary of Health and Human Services, in col-
16 laboration with the Assistant Secretary for Health, the Di-
17 rector of the Office of HIV/AIDS and Infectious Disease
18 Policy, the Director of the Centers for Disease Control and
19 Prevention, the Administrator of the Substance Abuse and
20 Mental Health Services Administration, the Director of
21 the Department of Housing and Urban Development, the
22 Director of the Office of AIDS Research, the Adminis-
23 trator of the Health Resources and Services Administra-
24 tion, and the Administrator of the Centers for Medicare
25 & Medicaid Services, shall expand and coordinate efforts

1 to align metrics across agencies and modify Federal data
2 systems, to—

3 (1) adopt the Institute of Medicine’s clinical
4 HIV care indicators as the core metrics for moni-
5 toring the quality of HIV care, mental health, sub-
6 stance abuse, and supportive services;

7 (2) better enable assessment of the impact of
8 the National HIV/AIDS Strategy and the Patient
9 Protection and Affordable Care Act on improving
10 HIV/AIDS care and access to supportive services for
11 individuals with HIV;

12 (3) expand the demographic data elements to be
13 captured by Federal data systems relevant to HIV
14 care to permit calculation of the indicators for sub-
15 groups of the population of people with diagnosed
16 HIV infection, including—

17 (A) age;

18 (B) race;

19 (C) ethnicity;

20 (D) sex (assigned at birth);

21 (E) gender identity;

22 (F) sexual orientation;

23 (G) current geographic marker of resi-
24 dence;

25 (H) income or poverty level; and

1 (I) primary means of reimbursement for
2 medical services (including Medicaid, Medicare,
3 the Ryan White HIV/AIDS Program, private
4 insurance, health maintenance organizations,
5 and no coverage); and

6 (4) streamline data collection and systematically
7 review all existing reporting requirements for feder-
8 ally funded HIV/AIDS programs to ensure that only
9 essential data are collected.

10 **SEC. 760. TRANSFER OF FUNDS FOR IMPLEMENTATION OF**
11 **NATIONAL HIV/AIDS STRATEGY.**

12 Title II of the Public Health Service Act (42 U.S.C.
13 202 et seq.) is amended by inserting after section 241 the
14 following:

15 **“SEC. 241A. TRANSFER OF FUNDS FOR IMPLEMENTATION**
16 **OF NATIONAL HIV/AIDS STRATEGY.**

17 “(a) TRANSFER AUTHORIZATION.—Of the discre-
18 tionary appropriations made available to the Department
19 of Health and Human Services for any fiscal year for pro-
20 grams and activities that, as determined by the Secretary
21 of Health and Human Services, pertain to HIV/AIDS, the
22 Secretary, in coordination with the Director of the Office
23 of National HIV/AIDS Policy, may transfer up to 1 per-
24 cent of such appropriations to the Office of the Assistant

1 Secretary for Health for implementation of the National
2 HIV/AIDS Strategy.

3 “(b) CONGRESSIONAL NOTIFICATION.—Not less than
4 30 days before making any transfer under this section,
5 the Secretary shall give notice of the transfer to the Con-
6 gress.

7 “(c) DEFINITIONS.—In this section:

8 “(1) HIV/AIDS.—The term ‘HIV/AIDS’ has
9 the meaning given to such term in section 2689.

10 “(2) NATIONAL HIV/AIDS STRATEGY.—The
11 term ‘National HIV/AIDS Strategy’ means the Na-
12 tional HIV/AIDS Strategy for the United States
13 issued by the President in July 2010 and includes
14 any subsequent revisions to such Strategy.”.

15 **SEC. 761. REPORT ON THE IMPLEMENTATION OF GOAL 4**
16 **(IMPROVED COORDINATION) OF THE NA-**
17 **TIONAL HIV/AIDS STRATEGY.**

18 (a) REPORT REQUIRED.—The President, in consulta-
19 tion with the heads of all relevant Federal departments
20 and agencies including the Department of Education, the
21 Department of Health and Human Services, the Depart-
22 ment of Housing and Urban Development, the Depart-
23 ment of Justice, the Department of Labor, the Depart-
24 ment of Veteran Affairs, and the Social Security Adminis-
25 tration, shall transmit to the Congress and make publicly

1 available a report on the status of implementation of Goal
2 4 of the National HIV/AIDS Strategy.

3 (b) CONTENTS.—The report required by subsection
4 (a) shall include a description, an analysis, and an evalua-
5 tion of—

6 (1) the extent to which the National HIV/AIDS
7 Strategy has improved coordination of efforts, en-
8 hanced capacity, and strengthened infrastructure in
9 order to maximize the effective delivery of HIV/
10 AIDS prevention, care, and treatment services at the
11 community level, including coordination—

12 (A) within and among Federal agencies
13 and departments;

14 (B) between the Federal Government and
15 State and local governments and health depart-
16 ments;

17 (C) between the Federal Government and
18 nonprofit foundations and civil society organiza-
19 tions, including community- and faith-based or-
20 ganizations focused on addressing the issue of
21 HIV/AIDS; and

22 (D) between the Federal Government and
23 private businesses; and

24 (2) efforts by the Federal Government to edu-
25 cate, involve, and establish and strengthen partner-

1 ships with civil society organizations, including
2 community- and faith-based organizations, in order
3 to implement the National HIV/AIDS Strategy and
4 achieve its goals.

5 (c) DEFINITION.—In this section, the term “National
6 HIV/AIDS Strategy” means the National HIV/AIDS
7 Strategy for the United States issued by the President in
8 July 2010, the revision to such Strategy issued in July
9 2015, and any subsequent revisions to such Strategy.

10 **Subtitle F—Diabetes**

11 **SEC. 771. RESEARCH, TREATMENT, AND EDUCATION.**

12 Subpart 3 of part C of title IV of the Public Health
13 Service Act (42 U.S.C. 285c et seq.) is amended by adding
14 at the end the following new section:

15 **“SEC. 434B. DIABETES IN MINORITY POPULATIONS.**

16 “(a) IN GENERAL.—The Director of NIH shall ex-
17 pand, intensify, and support ongoing research and other
18 activities with respect to prediabetes and diabetes, particu-
19 larly type 2, in minority populations.

20 “(b) RESEARCH.—

21 “(1) DESCRIPTION.—Research under subsection

22 (a) shall include investigation into—

23 “(A) the causes of diabetes, including so-
24 cioeconomic, geographic, clinical, environmental,
25 genetic, and other factors that may contribute

1 to increased rates of diabetes in minority popu-
2 lations; and

3 “(B) the causes of increased incidence of
4 diabetes complications in minority populations,
5 and possible interventions to decrease such inci-
6 dence.

7 “(2) INCLUSION OF MINORITY PARTICIPANTS.—
8 In conducting and supporting research described in
9 subsection (a), the Director of NIH shall seek to in-
10 clude minority participants as study subjects in clin-
11 ical trials.

12 “(c) REPORT; COMPREHENSIVE PLAN.—

13 “(1) IN GENERAL.—The Diabetes Mellitus
14 Interagency Coordinating Committee shall—

15 “(A) prepare and submit to the Congress,
16 not later than 6 months after the date of enact-
17 ment of this section, a report on Federal re-
18 search and public health activities with respect
19 to prediabetes and diabetes in minority popu-
20 lations; and

21 “(B) develop and submit to the Congress,
22 not later than 1 year after the date of enact-
23 ment of this section, an effective and com-
24 prehensive Federal plan (including all appro-
25 priate Federal health programs) to address

1 prediabetes and diabetes in minority popu-
2 lations.

3 “(2) CONTENTS.—The report under paragraph
4 (1)(A) shall at minimum address each of the fol-
5 lowing:

6 “(A) Research on diabetes and prediabetes
7 in minority populations, including such research
8 on—

9 “(i) genetic, behavioral, and environ-
10 mental factors; and

11 “(ii) prevention and complications
12 among individuals within these populations
13 who have already developed diabetes.

14 “(B) Surveillance and data collection on
15 diabetes and prediabetes in minority popu-
16 lations, including with respect to—

17 “(i) efforts to better determine the
18 prevalence of diabetes among Asian-Amer-
19 ican and Pacific Islander subgroups; and

20 “(ii) efforts to coordinate data collec-
21 tion on the American Indian population.

22 “(C) Community-based interventions to ad-
23 dress diabetes and prediabetes targeting minor-
24 ity populations, including—

1 “(i) the evidence base for such inter-
2 ventions;

3 “(ii) the cultural appropriateness of
4 such interventions; and

5 “(iii) efforts to educate the public on
6 the causes and consequences of diabetes.

7 “(D) Education and training programs for
8 health professionals (including community
9 health workers) on the prevention and manage-
10 ment of diabetes and its related complications
11 that is supported by the Health Resources and
12 Services Administration, including such pro-
13 grams supported by—

14 “(i) the National Health Service
15 Corps; or

16 “(ii) the community health centers
17 program under section 330.

18 “(d) EDUCATION.—The Director of NIH shall—

19 “(1) through the National Institute on Minority
20 Health and Health Disparities and the National Di-
21 abetes Education Program—

22 “(A) make grants to programs funded
23 under section 464z-4 (relating to centers of ex-
24 cellence) for the purpose of establishing a men-
25 toring program for health care professionals to

1 be more involved in weight counseling, obesity
2 research, and nutrition; and

3 “(B) provide for the participation of mi-
4 nority health professionals in diabetes-focused
5 research programs; and

6 “(2) make grants for programs to establish a
7 pipeline from high school to professional school that
8 will increase minority representation in diabetes-fo-
9 cused health fields by expanding Minority Access to
10 Research Careers (MARC) program internships and
11 mentoring opportunities for recruitment.

12 “(e) DEFINITIONS.—For purposes of this section:

13 “(1) DIABETES MELLITUS INTERAGENCY CO-
14 ORDINATING COMMITTEE.—The ‘Diabetes Mellitus
15 Interagency Coordinating Committee’ means the Di-
16 abetes Mellitus Interagency Coordinating Committee
17 established under section 429.

18 “(2) MINORITY POPULATION.—The term ‘mi-
19 nority population’ means a racial and ethnic minor-
20 ity group, as defined in section 1707.”.

21 **SEC. 772. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

22 Part B of title III of the Public Health Service Act
23 (42 U.S.C. 243 et seq.) is amended by inserting after sec-
24 tion 317X of such Act, as added, the following section:

1 **“SEC. 317Y. DIABETES IN MINORITY POPULATIONS.**

2 “(a) RESEARCH AND OTHER ACTIVITIES.—

3 “(1) IN GENERAL.—The Secretary, acting
4 through the Director of the Centers for Disease
5 Control and Prevention, shall conduct and support
6 research and public health activities with respect to
7 diabetes in minority populations.

8 “(2) CERTAIN ACTIVITIES.—Activities under
9 paragraph (1) regarding diabetes in minority popu-
10 lations shall include the following:

11 “(A) Further enhancing the National
12 Health and Nutrition Examination Survey by
13 oversampling Asian American, Native Hawai-
14 ian, and Pacific Islanders in appropriate geo-
15 graphic areas to better determine the preva-
16 lence of diabetes in such populations as well as
17 to improve the data collection of diabetes pene-
18 tration disaggregated into major ethnic groups
19 within such populations. The Secretary shall en-
20 sure that any such oversampling does not re-
21 duce the oversampling of other minority popu-
22 lations including African-American and Latino
23 populations.

24 “(B) Through the Division of Diabetes
25 Translation—

1 “(i) providing for prevention research
2 to better understand how to influence
3 health care systems changes to improve
4 quality of care being delivered to such pop-
5 ulations;

6 “(ii) carrying out model demonstra-
7 tion projects to design, implement, and
8 evaluate effective diabetes prevention and
9 control interventions for minority popu-
10 lations, including culturally appropriate
11 community-based interventions;

12 “(iii) developing and implementing a
13 strategic plan to reduce diabetes in minor-
14 ity populations through applied research to
15 reduce disparities and culturally and lin-
16 guistically appropriate community-based
17 interventions;

18 “(iv) supporting, through the national
19 diabetes prevention program under section
20 399V-3, diabetes prevention program sites
21 in underserved regions highly impacted by
22 diabetes; and

23 “(v) implementing, through the na-
24 tional diabetes prevention program under
25 section 399V-3, a demonstration program

1 developing new metrics measuring health
2 outcomes related to diabetes that can be
3 stratified by specific minority populations.

4 “(b) EDUCATION.—The Secretary, acting through
5 the Director of the Centers for Disease Control and Pre-
6 vention, shall direct the Division of Diabetes Translation
7 to conduct and support both programs to educate the pub-
8 lic on diabetes in minority populations and programs to
9 educate minority populations about the causes and effects
10 of diabetes.

11 “(c) DIABETES; HEALTH PROMOTION, PREVENTION
12 ACTIVITIES, AND ACCESS.—The Secretary, acting through
13 the Director of the Centers for Disease Control and Pre-
14 vention and the National Diabetes Education Program,
15 shall conduct and support programs to educate specific
16 minority populations through culturally appropriate and
17 linguistically appropriate information campaigns about
18 prevention of, and managing, diabetes.

19 “(d) DEFINITION.—For purposes of this section, the
20 term ‘minority population’ means a racial and ethnic mi-
21 nority group, as defined in section 1707.”.

22 **SEC. 773. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

23 Part P of title III of the Public Health Service Act
24 (42 U.S.C. 280g et seq.), as amended, is further amended
25 by adding at the end the following new section:

1 **“SEC. 399V-9. PROGRAMS TO EDUCATE HEALTH PRO-**
2 **VIDERS ON THE CAUSES AND EFFECTS OF DI-**
3 **ABETES IN MINORITY POPULATIONS.**

4 “(a) IN GENERAL.—The Secretary, acting through
5 the Director of the Health Resources and Services Admin-
6 istration, shall conduct and support programs described
7 in subsection (b) to educate health professionals on the
8 causes and effects of diabetes in minority populations.

9 “(b) PROGRAMS.—Programs described in this sub-
10 section, with respect to education on diabetes in minority
11 populations, shall include the following:

12 “(1) Giving priority, under the primary care
13 training and enhancement program under section
14 747—

15 “(A) to awarding grants to focus on or ad-
16 dress diabetes; and

17 “(B) to adding minority populations to the
18 list of vulnerable populations that should be
19 served by such grants.

20 “(2) Providing additional funds for the Health
21 Careers Opportunity Program, the Centers for Ex-
22 cellence, and the Minority Faculty Fellowship Pro-
23 gram to partner with the Office of Minority Health
24 under section 1707 and the National Institutes of
25 Health to strengthen programs for career opportuni-

1 ties focused on diabetes treatment and care within
2 underserved regions highly impacted by diabetes.

3 “(3) Developing a diabetes focus within, and
4 providing additional funds for, the National Health
5 Service Corps Scholarship Program—

6 “(A) to place individuals in areas that are
7 disproportionately affected by diabetes and to
8 provide diabetes treatment and care in such
9 areas; and

10 “(B) to provide such individuals continuing
11 medical education specific to diabetes care.”.

12 **SEC. 774. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

13 Part P of title III of the Public Health Service Act
14 (42 U.S.C. 280g et seq.), as amended, is further amended
15 by adding at the end the following section:

16 **“SEC. 399V-10. RESEARCH, EDUCATION, AND OTHER ACTIVI-**
17 **TIES REGARDING DIABETES IN AMERICAN IN-**
18 **DIAN POPULATIONS.**

19 “In addition to activities under sections 399V-6 and
20 434B, the Secretary, acting through the Indian Health
21 Service and in collaboration with other appropriate Fed-
22 eral agencies, shall—

23 “(1) conduct and support research and other
24 activities with respect to diabetes; and

1 “(2) coordinate the collection of data on clini-
2 cally and culturally appropriate diabetes treatment,
3 care, prevention, and services by health care profes-
4 sionals to the American Indian population.”.

5 **SEC. 775. UPDATED REPORT ON HEALTH DISPARITIES.**

6 The Secretary of Health and Human Services shall
7 seek to enter into an arrangement with the Institute of
8 Medicine under which the Institute will—

9 (1) not later than 1 year after the date of en-
10 actment of this Act, submit to the Congress an up-
11 dated version of the Institute’s 2002 report entitled
12 “Unequal Treatment: Confronting Racial and Ethnic
13 Disparities in Health Care”; and

14 (2) in such updated version, address how racial
15 and ethnic health disparities have changed since the
16 publication of the original report.

17 **Subtitle G—Lung Disease**

18 **SEC. 776. EXPANSION OF THE NATIONAL ASTHMA EDU-
19 CATION AND PREVENTION PROGRAM.**

20 (a) FINDINGS.—The Congress finds as follows:

21 (1) The prevalence of asthma has increased
22 since 1980 and affects 25 million Americans.

23 (2) Significant disparities in asthma morbidity
24 and mortality exist for both adults and children par-

1 ticularly for low-income and minority populations,
2 particularly African Americans and Puerto Ricans.

3 (3) African-American children are twice as like-
4 ly to have asthma as White children.

5 (4) In 2010, almost 4.5 million non-Hispanic
6 African Americans reported having asthma. African
7 Americans with asthma are three times as likely to
8 visit the emergency department and twice as likely
9 to get hospitalized as White patients with asthma.

10 (5) Puerto Ricans are 3.4 times as likely to die
11 from asthma compared with all other Hispanic or
12 Latino groups. Overall Hispanic Americans are 30
13 percent more likely to be hospitalized for asthma
14 than non-Hispanic Whites.

15 (6) More than 65 percent of adults with asthma
16 are women.

17 (b) IN GENERAL.—Not later than 2 years after the
18 date of the enactment of this Act, the Secretary of Health
19 and Human Services shall convene a working group com-
20 prised of patient groups, nonprofit organizations, medical
21 societies, and other relevant governmental and nongovern-
22 mental entities, including those that participate in the Na-
23 tional Asthma Education and Prevention Program, to de-
24 velop a report to Congress that—

1 (1) catalogs, with respect to asthma prevention,
2 management, and surveillance—

3 (A) the activities of the Federal Govern-
4 ment, including identifying all Federal pro-
5 grams that carry out asthma-related activities,
6 as well as assessment of the progress of the
7 Federal Government and States, with respect to
8 achieving the goals of the Healthy People 2020
9 initiative; and

10 (B) the activities of other entities that par-
11 ticipate in the program, including nonprofit or-
12 ganizations, patient advocacy groups, and med-
13 ical societies; and

14 (2) makes recommendations for the future di-
15 rection of asthma activities, in consultation with re-
16 searchers from the National Institutes of Health and
17 other member bodies of the National Asthma Edu-
18 cation and Prevention Program who are qualified to
19 review and analyze data and evaluate interventions,
20 including—

21 (A) a description of how the Federal Gov-
22 ernment may better coordinate and improve its
23 response to asthma including identifying any
24 barriers that may exist;

1 (B) a description of how the Federal Gov-
2 ernment may continue, expand, and improve its
3 private-public partnerships with respect to asth-
4 ma including identifying any barriers that may
5 exist;

6 (C) identification of steps that may be
7 taken to reduce the—

8 (i) morbidity, mortality, and overall
9 prevalence of asthma;

10 (ii) financial burden of asthma on so-
11 ciety;

12 (iii) burden of asthma on dispropor-
13 tionately affected areas, particularly those
14 in medically underserved populations (as
15 defined in section 330(b)(3) of the Public
16 Health Service Act (42 U.S.C.
17 254b(b)(3))); and

18 (iv) burden of asthma as a chronic
19 disease;

20 (D) identification of programs and policies
21 that have achieved the steps described in sub-
22 paragraph (C), and steps that may be taken to
23 expand such programs and policies to benefit
24 larger populations; and

1 (E) recommendations for future research
2 and interventions.

3 (c) REPORT TO CONGRESS.—At the end of the 5-year
4 period following the submission of the report under this
5 section, the National Asthma Education and Prevention
6 Program shall evaluate the analyses and recommendations
7 under such report and determine whether a new report
8 to the Congress is necessary, and make appropriate rec-
9 ommendations to the Congress.

10 **SEC. 777. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**
11 **FOR DISEASE CONTROL AND PREVENTION.**

12 Section 317I of the Public Health Service Act (42
13 U.S.C. 247b–10) is amended to read as follows:

14 **“SEC. 317I. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**
15 **FOR DISEASE CONTROL AND PREVENTION.**

16 “(a) PROGRAM FOR PROVIDING INFORMATION AND
17 EDUCATION TO THE PUBLIC.—The Secretary, acting
18 through the Director of the Centers for Disease Control
19 and Prevention, shall collaborate with State and local
20 health departments to conduct activities, including the
21 provision of information and education to the public re-
22 garding asthma including—

23 “(1) deterring the harmful consequences of un-
24 controlled asthma; and

1 “(2) disseminating health education and infor-
2 mation regarding prevention of asthma episodes and
3 strategies for managing asthma.

4 “(b) DEVELOPMENT OF STATE ASTHMA PLANS.—
5 The Secretary, acting through the Director of the Centers
6 for Disease Control and Prevention, shall collaborate with
7 State and local health departments to develop State plans
8 incorporating public health responses to reduce the burden
9 of asthma, particularly regarding disproportionately af-
10 fected populations.

11 “(c) COMPILATION OF DATA.—The Secretary, acting
12 through the Director of the Centers for Disease Control
13 and Prevention, shall, in cooperation with State and local
14 public health officials—

15 “(1) conduct asthma surveillance activities to
16 collect data on the prevalence and severity of asth-
17 ma, the effectiveness of public health asthma inter-
18 ventions, and the quality of asthma management, in-
19 cluding—

20 “(A) collection of household data on the
21 local burden of asthma;

22 “(B) surveillance of health care facilities;
23 and

24 “(C) collection of data not containing indi-
25 vidually identifiable information from electronic

1 health records or other electronic communica-
2 tions;

3 “(2) compile and annually publish data regard-
4 ing the prevalence and incidence of childhood asth-
5 ma, the child mortality rate, and the number of hos-
6 pital admissions and emergency department visits by
7 children associated with asthma nationally and in
8 each State and at the county level by age, sex, race,
9 and ethnicity, as well as lifetime and current preva-
10 lence; and

11 “(3) compile and annually publish data regard-
12 ing the prevalence and incidence of adult asthma,
13 the adult mortality rate, and the number of hospital
14 admissions and emergency department visits by
15 adults associated with asthma nationally and in each
16 State and at the county level by age, sex, race, eth-
17 nicity, industry, and occupation, as well as lifetime
18 and current prevalence.

19 “(d) COORDINATION OF DATA COLLECTION.—The
20 Director of the Centers for Disease Control and Preven-
21 tion, in conjunction with State and local health depart-
22 ments, shall coordinate data collection activities under
23 subsection (c)(2) so as to maximize comparability of re-
24 sults.

1 “(e) COLLABORATION.—The Centers for Disease
2 Control and Prevention are encouraged to collaborate with
3 national, State, and local nonprofit organizations to pro-
4 vide information and education about asthma, and to
5 strengthen such collaborations when possible.

6 “(f) ADDITIONAL FUNDING.—In addition to any
7 other authorization of appropriations that is available to
8 the Centers for Disease Control and Prevention for the
9 purpose of carrying out this section, there are authorized
10 to be appropriated to such Centers such sums as may be
11 necessary for each of fiscal years 2019 through 2023 for
12 the purpose of carrying out this section.”.

13 **SEC. 778. INFLUENZA AND PNEUMONIA VACCINATION CAM-**
14 **PAIGN.**

15 (a) IN GENERAL.—The Secretary of Health and
16 Human Services shall—

17 (1) enhance the annual campaign by the De-
18 partment of Health and Human Services to increase
19 the number of people vaccinated each year for influ-
20 enza and pneumonia; and

21 (2) include in such campaign the use of written
22 educational materials, public service announcements,
23 physician education, and any other means which the
24 Secretary deems effective.

1 (b) MATERIALS AND ANNOUNCEMENTS.—In carrying
2 out the annual campaign described in subsection (a), the
3 Secretary of Health and Human Services shall ensure
4 that—

5 (1) educational materials and public service an-
6 nouncements are readily and widely available in
7 communities experiencing disparities in the incidence
8 and mortality rates of influenza and pneumonia; and

9 (2) the campaign uses targeted, culturally ap-
10 propriate messages and messengers to reach under-
11 served communities.

12 (c) 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 2019 through 2023.

16 **SEC. 779. CHRONIC OBSTRUCTIVE PULMONARY DISEASE**
17 **ACTION PLAN.**

18 (a) FINDINGS.—The Congress finds as follows:

19 (1) Chronic obstructive pulmonary disease
20 (“COPD”) refers to chronic bronchitis and emphy-
21 sema, incurable diseases that make it difficult to ex-
22 hale all the air from one’s lungs, and that can cause
23 persistent coughing, shortness of breath, and spu-
24 tum.

1 (2) COPD exacerbations—episodes of acute dif-
2 ficulty breathing and moderate to severe fatigue—
3 are dangerous, and their treatment often requires
4 hospitalization.

5 (3) While smoking is the primary risk factor for
6 COPD, other risk factors include air pollution, occu-
7 pational exposures, heredity, a history of childhood
8 respiratory infections, and socioeconomic status.

9 (4) Over 13.5 million United States adults are
10 estimated to have COPD.

11 (5) COPD is the third-leading cause of death in
12 America, claiming over 134,000 lives in 2010.

13 (6) Since 2000, deaths for women with COPD
14 have exceeded deaths in men.

15 (7) Although African Americans have a lower
16 prevalence of COPD in the United States, research-
17 ers have shown that African Americans may be
18 underdiagnosed. Furthermore, research has shown
19 that African Americans develop COPD with less cu-
20 mulative smoke exposure and at a younger age.

21 (b) IN GENERAL.—The Director of the Centers for
22 Disease Control and Prevention shall conduct, support,
23 and expand public health strategies, prevention, diagnosis,
24 surveillance, and public and professional awareness activi-
25 ties regarding chronic obstructive pulmonary disease.

1 (c) NATIONAL ACTION PLAN.—

2 (1) DEVELOPMENT.—Not later than 2 years
3 after the date of the enactment of this Act, the Di-
4 rector of the National Heart, Lung, and Blood Insti-
5 tute, in consultation with the Director of the Centers
6 for Disease Control and Prevention, shall develop a
7 national action plan to address chronic obstructive
8 pulmonary disease in the United States with partici-
9 pation from patients, caregivers, health profes-
10 sionals, patient advocacy organizations, researchers,
11 providers, public health professionals, and other
12 stakeholders.

13 (2) CONTENTS.—At a minimum, such plan
14 shall include recommendations for—

15 (A) public health interventions for the pur-
16 pose of implementation of the national plan;

17 (B) biomedical, health services, and public
18 health research on chronic obstructive pul-
19 monary disease; and

20 (C) inclusion of chronic obstructive pul-
21 monary disease in the health data collections of
22 all Federal agencies.

23 (3) CONSIDERATION.—In developing such plan,
24 the Director of the National Heart, Lung, and Blood
25 Institute shall consider the recommendations and

1 findings of the Institute of Medicine in the report
2 entitled “A Nationwide Framework for Surveillance
3 of Cardiovascular and Chronic Lung Diseases” (July
4 22, 2011).

5 (d) CHRONIC DISEASE PREVENTION PROGRAMS.—
6 The Director of the National Heart, Lung, and Blood In-
7 stitute shall carry out the following:

8 (1) Conduct public education and awareness ac-
9 tivities with patient and professional organizations
10 to stimulate earlier diagnosis and improve patient
11 outcomes from treatment of chronic obstructive pul-
12 monary disease. To the extent known and relevant,
13 such public education and awareness activities shall
14 reflect differences in chronic obstructive pulmonary
15 disease by cause (tobacco, environmental, occupa-
16 tional, biological, and genetic) and include a focus
17 on outreach to undiagnosed and, as appropriate, mi-
18 nority populations.

19 (2) Supplement and expand upon the activities
20 of the National Heart, Lung, and Blood Institute by
21 making grants to nonprofit organizations, State and
22 local jurisdictions, and Indian Tribes for the purpose
23 of reducing the burden of chronic obstructive pul-
24 monary disease, especially in disproportionately im-

1 pacted communities, through public health interven-
2 tions and related activities.

3 (3) Coordinate with the Centers for Disease
4 Control and Prevention, the Indian Health Service,
5 the Health Resources and Services Administration,
6 and the Department of Veterans Affairs to develop
7 pilot programs to demonstrate best practices for the
8 diagnosis and management of chronic obstructive
9 pulmonary disease.

10 (4) Develop improved techniques and identify
11 best practices, in coordination with the Secretary of
12 Veterans Affairs, for assisting chronic obstructive
13 pulmonary disease patients to successfully stop
14 smoking, including identification of subpopulations
15 with different needs. Initiatives under this para-
16 graph may include research to determine whether
17 successful smoking cessation strategies are different
18 for chronic obstructive pulmonary disease patients
19 compared to such strategies for patients with other
20 chronic diseases.

21 (e) ENVIRONMENTAL AND OCCUPATIONAL HEALTH
22 PROGRAMS.—The Director of the Centers for Disease
23 Control and Prevention shall—

24 (1) support research into the environmental and
25 occupational causes and biological mechanisms that

1 contribute to chronic obstructive pulmonary disease;
2 and

3 (2) develop and disseminate public health inter-
4 ventions that will lessen the impact of environmental
5 and occupational causes of chronic obstructive pul-
6 monary disease.

7 (f) DATA COLLECTION.—Not later than 180 days
8 after the enactment of this Act, the Director of the Na-
9 tional Heart, Lung, and Blood Institute and the Director
10 of the Centers for Disease Control and Prevention, acting
11 jointly, shall assess the depth and quality of information
12 on chronic obstructive pulmonary disease that is collected
13 in surveys and population studies conducted by the Cen-
14 ters for Disease Control and Prevention, including wheth-
15 er there are additional opportunities for information to be
16 collected in the National Health and Nutrition Examina-
17 tion Survey, the National Health Interview Survey, and
18 the Behavioral Risk Factors Surveillance System surveys.
19 The Director of the National Heart, Lung, and Blood In-
20 stitute shall include the results of such assessment in the
21 national action plan under subsection (b).

22 (g) 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 2019 through 2023.

1 **Subtitle H—Tuberculosis**

2 **SEC. 781. ELIMINATION OF ALL FORMS OF TUBERCULOSIS.**

3 (a) **SHORT TITLE.**—This subtitle be cited as the
4 “End Tuberculosis Act”.

5 (b) **FINDINGS.**—The Congress makes the following
6 findings:

7 (1) In the United States, 9,272 people were di-
8 agnosed with tuberculosis (referred to in this section
9 as “TB”) in 2016.

10 (2) Disparities in TB exist and significantly im-
11 pact minority communities in the United States. The
12 Centers for Disease Control and Prevention (re-
13 ferred to in this section as “CDC”) finds that 87
14 percent of people diagnosed with TB in 2016 self-
15 identified as racial and ethnic minorities.

16 (3) African Americans comprised 21 percent of
17 people diagnosed with TB during 2016. The popu-
18 lation-adjusted rate of TB among African Americans
19 is 1.7 times higher than the national total, and 8.2
20 times higher than among Whites.

21 (4) Asian Americans, Native Hawaiians, and
22 other Pacific Islanders comprised 35 percent of peo-
23 ple diagnosed with TB during 2016. The population-
24 adjusted rate of TB among Asian Americans is 6.2
25 times higher than the national total, and 30 times

1 higher than among Whites. The population-adjusted
2 rate of TB among Native Hawaiians and other Pa-
3 cific Islanders is 4.8 times higher than the national
4 total, and 23.2 times higher than among Whites.

5 (5) Hispanics and Latinos comprised 28 per-
6 cent of people diagnosed with TB during 2016. The
7 population-adjusted rate of TB among Hispanics
8 and Latinos is 1.6 times higher than the national
9 total, and 7.5 times higher than among Whites.

10 (6) TB is both preventable and curable, but the
11 current rate of decline of TB in the United States
12 remains too slow to achieve TB elimination in this
13 century.

14 (7) TB is transmitted through the air when a
15 person who has TB disease in their lungs coughs or
16 sneezes. People who are in close proximity to the
17 person with TB can breathe in the TB bacteria, and
18 the bacteria will initially settle in their lungs. With-
19 out proper and timely diagnosis and access to treat-
20 ment, the TB bacteria may grow and spread to
21 other parts of their body.

22 (8) As many as 13,000,000 people in the
23 United States may have Latent TB Infection (re-
24 ferred to in this section as “LTBI”). People with
25 LTBI have TB bacteria in their bodies, but their

1 immune system is containing the bacteria, and they
2 are not sick, nor do they have any current risk of
3 spreading TB to others. LTBI can activate into in-
4 fectionous, life-threatening TB if not treated. Modeling
5 has shown that eliminating TB is not possible with-
6 out addressing LTBI.

7 (9) Comorbidities associated with TB include
8 cancer, diabetes mellitus, and HIV. People with
9 these medical conditions and compromised immune
10 systems are more likely to develop active TB disease
11 and to have worse outcomes from TB.

12 (10) Forms of active TB that do not show drug
13 resistance are classified as Drug-susceptible TB (re-
14 ferred to in this section as “DS-TB”). Drug-resist-
15 ant TB (referred to in this section as “DR-TB”) is
16 a rising threat to the public health of the United
17 States. DR-TB that exhibits resistance to two or
18 more first-line drugs is referred to as multi-drug re-
19 sistant TB (referred to in this section as “MDR-
20 TB”). MDR-TB that also is resistant to at least
21 one injectable second-line medication and at least
22 one fluoroquinolone is classified as extensively drug-
23 resistant TB (referred to in this section as “XDR-
24 TB”).

1 (11) Approximately 78 people in the United
2 States were diagnosed with MDR-TB in 2016. One
3 person was diagnosed with XDR-TB in the same
4 year.

5 (12) In the United States, direct treatment
6 costs average \$17,000 to treat a patient with DS-
7 TB, \$150,000 to treat a patient with MDR-TB, and
8 \$482,000 to treat a patient with XDR-TB. When
9 factoring in productivity losses during treatment,
10 DS-TB averages \$46,000, MDR-TB averages
11 \$294,000 and XDR-TB averages \$694,000. Treat-
12 ment is often difficult, with daily complex multi-pill
13 regimens and injections, with side-effects ranging
14 from hearing and vision loss to mental health issues.

15 (13) Recognizing the public health, economic
16 and societal costs to the threat of MDR-TB, the
17 National Action Plan to Combat MDR-TB (NAP)
18 was developed by the White House to provide the
19 United States with a comprehensive three-pronged
20 strategy to address MDR-TB by strengthening do-
21 mestic capacity to combat MDR-TB; improve inter-
22 national capacity and cooperation to combat MDR-
23 TB; accelerate basic and applied research and devel-
24 opment for new therapies, diagnostics and preven-
25 tion strategies to combat MDR-TB.

1 (14) Additional Federal support is necessary to
2 expand TB control efforts in case finding and treat-
3 ment to address LTBI in a national prevention ini-
4 tiative. Key policy and research breakthroughs in-
5 crease the success of a TB prevention initiative: the
6 U.S. Preventative Services Task Force recommenda-
7 tion’s “B” rating, screening for LTBI among high-
8 risk adults as a covered service increases the likeli-
9 hood that impacted racial and ethnic minority
10 groups can get tested for TB; a new, shorter course
11 treatment regimen (3HP) reduces the length of
12 treatment for LTBI from every day for 6 to 9
13 months to one dose per week for 12 weeks, increas-
14 ing likelihood of treatment completion; and the use
15 of blood-based diagnostic tests, Interferon-gamma
16 release assays or IGRAs, increases ability to detect
17 LTBI among patients in affected communities.

18 **SEC. 782. ADDITIONAL FUNDING FOR STATES IN COM-**
19 **BATING AND ELIMINATING TUBERCULOSIS.**

20 Section 317E(f) of the Public Health Act (42 U.S.C.
21 247b6(f)) is amended by adding at the end the following:

22 “(3) ADDITIONAL FUNDING FOR STATES IN
23 COMBATING AND ELIMINATING TUBERCULOSIS.—In
24 addition to amounts otherwise authorized to be ap-
25 propriated to carry out this section, there are au-

1 thorized to be appropriated such sums as may be
2 necessary to carry out sections 247–b(1)(2)(3) for
3 each of fiscal years 2019 through 2021.”.

4 **SEC. 783. STRENGTHENING CLINICAL RESEARCH FUNDING**
5 **FOR TUBERCULOSIS.**

6 (a) **IN GENERAL.**—The Secretary of Health and
7 Human Services shall expand and intensify support for
8 current and prospective research activities of the National
9 Institutes of Health, the Biomedical Advanced Research
10 and Development Authority, and the Centers for Disease
11 Control and Prevention Division of Tuberculosis Elimini-
12 nation to develop new therapeutics, diagnostics, vaccines,
13 and other prevention modalities in addressing all forms
14 of tuberculosis (in this section referred to as “TB”).

15 (b) **INCLUDED RESEARCH ACTIVITIES.**—Research
16 activities under subsection (a) shall include—

17 (1) research to develop novel, safe drugs and
18 drug regimens for the treatment of TB, including in
19 adolescent and pediatric populations and in pregnant
20 and lactating women;

21 (2) research to develop rapid diagnostic tests
22 for all forms of TB, including diagnostics that can
23 be used for pediatric populations and people living
24 with HIV, diagnostics that can detect extra pul-

1 monary TB and drug resistance, and diagnostics
2 that can be used at the point of care;

3 (3) research to advance basic knowledge of the
4 pathogenesis of TB and its major comorbidities, in-
5 cluding HIV and diabetes mellitus;

6 (4) research to improve knowledge and under-
7 standings of the role of latency in TB and the fac-
8 tors that increase the risk of latent TB infection
9 progressing to active, symptomatic TB disease;

10 (5) awarding grants and contracts to specifi-
11 cally develop new and needed vaccines to address
12 TB;

13 (6) awarding grants and contracts to support
14 the training and development of clinical researchers
15 whose research improves the landscape of tools to
16 combat TB; and

17 (7) awarding grants and contracts to support
18 capacity-building and develop clinical trial site infra-
19 structure in the United States and in TB endemic
20 countries to support the aforementioned research ac-
21 tivities.

22 **Subtitle I—Osteoarthritis and** 23 **Musculoskeletal Diseases**

24 **SEC. 785. FINDINGS.**

25 The Congress finds as follows:

1 (1) Eighty percent of African-American women
2 and nearly 74 percent of Hispanic men are either
3 overweight or obese, speeding the onset and progres-
4 sion of arthritis.

5 (2) Arthritis affects 46 million Americans, and
6 that number will rise to 67 million by the year 2030.

7 (3) Twenty-seven million Americans suffer from
8 osteoarthritis, the most common form of arthritis,
9 making it the leading cause of disability in the
10 United States. Osteoarthritis is sometimes referred
11 to as degenerative joint disease.

12 (4) Obesity accelerates the onset of arthritis: 70
13 percent of obese adults with mild osteoarthritis of
14 the knee at age 60 will develop advanced end-stage
15 disease by age 80. In contrast, just 43 percent of
16 nonobese adults will have end-stage disease over the
17 same time period.

18 (5) Arthritis affects one in five Americans, and
19 is the single greatest cause of chronic pain and dis-
20 ability in the United States.

21 (6) Women, African Americans, and Hispanics
22 have more severe arthritis and functional limitations.
23 These same individuals are more likely to be obese,
24 diabetic, and have higher incidence of heart dis-
25 ease—medical conditions that can be improved with

1 physical activity. Instead of moving; however, these
2 groups have an inactivity rate of 40 to 50 percent,
3 which continues to increase.

4 (7) Arthritis costs \$128 billion a year, including
5 \$81 billion in direct costs (medical) and \$47 billion
6 in indirect costs (lost earnings). Each year, \$309 bil-
7 lion in direct and indirect costs is lost due to dis-
8 parities in osteoarthritis and musculoskeletal dis-
9 eases.

10 (8) Obesity and other chronic health conditions
11 exacerbate the debilitating impact of arthritis, lead-
12 ing to inactivity, loss of independence, and a per-
13 petual cycle of comorbid chronic conditions.

14 (9) Sixty-one percent of arthritis sufferers are
15 women, and women represent 64 percent of an esti-
16 mated 43 million annual visits to physicians' offices
17 and outpatient clinics where arthritis was the pri-
18 mary diagnosis. Women also represented 60 percent
19 of approximately 1 million hospitalizations that oc-
20 curred in 2003 for which arthritis was the primary
21 diagnosis.

22 (10) Women ages 65 and older have up to 2½
23 times more disabilities than men of the same age.
24 Higher rates of obesity and arthritis among this
25 group explained up to 48 percent of the gender gap

1 in disability, above all other common chronic health
2 conditions.

3 (11) The primary indication for total knee
4 arthroplasty (TKA), also known as knee replace-
5 ment, is relief of significant, disabling pain caused
6 by severe arthritis.

7 (12) Knee replacement is surgery for people
8 with severe knee damage. Knee replacement can re-
9 lieve pain and allow you to be more active. When
10 you have a total knee replacement, the surgeon re-
11 moves damaged cartilage and bone from the surface
12 of your knee joint and replaces them with a man-
13 made surface of metal and plastic. In a partial knee
14 replacement, the surgeon only replaces one part of
15 your knee joint.

16 (13) Total hip replacement, also called total hip
17 arthroplasty (THA), is used if your hip pain inter-
18 feres with daily activities and more conservative
19 treatments have not helped. Arthritis damage is the
20 most common reason to need hip replacement.

21 (14) The odds of a family practice physician
22 recommending TKA to a male patient with moderate
23 arthritis are twice that of a female patient, while the
24 odds of an orthopaedic surgeon recommending TKA

1 to a male patient with moderate arthritis are 22
2 times that of a female patient.

3 (15) African Americans with doctor-diagnosed
4 arthritis have a higher prevalence of severe pain at-
5 tributable to arthritis, compared with Whites (34.0
6 percent versus 22.6 percent). African Americans,
7 compared to Whites, report a higher proportion of
8 work limitations (39.5 percent versus 28.0 percent)
9 and a higher prevalence of arthritis-attributable
10 work limitation (6.6 percent versus 4.6 percent).

11 (16) Hispanics are 50 percent more likely than
12 non-Hispanic Whites to report needing assistance
13 with at least one instrumental activity of daily living
14 and to have difficulty walking.

15 (17) African Americans and Hispanics were 1.3
16 times more likely to have activity limitation, 1.6
17 times more likely to have work limitations, and 1.9
18 times more likely to have severe joint pain than
19 Whites.

20 (18) In 2003, the Institute of Medicine reported
21 that the rates of TKA and THA among African-
22 American and Hispanic patients are significantly
23 lower than for Whites—even for those with equitable
24 health care coverage such as through Medicare or
25 the Department of Veterans Affairs.

1 (19) According to the Centers for Disease Con-
2 trol and Prevention, in 2000, African-American
3 Medicare enrollees were 37 percent less likely than
4 White Medicare enrollees to undergo total knee re-
5 placements. In 2006, the disparity increased to 39
6 percent.

7 (20) Even after adjusting for insurance and
8 health access, Hispanics and African Americans are
9 almost 50 percent less likely to undergo total knee
10 replacement than Whites.

11 **SEC. 786. OSTEOARTHRITIS AND OTHER MUSCULO-**
12 **SKELETAL HEALTH-RELATED ACTIVITIES OF**
13 **THE CENTERS FOR DISEASE CONTROL AND**
14 **PREVENTION.**

15 (a) EDUCATION AND AWARENESS ACTIVITIES.—The
16 Secretary of Health and Human Services, acting through
17 the Director of the Centers for Disease Control and Pre-
18 vention, shall direct the National Center for Chronic Dis-
19 ease Prevention and Health Promotion to conduct and ex-
20 pand the Health Community Program and Arthritis Pro-
21 gram to educate the public on—

22 (1) the causes of, preventive health actions for,
23 and effects of arthritis and other musculoskeletal
24 conditions in minority patient populations; and

1 (2) the effects of such conditions on other
2 comorbidities including obesity, hypertension, and
3 cardiovascular disease.

4 (b) PROGRAMS ON ARTHRITIS AND MUSCULO-
5 SKELETAL CONDITIONS.—Education and awareness pro-
6 grams of the Centers for Disease Control and Prevention
7 on arthritis and other musculoskeletal conditions in minor-
8 ity communities shall—

9 (1) be culturally and linguistically appropriate
10 to minority patients, targeting musculoskeletal
11 health promotion and prevention programs of each
12 major ethnic group, including—

13 (A) Native Americans and Alaska Natives;

14 (B) Asian Americans;

15 (C) African Americans/Blacks;

16 (D) Hispanic/Latino Americans; and

17 (E) Native Hawaiians and Pacific Island-
18 ers; and

19 (2) include public awareness campaigns directed
20 toward these patient populations that emphasize the
21 importance of musculoskeletal health, physical activ-
22 ity, diet and healthy lifestyle, and weight reduction
23 for overweight and obese patients.

24 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
25 out this section, there are authorized to be appropriated

1 such sums as are necessary for fiscal year 2019 and each
2 subsequent fiscal year.

3 **SEC. 787. GRANTS FOR COMPREHENSIVE OSTEOARTHRITIS**
4 **AND MUSCULOSKELETAL DISEASE HEALTH**
5 **EDUCATION WITHIN HEALTH PROFESSIONS**
6 **SCHOOLS.**

7 (a) PROGRAM AUTHORIZED.—The Secretary of
8 Health and Human Services (in this section referred to
9 as the “Secretary”), in coordination with the Secretary of
10 Education, shall award grants, on a competitive basis, to
11 academic health science centers, health professions
12 schools, and other institutions of higher education to en-
13 able such institutions to provide people with comprehen-
14 sive education on arthritis and musculoskeletal health,
15 particularly—

- 16 (1) obesity-related musculoskeletal diseases;
17 (2) arthritis and osteoarthritis;
18 (3) arthritis and musculoskeletal health dispari-
19 ties; and
20 (4) the relationship between arthritis and mus-
21 culoskeletal diseases and metabolic activity, psycho-
22 logical health, and comorbidities such as diabetes,
23 cardiovascular disease, and hypertension.

24 (b) DURATION.—Grants awarded under this section
25 shall be for a period of 5 years.

1 (c) APPLICATIONS.—An academic health science cen-
2 ter, health professions school, or other institution of high-
3 er education seeking a grant under this section shall sub-
4 mit an application to the Secretary at such time, in such
5 manner, and containing such information as the Secretary
6 may require.

7 (d) PRIORITY.—In awarding grants under this sec-
8 tion, the Secretary shall give priority to an institution of
9 higher education that—

10 (1) has an enrollment of needy students, as de-
11 fined in section 318(b) of the Higher Education Act
12 of 1965 (20 U.S.C. 1059e(b));

13 (2) is a Hispanic-serving institution, as defined
14 in section 502(a) of such Act (20 U.S.C. 1101a(a));

15 (3) is a Tribal College or University, as defined
16 in section 316(b) of such Act (20 U.S.C. 1059c(b));

17 (4) is an Alaska Native-serving institution, as
18 defined in section 317(b) of such Act (20 U.S.C.
19 1059d(b));

20 (5) is a Native Hawaiian-serving institution, as
21 defined in section 317(b) of such Act (20 U.S.C.
22 1059d(b));

23 (6) is a Predominately Black Institution, as de-
24 fined in section 318(b) of such Act (20 U.S.C.
25 1059e(b));

1 (7) is a Native American-serving, non-Tribal in-
2 stitution, as defined in section 319(b) of such Act
3 (20 U.S.C. 1059f(b));

4 (8) is an Asian-American and Native American
5 Pacific Islander-serving institution, as defined in
6 section 320(b) of such Act (20 U.S.C. 1059g(b)); or

7 (9) is a minority institution, as defined in sec-
8 tion 365 of such Act (20 U.S.C. 1067k), with an en-
9 rollment of needy students, as defined in section 312
10 of such Act (20 U.S.C. 1058).

11 (e) USES OF FUNDS.—An institution of higher edu-
12 cation receiving a grant under this section may use grant
13 funds to integrate issues relating to comprehensive arthri-
14 tis and musculoskeletal health into the academic or sup-
15 port sectors of the institution in order to reach a large
16 number of students, by carrying out 1 or more of the fol-
17 lowing activities:

18 (1) Developing educational content for issues
19 relating to comprehensive arthritis and musculo-
20 skeletal health education that will be incorporated
21 into first-year orientation or core courses.

22 (2) Creating innovative technology-based ap-
23 proaches to deliver arthritis and musculoskeletal
24 health education to students, faculty, and staff.

1 (3) Developing and employing peer-outreach
2 and education programs to generate discussion, edu-
3 cate, and raise awareness among students about
4 issues relating to arthritis and musculoskeletal
5 health disorders, and their relationship to diabetes,
6 hypertension, cardiovascular disease, psychological
7 health, and other comorbid conditions.

8 (f) REPORT TO CONGRESS.—

9 (1) IN GENERAL.—Not later than 1 year after
10 the date of the enactment of this Act, and annually
11 thereafter for a period of 5 years, the Secretary shall
12 prepare and submit to the appropriate committees of
13 Congress a report on the activities to provide health
14 professions students with comprehensive arthritis
15 and musculoskeletal health education funded under
16 this section.

17 (2) REPORT ELEMENTS.—The report described
18 in paragraph (1) shall include information about—

19 (A) the number of entities that are receiv-
20 ing grant funds;

21 (B) the specific activities supported by
22 grant funds;

23 (C) the number of students served by
24 grant programs; and

25 (D) the status of program evaluations.

1 **Subtitle J—Sleep and Circadian**
2 **Rhythm Disorders**

3 **SEC. 791. SHORT TITLE; FINDINGS.**

4 (a) **SHORT TITLE.**—This subtitle may be cited as the
5 “Sleep and Circadian Rhythm Disorders Health Dispari-
6 ties Act”.

7 (b) **FINDINGS.**—The Congress finds the following:

8 (1) Decrements in sleep health such as sleep
9 apnea, insufficient sleep time, and insomnia, affect
10 50–70 million United States adults. Twelve to eight-
11 een million United States adults have sleep apnea, a
12 chronic disorder characterized by one or more
13 pauses in breathing which can last from a few sec-
14 onds to minutes. They may occur 30 times or more
15 an hour, disrupting sleep and resulting in excessive
16 daytime sleepiness and loss in productivity.

17 (2) Seventy percent of high school students are
18 not getting enough sleep on school nights, while 33
19 percent of Americans get fewer than 7 hours of sleep
20 per night, and roughly 6,000 fatal motor vehicle
21 crashes are caused by drowsy drivers.

22 (3) Insufficient sleep and insomnia are more
23 prevalent in women. Women who are pregnant and
24 have sleep apnea are at an increased risk of cardio-
25 vascular complications during pregnancy. The im-

1 pact of disparities in sleep health is associated with
2 a growing number of health problems, including the
3 following:

4 (A) Hypertension.

5 (B) Cancer.

6 (C) Stroke.

7 (D) Cardiac arrhythmia.

8 (E) Chronic heart failure and heart dis-
9 ease.

10 (F) Diabetes.

11 (G) Cognitive functioning and behavior.

12 (H) Depression and bipolar disorder.

13 (I) Substance abuse.

14 (4) A “sleep disparity” exists in that poor sleep
15 quality is strongly associated with poverty and race.
16 Factors such as employment, education, and health
17 status, amongst others, significantly mediated this
18 effect only in poor subjects, suggesting a differential
19 vulnerability to these factors in poor relative to
20 nonpoor individuals in the context of sleep quality.

21 (5) African Americans sleep worse than Cauca-
22 sian Americans. African Americans take longer to
23 fall asleep, report poorer sleep quality, have more
24 light and less deep sleep, and nap more often and
25 longer.

1 (6) African Americans and individuals in lower
2 socioeconomic status groups may be at an increased
3 risk for sleep disturbances and associated health
4 consequences.

5 (7) Among young African Americans, the likeli-
6 hood of having sleep disordered breathing and exhib-
7 iting risk factors for poor sleep is twice that in
8 young Caucasians. Frequent snoring is more com-
9 mon among African American and Hispanic women
10 and Hispanic men compared to non-Hispanic Cauca-
11 sians, independent of other factors including obesity.

12 (8) African Americans with sleep-disordered
13 breathing develop symptoms at a younger age than
14 Caucasians but appear less likely to be diagnosed
15 and treated in a timely manner. This delay may at
16 least in part be due to reduced access to care.

17 (9) Sleep loss contributes to increased risk for
18 chronic conditions such as obesity, diabetes, and hy-
19 pertension, all of which have increased prevalence in
20 underserved, underrepresented minorities. Racial
21 and ethnic disparities related to obesity may also
22 contribute to disparities in health outcomes related
23 to sleep-disordered breathing.

1 (10) Non-Caucasian adults report an insomnia
2 rate of 12.9 percent compared to only 6.6 percent
3 for Caucasians.

4 (11) African-American women have a higher in-
5 cidence of insomnia than African-American men,
6 perhaps related in part to higher risk for chronic
7 persisting symptoms.

8 **SEC. 792. SLEEP AND CIRCADIAN RHYTHM DISORDERS RE-**
9 **SEARCH ACTIVITIES OF THE NATIONAL IN-**
10 **STITUTES OF HEALTH.**

11 (a) IN GENERAL.—The Director of the National In-
12 stitutes of Health, acting through the Director of the Na-
13 tional Heart, Lung, and Blood Institute, shall—

14 (1) continue to expand research activities ad-
15 dressing sleep health disparities; and

16 (2) continue implementation of the “NIH Sleep
17 Disorders Research Plan” across all institutes and
18 centers of the National Institutes of Health to im-
19 prove treatment and prevention of sleep health dis-
20 parities.

21 (b) REQUIRED RESEARCH ACTIVITIES.—In con-
22 ducting or supporting research relating to sleep and circa-
23 dian rhythm, the Director of the National Heart, Lung,
24 and Blood Institute shall—

1 (1) advance epidemiology and clinical research
2 to achieve a more complete understanding of dispari-
3 ties in domains of sleep health and across population
4 subgroups for which cardiovascular and metabolic
5 health disparities exist, including—

6 (A) prevalence and severity of sleep apnea;

7 (B) habitual sleep duration;

8 (C) sleep timing and regularity; and

9 (D) insomnia;

10 (2) develop study designs and analytical ap-
11 proaches to explain and predict multilevel and life-
12 course determinants of sleep health and to elucidate
13 the sleep-related causes of cardiovascular and meta-
14 bolic health disparities across the age spectrum, in-
15 cluding such determinants and causes that are—

16 (A) environmental;

17 (B) biological or genetic;

18 (C) psychosocial;

19 (D) societal;

20 (E) political; or

21 (F) economic;

22 (3) determine the contribution of sleep impair-
23 ments such as sleep apnea, insufficient sleep dura-
24 tion, irregular sleep schedules, and insomnia to un-

1 explained disparities in cardiovascular and metabolic
2 risk and disease outcomes;

3 (4) develop study designs, data sampling and
4 collection tools, and analytical approaches to opti-
5 mize understanding of mediating and moderating
6 factors, and feedback mechanisms coupling sleep to
7 cardiovascular and metabolic health disparities;

8 (5) advance research to understand cultural
9 and linguistic barriers (on the person, provider, or
10 system level) to access to care, medical diagnosis,
11 and treatment of sleep disorders in diverse popu-
12 lation groups;

13 (6) develop and test multilevel interventions (in-
14 cluding sleep health education in diverse commu-
15 nities) to reduce disparities in sleep health that will
16 impact ability to improve disparities in cardio-
17 vascular and metabolic risk or disease;

18 (7) create opportunities to integrate sleep and
19 health disparity science by strategically utilizing re-
20 sources (existing or anticipated cohorts), exchanging
21 scientific data and ideas (cross-over into scientific
22 meetings), and develop multidisciplinary investi-
23 gator-initiated grant applications; and

1 (c) REQUIRED SURVEILLANCE AND EDUCATION
2 AWARENESS ACTIVITIES.—In conducting or supporting
3 research relating to sleep and circadian rhythm disorders
4 surveillance and education awareness activities, the Direc-
5 tor of the Centers for Disease Control and Prevention
6 shall—

7 (1) ensure that such activities are culturally
8 and linguistically appropriate to minority patients,
9 targeting sleep and circadian rhythm health pro-
10 motion and prevention programs of each major eth-
11 nic group, including—

12 (A) Native Americans and Alaska Natives;

13 (B) Asian Americans;

14 (C) African Americans/Blacks;

15 (D) Hispanic/Latino-Americans; and

16 (E) Native Hawaiians and Pacific Island-
17 ers;

18 (2) collect and compile national and State sur-
19 veillance data on sleep disorders health disparities;

20 (3) continue to develop and implement new
21 sleep questions in public health surveillance systems
22 to increase public awareness of sleep health and
23 sleep disorders and their impact on health;

24 (4) publish monthly reports highlighting geo-
25 graphic, racial, and ethnic disparities in sleep health,

1 as well as relationships between insufficient sleep
2 and chronic disease, health risk behaviors, and other
3 outcomes as determined necessary by the Director;
4 and

5 (5) include public awareness campaigns that in-
6 form patient populations from major ethnic groups
7 about the prevalence of sleep and circadian rhythm
8 disorders and emphasize the importance of sleep
9 health.

10 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
11 out this section, there are authorized to be appropriated
12 such sums as may be necessary for fiscal year 2019 and
13 each subsequent fiscal year.

14 **SEC. 794. GRANTS FOR COMPREHENSIVE SLEEP AND CIR-**
15 **CADIAN HEALTH EDUCATION WITHIN**
16 **HEALTH PROFESSIONS SCHOOLS.**

17 (a) PROGRAM AUTHORIZED.—The Secretary of
18 Health and Human Services (in this section referred to
19 as the “Secretary”), in coordination with the Secretary of
20 Education, shall award grants, on a competitive basis, to
21 academic health science centers, health professions
22 schools, and other institutions of higher education to en-
23 able such institutions to provide people with comprehen-
24 sive education on sleep and circadian health, particu-
25 larly—

- 1 (1) poor sleep health;
- 2 (2) sleep disorders;
- 3 (3) sleep health disparities; and
- 4 (4) the relationship between sleep and circadian
- 5 health on metabolic activity, neurological activity,
- 6 comorbidities, and other diseases.

7 (b) DURATION.—Grants awarded under this section
8 shall be for a period of 5 years.

9 (c) APPLICATIONS.—Any academic health science
10 center, health professions school, or other institutions of
11 higher education seeking a grant under this section shall
12 submit an application to the Secretary at such time, in
13 such manner, and containing such information as the Sec-
14 retary may require.

15 (d) PRIORITY.—In awarding grants under this sec-
16 tion, the Secretary shall give priority to an institution
17 that—

18 (1) has an enrollment of needy students, as de-
19 fined in section 318(b) of the Higher Education Act
20 of 1965 (20 U.S.C. 1059e(b));

21 (2) is a Hispanic-serving institution, as defined
22 in section 502(a) of such Act (20 U.S.C. 1101a(a));

23 (3) is a Tribal College or University, as defined
24 in section 316(b) of such Act (20 U.S.C. 1059c(b));

1 (4) is an Alaska Native-serving institution, as
2 defined in section 317(b) of such Act (20 U.S.C.
3 1059d(b));

4 (5) is a Native Hawaiian-serving institution, as
5 defined in section 317(b) of such Act (20 U.S.C.
6 1059d(b));

7 (6) is a Predominately Black Institution, as de-
8 fined in section 318(b) of such Act (20 U.S.C.
9 1059e(b));

10 (7) is a Native American-serving, nontribal in-
11 stitution, as defined in section 319(b) of such Act
12 (20 U.S.C. 1059f(b));

13 (8) is an Asian-American and Native American
14 Pacific Islander-serving institution, as defined in
15 section 320(b) of such Act (20 U.S.C. 1059g(b)); or

16 (9) is a minority institution, as defined in sec-
17 tion 365 of such Act (20 U.S.C. 1067k), with an en-
18 rollment of needy students, as defined in section 312
19 of such Act (20 U.S.C. 1058).

20 (e) USES OF FUNDS.—An institution of higher edu-
21 cation receiving a grant under this section may use grant
22 funds to integrate issues relating to comprehensive sleep
23 and circadian health into the academic or support sectors
24 of the institution in order to reach a large number of stu-
25 dents, by carrying out 1 or more of the following activities:

1 (1) Developing educational content for issues
2 relating to comprehensive sleep and circadian health
3 education that will be incorporated into first-year
4 orientation or core courses.

5 (2) Creating innovative technology-based ap-
6 proaches to deliver sleep health education to stu-
7 dents, faculty, and staff.

8 (3) Developing and employing peer-outreach
9 and education programs to generate discussion, edu-
10 cate, and raise awareness among students about
11 issues relating to poor quality sleep, sleep and circa-
12 dian disorders, and the role sleep health plays in
13 other diseases and comorbidities.

14 (f) REPORT TO CONGRESS.—

15 (1) IN GENERAL.—Not later than 1 year after
16 the date of the enactment of this Act, and annually
17 thereafter for a period of 5 years, the Secretary shall
18 prepare and submit to the appropriate committees of
19 Congress a report on the activities to provide health
20 professions students with comprehensive sleep and
21 circadian health education funded under this section.

22 (2) REPORT ELEMENTS.—The report described
23 in paragraph (1) shall include information about—

1 (A) the number of eligible entities and in-
2 stitutions of higher education that are receiving
3 grant funds;

4 (B) the specific activities supported by
5 grant funds;

6 (C) the number of students served by
7 grant programs; and

8 (D) the status of program evaluations.

9 **SEC. 795. REPORT ON IMPACT OF SLEEP AND CIRCADIAN**
10 **HEALTH DISORDERS IN VULNERABLE AND**
11 **RACIAL/ETHNIC POPULATIONS.**

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 submit to the Congress and the
15 President a report on the impact of sleep and circadian
16 health disorders for racial and ethnic minority commu-
17 nities and other vulnerable populations.

18 (b) CONTENTS.—The report under subsection (a)
19 shall include information on the—

20 (1) progress that has been made in reducing
21 the impact of sleep and circadian health disorders in
22 such communities and populations;

23 (2) opportunities that exist to make additional
24 progress in reducing the impact of sleep and circa-

1 dian health disorders in such communities and popu-
2 lations;

3 (3) challenges that may impede such additional
4 progress; and

5 (4) Federal funding necessary to achieve sub-
6 stantial reductions in sleep and circadian health dis-
7 orders in racial and ethnic minority communities.

8 **Subtitle K—Sickle Cell Disease Re-**
9 **search, Surveillance, Preven-**
10 **tion, and Treatment**

11 **SEC. 796. SHORT TITLE.**

12 This subtitle may be cited as the “Sickle Cell Disease
13 Research, Surveillance, Prevention, and Treatment Act of
14 2018”.

15 **SEC. 796A. SICKLE CELL DISEASE RESEARCH.**

16 Part P of title III of the Public Health Service Act
17 (42 U.S.C. 280g et seq.), as amended, is further amended
18 by adding at the end the following:

19 **“SEC. 399V-11. NATIONAL SICKLE CELL DISEASE RE-**
20 **SEARCH, SURVEILLANCE, PREVENTION, AND**
21 **TREATMENT PROGRAM.**

22 “(a) RESEARCH.—The Secretary may conduct or
23 support research to expand the understanding of the cause
24 of, and to find a cure for, sickle cell disease.”.

1 **SEC. 796B. SICKLE CELL DISEASE SURVEILLANCE.**

2 Section 399V–11 of the Public Health Service Act,
3 as added by section 796A, is amended by adding at the
4 end the following:

5 “(b) SURVEILLANCE.—

6 “(1) GRANTS.—The Secretary may, for each
7 fiscal year for which appropriations are available to
8 carry out this subsection, make grants—

9 “(A) to conduct surveillance and maintain
10 data on the prevalence and distribution of sickle
11 cell disease and its associated health outcomes,
12 complications, and treatments;

13 “(B) to conduct public health initiatives
14 with respect to sickle cell disease, including—

15 “(i) increasing efforts to improve ac-
16 cess to, and receipt of, high-quality sickle
17 cell disease-related health care, including
18 the use of treatments approved under sec-
19 tion 505 of the Federal Food, Drug, and
20 Cosmetic Act or licensed under section 351
21 of this Act;

22 “(ii) working with partners to improve
23 health outcomes of people with sickle cell
24 disease over their lifespan by promoting
25 guidelines for sickle cell disease screening,
26 prevention, and treatment, including man-

1 agement of sickle cell disease complica-
2 tions;

3 ““(iii) providing support to community-
4 based organizations and State and local
5 health departments in conducting sickle
6 cell disease education and training activi-
7 ties for patients, communities, and health
8 care providers; and

9 ““(iv) supporting and training State
10 health departments and regional labora-
11 tories in comprehensive testing to identify
12 specific forms of sickle cell disease in peo-
13 ple of all ages; and

14 “(C) to identify and evaluate promising
15 strategies for prevention and treatment of sickle
16 cell disease complications, including through—

17 “(i) improving estimates of the na-
18 tional incidence and prevalence of sickle
19 cell disease, including estimates about the
20 specific types of sickle cell disease;

21 “(ii) identifying health disparities re-
22 lated to sickle cell disease;

23 “(iii) assessing the utilization of
24 therapies and strategies to prevent com-
25 plications related to sickle cell disease; and

1 “(iv) evaluating the impact of genetic,
2 environmental, behavioral, and other risk
3 factors that may affect sickle cell disease
4 health outcomes.

5 “(2) POPULATION INCLUDED.—The Secretary
6 shall, to the extent practicable, award grants under
7 this subsection to States, academic institutions, or
8 nonprofit organizations across the United States so
9 as to include data on the majority of the United
10 States population with sickle cell disease.

11 “(3) APPLICATION.—To seek a grant under this
12 subsection, a State, academic institution, or non-
13 profit organization shall submit an application to the
14 Secretary at such time, in such manner, and con-
15 taining such information as the Secretary may re-
16 quire.

17 “(4) DEFINITIONS.—In this subsection:

18 “(A) SECRETARY.—The term ‘Secretary’
19 means the Secretary of Health and Human
20 Services, acting through the Director of the Na-
21 tional Center on Birth Defects and Develop-
22 mental Disabilities.

23 “(B) STATE.—The term ‘State’ includes
24 the 50 States, the District of Columbia, the
25 Commonwealth of Puerto Rico, the United

1 States Virgin Islands, the Commonwealth of the
2 Northern Mariana Islands, American Samoa,
3 Guam, the Federated States of Micronesia, the
4 Republic of the Marshall Islands, and the Re-
5 public of Palau.”.

6 **SEC. 796C. SICKLE CELL DISEASE PREVENTION AND**
7 **TREATMENT.**

8 (a) REAUTHORIZATION.—Section 712(c) of the
9 American Jobs Creation Act of 2004 (Public Law 108–
10 357; 42 U.S.C. 300b–1 note) is amended—

11 (1) by striking “Sickle Cell Disease” each place
12 it appears and inserting “sickle cell disease”;

13 (2) in paragraph (1)(A), by striking “grants to
14 up to 40 eligible entities for each fiscal year in which
15 the program is conducted under this section for the
16 purpose of developing and establishing systemic
17 mechanisms to improve the prevention and treat-
18 ment of Sickle Cell Disease” and inserting “grants
19 to up to 25 eligible entities for each fiscal year in
20 which the program is conducted under this section
21 for the purpose of developing and establishing sys-
22 temic mechanisms to improve the prevention and
23 treatment of sickle cell disease in populations with
24 a high density of sickle cell disease patients”;

25 (3) in paragraph (1)(B)—

1 (A) by striking clause (ii) (relating to pri-
2 ority); and

3 (B) by striking “GRANT AWARD REQUIRE-
4 MENTS” and all that follows through “the ad-
5 ministrator shall” and inserting “GEOGRAPHIC
6 DIVERSITY.—The Administrator shall”;

7 (4) in paragraph (2), by adding the following
8 new subparagraph at the end:

9 “(E) To expand, coordinate, and imple-
10 ment transition services for adolescents with
11 sickle cell disease making the transition to adult
12 health care.”; and

13 (5) in paragraph (6), by striking “\$10,000,000
14 for each of fiscal years 2005 through 2009” and in-
15 serting “\$4,455,000 for each of fiscal years 2019
16 through 2023”.

17 (b) TECHNICAL CHANGES.—Subsection (c) of section
18 712 of the American Jobs Creation Act of 2004 (Public
19 Law 108–357; 42 U.S.C. 300b–1 note), as amended by
20 subsection (a), is—

21 (1) transferred to the Public Health Service Act
22 (42 U.S.C. 201 et seq.); and

23 (2) inserted at the end of section 399V–11 of
24 such Act, as added and amended by sections 796A
25 and 796B.

1 **SEC. 796D. COLLABORATION WITH COMMUNITY-BASED EN-**
 2 **TITIES.**

3 Section 399V–11 of the Public Health Service Act,
 4 as amended by section 796C, is further amended by add-
 5 ing at the end the following:

6 “(d) COLLABORATION WITH COMMUNITY-BASED EN-
 7 TITIES.—To be eligible to receive a grant or other assist-
 8 ance under subsection (b) or (c), an entity must have in
 9 effect a collaborative agreement with a community-based
 10 organization with 5 or more years of experience in pro-
 11 viding services to sickle cell disease patients.”.

12 **TITLE VIII—HEALTH**
 13 **INFORMATION TECHNOLOGY**

14 **SEC. 800. DEFINITIONS.**

15 In this title:

16 (1) **CERTIFIED ELECTRONIC HEALTH RECORD**
 17 **TECHNOLOGY.**—The term “Certified Electronic
 18 Health Record Technology” has the meaning given
 19 to that term in section 3000 of the Public Health
 20 Service Act (42 U.S.C. 300jj).

21 (2) **EHR.**—The term “EHR” means an elec-
 22 tronic health record.

1 **Subtitle A—Reducing Health**
2 **Disparities Through Health IT**

3 **SEC. 801. HRSA ASSISTANCE TO HEALTH CENTERS FOR**
4 **PROMOTION OF HEALTH IT.**

5 The Secretary of Health and Human Services, acting
6 through the Administrator of the Health Resources and
7 Services Administration, shall expand and intensify the
8 programs and activities of the Administration (directly or
9 through grants or contracts) to provide technical assist-
10 ance and resources to health centers (as defined in section
11 330(a) of the Public Health Service Act (42 U.S.C.
12 254b(a)) to adopt and meaningfully use Certified Elec-
13 tronic Health Record Technology for the management of
14 chronic diseases and health conditions and reduction of
15 health disparities.

16 **SEC. 802. ASSESSMENT OF IMPACT OF HEALTH IT ON RA-**
17 **CIAL AND ETHNIC MINORITY COMMUNITIES;**
18 **OUTREACH AND ADOPTION OF HEALTH IT IN**
19 **SUCH COMMUNITIES.**

20 (a) NATIONAL COORDINATOR FOR HEALTH INFOR-
21 MATION TECHNOLOGY.—

22 (1) IN GENERAL.—The National Coordinator
23 for Health Information Technology shall conduct an
24 evaluation of the level of use and accessibility of
25 electronic health records in racial and ethnic minor-

1 ity communities focusing on whether patients in
2 those communities have providers with electronic
3 health records, stratified by providers participating
4 in Medicare and Medicaid programs, and whether
5 such providers have received EHR incentive pay-
6 ments under the HITECH Act, and by providers
7 participating in the Merit-Based Incentive Payment
8 System (MIPS) under the Quality Payment Pro-
9 gram (QPP) established by the Medicare Access and
10 CHIP Reauthorization Act of 2015 (MACRA).

11 (2) CONTENT.—In conducting the evaluation
12 under paragraph (1), the National Coordinator shall
13 publish the results of a study regarding the 100,000
14 providers recruited by the Regional Extension Cen-
15 ter established under section 3012 of the Public
16 Health Service Act (42 U.S.C. 300jj–32), including
17 the race and ethnicity of such providers and the pop-
18 ulations served by such providers, with the popu-
19 lations stratified by providers participating in Medi-
20 care and Medicaid programs, and whether such pro-
21 viders have received EHR incentive payments under
22 the HITECH Act, and by providers participating in
23 the MIPS.

24 (b) NATIONAL CENTER FOR HEALTH STATISTICS.—
25 As soon as practicable after the date of enactment of this

1 Act, the Director of the National Center for Health Statis-
2 ties shall provide to Congress a more detailed analysis of
3 the data presented in NCHS Data Brief No. 236, Adop-
4 tion of Certified Electronic Health Record Systems and
5 Electronic Information Sharing in Physician Offices:
6 United States, 2013 and 2014 the Data Brief 79.

7 (c) CENTERS FOR MEDICARE & MEDICAID SERV-
8 ICES.—

9 (1) IN GENERAL.—As part of the process of
10 collecting information, with respect to a provider, at
11 registration and attestation for purposes of the
12 Medicare and Medicaid Electronic Health Records
13 Incentive Programs and MIPS, the Secretary of
14 Health and Human Services shall collect the race
15 and ethnicity of such provider.

16 (2) MEDICARE AND MEDICAID ELECTRONIC
17 HEALTH RECORDS INCENTIVE PROGRAMS DE-
18 FINED.—For purposes of paragraph (1), the term
19 “Medicare and Medicaid Electronic Health Records
20 Incentive Programs” means the incentive programs
21 under section 1814(l)(3), subsections (a)(7) and (o)
22 of section 1848, subsections (l) and (m) of section
23 1853, subsections (b)(3)(B)(ix)(I) and (n) of section
24 1886, and subsections (a)(3)(F) and (t) of section
25 1903 of the Social Security Act (42 U.S.C.

1 1395f(l)(3), 1395w-4, 1395w-23, 1395ww, and
2 1396b).

3 (d) NATIONAL COORDINATOR'S ASSESSMENT OF IM-
4 PACT OF HIT.—Section 3001(e)(6)(C) of the Public
5 Health Service Act (42 U.S.C. 300jj-11(e)(6)(C)) is
6 amended—

7 (1) in the heading by inserting “, RACIAL AND
8 ETHNIC MINORITY COMMUNITIES,” after “HEALTH
9 DISPARITIES”;

10 (2) by inserting “, in communities with a high
11 proportion of individuals from racial and ethnic mi-
12 nority groups (as defined in section 1707(g)), in-
13 cluding people with disabilities in these groups,”
14 after “communities with health disparities”; and

15 (3) by adding at the end the following new sen-
16 tence: “In any publication under the previous sen-
17 tence, the National Coordinator shall include best
18 practices for encouraging partnerships between the
19 Federal Government, States, and private entities to
20 expand outreach for and the adoption of certified
21 EHR technology in communities with a high propor-
22 tion of individuals from racial and ethnic minority
23 groups (as so defined), while also maintaining the
24 accessibility requirements of section 508 of the Re-
25 habilitation Act to encourage patient involvement in

1 patient health care. The National Coordinator
2 shall—

3 “(i) not later than 6 months after the
4 submission to the Congress of the report
5 required by section 822 of the Health Eq-
6 uity and Accountability Act of 2018, estab-
7 lish criteria for evaluating the impact of
8 health information technology on commu-
9 nities with a high proportion of individuals
10 from racial and ethnic minority groups (as
11 so defined) taking into account the find-
12 ings in such report; and

13 “(ii) not later than 12 months after
14 the submission to the Congress of such re-
15 ports, conduct and publish the results of
16 an evaluation of such impact.”.

17 **Subtitle B—Modifications To**
18 **Achieve Parity in Existing Pro-**
19 **grams**

20 **SEC. 811. EXTENDING FUNDING TO STRENGTHEN THE**
21 **HEALTH IT INFRASTRUCTURE IN RACIAL**
22 **AND ETHNIC MINORITY COMMUNITIES.**

23 Section 3011 of the Public Health Service Act (42
24 U.S.C. 300jj–31) is amended—

1 (1) in subsection (a), by adding at the end the
2 following new paragraph:

3 “(8) Activities described in the previous para-
4 graphs of this subsection with respect to commu-
5 nities with a high proportion of individuals from ra-
6 cial and ethnic minority groups (as defined in sec-
7 tion 1707(g)).”; and

8 (2) by adding at the end the following new sub-
9 section:

10 “(e) ANNUAL REPORT ON EXPENDITURES.—The
11 National Coordinator shall report annually to the Con-
12 gress on activities and expenditures under this section.”.

13 **SEC. 812. EXTENDING COMPETITIVE GRANTS FOR THE DE-**
14 **VELOPMENT OF LOAN PROGRAMS TO FACILI-**
15 **TATE ADOPTION OF CERTIFIED ELECTRONIC**
16 **HEALTH RECORD TECHNOLOGY BY PRO-**
17 **VIDERS SERVING RACIAL AND ETHNIC MI-**
18 **NORITY GROUPS.**

19 Section 3014(e) of the Public Health Service Act (42
20 U.S.C. 300jj–34(e)) is amended—

21 (1) in paragraph (3), by striking at the end
22 “or”;

23 (2) in paragraph (4), by striking the period at
24 the end and inserting “; or”; and

1 nities with a high proportion of individuals
2 from racial and ethnic minority groups (as
3 defined in section 1707(g)), the National
4 Coordinator shall, to the greatest extent
5 possible, coordinate with an entity de-
6 scribed in clause (ii).

7 “(ii) MINORITY-SERVING INSTITU-
8 TIONS.—For purposes of clause (i), an en-
9 tity described in this clause is a historically
10 Black college or university, a Hispanic-
11 serving institution, a Tribal college or uni-
12 versity, or an Asian-American-, Native
13 American-, Pacific Islander-serving institu-
14 tion with an accredited public health,
15 health policy, or health services research
16 program.”.

17 **SEC. 822. STUDY OF HEALTH INFORMATION TECHNOLOGY**
18 **IN MEDICALLY UNDERSERVED COMMU-**
19 **NITIES.**

20 (a) IN GENERAL.—Not later than 24 months after
21 the date of enactment of this Act, the Secretary of Health
22 and Human Services shall—

23 (1) enter into an agreement with the National
24 Academies of Sciences, Engineering, and Medicine to
25 conduct a study on the development, implementa-

1 tion, and effectiveness of health information tech-
2 nology within medically underserved areas (as de-
3 scribed in subsection (c)); and

4 (2) submit a report to Congress describing the
5 results of such study, including any recommenda-
6 tions for legislative or administrative action.

7 (b) STUDY.—The study described in subsection
8 (a)(1) shall—

9 (1) identify barriers to successful implementa-
10 tion of health information technology in medically
11 underserved areas;

12 (2) examine the impact of health information
13 technology on providing quality care and reducing
14 the cost of care to individuals in such areas, includ-
15 ing the impact of such technology on improved
16 health outcomes for individuals, including which
17 technology worked for which population and how it
18 improved health outcomes for that population;

19 (3) examine the impact of health information
20 technology on improving health care-related deci-
21 sions by both patients and providers in such areas;

22 (4) identify specific best practices for using
23 health information technology to foster the con-
24 sistent provision of physical accessibility and reason-

1 able policy accommodations in health care to individ-
2 uals with disabilities in such areas;

3 (5) assess the feasibility and costs associated
4 with the use of health information technology in
5 such areas;

6 (6) evaluate whether the adoption and use of
7 qualified electronic health records (as described in
8 section 3000(13) of the Public Health Service Act
9 (42 U.S.C. 300jj(13)) is effective in reducing health
10 disparities, including analysis of clinical quality
11 measures reported by Medicare and Medicaid pro-
12 viders pursuant to programs to encourage the adop-
13 tion and use of Certified Electronic Health Record
14 Technology;

15 (7) identify providers in medically underserved
16 areas that are not electing to adopt and use elec-
17 tronic health records and determine what barriers
18 are preventing those providers from adopting and
19 using such records; and

20 (8) examine urban and rural community health
21 systems and determine the impact that health infor-
22 mation technology may have on the capacity of pri-
23 mary health providers in those systems.

24 (c) MEDICALLY UNDERSERVED AREA.—The term
25 “medically underserved area” means—

1 (1) a population that has been designated as a
2 medically underserved population under section
3 330(b)(3) of the Public Health Service Act (42
4 U.S.C. 254b(b)(3));

5 (2) an area that has been designated as a
6 health professional shortage area under section 332
7 of the Public Health Service Act (42 U.S.C. 254e);

8 (3) an area or population that has been des-
9 ignated as a medically underserved community under
10 section 799B(6) of the Public Health Service Act
11 (42 U.S.C. 295p(6)); or

12 (4) an area or population that—

13 (A) is not described in paragraphs (1)
14 through (3) of this subsection;

15 (B) experiences significant barriers to ac-
16 cessing quality health services; and

17 (C) has a high prevalence of diseases or
18 conditions described in title VII of this Act,
19 with such diseases or conditions having a dis-
20 proportionate impact on racial and ethnic mi-
21 nority groups (as defined in section 1707(g) of
22 the Public Health Service Act (42 U.S.C.
23 300u–6(g))) or a subgroup of people with dis-
24 abilities who have specific functional impair-
25 ments.

1 **Subtitle D—Closing Gaps in**
2 **Funding To Adopt Certified EHRs**

3 **SEC. 831. EXTENDING MEDICAID EHR INCENTIVE PAY-**
4 **MENTS TO REHABILITATION FACILITIES,**
5 **LONG-TERM CARE FACILITIES, AND HOME**
6 **HEALTH AGENCIES.**

7 Section 1903(t)(2)(B) of the Social Security Act (42
8 U.S.C. 1396b(t)(2)(B)) is amended—

9 (1) in clause (i), by striking “, or” and insert-
10 ing a semicolon;

11 (2) in clause (ii), by striking the period at the
12 end and inserting a semicolon; and

13 (3) by inserting after clause (ii) the following
14 new clauses:

15 “(iii) a rehabilitation facility (as defined in sec-
16 tion 1886(j)(1)) that furnishes acute or subacute re-
17 habilitation services;

18 “(iv) a long-term care hospital (as defined in
19 section 1886(d)(1)(B)(iv)(I)); or

20 “(v) a home health agency (as defined in sec-
21 tion 1861(o)).”.

1 **SEC. 832. EXTENDING PHYSICIAN ASSISTANT ELIGIBILITY**
2 **FOR MEDICAID ELECTRONIC HEALTH**
3 **RECORD INCENTIVE PAYMENTS.**

4 (a) **IN GENERAL.**—Section 1903(t)(3)(B)(v) of the
5 Social Security Act (42 U.S.C. 1396b(t)(3)(B)(v)) is
6 amended to read as follows:

7 “(v) physician assistant.”.

8 (b) **EFFECTIVE DATE.**—The amendment made by
9 subsection (a) shall apply with respect to amounts ex-
10 pended under section 1903(a)(3)(F) of the Social Security
11 Act (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters be-
12 ginning on or after the date of the enactment of this Act.

13 **TITLE IX—ACCOUNTABILITY**
14 **AND EVALUATION**

15 **SEC. 901. PROHIBITION ON DISCRIMINATION IN FEDERAL**
16 **ASSISTED HEALTH CARE SERVICES AND RE-**
17 **SEARCH PROGRAMS ON THE BASIS OF SEX,**
18 **RACE, COLOR, NATIONAL ORIGIN, MARITAL**
19 **STATUS, FAMILIAL STATUS, SEXUAL ORI-**
20 **ENTATION, GENDER IDENTITY, OR DIS-**
21 **ABILITY STATUS.**

22 (a) **IN GENERAL.**—No person in the United States
23 shall, on the basis of sex, race, color, national origin, mar-
24 ital status, familial status, sexual orientation, gender iden-
25 tity, or disability status, be excluded from participation
26 in, be denied the benefits of, or be subjected to discrimina-

1 tion under any health program or activity, including any
2 health research program or activity, receiving Federal fi-
3 nancial assistance.

4 (b) DEFINITION.—In this section, the term “familial
5 status” means, with respect to one or more individuals—

6 (1) being domiciled with any individual related
7 by blood or affinity whose close association with the
8 individual is the equivalent of a family relationship;

9 (2) being in the process of securing legal cus-
10 tody of any individual; or

11 (3) being pregnant.

12 **SEC. 902. TREATMENT OF MEDICARE PAYMENTS UNDER**
13 **TITLE VI OF THE CIVIL RIGHTS ACT OF 1964.**

14 A payment to a provider of services, physician, or
15 other supplier under part B, C, or D of title XVIII of
16 the Social Security Act shall be deemed a grant, and not
17 a contract of insurance or guaranty, for the purposes of
18 title VI of the Civil Rights Act of 1964.

19 **SEC. 903. ACCOUNTABILITY AND TRANSPARENCY WITHIN**
20 **THE DEPARTMENT OF HEALTH AND HUMAN**
21 **SERVICES.**

22 Title XXXIV of the Public Health Service Act, as
23 amended by titles I, II, and III of this Act, is further
24 amended by inserting after subtitle B the following:

1 **“Subtitle C—Strengthening**
2 **Accountability**

3 **“SEC. 3441. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.**

4 “(a) IN GENERAL.—The Secretary shall establish
5 within the Office for Civil Rights an Office of Health Dis-
6 parities, which shall be headed by a director to be ap-
7 pointed by the Secretary.

8 “(b) PURPOSE.—The Office of Health Disparities
9 shall ensure that the health programs, activities, and oper-
10 ations of health entities which receive Federal financial as-
11 sistance are in compliance with title VI of the Civil Rights
12 Act, which prohibits discrimination on the basis of race,
13 color, or national origin. The activities of the Office shall
14 include the following:

15 “(1) The development and implementation of
16 an action plan to address racial and ethnic health
17 care disparities, which shall address concerns relat-
18 ing to the Office for Civil Rights as released by the
19 United States Commission on Civil Rights in the re-
20 port entitled ‘Health Care Challenge: Acknowledging
21 Disparity, Confronting Discrimination, and Ensuring
22 Equity’ (September 1999) in conjunction with
23 the reports by the Institute of Medicine entitled ‘Un-
24 equal Treatment: Confronting Racial and Ethnic
25 Disparities in Health Care’, ‘Crossing the Quality

1 Chasm: A New Health System for the 21st Cen-
2 tury’, ‘In the Nation’s Compelling Interest: Ensur-
3 ing Diversity in the Health Care Workforce’, ‘The
4 National Partnership for Action to End Health Dis-
5 parities’, and ‘The Health of Lesbian, Gay, Bisexual,
6 and Transgender People’, and other related reports
7 by the Institute of Medicine. This plan shall be pub-
8 licly disclosed for review and comment and the final
9 plan shall address any comments or concerns that
10 are received by the Office.

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

14 “(3) The review of racial, ethnic, gender iden-
15 tity, sexual orientation, sex, disability status, socio-
16 economic status, and primary language health data
17 collected by Federal health agencies to assess health
18 care disparities related to intentional discrimination
19 and policies and practices that have a disparate im-
20 pact on minorities.

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

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

1 “(6) Coordination and oversight of activities of
2 the civil rights compliance offices established under
3 section 3442.

4 “(7) Ensuring—

5 “(A) at a minimum, compliance with the
6 1997 Office of Management and Budget Stand-
7 ards for Maintaining, Collecting, and Pre-
8 senting Federal Data on Race and Ethnicity;
9 and

10 “(B) consideration of available data and
11 language standards such as—

12 “(i) the standards for collecting and
13 reporting data under section 3101; and

14 “(ii) the National Standards on Cul-
15 turally and Linguistically Appropriate
16 Services of the Office of Minority Health
17 within the Department of Health and
18 Human Services.

19 “(c) FUNDING AND STAFF.—The Secretary shall en-
20 sure the effectiveness of the Office of Health Disparities
21 by ensuring that the Office is provided with—

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

24 “(2) staff with expertise in—

25 “(A) epidemiology;

1 “(B) statistics;
2 “(C) health quality assurance;
3 “(D) minority health and health dispari-
4 ties;
5 “(E) cultural and linguistic competency;
6 “(F) civil rights; and
7 “(G) social, behavioral, and economic de-
8 terminants of health.

9 “(d) REPORT.—Not later than December 31, 2019,
10 and annually thereafter, the Secretary, in collaboration
11 with the Director of the Office for Civil Rights and the
12 Deputy Assistant Secretary for Minority Health, shall
13 submit a report to the Committee on Health, Education,
14 Labor, and Pensions of the Senate and the Committee on
15 Energy and Commerce of the House of Representatives
16 that includes—

17 “(1) the number of cases filed, broken down by
18 category;

19 “(2) the number of cases investigated and
20 closed by the office;

21 “(3) the outcomes of cases investigated;

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

1 “(5) the number of other lingering and emerg-
2 ing cases in which civil rights inequities can be dem-
3 onstrated; and

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

6 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated to carry out this section
8 such sums as may be necessary for each of fiscal years
9 2019 through 2024.

10 **“SEC. 3442. ESTABLISHMENT OF HEALTH PROGRAM OF-**
11 **FICES FOR CIVIL RIGHTS WITHIN FEDERAL**
12 **HEALTH AND HUMAN SERVICES AGENCIES.**

13 “(a) IN GENERAL.—The Secretary shall establish
14 civil rights compliance offices in each agency within the
15 Department of Health and Human Services that admin-
16 isters health programs.

17 “(b) PURPOSE OF OFFICES.—Each office established
18 under subsection (a) shall ensure that recipients of Fed-
19 eral financial assistance under Federal health programs
20 administer their programs, services, and activities in a
21 manner that—

22 “(1) does not discriminate, either intentionally
23 or in effect, on the basis of race, national origin, lan-
24 guage, ethnicity, sex, age, disability, sexual orienta-
25 tion, and gender identity; and

1 “(2) promotes the reduction and elimination of
2 disparities in health and health care based on race,
3 national origin, language, ethnicity, sex, age, dis-
4 ability, sexual orientation, and gender identity.

5 “(c) POWERS AND DUTIES.—The offices established
6 in subsection (a) shall have the following powers and du-
7 ties:

8 “(1) The establishment of compliance and pro-
9 gram participation standards for recipients of Fed-
10 eral financial assistance under each program admin-
11 istered by an agency within the Department of
12 Health and Human Services including the establish-
13 ment of disparity reduction standards to encompass
14 disparities in health and health care related to race,
15 national origin, language, ethnicity, sex, age, dis-
16 ability, sexual orientation, and gender identity.

17 “(2) The development and implementation of
18 program-specific guidelines that interpret and apply
19 Department of Health and Human Services guid-
20 ance under title VI of the Civil Rights Act of 1964
21 and section 1557 of the Patient Protection and Af-
22 fordable Care Act to each Federal health program
23 administered by the agency.

24 “(3) The development of a disparity-reduction
25 impact analysis methodology that shall be applied to

1 every rule issued by the agency and published as
2 part of the formal rulemaking process under sections
3 555, 556, and 557 of title 5, United States Code.

4 “(4) Oversight of data collection, analysis, and
5 publication requirements for all recipients of Federal
6 financial assistance under each Federal health pro-
7 gram administered by the agency; compliance with,
8 at a minimum, the 1997 Office of Management and
9 Budget Standards for Maintaining, Collecting, and
10 Presenting Federal Data on Race and Ethnicity; and
11 consideration of available data and language stand-
12 ards such as—

13 “(A) the standards for collecting and re-
14 porting data under section 3101; and

15 “(B) the National Standards on Culturally
16 and Linguistically Appropriate Services of the
17 Office of Minority Health within the Depart-
18 ment of Health and Human Services.

19 “(5) The conduct of publicly available studies
20 regarding discrimination within Federal health pro-
21 grams administered by the agency as well as dis-
22 parity reduction initiatives by recipients of Federal
23 financial assistance under Federal health programs.

24 “(6) Annual reports to the Committee on
25 Health, Education, Labor, and Pensions and the

1 Committee on Finance of the Senate and the Com-
2 mittee on Energy and Commerce and the Committee
3 on Ways and Means of the House of Representatives
4 on the progress in reducing disparities in health and
5 health care through the Federal programs adminis-
6 tered by the agency.

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

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

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

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

1 “(1) under the Social Security Act (42 U.S.C.
2 301 et seq.) that pay for health care and services;
3 and

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

9 **SEC. 904. UNITED STATES COMMISSION ON CIVIL RIGHTS.**

10 (a) COORDINATION WITHIN DEPARTMENT OF JUSTICE OF ACTIVITIES REGARDING HEALTH DISPARITIES.—Section 3(a) of the Civil Rights Commission Act
11 TICE OF ACTIVITIES REGARDING HEALTH DISPARI-
12 TIES.—Section 3(a) of the Civil Rights Commission Act
13 of 1983 (42 U.S.C. 1975a(a)) is amended—

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

16 (2) in paragraph (2), by striking the period at
17 the end and inserting “; and”; and

18 (3) by adding at the end the following:

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

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

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

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

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

10 (b) **AUTHORIZATION OF APPROPRIATIONS.**—Section
11 5 of the Civil Rights Commission Act of 1983 (42 U.S.C.
12 1975c) is amended by striking the first sentence and in-
13 serting the following: “For the purpose of carrying out
14 this Act, there are authorized to be appropriated
15 \$30,000,000 for fiscal year 2019, and such sums as may
16 be necessary for each of the fiscal years 2020 through
17 2024.”.

18 **SEC. 905. SENSE OF CONGRESS CONCERNING FULL FUND-**
19 **ING OF ACTIVITIES TO ELIMINATE RACIAL**
20 **AND ETHNIC HEALTH DISPARITIES.**

21 (a) **FINDINGS.**—Congress makes the following find-
22 ings:

23 (1) The health status of the American populace
24 is declining and the United States currently ranks

1 below most industrialized nations in health status
2 measured by longevity, sickness, and mortality.

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

7 (3) Lesbian, gay, bisexual, transgender, queer,
8 and questioning (LGBTQ) populations experience
9 significant personal and structural barriers to ob-
10 taining high-quality health care.

11 (4) Efforts to improve minority health have
12 been limited by inadequate resources (funding, staff-
13 ing, and stewardship) and lack of accountability.

14 (b) SENSE OF CONGRESS.—It is the sense of Con-
15 gress that—

16 (1) health disparities negatively impact out-
17 comes for health and human security of the Nation;

18 (2) reducing racial, ethnic, sexual, and gender
19 disparities in prevention and treatment are unique
20 civil and human rights challenges and as such Fed-
21 eral agencies and health care entities and systems
22 receiving Federal funds must be accountable for
23 their role in causing disparities and inequity;

24 (3) funding should be doubled by fiscal year
25 2020 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 (4) adequate funding by fiscal year 2020, and
6 subsequent funding increases, should be provided for
7 health and human service professions training pro-
8 grams, the Racial and Ethnic Approaches to Com-
9 munity Health (REACH) Initiative at the Centers
10 for Disease Control and Prevention, the Minority
11 HIV/AIDS Initiative, and the Excellence Centers to
12 Eliminate Ethnic/Racial Disparities (EXCEED)
13 Program at the Agency for Healthcare Research and
14 Quality;

15 (5) funding should be fully restored to the Ra-
16 cial and Ethnic Approaches to Community Health
17 (REACH) Initiative at the Centers for Disease Con-
18 trol and Prevention, which has been a successful
19 program at the community health level, and efforts
20 should continue to place a strong emphasis on build-
21 ing community capacity to secure financial resources
22 and technical assistance to eliminate health dispari-
23 ties;

24 (6) adequate funding for fiscal year 2020 and
25 increased funding for future years should be pro-

1 vided for the REACH Initiative’s United States Risk
2 Factor Survey to ensure adequate data collection to
3 track health disparities, and there should be appro-
4 priate avenues provided to disseminate findings to
5 the general public;

6 (7) current and newly created health disparity
7 elimination incentives, programs, agencies, and de-
8 partments under this Act (and the amendments
9 made by this Act) should receive adequate staffing
10 and funding by fiscal year 2020; and

11 (8) stewardship and accountability should be
12 provided to the Congress and the President for
13 measurable and sustainable progress toward health
14 disparity elimination.

15 **SEC. 906. GAO AND NIH REPORTS.**

16 (a) GAO REPORT ON NIH GRANT RACIAL AND ETH-
17 NIC DIVERSITY.—

18 (1) IN GENERAL.—The Comptroller General of
19 the United States shall conduct a study on the racial
20 and ethnic diversity among the following groups:

21 (A) All applicants for grants, contracts,
22 and cooperative agreements awarded by the Na-
23 tional Institutes of Health during the period be-
24 ginning on January 1, 2006, and ending De-
25 cember 31, 2017.

1 (B) All recipients of such grants, con-
2 tracts, and cooperative agreements.

3 (C) All members of the peer review panels
4 of such applicants and recipients, respectively.

5 (2) REPORT.—Not later than six months after
6 the date of the enactment of this Act, the Comp-
7 troller General shall complete the study under para-
8 graph (1) and submit to Congress a report con-
9 taining the results of such study.

10 (b) NIH REPORT ON CERTAIN AUTHORITY OF NA-
11 TIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH
12 DISPARITIES.—Not later than six months after the date
13 of the enactment of this Act, and biennially thereafter, the
14 Director of the National Institutes of Health, in collabora-
15 tion with the Director of the National Institute on Minor-
16 ity Health and Health Disparities, shall submit to Con-
17 gress a report that details and evaluates—

18 (1) the steps taken during the applicable report
19 period by the Director of the National Institutes of
20 Health to enforce the expanded planning, coordina-
21 tion, review, and evaluation authority provided the
22 National Institute on Minority Health and Health
23 Disparities under section 464z–3(h) of the Public
24 Health Service Act (42 U.S.C. 285(h)), as added by
25 section 10334(c) of the Patient Protection and Af-

1 fordable Care Act, over all minority health and
2 health disparity research that is conducted or sup-
3 ported by the Institutes and Centers at the National
4 Institutes of Health; and

5 (2) the outcomes of such steps.

6 (c) GAO REPORT RELATED TO RECIPIENTS OF
7 PPACA FUNDING.—Not later than one year after the
8 date of the enactment of this Act and biennially thereafter
9 until 2022, the Comptroller General of the United States
10 shall submit to Congress a report that identifies—

11 (1) the racial and ethnic diversity of commu-
12 nity-based organizations that applied for Federal en-
13 rollment funding provided pursuant to the provisions
14 of (and amendments made by) the Patient Protec-
15 tion and Affordable Care Act;

16 (2) the percentage of such organizations that
17 were awarded such funding; and

18 (3) the impact of such community-based organi-
19 zations' enrollment efforts on the insurance status of
20 their communities.

21 (d) ANNUAL REPORT ON ACTIVITIES OF NATIONAL
22 INSTITUTE ON MINORITY HEALTH AND HEALTH DIS-
23 PARITIES.—The Director of the National Institute on Mi-
24 nority Health and Health Disparities shall prepare an an-
25 nual report on the activities carried out or to be carried

1 out by the Institute, and shall submit each such report
2 to the Committee on Health, Education, Labor, and Pen-
3 sions of the Senate, the Committee on Energy and Com-
4 merce of the House of Representatives, the Secretary of
5 Health and Human Services, and the Director of the Na-
6 tional Institutes of Health. With respect to the fiscal year
7 involved, the report shall—

8 (1) describe and evaluate the progress made in
9 health disparities research conducted or supported
10 by institutes and centers of the National Institutes
11 of Health;

12 (2) summarize and analyze expenditures made
13 for activities with respect to health disparities re-
14 search conducted or supported by the National Insti-
15 tutes of Health;

16 (3) include a separate statement applying the
17 requirements of paragraphs (1) and (2) specifically
18 to minority health disparities research; and

19 (4) contain such recommendations as the Direc-
20 tor of the Institute considers appropriate.

1 **TITLE X—ADDRESSING SOCIAL**
2 **DETERMINANTS AND IM-**
3 **PROVING ENVIRONMENTAL**
4 **JUSTICE**

5 **Subtitle A—In General**

6 **SEC. 1001. DEFINITIONS.**

7 (a) **DETERMINANTS OF HEALTH.**—The term “deter-
8 minants of health”—

9 (1) refers to the range of personal, social, eco-
10 nomic, and environmental factors that influence
11 health status; and

12 (2) includes social determinants of health
13 (which are sometimes referred to as “social and eco-
14 nomic determinants of health” or “socioeconomic de-
15 terminants of health”), environmental determinants
16 of health, and personal determinants of health.

17 (b) **ENVIRONMENTAL DETERMINANTS OF**
18 **HEALTH.**—The term “environmental determinants of
19 health” refers to the broad physical, psychological, social,
20 and aesthetic environment.

21 (c) **PERSONAL DETERMINANTS OF HEALTH.**—The
22 term “personal determinants of health” refers to an indi-
23 vidual’s behavior, biology, and genetics.

24 (d) **SOCIAL DETERMINANTS OF HEALTH.**—The term
25 “social determinants of health” refers to a subset of deter-

1 minants of the health of individuals and environments
2 (such as communities, neighborhoods, and societies) that
3 describe people's social identity, describe the social and
4 economic resources to which people have access, and de-
5 scribe the conditions in which people work, live, and play.

6 **SEC. 1002. FINDINGS.**

7 The Congress finds as follows:

8 (1) There are more opportunities to improve
9 health for everyone when we understand that health
10 starts, first, not in a medical setting, but in our
11 families, in our schools and workplaces, in our
12 neighborhoods, and in the air we breathe and water
13 we drink.

14 (2) The social determinants of health are the
15 largest predictors of health outcomes.

16 (3) Healthy People 2020 identifies health and
17 health care quality as a function of not only access
18 to health care, but also the social determinants of
19 health, categorized into the following: neighborhoods
20 and the built environment; social and community
21 context; education; and economic stability. The fol-
22 lowing examples illustrate the nexus between the un-
23 equal distribution of the social determinants of
24 health and health disparities:

1 (A) The built environment influences resi-
2 dents' level of physical activity. Neighborhoods
3 with high levels of poverty are significantly less
4 likely to have places where children can be
5 physically active, such as parks, green spaces,
6 and bike paths and lanes. Neighborhoods and
7 communities can provide opportunities for phys-
8 ical activity and support active lifestyles
9 through accessible and safe parks and open
10 spaces and through land use policy, zoning, and
11 healthy community design.

12 (B) Emotional and physical health and
13 well-being are directly impacted by perceived
14 levels of safety, such as unlit streets at night.
15 Community members have expressed that safety
16 is not only a barrier to accessing programs and
17 services that increase quality of life but they
18 are also not able to access physical activity in
19 their community through the built environment.

20 (C) In many workplace environments, toxic
21 chemicals have lasting detrimental effects on
22 employees' health. The hazardous compounds
23 found in most nail salon products affect the
24 respiratory system, reproductive system, and
25 central nervous system, and also cause kidney

1 and liver damage. Recognizing the importance
2 of addressing occupational hazards as a matter
3 of public health, especially for Asian-American
4 women who constitute 40 percent of nail salon
5 technicians—with Vietnamese-American women
6 accounting for 37 percent of this—the White
7 House Initiative on Asian American Pacific Is-
8 landers has created an interagency working
9 group to coordinate efforts by the Environ-
10 mental Protection Agency, Occupational and
11 Safety Health Administration, Food and Drug
12 Administration, and other Federal agencies to
13 create programming, draft regulations, and con-
14 duct more outreach on educating workers on
15 health and safety issues.

16 (D) Historical and institutional discrimina-
17 tion against certain racial groups in the United
18 States has shaped the way in which social and
19 economic resources and exposure to health pro-
20 moting environments are distributed. Income,
21 education, occupation, neighborhood conditions,
22 schools, workplaces, the use of and health and
23 social services, and experiences with the crimi-
24 nal justice system are all highly patterned by
25 race, with racial minorities (compared to

1 Whites) experiencing more that is health harm-
2 ing. Finding ways to uncouple the link between
3 race and access to resources and healthy envi-
4 ronments is a principal means of reducing
5 health disparities. Additionally, the anticipation
6 of racism itself causes higher psychological and
7 cardiovascular stress levels that are linked to
8 poor health outcomes. Remedying discrimina-
9 tory practices at the individual and systemic
10 levels will likely reduce health disparities caused
11 by this unequal distribution of stress.

12 (E) Poor health among Native Americans
13 has largely been driven by post-colonial oppres-
14 sion and historical trauma. The expropriation of
15 native lands and territories to the American
16 state had severe consequences on Native Amer-
17 ican health. This resulted in the deprivation of
18 traditional food sources—and nutrients—for
19 Native Americans and also the destruction of
20 traditional economies and community organiza-
21 tion. Today, Native Americans have twice the
22 rate of diabetes than non-Hispanic Whites. Rec-
23 ognition of the origins of the diabetes as having
24 a social and community context, rather than
25 just individual responsibility and genetic pre-

1 disposition, will shape better policy to provide
2 food security.

3 (F) In the context of prisons, overcrowding
4 has led to the deterioration of the physical and
5 mental health of individuals after they leave
6 prison. In particular, the mass incarceration of
7 African-American males as a result of unequal
8 contact with and treatment in the criminal jus-
9 tice system has contributed to an overburdening
10 of certain infectious diseases within the African-
11 American community. As a social institution,
12 incarceration amplifies existing adverse health
13 conditions by concentrating diseases and harm
14 health behaviors such as tobacco use, drug use,
15 and violence.

16 (G) Educational attainment is the strong-
17 est predictor of adult mortality. It is a basic
18 component of socioeconomic status by shaping
19 earning potential to access resources that pro-
20 mote health. People with more education are
21 less likely to report that they are in poor health,
22 and are also less likely to have diabetes and
23 other chronic diseases.

24 (H) Similarly, reading ability is a strong
25 predictor of adult health status and is often

1 correlated with other child health issues, such
2 as developmental problems, vision and hearing
3 impairments, and frequent school absence due
4 to illness.

5 (I) Individuals with lower levels of edu-
6 cational attainment are much more likely to re-
7 port to be current smokers. In 2015, smoking
8 prevalence was 34.1 percent among adults with
9 a GED diploma, 24.2 percent with less than a
10 high school diploma, and 19.8 percent with a
11 high school diploma, while dropping signifi-
12 cantly to 7.4 percent among adults with an un-
13 dergraduate college degree and 3.6 percent with
14 a postgraduate college degree.

15 (J) Social class differences account for a
16 large part of health disparities. For example,
17 children living in poverty experience poorer
18 housing conditions, increased exposure to in-
19 door allergens and toxins (such as pesticides,
20 lead, mercury, radon, air pollution, and carcino-
21 gens), and more psychological stress. These ex-
22 periences culminate in worse adult health as
23 compared with children with higher socio-
24 economic status. Specifically, children living in
25 socioeconomic neighborhoods have higher rates

1 of asthma due to higher rates of psychological
2 stress resulting from higher rates of violence.

3 (K) Lesbian, gay, bisexual, transgender,
4 queer, questioning, questioning and intersex
5 (LGBTQIA) individuals face health disparities
6 linked to societal stigma, discrimination, and
7 denial of their civil and human rights. Discrimi-
8 nation against LGBTQIA individuals has been
9 associated with high rates of psychiatric dis-
10 orders, substance abuse, and suicide. Experi-
11 ences of violence and victimization are frequent
12 for LGBTQIA individuals, and have long-last-
13 ing effects on the individual and the commu-
14 nity. Personal, family, and social acceptance of
15 sexual orientation and gender identity affects
16 the mental health and personal safety of
17 LGBTQIA individuals.

18 (L) Individuals in older and cheaper hous-
19 ing are at higher risks to be exposed to lead,
20 particularly in housing built prior to 1960. The
21 threat of lead poisoning disproportionately af-
22 fects vulnerable populations, with children living
23 in poverty (5.6 percent) and Black children
24 (5.6) experiencing the highest rates. According
25 to the Department of Housing and Urban De-

1 velopment, about 3.6 million homes nationwide
2 that house young children have lead hazards
3 such as peeling paint, contaminated dust, or
4 toxic soil. The combined cost of medical treat-
5 ment and special education for lead poisoned
6 children averages about \$5,600 per child per
7 year, and lead poisoning costs the United
8 States an estimated \$50 billion annually.

9 (4) Laws and regulations that improve opportu-
10 nities to live in safe neighborhoods, with more social
11 cohesion, attain higher education, sustain stable em-
12 ployment, and bridge class differences help foster
13 the health and safety of individuals.

14 (5) The global public health community has
15 reached consensus through the Rio Political Declara-
16 tion of Social Determinants of Health that
17 “[c]ollaboration in coordinated and intersectoral pol-
18 icy actions has proven to be effective. Health in All
19 Policies, together with intersectoral cooperation and
20 action, is one promising approach to enhance ac-
21 countability in other sectors of health, as well as the
22 promotion of health equity and more inclusive and
23 productive societies.”.

1 **SEC. 1003. HEALTH IMPACT ASSESSMENTS.**

2 (a) FINDINGS.—Congress makes the following find-
3 ings:

4 (1) Health Impact Assessment is a tool to help
5 planners, health officials, decisionmakers, and the
6 public make more informed decisions about the po-
7 tential health effects of proposed plans, policies, pro-
8 grams, and projects in order to maximize health
9 benefits and minimize harms.

10 (2) Health Impact Assessments can be done at
11 a fraction of the cost and time typically required for
12 other planning and permitting reviews.

13 (3) Health Impact Assessments can build com-
14 munity support and reduce opposition to a project or
15 policy, thereby facilitating economic growth by aid-
16 ing the development of consensus regarding new de-
17 velopment proposals.

18 (4) Health Impact Assessments facilitate col-
19 laboration across sectors.

20 (b) PURPOSES.—It is the purpose of this section to—

21 (1) provide more information about the poten-
22 tial human health effects of policy decisions and the
23 distribution of those effects;

24 (2) improve how health is considered in plan-
25 ning and decisionmaking processes; and

1 (3) build stronger, healthier communities
2 through the use of Health Impact Assessment.

3 (c) HEALTH IMPACT ASSESSMENTS.—Part P of title
4 III of the Public Health Service Act (42 U.S.C. 280g et
5 seq.), as amended, is further amended by adding at the
6 end the following:

7 **“SEC. 399V–12. HEALTH IMPACT ASSESSMENTS.**

8 “(a) DEFINITIONS.—In this section and section
9 399V–13:

10 “(1) ADMINISTRATOR.—The term ‘Adminis-
11 trator’ means the Administrator of the Environ-
12 mental Protection Agency.

13 “(2) BUILT ENVIRONMENT.—The term ‘built
14 environment’ means the components of the environ-
15 ment, and the location of these components in a geo-
16 graphically defined space, that are created or modi-
17 fied by individuals to form the physical and social
18 characteristics of a community or enhance quality of
19 human life, including—

20 “(A) homes, schools, and places of work
21 and worship;

22 “(B) parks, recreation areas, and green-
23 ways;

24 “(C) transportation systems;

1 “(D) business, industry, and agriculture;
2 and

3 “(E) land-use plans, projects, and policies
4 that impact the physical or social characteris-
5 tics of a community, including access to services
6 and amenities.

7 “(3) DIRECTOR.—The term ‘Director’ means
8 the Director of the Centers for Disease Control and
9 Prevention.

10 “(4) ELIGIBLE ENTITY.—The term ‘eligible en-
11 tity’ means a unit of State or Tribal government the
12 jurisdiction of which includes individuals or popu-
13 lations the health of which are, or will be, affected
14 by an activity or a proposed activity.

15 “(5) ELIGIBLE INSTITUTION.—The term ‘eligi-
16 ble institution’ means a public agency or private
17 nonprofit institution that submits to the Secretary,
18 in consultation with the Administrator, an applica-
19 tion for a grant authorized under such section at
20 such time, in such manner, and containing such
21 agreements, assurances, and information as the Sec-
22 retary and Administrator may require.

23 “(6) HEALTH IMPACT ASSESSMENT.—The term
24 ‘Health Impact Assessment’ means a systematic
25 process that uses an array of data sources and ana-

1 lytic methods and considers input from stakeholders
2 to determine the potential effects of a proposed pol-
3 icy, plan, program, or project on the health of a pop-
4 ulation and the distribution of those effects within
5 the population. Such term includes identifying and
6 recommending appropriate actions on monitoring
7 and maximizing potential benefits and minimizing
8 the potential harms.

9 “(7) HEALTH DISPARITIES.—The term ‘health
10 disparities’ are a particular type of health dif-
11 ferences that are closely linked with social, economic,
12 and/or environmental disadvantage. Health dispari-
13 ties adversely affect groups of people who have sys-
14 tematically experienced greater obstacles to health
15 based on their racial or ethnic group; religion; socio-
16 economic status; gender; age; mental health; cog-
17 nitive, sensory, or physical disability; sexual orienta-
18 tion or gender identity; geographic location; or other
19 characteristics historically linked to discrimination
20 or exclusion.

21 “(8) PROPOSED ACTIVITY.—The term ‘proposed
22 activity’ means a proposed policy, program, plan, or
23 project currently under consideration by a local,
24 State, Tribal, or Federal agency or government.

1 “(b) ESTABLISHMENT.—The Secretary, acting
2 through the Director and in collaboration with the Admin-
3 istrator, shall carry out the following:

4 “(1) Establish a program at the National Cen-
5 ter for Environmental Health at the Centers for Dis-
6 ease Control and Prevention focused on advancing
7 the field of Health Impact Assessment. In devel-
8 oping and implementing the program, the Director
9 of the National Center for Environmental Health
10 shall consult with the Director of the National Cen-
11 ter for Chronic Disease Prevention and Health Pro-
12 motion as well as relevant offices within the Depart-
13 ment of Housing and Urban Development, the De-
14 partment of Transportation, and the Department of
15 Agriculture. The program shall include—

16 “(A) collecting and disseminating best
17 practices;

18 “(B) administering capacity building
19 grants to States to support grantees in initi-
20 ating Health Impact Assessments, in accord-
21 ance with subsection (d);

22 “(C) providing technical assistance;

23 “(D) developing training tools and pro-
24 viding training on conducting Health Impact

1 Assessment and the implementation of built en-
2 vironment and health indicators;

3 “(E) making information available, as ap-
4 propriate, regarding the existence of other com-
5 munity healthy living tools, checklists, and indi-
6 ces that help connect public health to other sec-
7 tors, and tools to help examine the effect of the
8 indoor built environment and building codes on
9 population health;

10 “(F) conducting research and evaluations
11 of Health Impact Assessments; and

12 “(G) awarding competitive extramural re-
13 search grants.

14 “(2) In accordance with subsection (c), develop
15 guidance and guidelines to conduct Health Impact
16 Assessments.

17 “(3) In accordance with subsection (d), estab-
18 lish a grant program to allow States to fund eligible
19 entities to conduct Health Impact Assessments.

20 “(c) GUIDANCE.—The Director, in consultation with
21 the Director of the National Center for Environmental
22 Health and, the Director of the National Center for
23 Chronic Disease Prevention and Health Promotion, and
24 relevant offices within the Department of Housing and

1 Urban Development, the Department of Transportation,
2 and the Department of Agriculture, shall—

3 “(1) develop guidance for conducting Health
4 Impact Assessment, including—

5 “(A) background on national and inter-
6 national efforts to bridge urban planning and
7 public health institutions and disciplines, in-
8 cluding a review of Health Impact Assessment
9 best practices internationally;

10 “(B) evidence-based direct and indirect
11 pathways that link land-use planning, transpor-
12 tation, and housing policy and objectives to
13 human health outcomes;

14 “(C) data resources and quantitative and
15 qualitative forecasting methods to evaluate both
16 the status of health determinants and health ef-
17 fects, including identification of existing pro-
18 grams that can disseminate these resources;

19 “(D) best practices for inclusive public in-
20 volvement in conducting Health Impact Assess-
21 ments; and

22 “(E) technical assistance for other agen-
23 cies seeking to develop their own guidelines and
24 procedures for Health Impact Assessment;

1 “(2) in developing the guidance, consider avail-
2 able international Health Impact Assessment guid-
3 ance, North American Health Impact Assessment
4 Practice Standards, and recommendations from the
5 National Academy of Science; and

6 “(3) not later than 1 year after the date of en-
7 actment of this section, publish the guidance.

8 “(d) GRANT PROGRAM.—The Secretary, acting
9 through the Director and in collaboration with the Admin-
10 istrator, shall establish a program under which the Sec-
11 retary shall award grants to States to fund eligible entities
12 for capacity building or to prepare Health Impact Assess-
13 ments, and shall ensure that States receiving a grant
14 under this subsection further support training and tech-
15 nical assistance for grantees under the program by fund-
16 ing and overseeing appropriate local, State, Tribal, Fed-
17 eral, university, or nonprofit Health Impact Assessment
18 experts to provide technical assistance. Such assessments
19 shall—

20 “(1) ensure that appropriate health factors are
21 taken into consideration as early as practicable dur-
22 ing the planning, review, or decisionmaking proc-
23 esses;

24 “(2) assess the effect on the health of individ-
25 uals and populations of proposed policies, projects,

1 or plans that result in modifications to the built en-
2 vironment; and

3 “(3) assess the distribution of health effects
4 across various factors, such as race, income, eth-
5 nicity, age, disability status, gender, and geography.

6 “(e) APPLICATIONS.—

7 “(1) IN GENERAL.—To be eligible to receive a
8 grant under this section, an eligible entity shall sub-
9 mit to the Secretary an application in accordance
10 with this subsection, at such time, in such manner,
11 and containing such additional information as the
12 Secretary may require.

13 “(2) INCLUSION.—An application under this
14 subsection shall include a list of proposed activities
15 that require or would benefit from conducting a
16 Health Impact Assessment within six months of
17 awarding funds. The list should be accompanied by
18 supporting documentation, including letters of sup-
19 port, from potential conductors of Health Impact
20 Assessments for the listed proposed activities. Each
21 application should also include an assessment by the
22 eligible entity of the health of the population of its
23 jurisdiction and describe potential adverse or positive
24 effects on health that the proposed activities may
25 create.

1 “(3) PREFERENCE.—Preference in awarding
2 funds under this section may be given to eligible en-
3 tities that demonstrate the potential to significantly
4 improve population health or lower health care costs
5 as a result of potential Health Impact Assessment
6 work.

7 “(f) USE OF FUNDS.—

8 “(1) IN GENERAL.—An eligible entity shall use
9 amounts provided under a grant under this section
10 to conduct Health Impact Assessment capacity
11 building or to conduct or fund subgrantees to con-
12 duct a Health Impact Assessment for a proposed ac-
13 tivity in accordance with this subsection.

14 “(2) PURPOSES.—The purposes of a Health
15 Impact Assessment under this subsection are—

16 “(A) to facilitate the involvement of Tribal,
17 State, and local public health officials in com-
18 munity planning, transportation, housing, and
19 land use decisions and other decisions affecting
20 the built environment to identify any potential
21 health concern or health benefit relating to an
22 activity or proposed activity;

23 “(B) to provide for an investigation of any
24 health-related issue of concern raised in a plan-
25 ning process, an environmental impact assess-

1 ment process, or policy appraisal relating to a
2 proposed activity;

3 “(C) to describe and compare alternatives
4 (including no-action alternatives) to a proposed
5 activity to provide clarification with respect to
6 the potential health outcomes associated with
7 the proposed activity and, where appropriate, to
8 the related benefit-cost or cost-effectiveness of
9 the proposed activity and alternatives;

10 “(D) to contribute, when applicable, to the
11 findings of a planning process, policy appraisal,
12 or an environmental impact statement with re-
13 spect to the terms and conditions of imple-
14 menting a proposed activity or related mitiga-
15 tion recommendations, as necessary;

16 “(E) to ensure that the disproportionate
17 distribution of negative impacts among vulner-
18 able populations is minimized as much as pos-
19 sible;

20 “(F) to engage affected community mem-
21 bers and ensure adequate opportunity for public
22 comment on all stages of the Health Impact As-
23 sessment;

24 “(G) where appropriate, to consult with
25 local and county health departments and appro-

1 appropriate organizations, including planning, trans-
2 portation, and housing organizations and pro-
3 viding them with information and tools regard-
4 ing how to conduct and integrate Health Im-
5 pact Assessment into their work; and

6 “(H) to inspect homes, water systems, and
7 other elements that pose risks to lead exposure,
8 with an emphasis on areas that pose a higher
9 risk to children.

10 “(3) ELIGIBLE ACTIVITIES.—

11 “(A) IN GENERAL.—Eligible entities fund-
12 ed under this subsection shall conduct an eval-
13 uation of any proposed activity to determine
14 whether it will have a significant adverse or
15 positive effect on the health of the affected pop-
16 ulation in the jurisdiction of the eligible entity,
17 based on the criteria described in subparagraph
18 (B).

19 “(B) CRITERIA.—The criteria described in
20 this subparagraph include, as applicable to the
21 proposed activity, the following:

22 “(i) Any substantial adverse effect or
23 significant health benefit on health out-
24 comes or factors known to influence health,
25 including the following:

1 “(I) Physical activity.

2 “(II) Injury.

3 “(III) Mental health.

4 “(IV) Accessibility to health-pro-
5 moting goods and services.

6 “(V) Respiratory health.

7 “(VI) Chronic disease.

8 “(VII) Nutrition.

9 “(VIII) Land use changes that
10 promote local, sustainable food
11 sources.

12 “(IX) Infectious disease.

13 “(X) Health disparities.

14 “(XI) Existing air quality,
15 ground or surface water quality or
16 quantity, or noise levels.

17 “(XII) Lead exposure.

18 “(ii) Other factors that may be con-
19 sidered, including—

20 “(I) the potential for a proposed
21 activity to result in systems failure
22 that leads to a public health emer-
23 gency;

24 “(II) the probability that the pro-
25 posed activity will result in a signifi-

1 cant increase in tourism, economic de-
2 velopment, or employment in the ju-
3 risdiction of the eligible entity;

4 “(III) any other significant po-
5 tential hazard or enhancement to
6 human health, as determined by the
7 eligible entity; or

8 “(IV) whether the evaluation of a
9 proposed activity would duplicate an-
10 other analysis or study being under-
11 taken in conjunction with the pro-
12 posed activity.

13 “(C) FACTORS FOR CONSIDERATION.—In
14 evaluating a proposed activity under subpara-
15 graph (A), an eligible entity may take into con-
16 sideration any reasonable, direct, indirect, or
17 cumulative effect that can be clearly related to
18 potential health effects and that is related to
19 the proposed activity, including the effect of
20 any action that is—

21 “(i) included in the long-range plan
22 relating to the proposed activity;

23 “(ii) likely to be carried out in coordi-
24 nation with the proposed activity;

1 “(iii) dependent on the occurrence of
2 the proposed activity; or

3 “(iv) likely to have a disproportionate
4 impact on high-risk or vulnerable popu-
5 lations.

6 “(4) REQUIREMENTS.—A Health Impact As-
7 sessment prepared with funds awarded under this
8 subsection shall incorporate the following, after con-
9 ducting the screening phase (identifying projects or
10 policies for which a Health Impact Assessment
11 would be valuable and feasible) through the applica-
12 tion process:

13 “(A) SCOPING.—Identifying which health
14 effects to consider and the research methods to
15 be utilized.

16 “(B) ASSESSING RISKS AND BENEFITS.—
17 Assessing the baseline health status and factors
18 known to influence the health status in the af-
19 fected community, which may include aggreg-
20 gating and synthesizing existing health assess-
21 ment evidence and data from the community.

22 “(C) DEVELOPING RECOMMENDATIONS.—
23 Suggesting changes to proposals to promote
24 positive or mitigate adverse health effects.

1 “(D) REPORTING.—Synthesizing the as-
2 sessment and recommendations and commu-
3 nicating the results to decisionmakers.

4 “(E) MONITORING AND EVALUATING.—
5 Tracking the decision and implementation effect
6 on health determinants and health status.

7 “(5) PLAN.—An eligible entity that is awarded
8 a grant under this section shall develop and imple-
9 ment a plan, to be approved by the Director, for
10 meaningful and inclusive stakeholder involvement in
11 all phases of the Health Impact Assessment. Stake-
12 holders may include community-based organizations,
13 youth-serving organizations, planners, public health
14 experts, State and local public health departments
15 and officials, health care experts or officials, housing
16 experts or officials, and transportation experts or of-
17 ficials.

18 “(6) SUBMISSION OF FINDINGS.—An eligible
19 entity that is awarded a grant under this section
20 shall submit the findings of any funded Health Im-
21 pact Assessment activities to the Secretary and
22 make these findings publicly available.

23 “(7) ASSESSMENT OF IMPACTS.—An eligible en-
24 tity that is awarded a grant under this section shall
25 ensure the assessment of the distribution of health

1 impacts (related to the proposed activity) across
2 race, ethnicity, income, age, gender, disability status,
3 and geography.

4 “(8) CONDUCT OF ASSESSMENT.—To the great-
5 est extent feasible, a Health Impact Assessment
6 shall be conducted under this section in a manner
7 that respects the needs and timing of the decision-
8 making process it evaluates.

9 “(9) METHODOLOGY.—In preparing a Health
10 Impact Assessment under this subsection, an eligible
11 entity or partner shall follow the guidance published
12 under subsection (c).

13 “(g) HEALTH IMPACT ASSESSMENT DATABASE.—
14 The Secretary, acting through the Director and in collabo-
15 ration with the Administrator, shall establish, maintain,
16 and make publicly available a Health Impact Assessment
17 database, including—

18 “(1) a catalog of Health Impact Assessments
19 received under this section;

20 “(2) an inventory of tools used by eligible enti-
21 ties to conduct Health Impact Assessments; and

22 “(3) guidance for eligible entities with respect
23 to the selection of appropriate tools described in
24 paragraph (2).

1 “(h) EVALUATION OF GRANTEE ACTIVITIES.—The
2 Secretary shall award competitive grants to Prevention
3 Research Centers, or nonprofit organizations or academic
4 institutions with expertise in Health Impact Assessments
5 to—

6 “(1) assist grantees with the provision of train-
7 ing and technical assistance in the conducting of
8 Health Impact Assessments;

9 “(2) evaluate the activities carried out with
10 grants under subsection (d); and

11 “(3) assist the Secretary in disseminating evi-
12 dence, best practices, and lessons learned from
13 grantees.

14 “(i) REPORT TO CONGRESS.—Not later than 1 year
15 after the date of enactment of this section, the Secretary
16 shall submit to Congress a report concerning the evalua-
17 tion of the programs under this section, including rec-
18 ommendations as to how lessons learned from such pro-
19 grams can be incorporated into future guidance docu-
20 ments developed and provided by the Secretary and other
21 Federal agencies, as appropriate.

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

1 **“SEC. 399V-13. IMPLEMENTATION OF RESEARCH FINDINGS**
2 **TO IMPROVE HEALTH OUTCOMES THROUGH**
3 **THE BUILT ENVIRONMENT.**

4 “(a) RESEARCH GRANT PROGRAM.—

5 “(1) GRANTS.—The Secretary, in collaboration
6 with the Administrator, shall award grants to eligi-
7 ble institutions to implement evidence-based pro-
8 gramming to improve the built environment and sub-
9 sequently human health. Factors that influence
10 health that may be considered include—

11 “(A) levels of physical activity;

12 “(B) consumption of nutritional foods;

13 “(C) rates of crime;

14 “(D) air, water, and soil quality;

15 “(E) risk or rate of injury;

16 “(F) accessibility to health-promoting
17 goods and services;

18 “(G) chronic disease rates;

19 “(H) community design;

20 “(I) housing; and

21 “(J) other indicators as determined appro-
22 priate by the Secretary.

23 “(2) RESEARCH.—The Secretary, in consulta-
24 tion with the Administrator, shall support research
25 under this section that—

1 “(A) uses evidence-based research to im-
2 prove the built environment and human health;

3 “(B) examines—

4 “(i) the scope and intensity of the im-
5 pact that the built environment (including
6 the various characteristics of the built en-
7 vironment) has on the human health; or

8 “(ii) the distribution of such impacts
9 by—

10 “(I) location; and

11 “(II) population subgroup;

12 “(C) is used to develop—

13 “(i) measures and indicators to ad-
14 dress health impacts and the connection of
15 health to the built environment;

16 “(ii) efforts to link the measures to
17 transportation, land use, and health data-
18 bases; and

19 “(iii) efforts to enhance the collection
20 of built environment surveillance data;

21 “(D) distinguishes carefully between per-
22 sonal attitudes and choices and external influ-
23 ences on behavior to determine how much the
24 association between the built environment and
25 the health of residents, versus the lifestyle pref-

1 erences of the people that choose to live in the
2 neighborhood, reflects the physical characteris-
3 tics of the neighborhood; and

4 “(E)(i) identifies or develops effective
5 intervention strategies focusing on enhance-
6 ments to the built environment that promote in-
7 creased use physical activity, access to nutri-
8 tious foods, or other health-promoting activities
9 by residents; and

10 “(ii) in developing the intervention strate-
11 gies under clause (i), ensures that the interven-
12 tion strategies will reach out to high-risk or vul-
13 nerable populations, including low-income urban
14 and rural communities and aging populations,
15 in addition to the general population.

16 “(3) SURVEYS.—The Secretary may use funds
17 appropriated under this section to support the ex-
18 pansion of national surveys and data tracking sys-
19 tems to provide more detailed information about the
20 connection between the built environment and
21 health.

22 “(4) PRIORITY.—In providing assistance under
23 the grant program under this section, the Secretary
24 and the Administrator shall give priority to pro-
25 gramming that incorporates—

1 “(A) interdisciplinary approaches; or

2 “(B) the expertise of the public health,
3 physical activity, urban planning, land use, and
4 transportation research communities in the
5 United States and abroad.

6 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated such sums as may be
8 necessary to carry out this section. Not to exceed 20 per-
9 cent of amounts appropriated for each fiscal year under
10 this subsection may be used for the research component
11 of the program under this section.”.

12 **SEC. 1004. IMPLEMENTATION OF RECOMMENDATIONS BY**
13 **ENVIRONMENTAL PROTECTION AGENCY.**

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

21 (1) The recommendation that the Agency’s pro-
22 gram and regional offices identify which programs,
23 policies, and activities need environmental justice re-
24 views and require these offices to establish a plan to
25 complete the necessary reviews.

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

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

11 (4) The recommendation that the Administrator
12 designate a responsible office to compile results of
13 environmental justice reviews and recommend appro-
14 priate actions.

15 (b) GAO RECOMMENDATIONS.—In developing rules
16 under laws administered by the Environmental Protection
17 Agency, the Administrator of the Agency shall, as prompt-
18 ly as practicable, carry out each of the following rec-
19 ommendations of the Comptroller General of the United
20 States as set forth in GAO Report numbered GAO-05-
21 289 entitled “EPA Should Devote More Attention to En-
22 vironmental Justice when Developing Clean Air Rules”:

23 (1) The recommendation that the Administrator
24 ensure that workgroups involved in developing a rule

1 devote attention to environmental justice while draft-
2 ing and finalizing the rule.

3 (2) The recommendation that the Administrator
4 enhance the ability of such workgroups to identify
5 potential environmental justice issues through such
6 steps as providing workgroup members with guid-
7 ance and training to help them identify potential en-
8 vironmental justice problems and involving environ-
9 mental justice coordinators in the workgroups when
10 appropriate.

11 (3) The recommendation that the Administrator
12 improve assessments of potential environmental jus-
13 tice impacts in economic reviews by identifying the
14 data and developing the modeling techniques needed
15 to assess such impacts.

16 (4) The recommendation that the Administrator
17 direct appropriate Agency officers and employees to
18 respond fully when feasible to public comments on
19 environmental justice, including improving the Agen-
20 cy's explanation of the basis for its conclusions, to-
21 gether with supporting data.

22 (c) 2004 INSPECTOR GENERAL REPORT.—The Ad-
23 ministrator of the Environmental Protection Agency shall,
24 as promptly as practicable, carry out each of the following
25 recommendations of the Inspector General of the Agency

1 as set forth in the report entitled “EPA Needs to Consist-
2 ently Implement the Intent of the Executive Order on En-
3 vironmental Justice” (Report No. 2004–P–00007):

4 (1) The recommendation that the Agency clear-
5 ly define the mission of the Office of Environmental
6 Justice (OEJ) and provide Agency staff with an un-
7 derstanding of the roles and responsibilities of the
8 Office.

9 (2) The recommendation that the Agency estab-
10 lish (through issuing guidance or a policy statement
11 from the Administrator) specific timeframes for the
12 development of definitions, goals, and measurements
13 regarding environmental justice and provide the re-
14 gions and program offices a standard and consistent
15 definition for a minority and low-income community,
16 with instructions on how the Agency will implement
17 and put into operation environmental justice in the
18 Agency’s daily activities.

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

1 The Administrator shall submit an initial report to Con-
2 gress within 6 months after the enactment of this Act re-
3 garding the Administrator's strategy for implementing the
4 recommendations referred to in paragraphs (1), (2), and
5 (3). Thereafter, the Administrator shall provide semi-
6 annual reports to Congress regarding the Administrator's
7 progress in implementing such recommendations and
8 modifying the Administrator's emergency management
9 procedures to incorporate environmental justice in the
10 Agency's Incident Command Structure (in accordance
11 with the December 18, 2006, letter from the Deputy Ad-
12 ministrator to the Acting Inspector General of the Agen-
13 cy).

14 (d) FEDERAL ACTION PLAN FOR SAVING LIVES,
15 PROTECTING PEOPLE AND THEIR FAMILIES FROM
16 RADON.—

17 (1) IN GENERAL.—Because radon is a naturally
18 occurring radioactive gas that is recognized as the
19 leading cause of lung cancer among nonsmokers and
20 is a particular environmental threat for low-income
21 and minority individuals because of the lack of infor-
22 mation about radon levels in their own homes, the
23 Administrator of the Environmental Protection
24 Agency shall within 6 months after the date of the
25 enactment of this Act, implement the action plan en-

1 titled “Protecting People and Families from Radon:
2 A Federal Action Plan for Saving Lives” (June 20,
3 2011), working with the Secretary of Health and
4 Human Services acting through the Director of the
5 Centers for Disease Control and Prevention, and
6 with the other Federal agencies mentioned in and as
7 set forth in the action plan.

8 (2) SPECIFIC STEPS.—In carrying out para-
9 graph (1), the Administrator shall take steps to
10 achieve each of the following:

11 (A) The recommendation that the
12 workgroup comprised of the Federal agencies
13 participating in the development of the action
14 plan referred to in paragraph (1) implement
15 specific steps within the current authority and
16 activities of each Federal agency to reduce ex-
17 posure to radon.

18 (B) The recommendation that such
19 workgroup meet on the 1-year anniversary of
20 the plan to assess and recognize achievements
21 of the plan.

22 (3) REPORT.—The Administrator shall report
23 to the Congress on the 1-year assessment of the
24 plan’s implementation, including the challenges re-
25 maining and the progress in reducing radon expo-

1 sure particularly to low-income and minority fami-
2 lies.

3 (e) FEDERAL ACTION PLAN FOR PREVENTING
4 CHILDHOOD LEAD POISONING.—

5 (1) FINDINGS.—The Congress finds the fol-
6 lowing:

7 (A) The effects of lead poisoning are irre-
8 versible and cost the United States millions an-
9 nually in medical and education costs.

10 (B) The cognitive effects suffered by lead
11 exposed children result in a lifetime of health
12 and behavioral problems, which makes preven-
13 tion efforts more critical.

14 (C) The risk is especially high for vulner-
15 able minority populations who are more likely
16 to live in older homes, where lead-based paint
17 is more likely to be present.

18 (2) ACTION PLAN.—The Administrator of the
19 Environmental Protection Agency shall, not later
20 than 6 months after the date of the enactment of
21 this Act, develop an action plan, working with the
22 Secretary of Health and Human Services acting
23 through the Director of the Centers for Disease
24 Control and Prevention, and other Federal agencies
25 as necessary.

1 (3) SPECIFIC STEPS.—In carrying out para-
2 graph (2), the Administrator of the Environmental
3 Protection Agency shall take steps to achieve each of
4 the following:

5 (A) The establishment of a working group,
6 comprised of representatives of the Federal
7 agencies participating in the development of the
8 action plan referred to in paragraph (2), to
9 make recommendations for implementation of
10 specific steps within the existing authority and
11 activities of each Federal agency to reduce ex-
12 posure to lead.

13 (B) The development by Federal agencies
14 of materials on the hazards of lead-based paint
15 aimed at educating tenants and landlords, and
16 how to both recognize potential causes for expo-
17 sure and how to remediate them.

18 **SEC. 1005. GRANT PROGRAM TO CONDUCT ENVIRON-**
19 **MENTAL HEALTH IMPROVEMENT ACTIVITIES**
20 **AND TO IMPROVE SOCIAL DETERMINANTS OF**
21 **HEALTH.**

22 (a) DEFINITIONS.—In this section:

23 (1) DIRECTOR.—The term “Director” means
24 the Director of the Centers for Disease Control and
25 Prevention, acting in collaboration with the Adminis-

1 trator of the Environmental Protection Agency and
2 the Director of the National Institute of Environ-
3 mental Health Sciences.

4 (2) ELIGIBLE ENTITY.—The term “eligible enti-
5 ty” means a State or local community that—

6 (A) bears a disproportionate burden of ex-
7 posure to environmental health hazards;

8 (B) bears a disproportionate burden of ex-
9 posure to unhealthy living conditions, low
10 standard housing conditions, low socioeconomic
11 status, poor nutrition, less opportunity for edu-
12 cational attainment, disproportionate unemploy-
13 ment rates, or lower literacy levels;

14 (C) has established a coalition—

15 (i) with not less than 1 community-
16 based organization or demonstration pro-
17 gram; and

18 (ii) with not less than 1—

19 (I) public health entity;

20 (II) health care provider organi-
21 zation;

22 (III) academic institution, includ-
23 ing any minority-serving institution
24 (including a Hispanic-serving institu-
25 tion, a historically Black college or

1 university, and a Tribal college or uni-
2 versity);

3 (IV) child-serving institution; or

4 (V) landlord or housing provider
5 working on lead remediation;

6 (D) ensures planned activities and funding
7 streams are coordinated to improve community
8 health; and

9 (E) submits an application in accordance
10 with subsection (c).

11 (b) ESTABLISHMENT.—The Director shall establish a
12 grant program under which eligible entities shall receive
13 grants to conduct environmental health improvement ac-
14 tivities and to improve social determinants of health.

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

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

21 (1) to promote environmental health;

22 (2) to address environmental health disparities
23 among all populations, including children; and

24 (3) to address racial and ethnic disparities in
25 social determinants of health.

1 (e) AMOUNT OF COOPERATIVE AGREEMENT.—

2 (1) IN GENERAL.—The Director shall award
3 grants to eligible entities at the 3 different funding
4 levels described in this subsection.

5 (2) LEVEL 1 COOPERATIVE AGREEMENTS.—

6 (A) IN GENERAL.—An eligible entity
7 awarded a grant under this paragraph shall use
8 the funds to identify environmental health prob-
9 lems and solutions by—

10 (i) establishing a planning and
11 prioritizing council in accordance with sub-
12 paragraph (B); and

13 (ii) conducting an environmental
14 health assessment in accordance with sub-
15 paragraph (C).

16 (B) PLANNING AND PRIORITIZING COUN-
17 CIL.—

18 (i) IN GENERAL.—A prioritizing and
19 planning council established under sub-
20 paragraph (A)(i) (referred to in this para-
21 graph as a “PPC”) shall assist the envi-
22 ronmental health assessment process and
23 environmental health promotion activities
24 of the eligible entity.

1 (ii) MEMBERSHIP.—Membership of a
2 PPC shall consist of representatives from
3 various organizations within public health,
4 planning, development, and environmental
5 services and shall include stakeholders
6 from vulnerable groups such as children,
7 the elderly, disabled, and minority ethnic
8 groups that are often not actively involved
9 in democratic or decisionmaking processes.

10 (iii) DUTIES.—A PPC shall—

11 (I) identify key stakeholders and
12 engage and coordinate potential part-
13 ners in the planning process;

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

17 (III) conduct an in-depth review
18 of the nature and extent of the need
19 for an environmental health assess-
20 ment, including a local epidemiological
21 profile, an evaluation of the service
22 provider capacity of the community,
23 and a profile of any target popu-
24 lations; and

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

5 (C) ENVIRONMENTAL HEALTH ASSESS-
6 MENT.—

7 (i) IN GENERAL.—A PPC shall carry
8 out an environmental health assessment to
9 identify environmental health concerns.

10 (ii) ASSESSMENT PROCESS.—The
11 PPC shall—

12 (I) define the goals of the assess-
13 ment;

14 (II) generate the environmental
15 health issue list;

16 (III) analyze issues with a sys-
17 tems framework;

18 (IV) develop appropriate commu-
19 nity environmental health indicators;

20 (V) rank the environmental
21 health issues;

22 (VI) set priorities for action;

23 (VII) develop an action plan;

24 (VIII) implement the plan; and

1 (IX) evaluate progress and plan-
2 ning for the future.

3 (D) EVALUATION.—Each eligible entity
4 that receives a grant under this paragraph shall
5 evaluate, report, and disseminate program find-
6 ings and outcomes.

7 (E) TECHNICAL ASSISTANCE.—The Direc-
8 tor may provide such technical and other non-
9 financial assistance to eligible entities as the
10 Director determines to be necessary.

11 (3) LEVEL 2 COOPERATIVE AGREEMENTS.—

12 (A) ELIGIBILITY.—

13 (i) IN GENERAL.—The Director shall
14 award grants under this paragraph to eli-
15 gible entities that have already—

16 (I) established broad-based col-
17 laborative partnerships; and

18 (II) completed environmental as-
19 sessments.

20 (ii) NO LEVEL 1 REQUIREMENT.—To
21 be eligible to receive a grant under this
22 paragraph, an eligible entity is not re-
23 quired to have successfully completed a
24 Level 1 Cooperative Agreement (as de-
25 scribed in paragraph (2)).

1 (B) USE OF GRANT FUNDS.—An eligible
2 entity awarded a grant under this paragraph
3 shall use the funds to further activities to carry
4 out environmental health improvement activi-
5 ties, including—

6 (i) addressing community environ-
7 mental health priorities in accordance with
8 paragraph (2)(C)(ii), including—

9 (I) geography;

10 (II) the built environment;

11 (III) air quality;

12 (IV) water quality;

13 (V) land use;

14 (VI) solid waste;

15 (VII) housing;

16 (VIII) crime;

17 (IX) socioeconomic status;

18 (X) ethnicity, social construct

19 and language preference;

20 (XI) educational attainment;

21 (XII) employment;

22 (XIII) food safety;

23 (XIV) nutrition;

24 (XV) health care services; and

25 (XVI) injuries;

1 (ii) building partnerships between
2 planning, public health, and other sectors,
3 including child-serving institutions, to ad-
4 dress how the built environment impacts
5 food availability and access and physical
6 activity to promote healthy behaviors and
7 lifestyles and reduce overweight and obe-
8 sity, musculoskeletal diseases, respiratory
9 conditions, dental, oral and mental health
10 conditions, poverty, and related co-
11 morbidities;

12 (iii) establishing programs to ad-
13 dress—

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

18 (II) how those conditions influ-
19 ence the concerns and needs of people
20 who have impaired mobility and use
21 assistance devices, including wheel-
22 chairs, lower limb prostheses, and hip,
23 knee, and other joint replacements;
24 and

1 (iv) convening intervention and dem-
2 onstration programs that examine the role
3 of the social environment in connection
4 with the physical and chemical environ-
5 ment in—

6 (I) determining access to nutri-
7 tional food;

8 (II) improving physical activity to
9 reduce overweight, obesity, and co-
10 morbidities and increase quality of
11 life; and

12 (III) location and access to med-
13 ical facilities.

14 (4) LEVEL 3 COOPERATIVE AGREEMENTS.—

15 (A) IN GENERAL.—An eligible entity
16 awarded a grant under this paragraph shall use
17 the funds to identify and address racial and
18 ethnic disparities in social determinants of
19 health by creating demonstration programs that
20 assess the feasibility of establishing a federally
21 funded comprehensive program and describe
22 key outcomes that address racial and ethnic dis-
23 parities in social determinants of health.

24 (B) PROGRAM DESIGN.—

1 (i) EVALUATION.—No later than 1
2 year after enactment of this Act, the Di-
3 rector shall evaluate the best practices of
4 existing programs from the private, public,
5 community based, and academically sup-
6 ported initiatives focused on reducing dis-
7 parities in the social determinants of
8 health for racial and ethnic populations.

9 (ii) DEMONSTRATION PROJECTS.—
10 Not later than two years after the date of
11 enactment of this Act, the Director shall
12 implement at least ten demonstration
13 projects including at least one project for
14 each major racial and ethnic minority
15 group, each of which is unique to the cul-
16 tural and linguistic needs of each of the
17 following groups:

18 (I) Native Americans and Alaska
19 Natives.

20 (II) Asian Americans.

21 (III) African Americans/Blacks.

22 (IV) Hispanic/Latino-Americans.

23 (V) Native Hawaiians and Pacific
24 Islanders.

1 (iii) REPORT TO CONGRESS.—No later
2 than 2 years after the implementation of
3 the initial demonstration projects, the Di-
4 rector shall submit to Congress a report
5 which includes—

6 (I) a description of each dem-
7 onstration project and design;

8 (II) an evaluation of the cost-ef-
9 fectiveness of each project’s preven-
10 tion and treatment efforts;

11 (III) an evaluation of the cultural
12 and linguistic appropriateness of each
13 project by racial and ethnic group;
14 and

15 (IV) an evaluation of the bene-
16 ficiary’s health status improvement
17 under the demonstration project.

18 (iv) ANY OTHER INFORMATION
19 DEEMED APPROPRIATE BY THE DIREC-
20 TOR.—The Director shall require any other
21 information deemed appropriate to be
22 shared by or developed by eligible entities
23 awarded a grant under this paragraph, in-
24 cluding the following:

1 (I) Developing models and evalu-
2 ating methods that improve the cul-
3 tural and linguistically appropriate
4 services provided through the Centers
5 for Disease Control and Prevention to
6 target individuals impacted by health
7 disparities based on their race, eth-
8 nicity, and gender.

9 (II) Promoting the collaboration
10 between primary and specialty care
11 health care providers and patients, to
12 ensure patients impacted by health
13 disparities based on race, ethnicity,
14 and gender are receiving comprehen-
15 sive and organized treatment and
16 care.

17 (III) Educating health care pro-
18 fessionals on the causes and effects of
19 disparities in the social determinants
20 of health as it relates to minority and
21 racial and ethnic communities and the
22 need for culturally and linguistically
23 appropriate care in the prevention and
24 treatment of high-impact diseases.

1 (IV) Encouraging collaboration
2 among community and patient-based
3 organizations which work to address
4 disparities in the social determinants
5 of health as it relates to high-impact
6 diseases in minority and racial and
7 ethnic populations.

8 (f) AUTHORIZATION OF APPROPRIATIONS.—There
9 are authorized to be appropriated to carry out this sec-
10 tion—

11 (1) \$25,000,000 for fiscal year 2019; and

12 (2) such sums as may be necessary for fiscal
13 years 2020 through 2022.

14 **SEC. 1006. ADDITIONAL RESEARCH ON THE RELATIONSHIP**
15 **BETWEEN THE BUILT ENVIRONMENT AND**
16 **THE HEALTH OF COMMUNITY RESIDENTS.**

17 (a) DEFINITION OF ELIGIBLE INSTITUTION.—In this
18 section, the term “eligible institution” means a public or
19 private nonprofit institution that submits to the Secretary
20 of Health and Human Services (in this section referred
21 to as the “Secretary”) and the Administrator of the Envi-
22 ronmental Protection Agency (in this section referred to
23 as the “Administrator”) an application for a grant under
24 the grant program authorized under subsection (b)(2) at
25 such time, in such manner, and containing such agree-

1 ments, assurances, and information as the Secretary and
2 Administrator may require.

3 (b) RESEARCH GRANT PROGRAM.—

4 (1) DEFINITION OF HEALTH.—In this section,
5 the term “health” includes—

6 (A) levels of physical activity;

7 (B) degree of mobility due to factors such
8 as musculoskeletal diseases, arthritis, and obe-
9 sity;

10 (C) consumption of nutritional foods;

11 (D) rates of crime;

12 (E) air, water, and soil quality;

13 (F) risk of injury;

14 (G) accessibility to health care services;

15 (H) levels of educational attainment; and

16 (I) other indicators as determined appro-
17 priate by the Secretary.

18 (2) GRANTS.—The Secretary, in collaboration
19 with the Administrator, shall provide grants to eligi-
20 ble institutions to conduct and coordinate research
21 on the built environment and its influence on indi-
22 vidual and population-based health.

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

1 (A) investigates and defines the causal
2 links between all aspects of the built environ-
3 ment and the health of residents;

4 (B) examines—

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

9 (ii) the variance in the health of resi-
10 dents by—

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

14 (II) population subgroup (includ-
15 ing children, the elderly, the disadvan-
16 taged); or

17 (iii) the importance of the built envi-
18 ronment to the total health of residents,
19 which is the primary variable of interest
20 from a public health perspective;

21 (C) is used to develop—

22 (i) measures to address health and the
23 connection of health to the built environ-
24 ment; and

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

3 (D) distinguishes carefully between per-
4 sonal attitudes and choices and external influ-
5 ences on observed behavior to determine how
6 much an observed association between the built
7 environment and the health of residents, versus
8 the lifestyle preferences of the people that
9 choose to live in the neighborhood, reflects the
10 physical characteristics of the neighborhood;
11 and

12 (E)(i) identifies or develops effective inter-
13 vention strategies to promote better health
14 among residents with a focus on behavioral
15 interventions and enhancements of the built en-
16 vironment that promote increased use by resi-
17 dents; and

18 (ii) in developing the intervention strate-
19 gies under clause (i), ensures that the interven-
20 tion strategies will reach out to high-risk popu-
21 lations, including racial and ethnic minorities,
22 low-income urban and rural communities, and
23 children.

24 (4) PRIORITY.—In providing assistance under
25 the grant program authorized under paragraph (2),

1 the Secretary and the Administrator shall give pri-
2 ority to research that incorporates—

3 (A) minority-serving institutions as grant-

4 ees;

5 (B) interdisciplinary approaches; or

6 (C) the expertise of the public health,

7 physical activity, nutrition and health care (in-

8 cluding child health), urban planning, and

9 transportation research communities in the

10 United States and abroad.

11 **SEC. 1007. ENVIRONMENT AND PUBLIC HEALTH RESTORA-**

12 **TION.**

13 (a) FINDINGS.—

14 (1) GENERAL FINDINGS.—The Congress finds
15 as follows:

16 (A) As human beings, we share our envi-
17 ronment with a wide variety of habitats and
18 ecosystems that nurture and sustain a diversity
19 of species.

20 (B) The abundance of natural resources in
21 our environment forms the basis for our econ-
22 omy and has greatly contributed to human de-
23 velopment throughout history.

24 (C) The accelerated pace of human devel-
25 opment over the last several hundred years has

1 significantly impacted our natural environment
2 and its resources, the health and diversity of
3 plant and animal wildlife, the availability of
4 critical habitats, the quality of our air and our
5 water, and our global climate.

6 (D) The intervention of the Federal Gov-
7 ernment is necessary to minimize and mitigate
8 human impact on the environment for the ben-
9 efit of public health, to maintain air quality and
10 water quality, to sustain the diversity of plants
11 and animals, to combat global climate change,
12 and to protect the environment.

13 (E) Laws and regulations in the United
14 States have been created and promulgated to
15 minimize and mitigate human impact on the en-
16 vironment for the benefit of public health, to
17 maintain air quality and water quality, to sus-
18 tain wildlife, and to protect the environment.

19 (F) Such laws include the Antiquities Act
20 of 1906 (16 U.S.C. 431 et seq.) initiated by
21 President Theodore Roosevelt to create the na-
22 tional park system, the National Environmental
23 Policy Act of 1969 (42 U.S.C. 4321 et seq.),
24 the Clean Air Act (42 U.S.C. 7401 et seq.), the
25 Federal Water Pollution Control Act (33 U.S.C.

1 1251 et seq.), the Comprehensive Environ-
2 mental Response, Compensation, and Liability
3 Act of 1980 (42 U.S.C. 9601 et seq.), the En-
4 dangered Species Act of 1973 (Public Law 93-
5 205), and the National Forest Management Act
6 of 1976 (Public Law 94-588).

7 (G) Attempts to repeal or weaken key envi-
8 ronmental safeguards pose dangers to the pub-
9 lic health, air quality, water quality, wildlife,
10 and the environment.

11 (2) FINDINGS ON CHANGES AND PROPOSED
12 CHANGES IN LAW.—The Congress finds that, since
13 2001, the following changes and proposed changes
14 to existing law or regulations have negatively im-
15 pacted or will negatively impact the environment and
16 public health:

17 (A) CLEAN WATER.—

18 (i) On May 9, 2002, the Environ-
19 mental Protection Agency (EPA) and the
20 Army Corps of Engineers put forth a final
21 rule that reconciled regulations imple-
22 menting section 404 of the Federal Water
23 Pollution Control Act by redefining the
24 term “fill material” and amending the def-
25 inition of the term “discharge of fill mate-

1 rial”, reversing a 25-year-old regulation.
2 The new rule fails to restrict the dumping
3 of hardrock mining waste, construction de-
4 bris, and other industrial wastes into riv-
5 ers, streams, lakes, and wetlands. The rule
6 further allows destructive mountaintop re-
7 moval coal mining companies to dump
8 waste into streams and lakes, polluting the
9 surrounding natural habitat and poisoning
10 plants and animals that depend on those
11 water sources.

12 (ii) On February 12, 2003, the Envi-
13 ronmental Protection Agency published the
14 rule “National Pollutant Discharge Elim-
15 ination System Permit Regulation and Ef-
16 fluent Limitation Guidelines and Stand-
17 ards for Concentrated Animal Feeding Op-
18 erations”, new livestock waste regulations
19 that aimed to control factory farm pollu-
20 tion but which would severely undermine
21 existing protections under the Federal
22 Water Pollution Control Act. This regula-
23 tion allows large-scale animal factories to
24 foul the Nation’s waters with animal
25 waste, allows livestock owners to draft

1 their own pollution-management plans and
2 avoid ground water monitoring, legalizes
3 the discharge of contaminated runoff water
4 rich in nitrogen, phosphorus, bacteria, and
5 metals, and ensures that large factory
6 farms are not held liable for the environ-
7 mental damage they cause. In a 2005 Fed-
8 eral court decision (“Waterkeeper Alliance,
9 et al. v. Environmental Protection Agen-
10 cy”, 399 F.3d 486 (2nd Cir. 2005)), major
11 parts of the rule were upheld, others va-
12 cated, and still others remanded back to
13 the EPA. On November 20, 2008, the En-
14 vironmental Protection Agency published a
15 revised final rule which undermines envi-
16 ronmental protection provisions by remov-
17 ing mandatory permitting requirements
18 and allowing large animal farms to self-
19 certify the absence of pollutant discharge
20 activity.

21 (iii) On March 19, 2003, the Environ-
22 mental Protection Agency published a new
23 rule regarding the Total Maximum Daily
24 Load program of the Federal Water Pollu-
25 tion Control Act that regulates the max-

1 imum amount of a particular pollutant
2 that can be present in a body of water and
3 still meet water quality standards. The new
4 rule withdrew the existing regulation put
5 forth on July 13, 2000, and halted mo-
6 mentum in cleaning up polluted waterways
7 throughout the Nation. By abandoning the
8 existing rule, the Environmental Protection
9 Agency is undermining the effectiveness of
10 cleanup plans and is allowing States to
11 avoid cleaning polluted waters entirely by
12 dropping them from their cleanup lists.
13 Waterways play a crucial role in the lives
14 of the people of the United States and are
15 critical to the livelihood of fish and wildlife.
16 The result of dropping the July 2000 rule
17 is that the restoration of polluted rivers,
18 shoreslines, and lakes will be delayed, harm-
19 ing more fish and wildlife and worsening
20 the quality of drinking water.

21 (iv) On December 2, 2008, the Envi-
22 ronmental Protection Agency and the
23 Army Corps of Engineers jointly issued a
24 guidance document in the form of a legal
25 memorandum, titled “Clean Water Act Ju-

1 jurisdiction Following the U.S. Supreme
2 Court’s Decision in *Rapanos v. United*
3 *States & Carabell v. United States*”. This
4 new guidance dictates enforcement actions
5 under the Federal Water Pollution Control
6 Act and calls for a complicated “case-by-
7 case” analysis to determine jurisdiction for
8 waterways that do not flow all year. Such
9 actions endanger small streams and wet-
10 lands that serve as important habitats for
11 aquatic life, which play a fundamental role
12 in safeguarding sources of clean drinking
13 water and mitigate the risks and effects of
14 floods and droughts. Further, the defini-
15 tion provided therein for “waters of the
16 United States” is applicable to the Federal
17 Water Pollution Control Act as a whole,
18 potentially affecting programs that control
19 industrial pollution and sewage levels, pre-
20 vent oil spills, and set water quality stand-
21 ards for all waters in the United States
22 protected under the Federal Water Pollu-
23 tion Control Act.

24 (B) FORESTS AND LAND MANAGEMENT.—

1 (i) On December 3, 2003, the Presi-
2 dent signed into law the Healthy Forests
3 Restoration Act of 2003 (Public Law 108-
4 148; 16 U.S.C. 6501 et seq.). Although the
5 law attempts to reduce the risk of cata-
6 strophic forest fires, it provides a boon to
7 timber companies by accelerating the ag-
8 gressive thinning of backcountry forests
9 that are far from at-risk communities. The
10 law allows for increased logging of large,
11 fire-resistant trees that are not in close
12 proximity of homes and communities; it
13 undermines critical protections for endan-
14 gered species by exempting Federal land
15 management agencies from consulting with
16 the United States Fish and Wildlife Serv-
17 ice before approving any action that could
18 harm endangered plants or wildlife; and it
19 limits public participation by reducing the
20 number of environmental project reviews.

21 (ii) On April 21, 2008, the Depart-
22 ment of Agriculture issued a Final Plan-
23 ning Rule and Record of Decision for Na-
24 tional Forest System Land Management
25 Planning. Similar to rules enacted by the

1 Administration on January 5, 2005, later
2 remanded back to the agency in Federal
3 district court for violating the National
4 Environmental Policy Act of 1969, the En-
5 dangered Species Act of 1973, and the Ad-
6 ministrative Procedure Act (“Citizens for
7 Better Forestry v. United States Depart-
8 ment of Agriculture”, 481 F. Supp. 2d
9 1059 (N.D. Cal. 2007)), this revised rule
10 eliminates strict forest planning standards
11 established in 1982, and opens millions of
12 acres of public lands to damaging and
13 invasive logging, mining, and drilling oper-
14 ations. These regulations would reverse
15 more than 20 years of protection for wild-
16 life and national forests by removing the
17 overall goal of ensuring ecological sustain-
18 ability in managing the national forest sys-
19 tem, weakening the National Forest Man-
20 agement Act of 1976, and effectively end-
21 ing the review of forest management plans
22 under the National Environmental Policy
23 Act of 1969.

24 (iii) On September 20, 2006, the Dis-
25 trict Court for the Northern District of

1 California vacated the Protection of Inven-
2 toried Roadless Areas rule, enacted on May
3 13, 2005, which gave State Governors 18
4 months to petition the Federal Government
5 to either restore the previous rule for their
6 States, or submit a new management and
7 development plan for national forest areas
8 inventoried under the rule. Despite the
9 enjoinder of the Administration's 2005
10 rule, and the subsequent restoration of the
11 original Roadless Area Conservation Rule,
12 the United States Forest Service has con-
13 tinued to allow States to petition for a spe-
14 cial rule under the authority of the Admin-
15 istrative Procedure Act, publishing a final
16 special rule for Idaho on October 16, 2008.
17 As a result, 58.5 million acres of wild na-
18 tional forests are still vulnerable to log-
19 ging, road building, and other develop-
20 ments that may fragment natural habitats
21 and negatively impact fish and wildlife.

22 (iv) On November 17, 2008, the De-
23 partment of the Interior's Bureau of Land
24 Management (BLM) signed the Record of
25 Decision (ROD) amending 12 resource

1 management plans in Colorado, Utah, and
2 Wyoming, opening 2,000,000 acres of pub-
3 lic lands to commercial tar sands and oil
4 shale exploration and development. On No-
5 vember 18, 2008, the BLM published a
6 final rule for Oil Shale Management set-
7 ting the policies and procedures for a com-
8 mercial leasing program for the manage-
9 ment of federally owned oil shale in those
10 three States. Previously barred by a con-
11 gressional moratorium on the commercial
12 leasing regulations for oil shale until Sep-
13 tember 30, 2008, the development of oil
14 shale on public lands poses a serious threat
15 to land conservation, endangered and
16 threatened species, and critical habitat.
17 Domestic shale oil production allowed by
18 these regulations is highly water and en-
19 ergy intensive, the impacts of which will in-
20 tensify existing water scarcity in the arid
21 Western Region and potentially degrade
22 air and water quality for surrounding pop-
23 ulations.

24 (C) SCIENTIFIC REVIEW.—On December
25 16, 2008, the United States Fish and Wildlife

1 Service of the Department of the Interior and
2 the National Oceanic and Atmospheric Admin-
3 istration of the Department of Commerce joint-
4 ly issued a new rule amending regulations gov-
5 erning interagency cooperation under section 7
6 of the Endangered Species Act of 1973 (ESA).
7 This rule undermines the intention of the ESA
8 to protect species and the ecosystems upon
9 which they depend by allowing Federal agencies
10 to carry out, permit, or fund an action without
11 proper environmental review and expert third-
12 party consultation from Federal wildlife ex-
13 perts. Under this new rule, Federal agencies
14 can unilaterally circumvent the formal review
15 process, eliminating longstanding and scientif-
16 ically grounded safeguards that serve to protect
17 the biodiversity of our Nation's ecosystems and
18 avert harm to thousands of endangered and
19 threatened species.

20 (b) STATEMENT OF POLICY.—It is the policy of the
21 United States Government to work in conjunction with
22 States, territories, Tribal governments, international orga-
23 nizations, and foreign governments in order to act as a
24 steward of the environment for the benefit of public
25 health, to maintain air quality and water quality, to sus-

1 tain the diversity of plant and animal species, to combat
2 global climate change, and to protect the environment for
3 future generations to enjoy.

4 (c) STUDY AND REPORT ON PUBLIC HEALTH OR EN-
5 VIRONMENTAL IMPACT OF REVISED RULES, REGULA-
6 TIONS, LAWS, OR PROPOSED LAWS.—

7 (1) STUDY.—Not later than 30 days after the
8 date of enactment of this Act, the President shall
9 enter into an arrangement under which the National
10 Academy of Sciences will conduct a study to deter-
11 mine the impact on public health, air quality, water
12 quality, wildlife, and the environment of the fol-
13 lowing regulations, laws, and proposed laws:

14 (A) CLEAN WATER.—

15 (i) Final revisions to the Federal
16 Water Pollution Control Act regulatory
17 definitions of “fill material” and “dis-
18 charge of fill material”, finalized and pub-
19 lished in the Federal Register on May 9,
20 2002 (67 Fed. Reg. 31129), amending
21 part 232 of title 40, Code of Federal Regu-
22 lations.

23 (ii) Revised National Pollutant Dis-
24 charge Elimination System Permit Regula-
25 tion and Effluent Limitation Guidelines

1 and Standards for Concentrated Animal
2 Feeding Operations in response to the
3 “Waterkeeper Alliance, et al. v. Environ-
4 mental Protection Agency” decision, final-
5 ized and published in the Federal Register
6 on November 20, 2008 (73 Fed. Reg.
7 225), amending parts 9, 122, and 412 of
8 title 40, Code of Federal Regulations.

9 (iii) A March 19, 2003, rule published
10 in the Federal Register (68 Fed. Reg.
11 13608) withdrawing a July 13, 2000, rule
12 revising the Total Maximum Daily Load
13 program of the Federal Water Pollution
14 Control Act (65 Fed. Reg. 43586), amend-
15 ing parts 9, 122, 123, 124, and 130 of
16 title 40, Code of Federal Regulations.

17 (iv) Official Guidance Document,
18 “Clean Water Act Jurisdiction Following
19 the United States Supreme Court’s Deci-
20 sion in *Rapanos v. United States &*
21 *Carabell v. United States*”, issued on De-
22 cember 2, 2008, relating to jurisdiction
23 under section 404 of the Federal Water
24 Pollution Control Act.

25 (B) FORESTS AND LAND MANAGEMENT.—

1 (i) Healthy Forests Restoration Act of
2 2003, signed into law on December 3,
3 2003 (Public Law 108–148; 16 U.S.C.
4 6501 et seq.).

5 (ii) National Forest System Land
6 Management Planning Rule, finalized and
7 published in the Federal Register on April
8 21, 2008 (73 Fed. Reg. 21468), replacing
9 the 2005 final rule (70 Fed. Reg. 1022,
10 Jan. 5, 2005), as amended March 3, 2006
11 (71 Fed. Reg. 10837), and the 2000 final
12 rule adopted on November 9, 2000 (65
13 Fed. Reg. 67514), as amended on Sep-
14 tember 29, 2004 (69 Fed. Reg. 58055),
15 amending title 36, Code of Federal Regula-
16 tions, part 219.

17 (iii) The application of the Adminis-
18 trative Procedure Act (5 U.S.C. 551 to
19 559, 701 to 706, et seq.), such that States
20 may petition for a special rule for the
21 roadless areas in all or part of said State.

22 (iv) Record of Decision, “Oil Shale
23 and Tar Sands Resources Resource Man-
24 agement Plan Amendments”, issued on
25 November 17, 2008, along with the Final

1 Rule, Oil Shale Management-General, pub-
2 lished in the Federal Register on Novem-
3 ber 18, 2008 (73 Fed. Reg. 223), amend-
4 ing title 43, Code of Federal Regulations,
5 parts 3900, 3910, 3920, and 3930.

6 (C) SCIENTIFIC REVIEW.—Final Rule,
7 Interagency Cooperation Under the Endangered
8 Species Act, published in the Federal Register
9 on December 16, 2008, amending title 50, Code
10 of Federal Regulations, part 402.

11 (2) METHOD.—In conducting the study under
12 paragraph (1), the National Academy of Sciences
13 may utilize and compare existing scientific studies
14 regarding the regulations, laws, and proposed laws
15 listed in paragraph (1).

16 (3) REPORT.—Under the arrangement entered
17 into under paragraph (1), not later than 270 days
18 after the date on which such arrangement is entered
19 into, the National Academy of Sciences shall make
20 publicly available and shall submit to the Congress
21 and to the head of each department and agency of
22 the Federal Government that issued, implements, or
23 would implement a regulation, law, or proposed law
24 listed in paragraph (1), a report containing—

1 (A) a description of the impact of all such
2 regulations, laws, and proposed laws on public
3 health, air quality, water quality, wildlife, and
4 the environment, compared to the impact of
5 preexisting regulations, or laws in effect, includ-
6 ing—

7 (i) any negative impacts to air quality
8 or water quality;

9 (ii) any negative impacts to wildlife;

10 (iii) any delays in hazardous waste
11 cleanup that are projected to be hazardous
12 to public health; and

13 (iv) any other negative impact on pub-
14 lic health or the environment; and

15 (B) any recommendations that the Na-
16 tional Academy of Sciences considers appro-
17 priate to maintain, restore, or improve in whole
18 or in part protections for public health, air
19 quality, water quality, wildlife, and the environ-
20 ment for each of the regulations, laws, and pro-
21 posed laws listed in paragraph (1), which may
22 include recommendations for the adoption of
23 any regulation or law in place or proposed prior
24 to January 1, 2001.

1 (d) DEPARTMENT AND AGENCY REVISION OF EXIST-
2 ING RULES, REGULATIONS, OR LAWS.—Not later than
3 180 days after the date on which the report is submitted
4 pursuant to subsection (c)(3), the head of each depart-
5 ment and agency that has issued or implemented a regula-
6 tion or law listed in subsection (c)(1) shall submit to the
7 Congress a plan describing the steps such department or
8 such agency will take, or has taken, to restore or improve
9 protections for public health and the environment in whole
10 or in part that were in existence prior to the issuance of
11 such regulation or law.

12 **SEC. 1008. GAO REPORT ON HEALTH EFFECTS OF DEEP-**
13 **WATER HORIZON OIL RIG EXPLOSION IN THE**
14 **GULF COAST.**

15 (a) STUDY.—The Comptroller General of the United
16 States shall conduct a study on the type and scope of
17 health care services administered through the Department
18 of Health and Human Services addressing the provision
19 of health care to racial and ethnic minorities, including
20 residents, cleanup workers, and volunteers, affected by the
21 explosion of the mobile offshore drilling unit Deepwater
22 Horizon that occurred on April 20, 2010.

23 (b) SPECIFIC COMPONENTS; REPORTING.—In car-
24 rying out subsection (a), the Comptroller General shall—

1 (1) assess the type, size, and scope of programs
2 administered by the Department of Health and
3 Human Services that focus on provision of health
4 care to communities in the Gulf Coast;

5 (2) identify the merits and disadvantages asso-
6 ciated with each the programs;

7 (3) perform an analysis of the costs and bene-
8 fits of the programs;

9 (4) determine whether there is any duplication
10 of programs; and

11 (5) not later than 180 days after the date of
12 the enactment of this Act, submit to Congress a re-
13 port containing—

14 (A) the findings of the study conducted
15 under this section; and

16 (B) recommendations for improving access
17 to health care for racial and ethnic minorities.

18 **Subtitle B—Gun Violence**

19 **SEC. 1011. FINDINGS.**

20 Congress finds as follows:

21 (1) On average, 86 Americans are killed by
22 guns each day.

23 (2) An estimated 15,549 people were killed by
24 guns in 2017, not including suicides.

1 (3) Gun violence disproportionately affects com-
2 munities of color, especially African Americans (who
3 comprise around 14 percent of the United States
4 population but account for more than half the coun-
5 try’s gun homicide victims).

6 (4) On average, there is more than one mass
7 shooting each day in the United States.

8 **SEC. 1012. REAFFIRMING RESEARCH AUTHORITY OF THE**
9 **CENTERS FOR DISEASE CONTROL AND PRE-**
10 **VENTION.**

11 (a) IN GENERAL.—Section 391 of the Public Health
12 Service Act (42 U.S.C. 280b) is amended—

13 (1) in subsection (a)(1), by striking “research
14 relating to the causes, mechanisms, prevention, diag-
15 nosis, treatment of injuries, and rehabilitation from
16 injuries;” and inserting “research, including data
17 collection, relating to—

18 “(A) the causes, mechanisms, prevention,
19 diagnosis, and treatment of injuries, including
20 with respect to gun violence; and

21 “(B) rehabilitation from such injuries;”;
22 and

23 (2) by adding at the end the following new sub-
24 section:

1 “(c) NO ADVOCACY OR PROMOTION OF GUN CON-
2 TROL.—Nothing in this section shall be construed to—

3 “(1) authorize the Secretary to give assistance,
4 make grants, or enter into cooperative agreements or
5 contracts for the purpose of advocating or promoting
6 gun control; or

7 “(2) permit a recipient of any assistance, grant,
8 cooperative agreement, or contract under this section
9 to use such assistance, grant, agreement, or contract
10 for the purpose of advocating or promoting gun con-
11 trol.”.

12 **SEC. 1013. NATIONAL VIOLENT DEATH REPORTING SYSTEM.**

13 The Secretary of Health and Human Services, acting
14 through the Director of the Centers for Disease Control
15 and Prevention, shall improve, particularly through the in-
16 clusion of additional States, the National Violent Death
17 Reporting System, as authorized by title III of the Public
18 Health Service Act (42 U.S.C. 241 et seq.). Participation
19 in the system by the States shall be voluntary.

20 **SEC. 1014. REPORT ON EFFECTS OF GUN VIOLENCE ON**
21 **PUBLIC HEALTH.**

22 Not later than one year after the date of the enact-
23 ment of this Act, and annually thereafter, the Surgeon
24 General of the Public Health Service shall submit to Con-
25 gress a report on the effects on public health, including

1 mental health, of gun violence in the United States during
2 the preceding year, and the status of actions taken to ad-
3 dress such effects.

4 **SEC. 1015. REPORT ON EFFECTS OF GUN VIOLENCE ON**
5 **MENTAL HEALTH IN MINORITY COMMU-**
6 **NITIES.**

7 Not later than one year after the date of the enact-
8 ment of this Act, the Deputy Assistant Secretary for Mi-
9 nority Health in the Office of the Secretary of Health and
10 Human Services shall submit to the Congress a report on
11 the effects of gun violence on public health, including men-
12 tal health, in minority communities in the United States,
13 and the status of actions taken to address such effects.

○