areas, which traditionally suffer from limited access to care.

The coronavirus pandemic has shed a light on the current disparities riddled throughout our health care system.

As an increasing number of students go back to school, schools are on the front line in terms of managing the pandemic, and school-based health centers will be at the center of that response, making this reauthorization more essential than ever.

We must utilize this opportunity to strengthen these programs with additional federal funding.

I ask my colleagues on both sides of the aisle to come together and pass this important legislation.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. PALLONE) that the House suspend the rules and pass the bill, H.R. 2075, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

TRIBAL HEALTH DATA IMPROVEMENT ACT OF 2020

Mr. PALLONE. Madam Speaker, I move to suspend the rules and pass the bill (H.R. 7948) to amend the Public Health Service Act with respect to the collection and availability of health data with respect to Indian Tribes, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 7948

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Tribal Health Data Improvement Act of 2020''.

SEC. 2. COLLECTION AND AVAILABILITY OF HEALTH DATA WITH RESPECT TO INDIAN TRIBES.

(a) DATA COLLECTION.—Section 3101(a)(1) of the Public Health Service Act (42 U.S.C. 300kk(a)(1)) is amended—

(1) by striking '', by not later than 2 years after the date of enactment of this title,''; and

(2) in subparagraph (B), by inserting ''Tribal,'' after ''State,''.

(b) DATA REPORTING AND DISSEMINATION.—Section 3101(c) of the Public Health Service Act (42 U.S.C. 300kk(c)) is amended—

(1) by amending subparagraph (F) of paragraph (1) to read as follows:

''(F) the Indian Health Service, Indian Tribes, Tribal organizations, and epidemiology centers authorized under the Indian Health Care Improvement Act;''; and

(2) in paragraph (3), by inserting ''Indian Tribes, Tribal organizations, and epidemiology centers,'' after ''Federal agencies,''.

(c) PROTECTION AND SHARING OF DATA.—Section 3101(e) of the Public Health Service Act (42 U.S.C. 300kk(e)) is amended by adding at the end the following new paragraphs:

''(3) DATA SHARING STRATEGY.—With respect to data access for Tribal epidemiology centers and Tribes, the Secretary shall create a data sharing strategy that takes into consideration recommendations by the Secretary's Tribal Advisory Committee for—

''(A) ensuring that Tribal epidemiology centers and Indian Tribes have access to the data sources necessary to accomplish their public health responsibilities; and

''(B) protecting the privacy and security of such data.

''(4) TRIBAL PUBLIC HEALTH AUTHORITY.—

''(A) AVAILABILITY.—Beginning not later than 180 days after the date of the enactment of the Tribal Health Data Improvement Act of 2020, the Secretary shall make available to the entities listed in subparagraph (B) all data that is collected pursuant to this title with respect to health care and public health surveillance programs and activities, including such programs and activities that are federally supported or conducted, so long as—

''(i) such entities request the data pursuant to statute; and

''(ii) the data is requested for use—

''(I) consistent with Federal law and obligations; and

''(II) to satisfy a particular purpose or carry out a specific function consistent with the purpose for which the data was collected.

''(B) ENTITIES.—The entities listed in this subparagraph are—

''(i) the Indian Health Service;

''(ii) Indian Tribes and Tribal organizations; and

''(iii) epidemiology centers.''.

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

(1) by striking subsections (g) and (h); and

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

(e) DEFINITIONS.—After executing the amendments made by subsection (d), section 3101 of the Public Health Service Act (42 U.S.C. 300kk) is amended by inserting after subsection (f) the following new subsection:

''(g) DEFINITIONS.—In this section:

''(1) The term 'epidemiology center' means an epidemiology center established under section 214 of the Indian Health Care Improvement Act, including such Tribal epidemiology centers serving Indian Tribes regionally and any Tribal epidemiology center serving Urban Indian organizations nationally.

''(2) The term 'Indian Tribe' has the meaning given to the term 'Indian tribe' in section 4 of the Indian Self-Determination and Education Assistance Act.

''(3) The term 'Tribal organization' has the meaning given to the term 'tribal organization' in section 4 of the of the Indian Self-Determination and Education Assistance Act.

''(4) The term 'Urban Indian organization' has the meaning given to that term in section 4 of the Indian Health Care Improvement Act.''.

(f) TECHNICAL CORRECTION.—Section 3101(b) of the Public Health Service Act (42 U.S.C. 300kk(b)) is amended by striking ''DATA ANALYSIS.—'' and all that follows through ''For each federally'' and inserting ''DATA ANALYSIS.—For each federally''.

SEC. 3. IMPROVING HEALTH STATISTICS REPORTING WITH RESPECT TO INDIAN TRIBES.

(a) TECHNICAL AID TO STATES AND LOCALITIES.—Section 306(d) of the Public Health Service Act (42 U.S.C. 242k(d)) is amended by inserting '', Indian Tribes, Tribal organizations, and epidemiology centers'' after ''jurisdictions''.

(b) COOPERATIVE HEALTH STATISTICS SYSTEM.—Section 306(e)(3) of the Public Health Service Act (42 U.S.C. 242k(e)(3)) is amended by inserting '', Indian Tribes, Tribal organizations, and epidemiology centers'' after ''health agencies''.

(c) FEDERAL-STATE-TRIBAL COOPERATION.—Section 306(f) of the Public Health Service Act (42 U.S.C. 242k(f)) is amended—

(1) by inserting ''the Indian Health Service,'' before ''the Departments of Commerce'';

(2) by inserting a comma after ''the Departments of Commerce and Labor'';

(3) by inserting '', Indian Tribes, Tribal organizations, and epidemiology centers'' after ''State and local health departments and agencies''; and

(4) by striking ''he shall'' and inserting ''the Secretary shall''.

(d) REGISTRATION AREA RECORDS.—Section 306(h)(1) of the Public Health Service Act (42 U.S.C. 242k(h)(1)) is amended—

(1) by striking ''in his discretion'' and inserting ''in the discretion of the Secretary''; and

(2) by striking ''Hispanics, Asian Americans, and Pacific Islanders'' and inserting ''American Indians and Alaska Natives, Hispanics, Asian Americans, and Native Hawaiian and other Pacific Islanders''.

(e) NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS.—Section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)) is amended—

(1) in paragraph (3), by striking '', not later than 60 days after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996,'' each place it appears; and

(2) in paragraph (7), by striking ''Not later than 1 year after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, and annually thereafter, the Committee shall'' and inserting ''The Committee shall, on an biennial basis,''.

(f) GRANTS FOR ASSEMBLY AND ANALYSIS OF DATA ON ETHNIC AND RACIAL POPULATIONS.—Section 306(m)(4) of the Public Health Service Act (42 U.S.C. 242k(m)(4)) is amended—

(1) in subparagraph (A)—

(A) by striking ''Subject to subparagraph (B), the'' and inserting ''The''; and

(B) by striking ''and major Hispanic subpopulation groups and American Indians'' and inserting '', major Hispanic subgroups, and American Indians and Alaska Natives''; and

(2) by amending subparagraph (B) to read as follows:

''(B) In carrying out subparagraph (A), with respect to American Indians and Alaska Natives, the Secretary shall—

''(i) consult with Indian Tribes, Tribal organizations, the Tribal Technical Advisory Group of the Centers for Medicare & Medicaid Services maintained under section 5006(e) of the American Recovery and Reinvestment Act of 2009, and the Tribal Advisory Committee established by the Centers for Disease Control and Prevention, in coordination with epidemiology centers, to develop guidelines for State and local health agencies to improve the quality and accuracy of data with respect to the birth and death records of American Indians and Alaska Natives;

''(ii) confer with Urban Indian organizations to develop guidelines for State and local health agencies to improve the quality and accuracy of data with respect to the birth and death records of American Indians and Alaska Natives;

''(iii) enter into cooperative agreements with Indian Tribes, Tribal organizations, Urban Indian organizations, and epidemiology centers to address misclassification and undersampling of American Indians and Alaska Natives with respect to—

''(I) birth and death records; and

''(II) health care and public health surveillance systems, including, but not limited to, data with respect to chronic and infectious diseases, unintentional injuries, environmental health, child and adolescent health, maternal health and mortality, foodborne and waterborne illness, reproductive health, and any other notifiable disease or condition;

''(iv) encourage States to enter into data sharing agreements with Indian Tribes, Tribal organizations, and epidemiology centers to improve the quality and accuracy of public health data; and

''(v) not later than 180 days after the date of enactment of the Tribal Health Data Improvement Act of 2020, and biennially thereafter, issue a report on the following:

''(I) Which States have data sharing agreements with Indian Tribes, Tribal organizations,

Urban Indian organizations, and Tribal epidemiology centers to improve the quality and accuracy of health data.

''(II) What the Centers for Disease Control and Prevention is doing to encourage States to enter into data sharing agreements with Indian Tribes, Tribal organizations, Urban Indian organizations, and Tribal epidemiology centers to improve the quality and accuracy of health data.

''(III) Best practices and guidance for States, Indian Tribes, Tribal organizations, Urban Indian organizations, and Tribal epidemiology centers that wish to enter into data sharing agreements.

''(IV) Best practices and guidance for local, State, Tribal, and Federal uniform standards for the collection of data on race and ethnicity.''.

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

(1) by redesignating subsection (n) as subsection (o); and

(2) by inserting after subsection (m) the following:

''(n) In this section:

''(1) The term 'epidemiology center' means an epidemiology center established under section 214 of the Indian Health Care Improvement Act, including such Tribal epidemiology centers serving Indian Tribes regionally and any Tribal epidemiology center serving Urban Indian organizations nationally.

''(2) The term 'Indian Tribe' has the meaning given to the term 'Indian tribe' in section 4 of the Indian Self-Determination and Education Assistance Act.

''(3) The term 'Tribal organization' has the meaning given to the term 'tribal organization' in section 4 of the Indian Self-Determination and Education Assistance Act.

''(4) The term 'Urban Indian organization' has the meaning given to that term in section 4 of the Indian Health Care Improvement Act.''.

(h) AUTHORIZATION OF APPROPRIATIONS.—Section 306(o) of the Public Health Service Act, as redesignated by subsection (g), is amended to read as follows:

''(o)(1) To carry out this section, there is authorized to be appropriated $185,000,000 for each of the fiscal years 2021 through 2025.

''(2) Of the amount authorized to be appropriated to carry out this section for a fiscal year, the Secretary shall not use more than 10 percent for the combined costs of—

''(A) administration of this section; and

''(B) carrying out subsection (m)(2).''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey (Mr. PALLONE) and the gentleman from Oregon (Mr. WALDEN) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey.

GENERAL LEAVE

Mr. PALLONE. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on H.R. 7948.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mr. PALLONE. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, the health of American Indian and Alaska Native populations lags behind all other races in the United States. Economic adversity and poor social conditions have contributed to disproportionate disease burden, lower life expectancies, and other health inequalities in Tribal communities. Tragically, Tribal members are expected to live 5.5 fewer years than other races.

Now, the coronavirus pandemic has further highlighted these longstanding health inequalities. According to CDC data, more than one-third of nonelderly American Indians and Alaska Natives are at high risk of developing a serious illness resulting from a COVID–19 infection, compared with one-fifth of the White nonelderly adults.

Today, we are taking an important step in improving health outcomes by improving data access for Tribal Epidemiology Centers. These centers manage regional public health information systems, disease prevention and control programs, and coordinate with other public health authorities in the collection and study of epidemiological data. None of these functions work if Federal, State, and local partners are not sharing relevant data in a secured manner.

H.R. 7948, the Tribal Health Data Improvement Act, ensures that Tribal Nations are equipped with the necessary public health data to operate public health programs and improve health outcomes within their communities. It does this by clarifying the Federal role in collection and availability of health data with respect to Indian Tribes.

The legislation also mandates ways of improving health statistics reporting with respect to Indian Tribes, such as requiring the Secretary to release all applicable public health data on Tribal Epidemiology Centers within 180 days of enactment and requiring the CDC to expand and improve their assistance to States with respect to sharing data with Tribal entities.

Finally, the bill reauthorizes the National Center for Health Statistics with additional funding for the new programs that are established by the bill.

I want to thank Representatives GIANFORTE, LUJÁN, RODGERS, MULLIN, O'HALLERAN, and RUIZ for the excellent bipartisan work on this legislation.

I urge my colleagues to support the bill, and I reserve the balance of my time.

Mr. WALDEN. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I rise today in strong support of H.R. 7948, the Tribal Health Data Improvement Act, introduced by my Energy and Commerce Committee colleagues, Representatives GIANFORTE, RUIZ, RODGERS, O'HALLERAN, and LUJÁN.

This is really important public health legislation. It addresses some chronic challenges that are faced by Tribal Nations and Tribal Epidemiology Centers as they try to gain access to critical Federal healthcare and public health surveillance data.

Obtaining this data is critical for engaging in preventive public health work and combating current health crises in American Indian and Alaska Native communities. However, structural barriers to accessing data have been especially problematic during the COVID–19 pandemic, which, tragically, has disproportionately impacted these very communities.

In order to ensure Tribal Nations and Tribal Epidemiology Centers have access to the data necessary to accomplish public health priorities, this legislation requires the Secretary of Health and Human Services to create a data-sharing strategy that takes into consideration the recommendations of the Secretary's Tribal Advisory Committee.

In addition, in reauthorizing the CDC's National Center for Health Statistics, the bill requires the Secretary to make public health surveillance data available to the Indian Health Service, Indian Tribes, Tribal organizations, and Tribal Epidemiology Centers, so long as the data requested for use is consistent with Federal law and, of course, obligations.

The Secretary must also consult with Indian Tribes, Tribal organizations, urban Indian organizations, and the Tribal Health Advisory Group of the Centers for Medicare and Medicaid Services to develop guidelines for State and local health agencies to improve the quality and accuracy of birth and death records of American Indians and Alaska Natives.

By improving the sharing of data between the Federal Government and the Tribes, this important bill would help address the health disparities in American Indian and Alaska Native communities.

Madam Speaker, I urge a ''yes'' vote on this legislation, and I reserve the balance of my time.

□ 1530

Mr. PALLONE. Madam Speaker, I yield such time as he may consume to the gentleman from New Mexico (Mr. LUJÁN), a leader on Tribal issues.

Mr. LUJÁN. Madam Speaker, during this COVID–19 pandemic, which has already killed more than 200,000 Americans, it is crucial that the CDC and State health departments are sharing essential, lifesaving public health data from Tribal epidemiology centers to protect the health of the people they serve.

TECs, like any State or local health department, are legally entitled to access to the same data, but for the first months of the public health emergency, this data was withheld, despite the urging of Tribal leaders, myself, and fellow members of the Energy and Commerce Committee.

This data, including information on COVID–19 testing, positive case numbers, contact tracing, and more, is essential for Tribes and TECs to protect the health and well-being of the communities they serve.

That is why Representative GIANFORTE and I introduced the bipartisan Tribal Health Data Improvement Act with the support of the National

Indian Health Board. While the CDC Director has fulfilled the commitment he made to me to share COVID-related data with all the TECs, there are still barriers to accessing other important data sets that are crucial to protecting the public health during and after this pandemic.

This important legislation makes it clear that the Department of Health and Human Services and State health departments are required to share data with Tribal health authorities, and it includes additional funding to make this happen.

This legislation is about justice and living up to the Federal Government's legal responsibility. It would help save lives as we continue working to defeat this virus. Tribes and TECs are working hard to protect public health in their communities, and it is their right to access the CDC data to do so.

Madam Speaker, I look forward to seeing the House pass this legislation, and I will urge my colleagues in the Senate to act with the same urgency.

Mr. WALDEN. Madam Speaker, I want to thank my colleagues, especially my friend from New Mexico for his leadership on this legislation. I would just say that they have all worked very hard on this. It is extraordinarily important to pass this.

Madam Speaker, I yield back the balance of my time.

Mr. PALLONE. Madam Speaker, I also urge support of the bill, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. PALLONE) that the House suspend the rules and pass the bill, H.R. 7948, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

PURSUING EQUITY IN MENTAL HEALTH ACT

Mr. PALLONE. Madam Speaker, I move to suspend the rules and pass the bill (H.R. 5469) to address mental health issues for youth, particularly youth of color, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 5469

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Pursuing Equity in Mental Health Act''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

TITLE I—HEALTH EQUITY AND ACCOUNTABILITY

SEC. 101. INTEGRATED HEALTH CARE DEMONSTRATION PROGRAM.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.) is amended by adding at the end the following:

''SEC. 554. INTERPROFESSIONAL HEALTH CARE TEAMS FOR PROVISION OF BEHAVIORAL HEALTH CARE IN PRIMARY CARE SETTINGS.

''(a) GRANTS.—The Secretary shall award grants to eligible entities for the purpose of establishing interprofessional health care teams that provide behavioral health care.

''(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall be a Federally qualified health center (as defined in section 1861(aa) of the Social Security Act), rural health clinic, or behavioral health program, serving a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)).

''(c) SCIENTIFICALLY BASED.—Integrated health care funded through this section shall be scientifically based, taking into consideration the results of the most recent peer-reviewed research available.

''(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $20,000,000 for each of the first 5 fiscal years following the date of enactment of the Pursuing Equity in Mental Health Act.''.

SEC. 102. ADDRESSING RACIAL AND ETHNIC MINORITY MENTAL HEALTH DISPARITIES RESEARCH GAPS.

Not later than 6 months after the date of the enactment of this Act, the Director of the National Institutes of Health shall enter into an arrangement with the National Academies of Sciences, Engineering, and Medicine (or, if the National Academies of Sciences, Engineering, and Medicine decline to enter into such an arrangement, the Patient-Centered Outcomes Research Institute, the Agency for Healthcare Research and Quality, or another appropriate entity)—

(1) to conduct a study with respect to mental health disparities in racial and ethnic minority groups (as defined in section 1707(g) of the Public Health Service Act (42 U.S.C. 300u–6(g))); and

(2) to submit to the Congress a report on the results of such study, including—

(A) a compilation of information on the dynamics of mental disorders in such racial and ethnic minority groups; and

(B) a compilation of information on the impact of exposure to community violence, adverse childhood experiences, structural racism, and other psychological traumas on mental disorders in such racial and minority groups.

SEC. 103. HEALTH PROFESSIONS COMPETENCIES TO ADDRESS RACIAL AND ETHNIC MINORITY MENTAL HEALTH DISPARITIES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall award grants to qualified national organizations for the purposes of—

(1) developing, and disseminating to health professional educational programs best practices or core competencies addressing mental health disparities among racial and ethnic minority groups for use in the training of students in the professions of social work, psychology, psychiatry, marriage and family therapy, mental health counseling, and substance misuse counseling; and

(2) certifying community health workers and peer wellness specialists with respect to such best practices and core competencies and integrating and expanding the use of such workers and specialists into health care to address mental health disparities among racial and ethnic minority groups.

(b) BEST PRACTICES; CORE COMPETENCIES.—Organizations receiving funds under subsection (a) may use the funds to engage in the following activities related to the development and dissemination of best practices or core competencies described in subsection (a)(1):

(1) Formation of committees or working groups comprised of experts from accredited health professions schools to identify best practices and core competencies relating to mental health disparities among racial and ethnic minority groups.

(2) Planning of workshops in national fora to allow for public input into the educational needs associated with mental health disparities among racial and ethnic minority groups.

(3) Dissemination and promotion of the use of best practices or core competencies in undergraduate and graduate health professions training programs nationwide.

(4) Establishing external stakeholder advisory boards to provide meaningful input into policy and program development and best practices to reduce mental health disparities among racial and ethnic minority groups.

(c) DEFINITIONS.—In this section:

(1) QUALIFIED NATIONAL ORGANIZATION.—The term ''qualified national organization'' means a national organization that focuses on the education of students in one or more of the professions of social work, psychology, psychiatry, marriage and family therapy, mental health counseling, and substance misuse counseling.

(2) RACIAL AND ETHNIC MINORITY GROUP.—The term ''racial and ethnic minority group'' has the meaning given to such term in section 1707(g) of the Public Health Service Act (42 U.S.C. 300u–6(g)).

SEC. 104. RACIAL AND ETHNIC MINORITY BEHAVIORAL AND MENTAL HEALTH OUTREACH AND EDUCATION STRATEGY.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.), as amended by section 101, is further amended by adding at the end the following new section:

''SEC. 555. BEHAVIORAL AND MENTAL HEALTH OUTREACH AND EDUCATION STRATEGY.

''(a) IN GENERAL.—The Secretary shall, in consultation with advocacy and behavioral and mental health organizations serving racial and ethnic minority groups, develop and implement an outreach and education strategy to promote behavioral and mental health and reduce stigma associated with mental health conditions and substance abuse among racial and ethnic minority groups. Such strategy shall—

''(1) be designed to—

''(A) meet the diverse cultural and language needs of the various racial and ethnic minority groups; and

''(B) be developmentally and age-appropriate;

''(2) increase awareness of symptoms of mental illnesses common among such groups, taking into account differences within at-risk subgroups;

''(3) provide information on evidence-based, culturally and linguistically appropriate and adapted interventions and treatments;

''(4) ensure full participation of, and engage, both consumers and community members in the development and implementation of materials; and