

112TH CONGRESS  
1ST SESSION

# H. R. 2954

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

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## IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 15, 2011

Ms. LEE of California (for herself, Mrs. CHRISTENSEN, Ms. ROYBAL-ALLARD, Ms. BASS of California, Mr. BISHOP of Georgia, Ms. BORDALLO, Mr. BROOKS, Ms. BROWN of Florida, Mr. BUTTERFIELD, Mr. CARSON of Indiana, Ms. CHU, Mr. CLARKE of Michigan, Ms. CLARKE of New York, Mr. CLAY, Mr. CLEAVER, Mr. COHEN, Mr. CONYERS, Mr. CUMMINGS, Mr. DAVIS of Illinois, Ms. DEGETTE, Ms. DELAURO, Ms. EDWARDS, Mr. ELLISON, Mr. FALEOMAVAEGA, Mr. FATTAH, Ms. FUDGE, Mr. GONZALEZ, Mr. AL GREEN of Texas, Mr. GRIJALVA, Mr. GUTIERREZ, Ms. HAHN, Ms. HANABUSA, Mr. HASTINGS of Florida, Ms. HIRONO, Mr. HONDA, Mr. JACKSON of Illinois, Ms. JACKSON LEE of Texas, Mr. JOHNSON of Georgia, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. LEWIS of Georgia, Mr. KUCINICH, Ms. MATSUI, Mr. MCGOVERN, Mr. MEEKS, Ms. MOORE, Mrs. NAPOLITANO, Ms. NORTON, Mr. OLVER, Mr. PAYNE, Mr. PIERLUISI, Mr. RANGEL, Mr. REYES, Ms. RICHARDSON, Mr. RICHMOND, Mr. RUSH, Mr. SABLAN, Ms. LINDA T. SÁNCHEZ of California, Ms. SCHAKOWSKY, Mr. SCOTT of Virginia, Mr. DAVID SCOTT of Georgia, Mr. SERRANO, Mr. SIRES, Ms. SLAUGHTER, Mr. THOMPSON of Mississippi, Mr. TOWNS, Ms. WATERS, Mr. WATT, Ms. WILSON of Florida, and Ms. WOOLSEY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and the Workforce, the Budget, Veterans' Affairs, Armed Services, Agriculture, the Judiciary, 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 2011”.

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

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

- Sec. 1. Short title.
- Sec. 2. Table of contents.
- Sec. 3. Findings.

## TITLE I—DATA COLLECTION AND REPORTING

- Sec. 101. Amendment to the Public Health Service Act.
- Sec. 102. Elimination of prerequisite of direct appropriations for data collection and analysis.
- Sec. 103. Collection of race and ethnicity data by the Social Security Administration.
- Sec. 104. Revision of HIPAA claims standards.
- Sec. 105. National Center for Health Statistics.
- Sec. 106. Oversampling of Asian-Americans, Native Hawaiians, or Pacific Islanders and other underrepresented groups in Federal health surveys.
- Sec. 107. Geo-access study.
- Sec. 108. Racial, ethnic, and linguistic data collected by the Federal Government.
- Sec. 109. Data collection and analysis grants to minority-serving institutions.
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- Sec. 111. Optional collection of health data on immigrants and individuals in their households.
- Sec. 112. Standards for measuring socioeconomic status in collection of health data.
- Sec. 113. Safety and effectiveness of drugs with respect to racial and ethnic background.
- Sec. 114. GAO study on compliance with existing FDA requirements to present drug and device safety and effectiveness data by sex, age, and racial and ethnic subgroups.
- Sec. 115. Improving health data regarding Native Hawaiians and other Pacific Islanders.

TITLE II—CULTURALLY AND LINGUISTICALLY APPROPRIATE  
HEALTH CARE

- Sec. 201. Definitions.
- Sec. 202. Amendment to the Public Health Service Act.
- Sec. 203. Federal reimbursement for culturally and linguistically appropriate services under the Medicare, Medicaid, and State Children’s Health Insurance Programs.
- Sec. 204. Increasing understanding of and improving health literacy.
- Sec. 205. Assurances for receiving Federal funds.
- Sec. 206. Report on Federal efforts to provide culturally and linguistically appropriate health care services.
- Sec. 207. English for speakers of other languages.
- Sec. 208. Implementation.
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- Sec. 308. McNair Postbaccalaureate Achievement Program.
- Sec. 309. Rules for determination of full-time equivalent residents for cost reporting periods.
- Sec. 310. Developing and implementing strategies for local health equity.
- Sec. 311. Loan forgiveness for mental and behavioral health social workers.

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- Sec. 403. Designation of health empowerment zones.
- Sec. 404. Assistance to those seeking designation.
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- Sec. 412. Removing barriers to unsubsidized purchase of private insurance in American Health Benefit Exchanges.
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- Sec. 711. Viral hepatitis and liver cancer control and prevention.

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- Sec. 721. Acquired Bone Marrow Failure Diseases.

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- Sec. 741. Findings.
- Sec. 742. Addressing HIV/AIDS in communities of color.
- Sec. 743. HIV/AIDS reduction in racial and ethnic minority communities.
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- Sec. 745. Dental Education Loan Repayment Program.
- Sec. 746. Report on the implementation of the national HIV/AIDS strategy.
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- Sec. 751. Services to reduce HIV/AIDS in racial and ethnic minority communities.
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- Sec. 753. Report on impact of HIV/AIDS in racial and ethnic minority communities.
- Sec. 754. Study on status of HIV/AIDS epidemic among African-Americans.

Subtitle F—Diabetes

- Sec. 755. Treatment of diabetes in minority communities.
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## TITLE VIII—HEALTH INFORMATION TECHNOLOGY

### Subtitle A—Reducing Health Disparities Through Health IT

- Sec. 801. HRSA assistance to health centers for promotion of Health IT.
- Sec. 802. Assessment of impact of Health IT on racial and ethnic minority communities; outreach and adoption of Health IT in such communities.

### Subtitle B—Modifications to Achieve Parity in Existing Programs

- Sec. 811. Extending funding to strengthen the Health IT infrastructure in racial and ethnic minority communities.
- Sec. 812. Prioritizing regional extension center assistance to racial and ethnic minority groups.
- Sec. 813. Extending competitive grants for the development of loan programs to facilitate adoption of certified EHR technology by providers serving racial and ethnic minority groups.

### Subtitle C—Additional Research and Studies

- Sec. 831. Data collection and assessments conducted in coordination with minority-serving institutions.
- Sec. 832. IOM study and report on privacy concerns of certain minority populations.
- Sec. 833. Study of health information technology in medically underserved communities.

### Subtitle D—Closing Gaps in Funding To Adopt Certified EHRs

- Sec. 841. Application of Medicare HITECH payments to hospitals in Puerto Rico.
- Sec. 842. Extending Medicaid EHR incentive payments to long-term care facilities and home health agencies.
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## TITLE IX—ACCOUNTABILITY AND EVALUATION

- Sec. 901. Prohibition on discrimination in Federal assisted health care services and research programs on the basis of sex, race, color, national origin, sexual orientation, gender identity, or disability status.
- Sec. 902. Treatment of Medicare payments under Title VI of the Civil Rights Act of 1964.
- Sec. 903. Accountability and transparency within the Department of Health and Human Services.
- Sec. 904. United States Commission on Civil Rights.
- Sec. 905. Sense of Congress concerning full funding of activities to eliminate racial and ethnic health disparities.
- Sec. 906. GAO and NIH reports.

TITLE X—ADDRESSING SOCIAL DETERMINANTS AND IMPROVING  
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- Sec. 1001. Codification of Executive Order 12898.  
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Sec. 1003. Grant program.  
Sec. 1004. Additional research on the relationship between the built environment and the health of community residents.  
Sec. 1005. Environment and public health restoration.  
Sec. 1006. Healthy Food Financing Initiative.  
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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.

1           (3) By 2020, the Nation will face a shortage of  
2 health care providers and allied health workers and  
3 this shortage disproportionately affects health pro-  
4 fessional shortage areas where many racial and eth-  
5 nic minority populations reside.

6           (4) All efforts to reduce health disparities and  
7 barriers to quality health services require better and  
8 more consistent data.

9           (5) A full range of culturally and linguistically  
10 appropriate health care and public health services  
11 must be available and accessible in every community.

12           (6) Racial and ethnic minorities and under-  
13 served populations must be included early and equi-  
14 tably in health reform innovations.

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

22           (8) In 2011, the Department of Health and  
23 Human Services developed the HHS Action Plan to  
24 Reduce Racial and Ethnic Health Disparities and  
25 the National Stakeholder Strategy for Achieving



1 Health Equity, two strategic plans that represent  
2 the country's first coordinated roadmap to reducing  
3 health disparities. Along with the National Preven-  
4 tion Strategy and the National Health Care Quality  
5 Strategy, these comprehensive plans will work to in-  
6 crease the number of Americans who are healthy at  
7 every stage of life.

8 (9) The Department of Health and Human  
9 Services also developed other strategic planning doc-  
10 uments to combat disease disparities with a high im-  
11 pact on minority populations including the National  
12 HIV/AIDS Strategy, and the Action Plan for the  
13 Prevention, Care and Treatment of Viral Hepatitis.

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

## 18 **TITLE I—DATA COLLECTION** 19 **AND REPORTING**

### 20 **SEC. 101. AMENDMENT TO THE PUBLIC HEALTH SERVICE** 21 **ACT.**

22 (a) PURPOSE.—It is the purpose of this section to  
23 promote data collection, analysis, and reporting by race,  
24 ethnicity, sex, primary language, sexual orientation, dis-

1 ability status, gender identity, and socioeconomic status  
2 among federally supported health programs.

3 (b) AMENDMENT.—Title XXXIV of the Public  
4 Health Service Act, as amended by titles II and III of  
5 this Act, is further amended by inserting after subtitle A  
6 the following:

7 **“Subtitle B—Strengthening Data**  
8 **Collection, Improving Data**  
9 **Analysis, and Expanding Data**  
10 **Reporting**

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

12 “(a) REQUIREMENTS.—

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

18 “(A) require the collection, by the agency  
19 or program involved, of data on the race, eth-  
20 nicity, sex, primary language, sexual orienta-  
21 tion, disability status, gender identity, and so-  
22 cioeconomic status of each applicant for and re-  
23 cipient of health-related assistance under such  
24 program—

1           “(i) using, at a minimum, the stand-  
2           ards for data collection on race, ethnicity,  
3           sex, primary language, sexual orientation,  
4           disability status, gender identity, and so-  
5           cioeconomic status developed under section  
6           3101;

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

11          “(iii) additionally referring, where  
12          practicable, to the standards developed by  
13          the Institute of Medicine in ‘Race, Eth-  
14          nicity, and Language Data: Standardiza-  
15          tion for Health Care Quality Improve-  
16          ment’; and

17          “(iv) where practicable, through self-  
18          reporting;

19          “(B) with respect to the collection of the  
20          data described in subparagraph (A), for appli-  
21          cants and recipients who are minors, require  
22          communication assistance in speech or writing,  
23          and for applicants and recipients who are other-  
24          wise legally incapacitated, require that—

1           “(i) such data be collected from the  
2           parent or legal guardian of such an appli-  
3           cant or recipient; and

4           “(ii) the primary language of the par-  
5           ent or legal guardian of such an applicant  
6           or recipient be collected;

7           “(C) systematically analyze such data  
8           using the smallest appropriate units of analysis  
9           feasible to detect racial and ethnic disparities,  
10          as well as disparities along the lines of primary  
11          language, sex, disability status, sexual orienta-  
12          tion, gender identity, and socioeconomic status  
13          in health and health care, and report the results  
14          of such analysis to the Secretary, the Director  
15          of the Office for Civil Rights, each agency listed  
16          in section 3101(c)(1), the Committee on  
17          Health, Education, Labor, and Pensions and  
18          the Committee on Finance of the Senate, and  
19          the Committee on Energy and Commerce and  
20          the Committee on Ways and Means of the  
21          House of Representatives;

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

24          “(E) ensure that the provision of assist-  
25          ance to an applicant or recipient of assistance

1 is not denied or otherwise adversely affected be-  
2 cause of the failure of the applicant or recipient  
3 to provide race, ethnicity, primary language,  
4 sex, sexual orientation, disability status, gender  
5 identity, and socioeconomic status data.

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

8 “(A) permit the use of information col-  
9 lected under this subsection in a manner that  
10 would adversely affect any individual providing  
11 any such information; and

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

14 “(b) PROTECTION OF DATA.—The Secretary shall  
15 ensure (through the promulgation of regulations or other-  
16 wise) that all data collected pursuant to subsection (a) are  
17 protected—

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

1           “(2) from all inappropriate internal use by any  
2           entity that collects, stores, or receives the data, in-  
3           cluding use of such data in determinations of eligi-  
4           bility (or continued eligibility) in health plans, and  
5           from other inappropriate uses, as defined by the  
6           Secretary.

7           “(c) NATIONAL PLAN OF THE DATA COUNCIL.—The  
8           Secretary shall develop and implement a national plan to  
9           ensure the collection of data in a culturally appropriate  
10          and competent manner, to improve the collection, analysis,  
11          and reporting of racial, ethnic, sex, primary language, sex-  
12          ual orientation, disability status, gender identity, and so-  
13          cioeconomic status data at the Federal, State, territorial,  
14          tribal, and local levels, including data to be collected under  
15          subsection (a), and to ensure that data collection activities  
16          carried out under this section are in compliance with the  
17          standards developed under section 3101. The Data Coun-  
18          cil of the Department of Health and Human Services, in  
19          consultation with the National Committee on Vital Health  
20          Statistics, the Office of Minority Health, Office on Wom-  
21          en’s Health, and other appropriate public and private enti-  
22          ties, shall make recommendations to the Secretary con-  
23          cerning the development, implementation, and revision of  
24          the national plan. Such plan shall include recommenda-  
25          tions on how to—

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

4           “(2) expand awareness among Federal agencies,  
5 States, territories, Indian tribes, health providers,  
6 health plans, health insurance issuers, and the gen-  
7 eral public that data collection, analysis, and report-  
8 ing by race, ethnicity, primary language, sexual ori-  
9 entation, disability status, gender identity, and socio-  
10 economic status is legal and necessary to assure eq-  
11 uity and nondiscrimination in the quality of health  
12 care services;

13           “(3) ensure that future patient record systems  
14 have data code sets for racial, ethnic, primary lan-  
15 guage, sexual orientation, disability status, gender  
16 identity, and socioeconomic status identifiers and  
17 that such identifiers can be retrieved from clinical  
18 records, including records transmitted electronically;

19           “(4) improve health and health care data collec-  
20 tion and analysis for more population groups if such  
21 groups can be aggregated into the minimum race  
22 and ethnicity categories, including exploring the fea-  
23 sibility of enhancing collection efforts in States for  
24 racial and ethnic groups that comprise a significant  
25 proportion of the population of the State;

1           “(5) provide researchers with greater access to  
2 racial, ethnic, primary language, sexual orientation,  
3 disability status, gender identity, and socioeconomic  
4 status data, subject to privacy and confidentiality  
5 regulations; and

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

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

14           “(e) TECHNICAL ASSISTANCE FOR THE COLLECTION  
15 AND REPORTING OF DATA.—

16           “(1) IN GENERAL.—The Secretary may, either  
17 directly or through grant or contract, provide tech-  
18 nical assistance to enable a health care program or  
19 an entity operating under such program to comply  
20 with the requirements of this section.

21           “(2) TYPES OF ASSISTANCE.—Assistance pro-  
22 vided under this subsection may include assistance  
23 to—

24           “(A) enhance or upgrade computer tech-  
25 nology that will facilitate racial, ethnic, primary



1 language, sexual orientation, disability status,  
2 gender identity, and socioeconomic status data  
3 collection and analysis;

4 “(B) improve methods for health data col-  
5 lection and analysis including additional popu-  
6 lation groups beyond the Office of Management  
7 and Budget categories if such groups can be  
8 aggregated into the minimum race and ethnicity  
9 categories;

10 “(C) develop mechanisms for submitting  
11 collected data subject to existing privacy and  
12 confidentiality regulations; and

13 “(D) develop educational programs to in-  
14 form health insurance issuers, health plans,  
15 health providers, health-related agencies, and  
16 the general public that data collection and re-  
17 porting by race, ethnicity, primary language,  
18 sexual orientation, disability status, gender  
19 identity, and socioeconomic status are legal and  
20 essential for eliminating health and health care  
21 disparities.

22 “(f) ANALYSIS OF HEALTH DISPARITY DATA.—The  
23 Secretary, acting through the Director of the Agency for  
24 Healthcare Research and Quality and in coordination with  
25 the Administrator of the Centers for Medicare & Medicaid

1 Services, shall provide technical assistance to agencies of  
2 the Department of Health and Human Services in meeting  
3 Federal standards for health disparity data collection and  
4 for analysis of racial and ethnic disparities in health and  
5 health care in public programs by—

6           “(1) identifying appropriate quality assurance  
7 mechanisms to monitor for health disparities;

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

10           “(3) developing new quality measures relating  
11 to racial and ethnic disparities and their overlap  
12 with other disparity factors in health and health  
13 care;

14           “(4) identifying the level at which data analysis  
15 should be conducted; and

16           “(5) sharing data with external organizations  
17 for research and quality improvement purposes.

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

20           “(1) under the Social Security Act (42 U.S.C.  
21 301 et seq.) that pays for health care and services;  
22 and

23           “(2) under this Act that provides Federal finan-  
24 cial assistance for health care, biomedical research,

1 or health services research and or is designed to im-  
2 prove the public's health.

3 “(h) 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 2012 through 2017.

7 **“SEC. 3432. PROVISIONS RELATING TO NATIVE AMERICANS.**

8 “(a) ESTABLISHMENT OF EPIDEMIOLOGY CEN-  
9 TERS.—The Secretary shall establish an epidemiology cen-  
10 ter in each service area to carry out the functions de-  
11 scribed in subsection (b). Any new center established after  
12 the date of the enactment of the Health Equity and Ac-  
13 countability Act of 2011 may be operated under a grant  
14 authorized by subsection (d), but funding under such a  
15 grant shall not be divisible.

16 “(b) FUNCTIONS OF CENTERS.—In consultation with  
17 and upon the request of Indian tribes, tribal organizations,  
18 and urban indian organizations, each service area epidemi-  
19 ology center established under this subsection shall, with  
20 respect to such service area—

21 “(1) collect data relating to, and monitor  
22 progress made toward meeting, each of the health  
23 status objectives of the service, the Indian tribes,  
24 tribal organizations, and urban indian organizations  
25 in the service area;

1           “(2) evaluate existing delivery systems, data  
2 systems, and other systems that impact the improve-  
3 ment of Indian health;

4           “(3) assist Indian tribes, tribal organizations,  
5 and urban indian organizations in identifying their  
6 highest priority health status objectives and the  
7 services needed to achieve such objectives, based on  
8 epidemiological data;

9           “(4) make recommendations for the targeting  
10 of services needed by the populations served;

11           “(5) make recommendations to improve health  
12 care delivery systems for Indians and urban Indians;

13           “(6) provide requested technical assistance to  
14 Indian tribes, tribal organizations, and urban indian  
15 organizations in the development of local health  
16 service priorities and incidence and prevalence rates  
17 of disease and other illness in the community; and

18           “(7) provide disease surveillance and assist In-  
19 dian tribes, tribal organizations, and urban Indian  
20 organizations to promote public health.

21           “(c) TECHNICAL ASSISTANCE.—The Director of the  
22 Centers for Disease Control and Prevention shall provide  
23 technical assistance to the centers in carrying out the re-  
24 quirements of this subsection.

25           “(d) GRANTS FOR STUDIES.—

1           “(1) IN GENERAL.—The Secretary may make  
2 grants to Indian tribes, tribal organizations, urban  
3 indian organizations, and eligible intertribal con-  
4 sortia to conduct epidemiological studies of Indian  
5 communities.

6           “(2) ELIGIBLE INTERTRIBAL CONSORTIA.—An  
7 intertribal consortium is eligible to receive a grant  
8 under this subsection if—

9                   “(A) the intertribal consortium is incor-  
10 porated for the primary purpose of improving  
11 Indian health; and

12                   “(B) the intertribal consortium is rep-  
13 resentative of the Indian tribes or urban Indian  
14 communities in which the intertribal consortium  
15 is located.

16           “(3) APPLICATIONS.—An application for a  
17 grant under this subsection shall be submitted in  
18 such manner and at such time as the Secretary shall  
19 prescribe.

20           “(4) REQUIREMENTS.—An applicant for a  
21 grant under this subsection shall—

22                   “(A) demonstrate the technical, adminis-  
23 trative, and financial expertise necessary to  
24 carry out the functions described in paragraph  
25 (5);

1           “(B) consult and cooperate with providers  
2 of related health and social services in order to  
3 avoid duplication of existing services; and

4           “(C) demonstrate cooperation from Indian  
5 tribes or urban Indian organizations in the area  
6 to be served.

7           “(5) USE OF FUNDS.—A grant awarded under  
8 paragraph (1) may be used—

9           “(A) to carry out the functions described  
10 in subsection (b);

11           “(B) to provide information to and consult  
12 with tribal leaders, urban Indian community  
13 leaders, and related health staff on health care  
14 and health service management issues; and

15           “(C) in collaboration with Indian tribes,  
16 tribal organizations, and urban Indian commu-  
17 nities, to provide the service with information  
18 regarding ways to improve the health status of  
19 Indians.

20           “(e) ACCESS TO INFORMATION.—An epidemiology  
21 center operated by a grantee pursuant to a grant awarded  
22 under subsection (d) shall be treated as a public health  
23 authority for purposes of the Health Insurance Portability  
24 and Accountability Act of 1996 (Public Law 104–191; 110  
25 Stat. 2033), as such entities are defined in part 164.501

1 of title 45, Code of Federal Regulations (or a successor  
2 regulation). The Secretary shall grant such grantees ac-  
3 cess to and use of data, data sets, monitoring systems,  
4 delivery systems, and other protected health information  
5 in the possession of the Secretary.”.

6 **SEC. 102. ELIMINATION OF PREREQUISITE OF DIRECT AP-**  
7 **PROPRIATIONS FOR DATA COLLECTION AND**  
8 **ANALYSIS.**

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

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

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

14 **SEC. 103. COLLECTION OF RACE AND ETHNICITY DATA BY**  
15 **THE SOCIAL SECURITY ADMINISTRATION.**

16 Part A of title XI of the Social Security Act (42  
17 U.S.C. 1301 et seq.) is amended by adding at the end  
18 the following:

19 **“SEC. 1150C. COLLECTION OF RACE AND ETHNICITY DATA**  
20 **BY THE SOCIAL SECURITY ADMINISTRATION.**

21 “(a) REQUIREMENT.—The Commissioner of Social  
22 Security, in consultation with the Administrator of the  
23 Centers for Medicare & Medicaid Services, shall—

24 “(1) require the collection of data on the race,  
25 ethnicity, primary language, and disability status of

1 all applicants for Social Security account numbers or  
2 benefits under title II or part A of title XVIII and  
3 all individuals with respect to whom the Commis-  
4 sioner maintains records of wages and self-employ-  
5 ment income in accordance with reports received by  
6 the Commissioner or the Secretary of the Treas-  
7 ury—

8 “(A) using, at a minimum, the standards  
9 for data collection on race, ethnicity, primary  
10 language, and disability status developed under  
11 section 3101 of the Public Health Service Act;

12 “(B) where practicable, collecting data for  
13 additional population groups if such groups can  
14 be aggregated into the minimum race and eth-  
15 nicity categories; and

16 “(C) additionally referring, where prac-  
17 ticable, to the standards developed by the Insti-  
18 tute of Medicine in ‘Race, Ethnicity, and Lan-  
19 guage Data: Standardization for Health Care  
20 Quality Improvement’ (released August 31,  
21 2009);

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



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

3           “(B) the primary language of the parent  
4           or legal guardian of such an applicant or recipi-  
5           ent be used;

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

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

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

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

16          “(7) ensure that the provision of assistance to  
17          an applicant is not denied or otherwise adversely af-  
18          fected because of the failure of the applicant to pro-  
19          vide race, ethnicity, primary language, and disability  
20          status data.

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

1           “(1) under the same privacy protections as the  
2       Secretary applies to health data under the regula-  
3       tions promulgated under section 264(c) of the  
4       Health Insurance Portability and Accountability Act  
5       of 1996 (Public Law 104–191; 110 Stat. 2033) re-  
6       lating to the privacy of individually identifiable  
7       health information and other protections; and

8           “(2) from all inappropriate internal use by any  
9       entity that collects, stores, or receives the data, in-  
10      cluding use of such data in determinations of eligi-  
11      bility (or continued eligibility) in health plans, and  
12      from other inappropriate uses, as defined by the  
13      Secretary.

14       “(c) RULE OF CONSTRUCTION.—Nothing in this sec-  
15      tion shall be construed to permit the use of information  
16      collected under this section in a manner that would ad-  
17      versely affect any individual providing any such informa-  
18      tion.

19       “(d) TECHNICAL ASSISTANCE.—The Secretary may,  
20      either directly or by grant or contract, provide technical  
21      assistance to enable any health entity to comply with the  
22      requirements of this section.

23       “(e) 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 2012 through 2017.”.

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

4 (a) IN GENERAL.—Not later than 1 year after the  
5 date of enactment of this Act, the Secretary of Health and  
6 Human Services shall revise the regulations promulgated  
7 under part C of title XI of the Social Security Act (42  
8 U.S.C. 1320d et seq.), relating to the collection of data  
9 on race, ethnicity, and primary language in a health-re-  
10 lated transaction, to require—

11 (1) the use, at a minimum, of the standards for  
12 data collection on race, ethnicity, primary language,  
13 disability, and sex developed under section 3101 of  
14 the Public Health Service Act (42 U.S.C. 300kk);  
15 and

16 (2) the designation of the racial, ethnic, pri-  
17 mary language, disability, and sex code sets as re-  
18 quired for claims and enrollment data.

19 (b) DISSEMINATION.—The Secretary of Health and  
20 Human Services shall disseminate the new standards de-  
21 veloped under subsection (a) to all health entities that are  
22 subject to the regulations described in such subsection and  
23 provide technical assistance with respect to the collection  
24 of the data involved.

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

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

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

9                   (1) in paragraph (1), by striking “2003” and  
10           inserting “2016”;

11                   (2) in paragraph (2), in the first sentence, by  
12           striking “2003” and inserting “2016”; and

13                   (3) in paragraph (3), by striking “2002” and  
14           inserting “2016”.

15 **SEC. 106. OVERSAMPLING OF ASIAN-AMERICANS, NATIVE**  
16                   **HAWAIIANS, OR PACIFIC ISLANDERS AND**  
17                   **OTHER UNDERREPRESENTED GROUPS IN**  
18                   **FEDERAL HEALTH SURVEYS.**

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

1 **“SEC. 317U. OVERSAMPLING OF ASIAN-AMERICANS, NATIVE**  
2 **HAWAIIANS, OR PACIFIC ISLANDERS AND**  
3 **OTHER UNDERREPRESENTED GROUPS IN**  
4 **FEDERAL HEALTH SURVEYS.**

5 “(a) NATIONAL STRATEGY.—

6 “(1) IN GENERAL.—The Secretary of Health  
7 and Human Services, acting through the Director of  
8 the National Center for Health Statistics (referred  
9 to in this section as ‘NCHS’) of the Centers for Dis-  
10 ease Control and Prevention, and other agencies  
11 within the Department of Health and Human Serv-  
12 ices as the Secretary determines appropriate, shall  
13 develop and implement an ongoing and sustainable  
14 national strategy for oversampling Asian-Americans,  
15 Native Hawaiians, or Pacific Islanders, and other  
16 underrepresented populations as determined appro-  
17 priate by the Secretary in Federal health surveys.

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

22 “(A) shall consult with representatives of  
23 community groups, nonprofit organizations,  
24 nongovernmental organizations, and govern-  
25 ment agencies working with Asian-Americans,

1 Native Hawaiians, or Pacific Islanders, and  
2 other underrepresented populations; and

3 “(B) may solicit the participation of rep-  
4 resentatives from other Federal departments  
5 and agencies.

6 “(b) PROGRESS REPORT.—Not later than 2 years  
7 after the date of the enactment of this section, the Sec-  
8 retary shall submit to the Congress a progress report,  
9 which shall include the national strategy described in sub-  
10 section (a)(1).

11 “(c) AUTHORIZATION OF APPROPRIATIONS.—To  
12 carry out this section, there are authorized to be appro-  
13 priated such sums as may be necessary for fiscal years  
14 2012 through 2017.”.

15 **SEC. 107. GEO-ACCESS STUDY.**

16 The Administrator of the Substance Abuse and Men-  
17 tal Health Services Administration shall—

18 (1) conduct a study to—

19 (A) determine which geographic areas of  
20 the United States have shortages of specialty  
21 mental health providers; and

22 (B) assess the preparedness of speciality  
23 mental health providers to deliver culturally and  
24 linguistically appropriate, affordable, and acces-  
25 sible services; and

1           (2) submit a report to the Congress on the re-  
2           sults of such study.

3 **SEC. 108. RACIAL, ETHNIC, AND LINGUISTIC DATA COL-**  
4 **LECTED BY THE FEDERAL GOVERNMENT.**

5           (a) COLLECTION; SUBMISSION.—Not later than 90  
6 days after the date of the enactment of this Act, and Jan-  
7 uary 31 of each year thereafter, each department, agency,  
8 and office of the Federal Government that has collected  
9 racial, ethnic, or linguistic data during the preceding cal-  
10 endar year shall submit such data to the Secretary of  
11 Health and Human Services.

12           (b) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—  
13 Not later than April 30, 2012, and each April 30 there-  
14 after, the Secretary of Health and Human Services, acting  
15 through the Director of the National Institute on Minority  
16 Health and Health Disparities and the Deputy Assistant  
17 Secretary for Minority Health, shall—

18           (1) collect and analyze the racial, ethnic, and  
19 linguistic data submitted under subsection (a) for  
20 the preceding calendar year;

21           (2) make publicly available such data and the  
22 results of such analysis; and

23           (3) submit a report to the Congress on such  
24 data and analysis.

1 **SEC. 109. DATA COLLECTION AND ANALYSIS GRANTS TO MI-**  
 2 **NORITY-SERVING INSTITUTIONS.**

3 (a) **AUTHORITY.**—The Secretary of Health and  
 4 Human Services, acting through the National Institute on  
 5 Minority Health and Health Disparities and the Office of  
 6 Minority Health, may award grants to access and analyze  
 7 racial and ethnic, and where possible other health dis-  
 8 parity data, to monitor and report on progress to reduce  
 9 and eliminate disparities in health and health care.

10 (b) **ELIGIBLE ENTITY.**—In this section, the term “el-  
 11 igible entity” means a historically Black college or univer-  
 12 sity, an Hispanic-serving institution, a tribal college or  
 13 university, or an Asian-American, Native American, or Pa-  
 14 cific Islander-serving institution with an accredited public  
 15 health, health policy, or health services research program.

16 **SEC. 110. STANDARDS FOR MEASURING SEXUAL ORIENTA-**  
 17 **TION AND GENDER IDENTITY IN COLLECTION**  
 18 **OF HEALTH DATA.**

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

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

24 (2) in paragraph (1)(C), by inserting “sexual  
 25 orientation, gender identity,” before “and disability  
 26 status”; and



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

4 **SEC. 111. OPTIONAL COLLECTION OF HEALTH DATA ON IM-**  
5 **MIGRANTS AND INDIVIDUALS IN THEIR**  
6 **HOUSEHOLDS.**

7           Section 3101(a) of the Public Health Service Act (42  
8 U.S.C. 300k(a)) is amended by adding at the end the fol-  
9           lowing:

10           “(4) **OPTIONAL UNIFORM CATEGORIES.**—Not  
11           later than 12 months after the date of the enact-  
12           ment of this paragraph, the Secretary shall—

13                   “(A) enter into an arrangement with the  
14           Institute of Medicine of the National Academies  
15           (or, if the Institute of Medicine declines to  
16           enter into such an arrangement, another appro-  
17           priate entity) to—

18                           “(i) conduct a study and develop rec-  
19                           ommended standards for the optional col-  
20                           lection of data on immigrants, as well as  
21                           citizens living within immigrant households  
22                           (mixed-status households), in order to  
23                           measure disparities in health coverage,  
24                           health care access and quality, and health  
25                           status among these populations, and

1           “(ii) include ensuing recommendations  
2           and results in a report to the Secretary  
3           that includes best practices to protect the  
4           privacy of respondents to the full extent of  
5           applicable law;

6           “(B) promulgate standards based on the  
7           recommendations and results of subparagraph  
8           (A) for the optional collection of data in major  
9           health surveys and research; and

10          “(C) provide clear guidance that immi-  
11          grant and mixed-status households are optional  
12          uniform categories and data concerning such  
13          households shall—

14                 “(i) not be required to be collected by  
15                 the standards under subparagraph (B);

16                 “(ii) be collected only in accordance  
17                 with—

18                         “(I) the ‘Tri-Agency Guidance’  
19                         issued by the Food and Nutrition  
20                         Service of the Department of Agri-  
21                         culture, the Centers for Medicare &  
22                         Medicaid Services, the Administration  
23                         for Children and Families, and Office  
24                         for Civil Rights; and

25                         “(II) other applicable law; and

1 “(iii) not be collected for program ap-  
2 plication and enrollment processes beyond  
3 statutory requirements.”.

4 **SEC. 112. 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. 113. 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 505D the following:

20 **“SEC. 505E. 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       “(aa) 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 505E.”.

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 505E”.

18       **SEC. 114. GAO STUDY ON COMPLIANCE WITH EXISTING FDA**  
19                               **REQUIREMENTS TO PRESENT DRUG AND DE-**  
20                               **VICE SAFETY AND EFFECTIVENESS DATA BY**  
21                               **SEX, AGE, AND RACIAL AND ETHNIC SUB-**  
22                               **GROUPS.**

23       (a) IN GENERAL.—The Comptroller General of the  
24       United States shall conduct a study investigating the ex-  
25       tent to which sponsors of clinical studies of investigational

1 drugs, biologics, and devices and sponsors of applications  
2 for approval or licensure of new drugs, biologics, and de-  
3 vices comply with Food and Drug Administration require-  
4 ments and follow guidance for presentation of clinical  
5 study safety and effectiveness data by sex, age, and racial  
6 and ethnic subgroups.

7 (b) REPORT BY GAO.—

8 (1) SUBMISSION.—Not later than 18 months  
9 after the date of the enactment of this Act, the  
10 Comptroller General shall complete the study under  
11 subsection (a) and submit to the Committee on En-  
12 ergy and Commerce of the House of Representatives  
13 and the Committee on Health, Education, Labor,  
14 and Pensions of the Senate a report on the results  
15 of such study.

16 (2) CONTENTS.—The report required by para-  
17 graph (1) shall include each of the following:

18 (A) An assessment of the extent to which  
19 the Food and Drug Administration assists  
20 sponsors in complying with the requirements  
21 and following the guidance referred to in sub-  
22 section (a).

23 (B) An assessment of the effectiveness of  
24 the Food and Drug Administration's enforce-  
25 ment of compliance with such requirements.



1           (C) An analysis of the extent to which fe-  
2           males, racial and ethnic minorities, and adults  
3           of all ages are adequately represented in Food  
4           and Drug Administration-approved clinical  
5           studies (at all phases) so that product safety  
6           and effectiveness data can be evaluated by sex,  
7           age, and racial and ethnic subgroup.

8           (D) An analysis of the extent to which a  
9           summary of product safety and effectiveness  
10          data disaggregated by sex, age, and racial and  
11          ethnic subgroup is readily available to the pub-  
12          lic in a timely manner by means of the product  
13          label or the Food and Drug Administration's  
14          Web site.

15          (E) Recommendations for—

16                 (i) modifications to the requirements  
17                 and guidance referred to in subsection (a);  
18                 or

19                 (ii) oversight by the Food and Drug  
20                 Administration of such requirements.

21          (c) REPORT BY HHS.—Not later than 6 months  
22          after the submission by the Comptroller General of the  
23          report required under subsection (b), the Secretary of  
24          Health and Human Services shall submit to the Com-  
25          mittee on Energy and Commerce of the House of Rep-

1 representatives and the Committee on Health, Education,  
 2 Labor, and Pensions of the Senate a response to that re-  
 3 port, including a corrective action plan as needed to re-  
 4 spond to the recommendations in that report.

5 (d) DEFINITIONS.—In this section:

6 (1) The term “biologic” has the meaning given  
 7 to the term “biological product” in section 351(i) of  
 8 the Public Health Service Act (42 U.S.C. 262(i)).

9 (2) The term “device” has the meaning given to  
 10 such term in section 201(h) of the Federal Food,  
 11 Drug, and Cosmetic Act (21 U.S.C. 321(h)).

12 (3) The term “drug” has the meaning given to  
 13 such term in section 201(g) of the Federal Food,  
 14 Drug, and Cosmetic Act (21 U.S.C. 321(g)).

15 **SEC. 115. IMPROVING HEALTH DATA REGARDING NATIVE**  
 16 **HAWAIIANS AND OTHER PACIFIC ISLANDERS.**

17 Part B of title III of the Public Health Service Act  
 18 (42 U.S.C. 243 et seq.) is amended by inserting after sec-  
 19 tion 317U, as added, the following:

20 **“SEC. 317V. NATIVE HAWAIIAN AND OTHER PACIFIC IS-**  
 21 **LANDER HEALTH DATA.**

22 “(a) DEFINITIONS.—In this section:

23 “(1) COMMUNITY GROUP.—The term ‘commu-  
 24 nity group’ means a group of NHOPI who are orga-  
 25 nized at the community level, and may include a

1 church group, social service group, national advocacy  
2 organization, or cultural group.

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

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

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

19 “(5) NATIVE HAWAIIANS AND OTHER PACIFIC  
20 ISLANDERS (NHOPI).—The term ‘Native Hawaiians  
21 and Other Pacific Islanders’ or ‘NHOPI’ means peo-  
22 ple having origins in any of the original peoples of  
23 American Samoa, the Commonwealth of the North-  
24 ern Mariana Islands, the Federated States of Micro-  
25 nesia, Guam, Hawaii, the Republic of the Marshall

1 Islands, the Republic of Palau, or any other Pacific  
2 island.

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

9 “(b) NATIONAL STRATEGY.—

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

1           “(2) CONSULTATION.—In developing and imple-  
2           menting a national strategy, as described in para-  
3           graph (1), not later than 180 days after the date of  
4           enactment of the Health Equity and Accountability  
5           Act of 2011, the Secretary—

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

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

13           “(c) PRELIMINARY HEALTH SURVEY.—

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

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

1           “(A) useful in determining health status  
2           and health care needs; or

3           “(B) required for developing or imple-  
4           menting a national strategy.

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

13          “(4) TIMEFRAME.—The survey required under  
14          this subsection shall be completed not later than 18  
15          months after the date of enactment of the Health  
16          Equity and Accountability Act of 2011.

17          “(d) PROGRESS REPORT.—Not later than 2 years  
18          after the date of enactment of the Health Equity and Ac-  
19          countability Act of 2011, the Secretary shall submit to  
20          Congress a progress report, which shall include the na-  
21          tional strategy described in subsection (b)(1).

22          “(e) STUDY AND REPORT BY THE IOM.—

23                 “(1) IN GENERAL.—The Secretary shall enter  
24                 into an agreement with the Institute of Medicine to

1       conduct a study, with input from stakeholders in in-  
2       sular areas, on the following:

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

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

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

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

21              “(2) REPORT.—An agreement described in  
22      paragraph (1) shall require the Institute of Medicine  
23      to submit to the Secretary and to Congress, not  
24      later than 2 years after the date of the enactment  
25      of the Health Equity and Accountability Act of

1 2011, a report containing a description of the results  
2 of the study conducted under paragraph (1), includ-  
3 ing the conclusions and recommendations of the In-  
4 stitute of Medicine for each of the items described  
5 in subparagraphs (A) through (D) of such para-  
6 graph.

7 “(f) AUTHORIZATION OF APPROPRIATIONS.—To  
8 carry out this section, there are authorized to be appro-  
9 priated such sums as may be necessary for fiscal years  
10 2012 through 2017.”.

11 **TITLE II—CULTURALLY AND LIN-**  
12 **GUISTICALLY APPROPRIATE**  
13 **HEALTH CARE**

14 **SEC. 201. DEFINITIONS.**

15 In this title, the definitions contained in section 3400  
16 of the Public Health Service Act, as added by section 202,  
17 shall apply.

18 **SEC. 202. AMENDMENT TO THE PUBLIC HEALTH SERVICE**

19 **ACT.**

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

21 (1) Effective communication is essential to  
22 meaningful access to quality physical and mental  
23 health care.

24 (2) Research indicates that the lack of appro-  
25 priate language services creates languages barriers



1 that result in increased risk of misdiagnosis, ineffec-  
2 tive treatment plans and poor health outcomes for  
3 limited-English-proficient individuals and individuals  
4 with communication disabilities such as hearing, vi-  
5 sion or print impairments.

6 (3) The number of limited-English-speaking  
7 residents in the United States who speak English  
8 less than very well and, therefore, cannot effectively  
9 communicate with health and social service providers  
10 continues to increase significantly.

11 (4) The responsibility to fund language services  
12 in the provision of health care and health care-re-  
13 lated services to limited-English-proficient individ-  
14 uals and individuals with communication disabilities  
15 such as hearing, vision, or print impairments is a so-  
16 cietal one that cannot fairly be visited solely upon  
17 the health care, public health or social services com-  
18 munity.

19 (5) Title VI of the Civil Rights Act of 1964  
20 prohibits discrimination based on the grounds of  
21 race, color or national origin by any entity receiving  
22 Federal financial assistance. In order to avoid dis-  
23 crimination on the grounds of national origin, all  
24 programs or activities administered by the Depart-  
25 ment must take adequate steps to ensure that their

1 policies and procedures do not deny or have the ef-  
2 fect of denying limited-English-proficient individuals  
3 with equal access to benefits and services for which  
4 such persons qualify.

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

9 (7) All members of the health care and health-  
10 care-related-services community should continue to  
11 educate their staff and constituents about limited-  
12 English proficient and disability communication  
13 issues and help them identify resources to improve  
14 access to quality care for limited-English-proficient  
15 individuals and individuals with communication dis-  
16 abilities such as hearing, vision, or print impair-  
17 ments.

18 (8) Access to English as a second language and  
19 sign language instructions is an important mecha-  
20 nism for ensuring effective communication and elimi-  
21 nating the language barriers that impede access to  
22 health care.

23 (9) Competent languages services in health care  
24 settings should be available as a matter of course.

1 (b) AMENDMENT.—The Public Health Service Act  
2 (42 U.S.C. 201 et seq.) is amended by adding at the end  
3 the following:

4 **“TITLE XXXIV—CULTURALLY**  
5 **AND LINGUISTICALLY APPRO-**  
6 **PRIATE HEALTH CARE**

7 **“SEC. 3400. DEFINITIONS.**

8 “In this title:

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

12 “(2) COMMUNITY HEALTH WORKER.—The term  
13 ‘community health worker’ includes a community  
14 health advocate, a lay health educator, a community  
15 health representative, a peer health promoter, a  
16 community health outreach worker, and in Spanish,  
17 promotores de salud.

18 “(3) COMPETENT INTERPRETER SERVICES.—  
19 The term ‘competent interpreter services’ means a  
20 translanguage rendition of a spoken or signed mes-  
21 sage in which the interpreter comprehends the  
22 source language and can communicate comprehen-  
23 sively in the target language to convey the meaning  
24 intended in the source language. The interpreter  
25 knows health and health-related terminology and

1 provides accurate interpretations by choosing equiva-  
2 lent expressions that convey the best matching and  
3 meaning to the source language and captures, to the  
4 greatest possible extent, all nuances intended in the  
5 source message.

6 “(4) COMPETENT TRANSLATION SERVICES.—  
7 The term ‘competent translation services’ means a  
8 translanguage rendition of a written document in  
9 which the translator comprehends the source lan-  
10 guage and can write or sign comprehensively in the  
11 target language to convey the meaning intended in  
12 the source language. The translator knows health  
13 and health-related terminology and provides accurate  
14 translations by choosing equivalent expressions that  
15 convey the best matching and meaning to the source  
16 language and captures, to the greatest possible ex-  
17 tent, all nuances intended in the source document.

18 “(5) CULTURAL COMPETENCE.—The term ‘cul-  
19 tural competence’ means a set of congruent behav-  
20 iors, attitudes, and policies that come together in a  
21 system, agency, or among professionals that enables  
22 effective work in cross-cultural situations. In the  
23 preceding sentence—

24 “(A) the term ‘cultural’ refers to inte-  
25 grated patterns of human behavior that include

1 the language, thoughts, communications, ac-  
2 tions, customs, beliefs, values, and institutions  
3 of racial, ethnic, religious, or social groups, in-  
4 cluding lesbian, gay, bisexual, transgender and  
5 intersex individuals, and individuals with phys-  
6 ical and mental disabilities; and

7 “(B) the term ‘competence’ implies having  
8 the capacity to function effectively as an indi-  
9 vidual and an organization within the context of  
10 the cultural beliefs, behaviors, and needs pre-  
11 sented by consumers and their communities.

12 “(6) EFFECTIVE COMMUNICATION.—The term  
13 ‘effective communication’ means an exchange of in-  
14 formation between the provider of health care or  
15 health-care-related services and the recipient of such  
16 services who is limited in English proficiency, or has  
17 a communication impairment such as a hearing, vi-  
18 sion, or learning impairment, that enables access,  
19 understanding, and benefit from health care or  
20 health-care-related services, and full participation in  
21 the development of their treatment plan.

22 “(7) GRIEVANCE RESOLUTION PROCESS.—The  
23 term ‘grievance resolution process’ means all aspects  
24 of dispute resolution including filing complaints,  
25 grievance and appeal procedures, and court action.

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

9           “(9) HEALTH-CARE SERVICES.—The term  
10          ‘health care services’ means services that address  
11          physical as well as mental health conditions in all  
12          care settings.

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

17          “(11) INDIAN TRIBE.—The term ‘Indian tribe’  
18          means any Indian tribe, band, nation, or other orga-  
19          nized group or community, including any Alaska Na-  
20          tive village or group or regional or village corpora-  
21          tion as defined in or established pursuant to the  
22          Alaska Native Claims Settlement Act (85 Stat. 688)  
23          (43 U.S.C. 1601 et seq.), which is recognized as eli-  
24          gible for the special programs and services provided

1 by the United States to Indians because of their sta-  
2 tus as Indians.

3 “(12) INTEGRATED HEALTH CARE DELIVERY  
4 SYSTEM.—The term ‘integrated health care delivery  
5 system’ means an interdisciplinary system that  
6 brings together providers from the primary health,  
7 mental health, substance use and related disciplines  
8 to improve the health outcomes of an individual.  
9 Providers may include but are not limited to hos-  
10 pitals, health, mental health or substance use clinics  
11 and providers, home health agencies, ambulatory  
12 surgery centers, skilled nursing facilities, rehabilita-  
13 tion centers, and employed, independent or con-  
14 tracted physicians.

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

20 “(14) LANGUAGE ACCESS.—The term ‘language  
21 access’ means the provision of language services to  
22 an LEP individual or individual with communication  
23 disabilities designed to enhance that individual’s ac-  
24 cess to, understanding of or benefit from health care  
25 or health-care-related services.

1           “(15) LANGUAGE OR LANGUAGE ACCESS SERV-  
2           ICES.—The term ‘language or language access serv-  
3           ices’ means provision of health care services directly  
4           in a non-English language, interpretation, trans-  
5           lation, signage, video recording, and English or non-  
6           English alternative formats.

7           “(16) LEP.—The term ‘LEP’ means limited-  
8           English proficient.

9           “(17) LEP RELATED DATA COLLECTION AC-  
10          TIVITIES.—The term ‘LEP related data collection  
11          activities’ includes identifying, collecting, storing,  
12          tracking, and analyzing primary language data, and  
13          information on the methods used to meet the lan-  
14          guage access needs of limited-English-proficient indi-  
15          viduals.

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

20          “(19) MINORITY.—

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



1                   “(B) POPULATIONS.—The term ‘minority’,  
2                   with respect to populations, refers to racial and  
3                   ethnic minority groups.

4                   “(20) MINORITY GROUP.—The term ‘minority  
5                   group’ has the meaning given the term ‘racial and  
6                   ethnic minority group’.

7                   “(21) RACIAL AND ETHNIC MINORITY GROUP.—  
8                   The term ‘racial and ethnic minority group’ means  
9                   American Indians and Alaska Natives, African-  
10                  Americans (including Caribbean Blacks, Africans  
11                  and other Blacks), Asian-Americans, Hispanics (in-  
12                  cluding Latinos), and Native Hawaiians and other  
13                  Pacific Islanders.

14                  “(22) ON-SITE INTERPRETING/INTERPRETA-  
15                  TION.—The term ‘on-site interpreting/interpretation’  
16                  means a method of interpreting or interpretation for  
17                  which the interpreter is in the physical presence of  
18                  the provider of health care or health-care-related  
19                  services and the recipient of such services who is  
20                  limited in English proficiency or has a communica-  
21                  tion impairment such as hearing, vision, or learning.

22                  “(23) SECRETARY.—The term ‘Secretary’  
23                  means the Secretary of Health and Human Services.

24                  “(24) SIGHT TRANSLATION.—The term ‘sight  
25                  translation’ means the transmission of a written

1 message in one language into a spoken or signed  
2 message in another language, or an alternative for-  
3 mat in English or another language.

4 “(25) STATE.—The term ‘State’ means each of  
5 the several States, the District of Columbia, the  
6 Commonwealth of Puerto Rico, the Indian tribes,  
7 the United States Virgin Islands, Guam, American  
8 Samoa, and the Commonwealth of the Northern  
9 Mariana Islands.

10 “(26) TELEPHONIC INTERPRETATION.—The  
11 term ‘telephonic interpretation’ (also known as over  
12 the phone interpretation or OPI) means a method of  
13 interpreting/interpretation for which the interpreter  
14 is not in the physical presence of the provider of  
15 health care or related services and the limited-  
16 English-proficient recipient of such services but is  
17 connected via telephone.

18 “(27) TRANSLATION.—The term ‘translation’  
19 means the transmission of a written message in one  
20 language into a written or signed message in an-  
21 other language, and includes translation into an-  
22 other language or alternative format, such as large  
23 print font, Braille, audio recording, or CD.

24 “(28) VIDEO INTERPRETATION.—The term  
25 ‘video interpretation’ means a method of inter-

1       preting/interpretation for which the interpreter is  
2       not in the physical presence of the provider of health  
3       care or related services and the limited-English-pro-  
4       ficient recipient of such services but is connected via  
5       a video hook-up that includes both audio and video  
6       transmission.

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

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

3 “(a) PURPOSE.—As provided in Executive Order  
4 13166, it is the purpose of this section—

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

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

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

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

1 and activities by limited-English-proficient individ-  
2 uals; and

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

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

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

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

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

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

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

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

1           “(E) the resources the agency will provide  
2           to improve cultural competence to assist recipi-  
3           ents of Federal funds to improve access to  
4           health care or health-care-related programs and  
5           activities for limited-English-proficient individ-  
6           uals.

7           Each agency shall send a copy of such plan to the  
8           Department of Justice, which shall serve as the cen-  
9           tral repository of the Agency’s plans.

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

12           “(1) **IN GENERAL.—**Not later than 120 days  
13           after the date of enactment of this title, each Fed-  
14           eral agency providing health-care-related Federal fi-  
15           nancial assistance shall ensure that the guidance for  
16           recipients of Federal financial assistance developed  
17           by the agency to ensure compliance with title VI of  
18           the Civil Rights Act of 1964 (42 U.S.C. 2000d et  
19           seq.) is specifically tailored to the recipients of such  
20           assistance. Each agency shall send a copy of such  
21           guidance to the Department of Justice which shall  
22           serve as the central repository of the Agency’s plans.  
23           After approval by the Department of Justice, each  
24           agency shall publish its guidance document in the  
25           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 “Recipients of Federal financial assistance from the  
19 Secretary shall, to the extent reasonable and practicable  
20 after applying the 4-factor analysis described in title V  
21 of the Guidance to Federal Financial Assistance Recipi-  
22 ents Regarding Title VI Prohibition Against National Ori-  
23 gin Discrimination Affecting Limited-English Proficient  
24 Persons (June 12, 2002)—

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

7           “(2) ensure that staff at all levels and across all  
8           disciplines of the organization receive ongoing edu-  
9           cation and training in culturally and linguistically  
10          appropriate service delivery;

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

16          “(4) notify patients, in a culturally appropriate  
17          manner, of their right to receive language assistance  
18          services in their primary language;

19          “(5) ensure the competence of language assist-  
20          ance provided to limited-English-proficient patients  
21          by interpreters and bilingual staff, and ensure that  
22          family, particularly minor children, and friends are  
23          not used to provide interpretation services—

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

1           “(B) except on request of the patient, who  
2           has been informed in his or her preferred lan-  
3           guage of the availability of free interpretation  
4           services;

5           “(6) make available easily understood patient-  
6           related materials, if such materials exist for non-lim-  
7           ited-English-proficient patients, including informa-  
8           tion or notices about termination of benefits and  
9           post signage in the languages of the commonly en-  
10          countered groups or groups represented in the serv-  
11          ice area of the organization;

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

16          “(8) conduct initial and ongoing organizational  
17          assessments of culturally and linguistically appro-  
18          priate services-related activities and integrate valid  
19          linguistic, competence-related measures into the in-  
20          ternal audits, performance improvement programs,  
21          patient satisfaction assessments, and outcomes-based  
22          evaluations of the organization;

23          “(9) ensure that, consistent with the privacy  
24          protections provided for under the regulations pro-  
25          mulgated under section 264(c) of the Health Insur-

1       ance Portability and Accountability Act of 1996 (42  
2       U.S.C. 1320d–2 note)—

3               “(A) data on the individual patient’s race,  
4               ethnicity, primary language, alternative format  
5               preferences, and policy modification needs are  
6               collected in health records, integrated into the  
7               organization’s management information sys-  
8               tems, and periodically updated; and

9               “(B) if the patient is a minor or is inca-  
10              pacitated, the primary language of the parent  
11              or legal guardian is collected;

12             “(10) maintain a current demographic, cultural,  
13             and epidemiological profile of the community as well  
14             as a needs assessment to accurately plan for and im-  
15             plement services that respond to the cultural and  
16             linguistic characteristics of the service area of the  
17             organization;

18             “(11) develop participatory, collaborative part-  
19             nerships with communities and utilize a variety of  
20             formal and informal mechanisms to facilitate com-  
21             munity and patient involvement in designing and im-  
22             plementing culturally and linguistically appropriate  
23             services-related activities;

24             “(12) ensure that conflict and grievance resolu-  
25             tion processes are culturally and linguistically sen-

1       sitive and capable of identifying, preventing, and re-  
2       solving cross-cultural conflicts or complaints by pa-  
3       tients;

4               “(13) regularly make available to the public in-  
5       formation about their progress and successful inno-  
6       vations in implementing the standards under this  
7       section and provide public notice in their commu-  
8       nities about the availability of this information; and

9               “(14) if requested, regularly make available to  
10      the head of each Federal entity from which Federal  
11      funds are received, information about their progress  
12      and successful innovations in implementing the  
13      standards under this section as required by the head  
14      of such entity.

15 **“SEC. 3403. ROBERT T. MATSUI CENTER FOR CULTURAL**  
16                   **AND LINGUISTIC COMPETENCE IN HEALTH**  
17                   **CARE.**

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

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

5           “(2) TRANSLATION OF WRITTEN MATERIAL.—

6           “(A) The Center shall provide, directly or  
7 through contract, vital documents from com-  
8 petent translation services for providers of  
9 health care and health-care-related services at  
10 no cost to such providers. Materials may be  
11 submitted for translation into non-English lan-  
12 guages. Translation services shall be provided  
13 in a timely and reasonable manner and in ac-  
14 cordance with the guidelines and standards set  
15 forth in subsection (c) when such standards be-  
16 come available. The quality of such translation  
17 services shall be monitored and reported pub-  
18 licly.

19           “(B) For each form developed or revised  
20 by the Secretary that will be used by LEP indi-  
21 viduals in health care or health-care-related set-  
22 tings, the Center shall translate the form, at a  
23 minimum, into the top 15 non-English lan-  
24 guages in the United States according to the  
25 most recent data from the American Commu-

1           nity Survey or its replacement. The translation  
2           must be completed within 45 days of the Sec-  
3           retary receiving final approval of the form from  
4           the Office of Management and Budget.

5           “(3) TOLL-FREE CUSTOMER SERVICE TELE-  
6           PHONE NUMBER.—The Center shall provide,  
7           through a toll-free number, a customer service line  
8           for LEP individuals—

9                   “(A) to obtain information about federally  
10                  conducted or funded health programs, including  
11                  Medicare, Medicaid, and SCHIP;

12                   “(B) to obtain assistance with applying for  
13                  or accessing these programs and understanding  
14                  Federal notices written in English; and

15                   “(C) to learn how to access language serv-  
16                  ices.

17           “(4) HEALTH INFORMATION CLEARING-  
18           HOUSE.—

19                   “(A) IN GENERAL.—The Center shall de-  
20                  velop and maintain an information clearing-  
21                  house to facilitate the provision of language  
22                  services by providers of health care and health-  
23                  care-related services to reduce medical errors,  
24                  improve medical outcomes, to improve cultural  
25                  competence, reduce health care costs caused by

1           miscommunication with individuals with lim-  
2           ited-English proficiency, and reduce or elimi-  
3           nate the duplication of effort to translate mate-  
4           rials. The clearinghouse shall make such infor-  
5           mation available on the Internet and in print.  
6           Such information shall include the information  
7           described in the succeeding provisions of this  
8           paragraph.

9           “(B) DOCUMENT TEMPLATES.—The Cen-  
10          ter shall collect and evaluate for accuracy, de-  
11          velop, and make available templates for stand-  
12          ard documents that are necessary for patients  
13          and consumers to access and make educated de-  
14          cisions about their health care, including the  
15          following:

16               “(i) Administrative and legal docu-  
17               ments, including—

18                       “(I) intake forms;

19                       “(II) Medicare, Medicaid, and  
20                       SCHIP forms, including eligibility in-  
21                       formation;

22                       “(III) forms informing patient of  
23                       HIPAA compliance and consent; and



1                   “(IV) documents concerning in-  
2                   formed consent, advanced directives,  
3                   and waivers of rights.

4                   “(ii) Clinical information, such as how  
5                   to take medications, how to prevent trans-  
6                   mission of a contagious disease, and other  
7                   prevention and treatment instructions.

8                   “(iii) Public health, patient education,  
9                   and outreach materials, such as immuniza-  
10                  tion notices, health warnings, or screening  
11                  notices.

12                  “(iv) Additional health or health-care-  
13                  related materials as determined appro-  
14                  priate by the Director of the Center.

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

17                  “(i) ensure that the documents posted  
18                  in English and non-English languages are  
19                  culturally appropriate;

20                  “(ii) allow public review of the docu-  
21                  ments before dissemination in order to en-  
22                  sure that the documents are understand-  
23                  able and culturally appropriate for the tar-  
24                  get populations;

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

3                   “(iv) facilitate access to these docu-  
4                   ments;

5                   “(v) provide technical assistance with  
6                   respect to the access and use of such infor-  
7                   mation; and

8                   “(vi) carry out any other activities the  
9                   Secretary determines to be useful to fulfill  
10                  the purposes of the clearinghouse.

11                  “(D) LANGUAGE ASSISTANCE PRO-  
12                  GRAMS.—The Center shall provide for the col-  
13                  lection and dissemination of information on cur-  
14                  rent examples of language assistance programs  
15                  and strategies to improve language services for  
16                  LEP individuals, including case studies using  
17                  de-identified patient information, program sum-  
18                  maries, and program evaluations.

19                  “(E) CULTURAL AND LINGUISTIC COM-  
20                  PETENCE MATERIALS.—The Center shall pro-  
21                  vide information relating to culturally and lin-  
22                  guistically competent health care for minority  
23                  populations residing in the United States to all  
24                  health care providers and health-care-related

1 services at no cost. Such information shall in-  
2 clude—

3 “(i) tenets of culturally and linguis-  
4 tically competent care;

5 “(ii) cultural and linguistic com-  
6 petence self-assessment tools;

7 “(iii) cultural and linguistic com-  
8 petence training tools;

9 “(iv) strategic plans to increase cul-  
10 tural and linguistic competence in different  
11 types of providers of health care and  
12 health-care-related services, including re-  
13 gional collaborations among health care or-  
14 ganizations; and

15 “(v) cultural and linguistic com-  
16 petence information for educators, practi-  
17 tioners, and researchers.

18 “(F) INFORMATION ABOUT PROGRESS.—

19 The Center shall regularly collect and make  
20 publicly available information about the  
21 progress of entities receiving grants under sec-  
22 tion 3404 regarding successful innovations in  
23 implementing the obligations under this sub-  
24 section and provide public notice in the entities’

1 communities about the availability of this infor-  
2 mation;

3 “(b) DIRECTOR.—The Center shall be headed by a  
4 Director who shall be appointed by, and who shall report  
5 to, the Director of the Agency for Healthcare Research  
6 and Quality.

7 “(c) INTERPRETATION AND TRANSLATION GUIDE-  
8 LINES AND STANDARDS.—The Center shall convene a  
9 working group to develop and adopt interpretation and  
10 translation quality guidelines and standards for use by the  
11 Center. The guidelines and standards must be sufficient  
12 to ensure that LEP individuals have the equal opportunity  
13 to benefit from health care services to the same extent  
14 as non-LEP individuals. The guidelines and standards  
15 shall address the training, assessment, and certification of  
16 individuals to provide competent interpreter and trans-  
17 lator services to work in health care and health-care-re-  
18 lated settings and of bilingual staff who provide services  
19 directly in non-English languages. The working group may  
20 develop different guidelines and standards for bilingual  
21 staff, interpreters, and translators.

22 “(d) MEMBERSHIP.—

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

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

3           “(B) One member who represents a profes-  
4 sional interpreter association (that is not the  
5 National Council on Interpreting in Health  
6 Care) or translator association.

7           “(C) One member from a nonprofit com-  
8 munity-based organization that provides lan-  
9 guage services.

10          “(D) Three members recommended by the  
11 National Council on Interpreting in Health  
12 Care, including one individual who is a  
13 professional interpreter.

14          “(E) Four members who are health care or  
15 mental health providers or represent health care  
16 provider associations, including one individual  
17 who represents a health care practice of fewer  
18 than 5 clinicians.

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

22          “(2) GEOGRAPHIC REPRESENTATION.—The  
23 membership of the Working Group shall reflect a  
24 broad geographic representation including both

1 urban and rural representatives, including represent-  
2 atives of the United States territories.

3 “(3) PROHIBITED APPOINTMENTS.—Members  
4 of the Working Group shall not include Members of  
5 Congress or other elected Federal, State, or local  
6 government officials.

7 “(4) VACANCIES.—Any vacancies in the Work-  
8 ing Group shall not affect the power and duties of  
9 the Working Group but shall be filled in the same  
10 manner as the original appointment.

11 “(5) SUBCOMMITTEES.—The Working Group  
12 may establish subcommittees if doing so increases  
13 the efficiency of the Working Group in completing  
14 its tasks, including subcommittees to develop dif-  
15 ferent guidelines and standards for interpreters,  
16 translators, and bilingual staff.

17 “(6) ADVISORY PANEL TO THE WORKING  
18 GROUP.—The Working Group shall consult with the  
19 Advisory Panel in the development of the guidelines  
20 and standards. The Advisory Panel shall include—

21 “(A) representatives from the American  
22 Translators Association, Association of Lan-  
23 guage Companies, the National Center for  
24 State Courts, and States which have developed  
25 interpreter standards such as California, Mas-

1           sachusetts, and Oregon who have experience in  
2           the development or implementation of their or-  
3           ganizations' interpreter and translator certifi-  
4           cation programs;

5           “(B) Federal agencies including the Office  
6           for Civil Rights, the Office of Minority Health,  
7           the Centers for Medicare & Medicaid Services,  
8           and the National Institute on Minority Health  
9           and Health Disparities; and

10           “(C) other individuals or entities deter-  
11           mined appropriate by the Secretary who have  
12           specific expertise that will be useful to the  
13           Working Group.

14           “(7) PUBLICATION.—

15           “(A) DRAFT STANDARDS.—Not later than  
16           18 months after the date of enactment of this  
17           title, the Working Group shall—

18           “(i) prepare and make available to the  
19           public through the Internet, the Federal  
20           Register, and other appropriate public  
21           channels, a proposed set of interpretation  
22           and translation guidelines and standards  
23           for training, assessment, and certification;  
24           and

1                   “(ii) accept public comment on such  
2                   guidelines and standards for a period of  
3                   not less than 90 days.

4                   “(B) FINAL STANDARDS.—Not later than  
5                   120 days after the expiration of the public com-  
6                   ment period described in subparagraph (A), the  
7                   Director of the Agency for Healthcare Research  
8                   and Quality shall publish, after consultation  
9                   with and the approval of the Working Group,  
10                  final guidelines and standards in the Federal  
11                  Register and on the Internet.

12                  “(C) TESTING DEVELOPMENT.—Not later  
13                  than 120 days after the publication of the final  
14                  recommendations described in subparagraph  
15                  (B), the Director of the Agency for Healthcare  
16                  Research and Quality shall, if deemed necessary  
17                  by the Working Group, enter into a contract  
18                  with an entity experienced in the development  
19                  of designing certification tests in language re-  
20                  lated fields to develop such tests as may be nec-  
21                  essary to implement the guidelines and stand-  
22                  ards.

23                  “(D) PILOT PROJECT.—

24                         “(i) Not later than 120 days after  
25                         completion of the test development de-



1 scribed in subparagraph (C) or after publi-  
2 cation of the final guidelines and stand-  
3 ards, whichever is later, the Secretary shall  
4 design, fund, and implement a pilot project  
5 in up to 50 geographically and demo-  
6 graphically diverse sites, two of which must  
7 be in the United States territories, to test  
8 and evaluate implementation of the rec-  
9 ommendations.

10 “(ii) The Secretary shall consult with  
11 the Working Group and the Advisory  
12 Panel in development of the pilot project  
13 and report progress to the Working Group  
14 on an ongoing basis.

15 “(iii) The pilot project shall include  
16 interpreters and translators working with  
17 various provider types, including small  
18 group practices, hospitals, mental health  
19 and substance use clinics, and community  
20 health clinics, and shall include broad geo-  
21 graphic representation including both  
22 urban and rural representatives.

23 “(iv) The pilot project shall operate  
24 for not less than 2 nor more than 4 years,  
25 as determined by the Secretary.

1           “(v) If the Working Group determines  
2           that any revisions to guidelines and stand-  
3           ards are necessary as a result of the pilot  
4           project, it shall revise such guidelines and  
5           standards and the Director of the Agency  
6           for Healthcare Research and Quality shall  
7           publish the revisions in the Federal Reg-  
8           ister for notice and comment. Not later  
9           than 120 days after the expiration of the  
10          public comment period on such revisions,  
11          the Director of the Agency for Healthcare  
12          Research and Quality shall publish, after  
13          consultation with and the approval of the  
14          Working Group, final revisions to the  
15          guidelines and standards in the Federal  
16          Register and on the Internet.

17          “(8) ADMINISTRATION.—

18                 “(A) CHAIRPERSON.—Not later than 15  
19                 days after the date on which all members of the  
20                 Working Group have been appointed under sub-  
21                 section (d), the Working Group shall designate  
22                 its chairperson.

23                 “(B) COMPENSATION.—While serving on  
24                 the business of the Working Group (including  
25                 travel time), a member of the Working Group

1 or the Advisory Panel shall be entitled to com-  
2 pensation at the per diem equivalent of the rate  
3 provided for level IV of the Executive Schedule  
4 under section 5315 of title 5, United States  
5 Code, and while so serving away from home and  
6 the member's regular place of business, a mem-  
7 ber may be allowed travel expenses, as author-  
8 ized by the chairperson of the Working Group.  
9 For purposes of pay and employment benefits,  
10 rights, and privileges, all personnel of the  
11 Working Group shall be treated as if they were  
12 employees of the House of Representatives.

13 “(C) INFORMATION FROM FEDERAL AGEN-  
14 CIES.—The Working Group may secure directly  
15 from any Federal department or agency such  
16 information as the Working Group considers  
17 necessary to carry out this section. Upon re-  
18 quest of the Working Group, the head of such  
19 department or agency shall furnish such infor-  
20 mation. Any information that contains individ-  
21 ually identifiable information received by the  
22 Working Group shall not be disseminated or  
23 disclosed outside of the Working Group and  
24 shall not be used except by the Working Group.

1           “(D) DETAIL.—Not more than 10 Federal  
2 Government employees employed by the Depart-  
3 ment of Health and Human Services may be  
4 detailed to staff the Working Group under this  
5 section without further reimbursement. Any de-  
6 tail of an employee shall be without interruption  
7 or loss of civil service status or privilege.

8           “(E) TEMPORARY AND INTERMITTENT  
9 SERVICES.—The Working Group may procure  
10 temporary and intermittent services under sec-  
11 tion 3109(b) of title 5, United States Code, at  
12 rates for individuals which do not exceed the  
13 daily equivalent of the annual rate of basic pay  
14 prescribed for level V of the Executive Schedule  
15 under section 5316 of such title.

16           “(F) AUTHORIZATION OF APPROPRIA-  
17 TIONS.—There are authorized to be appro-  
18 priated to carry out this section such sums as  
19 may be necessary for the activities of the Work-  
20 ing Group and Advisory Panel for each of fiscal  
21 years 2012 through 2016, and for the funding  
22 of the pilot project.

23           “(9) DEEMED STATUS.—

24           “(A) CERTIFICATION BY PRIVATE ORGANI-  
25 ZATION.—If a private accreditation organization

1 establishes training, assessment, or certification  
2 standards for interpreters or translators in  
3 health care which the Secretary determines are  
4 at least equivalent to the training, assessment,  
5 or certification standards promulgated by the  
6 Secretary as described in subsection (c), the  
7 Secretary shall find that all organizations or in-  
8 dividuals accredited by such organization com-  
9 ply also with the standard described in sub-  
10 section (c) if—

11 “(i) such organization or individual  
12 authorizes the organization to release to  
13 the Secretary upon the Secretary’s request  
14 (or such State agency as the Secretary  
15 may designate) a copy of the most current  
16 accreditation survey of such organization  
17 or individual made by the organization, to-  
18 gether with any other information directly  
19 related to the survey as the Secretary may  
20 require (including corrective action plans);  
21 and

22 “(ii) such organization releases such a  
23 copy and any such information to the Sec-  
24 retary.

1           “(B) CERTIFICATION BY A STATE OR LO-  
2 CALITY.—If a State or locality has or estab-  
3 lishes training, assessment, or certification  
4 standards for interpreters or translators in  
5 health care which the Secretary determines are  
6 at least equivalent to the training, assessment,  
7 or certification standards promulgated by the  
8 Secretary as described in subsection (c), the  
9 Secretary shall find that all organizations or in-  
10 dividuals accredited by such State or locality  
11 comply also with the standard described in sub-  
12 section (c) if—

13                   “(i) such organization or individual  
14 authorizes the State or locality to release  
15 to the Secretary upon his request (or such  
16 State agency as the Secretary may des-  
17 ignate) a copy of the most current accredi-  
18 tation survey of such organization or indi-  
19 vidual made by such State or locality, to-  
20 gether with any other information directly  
21 related to the survey as the Secretary may  
22 require (including corrective action plans);  
23 and

1           “(ii) such State or locality releases  
2           such a copy and any such information to  
3           the Secretary.

4           “(C) TIMELY ACTION ON APPLICATION.—  
5           The Secretary shall determine, within 210 days  
6           after the date the Secretary receives an applica-  
7           tion by a private accrediting organization,  
8           State, or locality whether the process of the pri-  
9           vate accrediting organization, State, or locality  
10          meets the requirements with respect to training,  
11          assessment, or certification standards for inter-  
12          preters or translators with respect to which  
13          standards the application is made. The Sec-  
14          retary may not deny an application on the basis  
15          that it seeks to meet the requirements with re-  
16          spect to only one, or more than one, training,  
17          assessment, or certification standards for inter-  
18          preters or translators.

19          “(D) DISCLOSURE OF ACCREDITATION  
20          SURVEY.—The Secretary may not disclose any  
21          accreditation survey made and released to him  
22          by the National Council on Interpreting in  
23          Health Care or any State or locality of an ac-  
24          credited organization or individual, except that  
25          the Secretary may disclose such a survey and

1 information related to such a survey to the ex-  
2 tent such survey and information relate to an  
3 enforcement action taken by the Secretary.

4 “(E) DEFICIENCIES.—If the Secretary  
5 finds that an accredited organization or indi-  
6 vidual has significant deficiencies (as defined in  
7 regulations pertaining to the training, assess-  
8 ment, or certification standards), the organiza-  
9 tion or individual shall, after the date of notice  
10 of such finding to the organization and for such  
11 period as may be prescribed in regulations, be  
12 deemed not to meet the conditions or require-  
13 ments the organization or individual has been  
14 treated as meeting pursuant to subparagraph  
15 (A).

16 “(e) AVAILABILITY OF LANGUAGE ACCESS.—The Di-  
17 rector shall collaborate with the Administrator of the Of-  
18 fice of Minority Health, the Administrator of the Centers  
19 for Medicare & Medicaid Services, and the Administrator  
20 of the Health Resources and Services Administration to  
21 notify health care providers and health care organizations  
22 about the availability of language access services by the  
23 Center.

24 “(f) EDUCATION.—The Secretary, directly or through  
25 contract, shall undertake a national education campaign



1 to inform providers, LEP individuals, health professionals,  
2 graduate schools, and community health centers about—

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

5 “(2) the value of using trained interpreters and  
6 the risks associated with using family members,  
7 friends, minors, and untrained bilingual staff;

8 “(3) funding sources for developing and imple-  
9 menting language services; and

10 “(4) promising practices to effectively provide  
11 language services.

12 “(g) AUTHORIZATION OF APPROPRIATIONS.—In ad-  
13 dition to the amounts authorized under subsection  
14 (e)(8)(F), there are authorized to be appropriated to carry  
15 out this section such sums as may be necessary for each  
16 of fiscal years 2012 through 2016.

17 **“SEC. 3404. INNOVATIONS IN CULTURAL AND LINGUISTIC**  
18 **COMPETENCE GRANTS.**

19 “(a) IN GENERAL.—The Secretary, acting through  
20 the Director of the Agency for Healthcare Research and  
21 Quality, shall award grants to eligible entities to enable  
22 such entities to design, implement, and evaluate innova-  
23 tive, cost-effective programs to improve cultural com-  
24 petence and language access in health care for individuals  
25 with limited-English proficiency. The Director of the

1 Agency for Healthcare Research and Quality shall coordi-  
2 nate with, and ensure the participation of, other agencies  
3 including but not limited to the Health Resources and  
4 Services Administration, the Center on Minority Health  
5 and Health Disparities at the National Institutes of  
6 Health, and the Office of Minority Health, regarding the  
7 design and evaluation of the grants program.

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

10 “(1) be—

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

13 “(B) an organization described in section  
14 501(c)(3) of the Internal Revenue Code of  
15 1986;

16 “(C) a community health, mental health,  
17 or substance use center or clinic;

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

19 “(E) an integrated health care delivery  
20 system;

21 “(F) a public hospital;

22 “(G) a health care group, university, or  
23 college; or

24 “(H) other entity designated by the Sec-  
25 retary; and

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

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

7           “(1) develop, implement, and evaluate models of  
8 providing competent interpretation services through  
9 on-site interpretation, telephonic interpretation, or  
10 video interpretation;

11           “(2) implement strategies to recruit, retain, and  
12 promote individuals at all levels of the organization  
13 to maintain a diverse staff and leadership that can  
14 promote and provide language services to patient  
15 populations of the service area of the organization;

16           “(3) develop and maintain a needs assessment  
17 that identifies the current demographic, cultural,  
18 and epidemiological profile of the community to ac-  
19 curately plan for and implement language services  
20 needed in service area of the organization;

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

23           “(5) develop participatory, collaborative part-  
24 nerships with communities encompassing the LEP

1 patient populations being served to gain input in de-  
2 signing and implementing language services;

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

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

11 “(8) develop formal training programs, includ-  
12 ing continued professional development and edu-  
13 cation programs as well as supervision, for individ-  
14 uals interested in becoming dedicated health care in-  
15 terpreters and culturally competent providers;

16 “(9) provide staff language training instruction,  
17 which shall include information on the practical limi-  
18 tations of such instruction for non-native speakers;

19 “(10) develop policies that address compensa-  
20 tion in salary for staff who receive training to be-  
21 come either a staff interpreter or bi-lingual provider;

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

24 “(12) develop, implement, and evaluate models  
25 of improving cultural competence; and

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

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

17          “(e) EVALUATION.—

18                 “(1) An entity that receives a grant under this  
19                 section shall submit to the Secretary an evaluation  
20                 that describes, in the manner and to the extent re-  
21                 quired by the Secretary, the activities carried out  
22                 with funds received under the grant, and how such  
23                 activities improved access to health and health-care-  
24                 related services and the quality of health care for in-  
25                 dividuals with limited-English proficiency. Such eval-

1 uation shall be collected and disseminated through  
2 the Robert T. Matsui Center for Cultural and Lin-  
3 guistic Competence in Health Care established under  
4 section 3403. The Director of the Agency for  
5 Healthcare Research and Quality shall notify grant-  
6 ees of the availability of technical assistance for the  
7 evaluation and provide such assistance upon request.

8 “(2) The Director of the Agency for Healthcare  
9 Research and Quality shall evaluate or arrange with  
10 other individuals or organizations to evaluate  
11 projects funded under this section.

12 “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
13 is authorized to be appropriated to carry out this section,  
14 \$5,000,000 for each of fiscal years 2012 through 2016.

15 **“SEC. 3405. RESEARCH ON CULTURAL AND LANGUAGE COM-  
16 PETENCE.**

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

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

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

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

5           “(2) To identify health care providers’ and  
6 health administrators’ attitudes, knowledge, and  
7 awareness of the barriers to quality health care serv-  
8 ices that are faced by LEP individuals.

9           “(3) To identify optimal approaches for deliv-  
10 ering language access.

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

13           “(A) the collection by providers of health  
14 care and health-care-related services of data on  
15 the race, ethnicity, and primary language of re-  
16 cipients of such services, taking into account ex-  
17 isting research conducted by the Government or  
18 private sector;

19           “(B) the development and implementation  
20 of data collection and reporting systems; and

21           “(C) effective privacy safeguards for col-  
22 lected data.

23          “(5) To develop a minimum data collection set  
24 for primary language.

1           “(6) To evaluate the most effective ways in  
 2           which the Department can create or coordinate, and  
 3           then subsidize or otherwise fund telephonic interpre-  
 4           tation providers for health care providers, taking  
 5           into consideration, among other factors, the flexi-  
 6           bility necessary for such a system to accommodate  
 7           variations in—

8                   “(A) provider type;

9                   “(B) languages needed and their frequency  
 10           of use;

11                   “(C) type of encounter;

12                   “(D) time of encounter, including regular  
 13           business hours and after hours; and

14                   “(E) location of encounter.

15           “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
 16           are authorized to be appropriated to carry out this section,  
 17           such sums as may be necessary for each of fiscal years  
 18           2012 through 2016.”.

19           **SEC. 203. FEDERAL REIMBURSEMENT FOR CULTURALLY**  
 20                   **AND LINGUISTICALLY APPROPRIATE SERV-**  
 21                   **ICES UNDER THE MEDICARE, MEDICAID, AND**  
 22                   **STATE CHILDREN’S HEALTH INSURANCE**  
 23                   **PROGRAMS.**

24           (a) LANGUAGE ACCESS GRANTS FOR MEDICARE  
 25           PROVIDERS.—



1 (1) ESTABLISHMENT.—

2 (A) IN GENERAL.—Not later than 6  
3 months after the date of the enactment of this  
4 Act, the Secretary of Health and Human Serv-  
5 ices, acting through the Centers for Medicare &  
6 Medicaid Services and in consultation with the  
7 Center for Medicare and Medicaid Innovation,  
8 shall establish demonstration program under  
9 which the Secretary shall award grants to eligi-  
10 ble Medicare service providers to improve com-  
11 munication between such providers and limited-  
12 English-proficient Medicare beneficiaries, in-  
13 cluding beneficiaries who live in diverse and un-  
14 derserved communities.

15 (B) APPLICATION OF INNOVATION  
16 RULES.—The demonstration project under sub-  
17 paragraph (A) shall be conducted in a manner  
18 that is consistent with the applicable provisions  
19 of subsections (b), (c), and (d) of section 1115A  
20 of the Social Security Act.

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

24 (D) GRANT PERIOD.—Except as provided  
25 under paragraph (2)(D), each grant awarded

1 under this subsection shall be for a 3-year pe-  
2 riod.

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

6 (A) MEDICARE PROVIDER.—The entity  
7 must be—

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

10 (ii) a provider of services under part  
11 B of such title;

12 (iii) a Medicare Advantage organiza-  
13 tion offering a Medicare Advantage plan  
14 under part C of such title; or

15 (iv) a PDP sponsor offering a pre-  
16 scription drug plan under part D of such  
17 title.

18 (B) UNDERSERVED COMMUNITIES.—The  
19 entity must serve a community that with re-  
20 spect to necessary language services for improv-  
21 ing access and utilization of health care among  
22 limited-English proficient individuals, is  
23 disproportinaly underserved.

24 (C) APPLICATION.—The entity must pre-  
25 pare and submit to the Secretary an applica-

1           tion, at such time, in such manner, and accom-  
2           panied by such additional information as the  
3           Secretary may require.

4           (D) REPORTING.—In the case of a grantee  
5           that received a grant under this subsection in  
6           a previous year, such grantee is only eligible for  
7           continued payments under a grant under this  
8           subsection if the grantee met the reporting re-  
9           quirements under paragraph (9) for such year.  
10          If a grantee fails to meet the requirement of  
11          such paragraph for the first year of a grant, the  
12          Secretary may terminate the grant and solicit  
13          applications from new grantees to participate in  
14          the demonstration program.

15          (3) DISTRIBUTION.—To the extent feasible, the  
16          Secretary shall award—

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

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

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

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

25          (4) CONSIDERATIONS IN AWARDING GRANTS.—

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

4 (i) The grantees provide many dif-  
5 ferent types of language services.

6 (ii) The grantees serve Medicare bene-  
7 ficiaries who speak different languages,  
8 and who, as a population, have differing  
9 needs for language services.

10 (iii) The grantees serve Medicare  
11 beneficiaries in both urban and rural set-  
12 tings.

13 (iv) The grantees serve Medicare  
14 beneficiaries in at least two geographic re-  
15 gions, as defined by the Secretary.

16 (v) The grantees serve Medicare bene-  
17 ficiaries in at least two large metropolitan  
18 statistical areas with racial, ethnic, and  
19 economically diverse populations.

20 (B) PRIORITY FOR PARTNERSHIPS WITH  
21 COMMUNITY ORGANIZATIONS AND AGENCIES.—  
22 In awarding grants under this subsection, the  
23 Secretary shall give priority to eligible entities  
24 that have a partnership with—

25 (i) a community organization; or

1                   (ii) a consortia of community  
2                   organizations, state agencies, and local  
3                   agencies,  
4                   that has experience in providing language serv-  
5                   ices.

6                   (5) USE OF FUNDS FOR COMPETENT LANGUAGE  
7                   SERVICES.—

8                   (A) IN GENERAL.—Subject to subpara-  
9                   graph (E), a grantee may only use grant funds  
10                  received under this subsection to pay for the  
11                  provision of competent language services to  
12                  Medicare beneficiaries who are limited-English  
13                  proficient.

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

17                         (i) interpreter and translation services  
18                         that—

19                                 (I) subject to the exceptions  
20                                 under subparagraph (C)—

21   (aa) if the grantee operates  
22   in a State that has statewide  
23   health care interpreter standards,  
24   meet the State standards cur-  
25   rently in effect; or

1 (bb) if the grantee operates  
2 in a State that does not have  
3 statewide health care interpreter  
4 standards, utilizes competent in-  
5 terpreters who follow the Na-  
6 tional Council on Interpreting in  
7 Health Care’s Code of Ethics and  
8 Standards of Practice; and

9 (II) that, in the case of inter-  
10 preter services, are provided  
11 through—

12 (aa) on-site interpretation;  
13 (bb) telephonic interpreta-  
14 tion; or  
15 (cc) video interpretation;  
16 and

17 (ii) the direct provision of health care  
18 or health-care-related services by a com-  
19 petent bilingual health care provider.

20 (C) EXCEPTIONS.—The requirements of  
21 subparagraph (B)(i)(I) do not apply—

22 (i) to a Medicare beneficiary who is  
23 limited-English-proficient who has been in-  
24 formed, in the beneficiary’s primary lan-  
25 guage, of the availability of free interpreter

1 and translation services and who, instead,  
2 requests that a family member, friend, or  
3 other person provide such services, if the  
4 grantee documents such request in the  
5 beneficiary's medical record; or

6 (ii) in the case of a medical emergency  
7 where the delay directly associated with ob-  
8 taining a competent interpreter or trans-  
9 lation services would jeopardize the health  
10 of the patient.

11 Subparagraph (C)(ii) shall not be construed to  
12 exempt emergency rooms or similar entities  
13 that regularly provide health care services in  
14 medical emergencies to limited-English-pro-  
15 ficient patients from any applicable legal or reg-  
16 ulatory requirements related to providing com-  
17 petent interpreter and translation services with-  
18 out undue delay.

19 (D) MA ORGANIZATIONS AND PDP SPON-  
20 SORS.—If a grantee is a MA organization or a  
21 PDP sponsor, such entity must provide at least  
22 50 percent of the grant funds that the entity  
23 receives under this subsection directly to the en-  
24 tity's network providers (including physicians  
25 and pharmacies) for the purpose of providing

1 support for such providers to provide competent  
2 language services to Medicare beneficiaries who  
3 are limited-English proficient.

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

10 (6) DETERMINATION OF AMOUNT OF GRANT  
11 PAYMENTS.—

12 (A) IN GENERAL.—Payments to grantees  
13 under this subsection shall be calculated based  
14 on the estimated numbers of limited-English-  
15 proficient Medicare beneficiaries in a grantee’s  
16 service area utilizing—

17 (i) data on the numbers of limited-  
18 English-proficient individuals who speak  
19 English less than “very well” from the  
20 most recently available data from the Bu-  
21 reau of the Census or other State-based  
22 study the Secretary determines likely to  
23 yield accurate data regarding the number  
24 of such individuals in such service area; or



1           (ii) data provided by the grantee, if  
2           the grantee routinely collects data on the  
3           primary language of the Medicare bene-  
4           ficiaries that the grantee serves and the  
5           Secretary determines that the data is accu-  
6           rate and shows a greater number of lim-  
7           ited-English-proficient individuals than  
8           would be estimated using the data under  
9           clause (i).

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

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

21           (7) ASSURANCES.—Grantees under this sub-  
22           section shall—

23           (A) ensure that clinical and support staff  
24           receive appropriate ongoing education and

1 training in linguistically appropriate service de-  
2 livery;

3 (B) ensure the linguistic competence of bi-  
4 lingual providers;

5 (C) offer and provide appropriate language  
6 services at no additional charge to each patient  
7 with limited-English proficiency for all points of  
8 contact between the patient and the grantee, in  
9 a timely manner during all hours of operation;

10 (D) notify Medicare beneficiaries of their  
11 right to receive language services in their pri-  
12 mary language;

13 (E) post signage in the primary languages  
14 commonly used by the patient population in the  
15 service area of the organization; and

16 (F) ensure that—

17 (i) primary language data is collected  
18 for recipients of language services and  
19 such data is consistent with standards de-  
20 veloped under title XXXIV of the Public  
21 Health Service Act, as added by section  
22 202 of this Act, to the extent such stand-  
23 ards are available upon the initiation of the  
24 demonstration program; and

1           (ii) consistent with the privacy protec-  
2           tions provided under the regulations pro-  
3           mulgated pursuant to section 264(c) of the  
4           Health Insurance Portability and Account-  
5           ability Act of 1996 (42 U.S.C. 1320d-2  
6           note), if the recipient of language services  
7           is a minor or is incapacitated, primary lan-  
8           guage data is collected on the parent or  
9           legal guardian of such recipient.

10           (8) NO COST SHARING.—Limited-English-pro-  
11           ficient Medicare beneficiaries shall not have to pay  
12           cost-sharing or co-payments for competent language  
13           services provided under this demonstration program.

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

19                   (A) The number of Medicare beneficiaries  
20                   to whom competent language services are pro-  
21                   vided.

22                   (B) The primary languages of those Medi-  
23                   care beneficiaries.

24                   (C) The types of language services pro-  
25                   vided to such beneficiaries.

1 (D) Whether such language services were  
2 provided by employees of the grantee or  
3 through a contract with external contractors or  
4 agencies).

5 (E) The types of interpretation services  
6 provided to such beneficiaries, and the approxi-  
7 mate length of time such service is provided to  
8 such beneficiaries.

9 (F) The costs of providing competent lan-  
10 guage services.

11 (G) An account of the training or accredi-  
12 tation of bilingual staff, interpreters, and trans-  
13 lators providing services funded by the grant  
14 under this subsection.

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

21 (A) An analysis of the patient outcomes  
22 and the costs of furnishing care to the limited-  
23 English-proficient Medicare beneficiaries par-  
24 ticipating in the project as compared to such  
25 outcomes and costs for limited-English-pro-

1           efficient Medicare beneficiaries not participating,  
2           based on the data provided under paragraph (9)  
3           and any other information available to the Sec-  
4           retary.

5           (B) The effect of delivering language serv-  
6           ices on—

7                   (i) Medicare beneficiary access to care  
8                   and utilization of services;

9                   (ii) the efficiency and cost effective-  
10                  ness of health care delivery;

11                  (iii) patient satisfaction;

12                  (iv) health outcomes; and

13                  (v) the provision of culturally appro-  
14                  priate services provided to such  
15                  beneficiaries.

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

1           panded pursuant to subsection (c) of section  
2           1907 of this Act.

3           (D) Recommendations, if any, regarding  
4           the extension of such project to the entire Medi-  
5           care program, subject the to provision of section  
6           1115A(c) of the Social Security Act.

7           (11) APPROPRIATIONS.—There is appropriated  
8           to carry out this subsection, in equal parts from the  
9           Federal Hospital Insurance Trust Fund and the  
10          Federal Supplementary Medical Insurance Trust  
11          Fund, \$16,000,000 for each fiscal year of the dem-  
12          onstration program.

13          (b) LANGUAGE SERVICES UNDER THE MEDICARE  
14          PROGRAM.—

15               (1) Subsection (aa)(1) of section 1861 of the  
16               Social Security Act (42 U.S.C. 1395x) is amended—

17                     (A) in subparagraph (B), by striking the  
18                     “and” at the end;

19                     (B) in subparagrph (C), by inserting  
20                     “and” after the comma at the end; and

21                     (C) by inserting after subparagraph (C)  
22                     the following:

23                             “(D) language services as defined in sub-  
24                             section (iii),”.

1           (2) Section 1833(a) of the Social Security Act  
2           (42 U.S.C. 1395l(a)) is amended—

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

5                   (B) by edesignating paragraph (9) as para-  
6                   graph (10); and

7                   (C) by inserting after paragraph (8) the  
8                   following new paragraph:

9                   “(9) in the case of language services described  
10                  in section 1861(iii), 100 percent of the reasonable  
11                  charges for such services, as determined in consulta-  
12                  tion with the Medicare Payment Advisory Commis-  
13                  sion; and”.

14           (3) Section 1832(a)(2) of such Act (42 U.S.C.  
15           1395k(a)(2)) is amended—

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

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

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

22                   “(K) language services (as defined in sec-  
23                   tion 1861(iii)) furnished by a interpreter or  
24                   translator.”.

1           (4) Section 1861 of the Social Security Act (42  
2           U.S.C. 1395x) is amended by adding at the end the  
3           following new subsection:

4           “Language Services and Related Terms

5           “(iii)(1) LANGUAGE SERVICES DEFINED.—The term  
6           ‘language services’ has the same meaning given ‘language  
7           or language access services’ in section 3400 of the Public  
8           Health Service Act.

9           “(2) INTERPRETER SERVICES DEFINED.—For the  
10          purposes of this subsection, the term ‘interpreter services’  
11          has the meaning given ‘competent interpreter services’  
12          under section 3400(3) of the Public Health Service Act.

13          “(3) INTERPRETER DEFINED.—The term ‘inter-  
14          preter’—

15                 “(A) means an individual—

16                         “(i) who faithfully, accurately, and objec-  
17                         tively transmits a spoken message from one lan-  
18                         guage into another language; and

19                         “(ii) who knows health and health-related  
20                         terminology in both languages; and

21                 “(B) includes individuals who provide in-person,  
22                 telephonic, and video interpretation.

23          “(4) TRANSLATION DEFINED.—The term ‘trans-  
24          lation’ means the transmission of a written message in one



1 language into a written message in another language that  
2 retains the intended meaning of the original message.

3 “(5) LIMITED-ENGLISH-PROFICIENT AND LEP DE-  
4 FINED.—The terms ‘Limited-English-proficient’ and  
5 ‘LEP’ have the meaning given the term ‘limited english  
6 proficient’ under section 9101(25) of the Elementary and  
7 Secondary Education Act of 1965, except that subpara-  
8 graphs (A), (B), and (D) of such section not apply.”.

9 (5) WAIVER OF BUDGET NEUTRALITY.—For  
10 the 3-year period beginning on the date of enact-  
11 ment of this section, the budget neutrality provision  
12 of section 1848(c)(2)(B)(ii) of the Social Security  
13 Act (42 U.S.C. 1395w-4(c)(2)(B)(ii)) shall not  
14 apply to language services (as such term is defined  
15 in section 1861(iii) of such Act).

16 (c) MEDICARE PART C AND PART D.—

17 (1) IN GENERAL.—Medicare Advantage plans  
18 under part C of the Social Security Act and Pre-  
19 scription Drug Plans under part D of such Act shall  
20 provide effective language services to enrollees of  
21 such plans.

22 (2) REPORTING REQUIREMENTS.—Medicare  
23 Advantage and Prescription Drug plans shall annu-  
24 ally submit to the Secretary of Health and Human  
25 Services a report that contains information on the

1 plan's internal policies and procedures related to re-  
2 cruitment and retention efforts directed to workforce  
3 diversity and linguistically and culturally appropriate  
4 provision of services in each of the following con-  
5 texts:

6 (A) The collection of data in a manner  
7 that meets the requirements of title I of this  
8 Act, regarding the enrollee population.

9 (B) Education of staff and contractors who  
10 have routine contact with enrollees regarding  
11 the various needs of the diverse enrollee popu-  
12 lation.

13 (C) Evaluation of the health plan's lan-  
14 guage services programs and services with re-  
15 spect to the plan's enrollee population, such as  
16 through analysis of complaints or satisfaction  
17 survey results.

18 (D) Methods by which the plan provides to  
19 the Secretary information regarding the ethnic  
20 diversity of the plan's enrollee population.

21 (E) The periodic provision of educational  
22 information to plan enrollees on the plan's lan-  
23 guage services and programs.

24 (d) IMPROVING LANGUAGE SERVICES IN MEDICAID

25 AND SCHIP.—

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

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

5                   (B) striking “translation or interpretation  
6           services” and inserting “language services”;  
7           and

8                   (C) striking “children of families” and in-  
9           serting “individuals”.

10          (2) Section 1902(a)(10)(A) of the Social Secu-  
11          rity Act (42 U.S.C. 1396a(a)(10)(A)) is amended by  
12          striking “and (28)” and inserting “(28), and (29)”.

13          (3) Section 1905(a) of the Social Security Act  
14          (42 U.S.C. 1396d(a)) is amended by—

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

17                   (B) by redesignating paragraph (29) as  
18           paragraph (30); and

19                   (C) by inserting after paragraph (28) the  
20           following new paragraph:

21                   “(29) language services, as such term is defined  
22           in section 1861(iii), provided in a timely manner to  
23           limited-English-proficient individuals who need such  
24           services; and”.

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

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

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

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

9           “(F) language services described in section  
10 1905(a)(29); and”.

11          (5) Section 2103 of the Social Security Act (42  
12 U.S.C. 1397ee) is amended—

13          (A) in subsection (a), in the matter before  
14 paragraph (1), by striking “ and (7)” and in-  
15 serting “(7), and (9)”; and

16          (B) in subsection (e), by adding at the end  
17 the following new paragraph:

18          “(9) LANGUAGE SERVICES.—The child health  
19 assistance provided to a targeted low-income child  
20 shall include coverage of language services, as such  
21 term is defined in section 1861(iii), provided in a  
22 timely manner to limited-English-proficient individ-  
23 uals who need such services.”; and

24          (C) in subsection (e)(2)—

- 1 (i) in the heading, by striking “PRE-  
2 VENTIVE” and inserting “CERTAIN”; and  
3 (ii) by inserting “, subsection (c)(9),”  
4 after “subsection (c)(1)(C)”.

5 (6) Section 2110(a)(27) of the Social Security  
6 Act (42 U.S.C. 1397jj) is amended by striking  
7 “translation” and inserting “language services as  
8 described in section 2103(c)(9)”.

9 (7) Pursuant to the reporting requirement de-  
10 scribed in section 2107(b)(1) of the Social Security  
11 Act (42 U.S.C. 1397gg(b)(1)), the Secretary of  
12 Health and Human Services shall require that  
13 States collect data on—

14 (A) the primary language of individuals re-  
15 ceiving child health assistance under title XXI  
16 of the Social Security Act; and

17 (B) in the case of such individuals who are  
18 minors or incapacitated, the primary language  
19 of the individual’s parent or guardian.

20 (8) Section 2105 of the Social Security Act (42  
21 U.S.C. 1397ee(e)) is amended—

22 (A) in subsection (a)(1) by striking “75”  
23 and inserting “90”; and

24 (B) in subsection (c)(2)(A), by inserting  
25 before the period “, except that expenditures

1           pursuant to clause (iv) of subparagraph (D) of  
2           such paragraph shall not count towards this  
3           total”.

4           (e) FUNDING LANGUAGE SERVICES FURNISHED BY  
5 PROVIDERS OF HEALTH CARE AND HEALTH-CARE-RE-  
6 LATED SERVICES THAT SERVE HIGH RATES OF UNIN-  
7 SURED LEP INDIVIDUALS.—

8           (1) PAYMENT OF COSTS.—

9           (A) IN GENERAL.—Subject to subpara-  
10 graph (B), the Secretary of Health and Human  
11 Services shall make payments (on a quarterly  
12 basis) directly to eligible entities to support the  
13 provision of language services to limited-  
14 English-proficient individuals in an amount  
15 equal to an entity’s eligible costs (as defined  
16 under paragraph (3)) for such services for the  
17 quarter.

18           (B) FUNDING.—Out of any funds in the  
19 Treasury not otherwise appropriated, there are  
20 appropriated to the Secretary of Health and  
21 Human Services such sums as may be nec-  
22 essary for each of fiscal years 2012 through  
23 2016.

24           (C) RELATION TO MEDICAID DSH.—Pay-  
25 ments under this subsection shall not offset or

1           reduce payments under section 1923 of the So-  
2           cial Security Act, nor shall payments under  
3           such section be considered when determining  
4           uncompensated costs associated with the provi-  
5           sion of language services.

6           (2) ELIGIBLE ENTITY.—In order to receive  
7           grants under this paragraph, an entity must—

8                   (A) be a Medicaid provider that is—

9                           (i) a physician;

10                           (ii) a hospital with a low-income utili-  
11                           zation rate (as defined in section  
12                           1923(b)(3) of the Social Security Act (42  
13                           U.S.C. 1396r-4(b)(3))) of greater than 25  
14                           percent; or

15                           (iii) a federally qualified health center  
16                           (as defined in section 1905(l)(2)(B) of the  
17                           Social Security Act (42 U.S.C.  
18                           1396d(l)(2)(B)));

19                   (B) provide language services to at least 8  
20                   percent of the entity's total number of patients,  
21                   not later than 6 months after the date of the  
22                   enactment of the Act; and

23                   (C) prepare and submit an application to  
24                   the Secretary, at such time, in such manner,  
25                   and accompanied by such information as the

1 Secretary may require to ascertain the entity's  
2 eligibility for funding under this subsection.

3 (3) ELIGIBLE COSTS DEFINED.—

4 (A) IN GENERAL.—In this subsection, the  
5 term “eligible costs” means, with respect to an  
6 eligible entity that provides language services to  
7 LEP individuals, the product of—

8 (i) the average per person cost of lan-  
9 guage services, determined according to  
10 the methodology devised under subpara-  
11 graph (B); and

12 (ii) the number of limited-English-pro-  
13 ficient individuals who are provided lan-  
14 guage services by the entity and for whom  
15 no reimbursement is available for such  
16 services under the amendments made by  
17 subsections (a), (b), (c), or (d) or by pri-  
18 vate health insurance.

19 (B) METHODOLOGY.—

20 (i) IN GENERAL.—The Secretary shall  
21 establish a methodology to determine the  
22 average per person cost of language serv-  
23 ices.

24 (ii) DIFFERENT ENTITIES.—In estab-  
25 lishing such methodology, the Secretary



1           may establish different methodologies for  
2           different types of eligible entities.

3           (iii) NO INDIVIDUAL CLAIMS.—The  
4           Secretary may not require eligible entities  
5           to submit individual claims for language  
6           services for individual patients as a re-  
7           quirement for payment under this sub-  
8           section.

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

16          (5) REPORTING REQUIREMENTS.—Entities re-  
17          ceiving payment under this subsection shall provide  
18          the Secretary with a quarterly report on how the en-  
19          tity used such funds. Such report shall contain ag-  
20          gregate (and may not contain individualized) data  
21          collected using the instrument under paragraph (4)  
22          and shall otherwise be in a form and manner deter-  
23          mined by the Secretary.

24          (6) LANGUAGE SERVICES.—For purposes of  
25          this subsection, the term “language services” has

1 the meaning given such term in section 1861(iii) of  
2 the Social Security Act.

3 (7) GUIDELINES AND REPORT.—

4 (A) ESTABLISHMENT.—Not later than 6  
5 months after the date of enactment of this Act,  
6 the Secretary of Health and Human Services  
7 shall establish and distribute guidelines con-  
8 cerning the implementation of this subsection.

9 (B) REPORT.—Not later than 2 years after  
10 the date of enactment of this Act, and every 2  
11 years thereafter, the Secretary shall submit a  
12 report to Congress concerning the implementa-  
13 tion of this subsection.

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

20 (g) EFFECTIVE DATE.—The amendments made by  
21 this section shall take effect on October 1, 2011.

22 **SEC. 204. INCREASING UNDERSTANDING OF AND IMPROV-**  
23 **ING HEALTH LITERACY.**

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

1 ity and the Administrator of the Health Resources and  
2 Services Administration, in consultation with the Director  
3 of the National Institute on Minority Health and Health  
4 Disparities and the Office of Minority Health, shall award  
5 grants to eligible entities to improve health care for pa-  
6 tient populations that have low functional health literacy.

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

9 (1) be a hospital, health center or clinic, health  
10 plan, or other health entity (including a nonprofit  
11 minority health organization or association); and

12 (2) prepare and submit to the Secretary an ap-  
13 plication at such time, in such manner, and con-  
14 taining such information as the Secretary may re-  
15 quire.

16 (c) USE OF FUNDS.—

17 (1) AGENCY FOR HEALTHCARE RESEARCH AND  
18 QUALITY.—Grants awarded under subsection (a)  
19 through the Agency for Healthcare Research and  
20 Quality shall be used—

21 (A) to define and increase the under-  
22 standing of health literacy;

23 (B) to investigate the correlation between  
24 low health literacy and health and health care;

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

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

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

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

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

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

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

22 (E) the conduct of educational campaigns  
23 for patients and providers about low health lit-  
24 eracy; and

1 (F) other activities determined appropriate  
2 by the Administrator of the Health Resources  
3 and Services Administration.

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

8 (e) AUTHORIZATION OF APPROPRIATIONS.—There  
9 are authorized to be appropriated to carry out this section,  
10 such sums as may be necessary for each of fiscal years  
11 2012 through 2016.

12 **SEC. 205. ASSURANCES FOR RECEIVING FEDERAL FUNDS.**

13 (a) IN GENERAL.—Entities that receive Federal  
14 funds under sections 201 or 202 (including under the  
15 amendments made by such section), in order to ensure the  
16 right of LEP individuals to receive access to quality health  
17 care, shall—

18 (1) ensure that appropriate clinical and support  
19 staff receive ongoing education and training in lin-  
20 guistically appropriate service delivery;

21 (2) offer and provide appropriate language serv-  
22 ices at no additional charge to each patient with lim-  
23 ited-English proficiency at all points of contact, in a  
24 timely manner during all hours of operation;

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

3           (4) utilize only competent interpreter or trans-  
4           lation services which—

5                   (A) until adoption of the Interpreter and  
6                   Translator Guidelines and Standards described  
7                   in section 3403(c) of the Public Health Service  
8                   Act, are defined in section 3400 of the Public  
9                   Health Service Act; and

10                   (B) after adoption of the Interpreter and  
11                   Translator Guidelines and Standards described  
12                   in section 3403(c) of the Public Health Service  
13                   Act, meet those guidelines and standards;

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

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

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

24                           (B) The recipient informs the patient that  
25                           he or she has the option of having the recipient

1 provide an interpreter for him/her without  
2 charge, or of using his/her own interpreter.

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

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

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

19 (F) The recipient has the patient sign a  
20 waiver, witnessed by at least 1 individual not  
21 related to the patient, that includes the infor-  
22 mation stated in subparagraphs (A) through  
23 (E) and is translated into the patient's lan-  
24 guage.

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

12 **SEC. 206. REPORT ON FEDERAL EFFORTS TO PROVIDE CUL-**  
13                   **TURALLY AND LINGUISTICALLY APPRO-**  
14                   **PRIATE HEALTH CARE SERVICES.**

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

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



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

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

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

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

14          (b) **AUTHORIZATION OF APPROPRIATIONS.**—There  
15          are authorized to be appropriated to carry out this section  
16          such sums as may be necessary for each of fiscal years  
17          2012 through 2016.

18          **SEC. 207. ENGLISH FOR SPEAKERS OF OTHER LANGUAGES.**

19          (a) **GRANTS AUTHORIZED.**—The Secretary of Edu-  
20          cation is authorized to provide grants to eligible entities  
21          for the provision of English as a second language (here-  
22          after referred to as “ESL”) instruction and shall deter-  
23          mine, after consultation with appropriate stakeholders, the  
24          mechanism for administering and distributing such  
25          grants.

1 (b) ELIGIBLE ENTITY DEFINED.—For purposes of  
2 this section, the term “eligible entity” means a State or  
3 community-based organization that employs, and serves,  
4 minority populations.

5 (c) APPLICATION.—An eligible entity may apply for  
6 a grant under this section by submitting such information  
7 as the Secretary may require and in such form and man-  
8 ner as the Secretary may require.

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

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

18 (2) develop a plan, including, where appro-  
19 priate, public-private partnerships, for making ESL  
20 instruction progressively available to all individuals  
21 seeking instruction; and

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

1 (e) ADDITIONAL DUTIES OF THE SECRETARY.—The  
2 Secretary of Education shall—

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

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

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

12 (B) the extent of waiting lists including  
13 how many programs maintain waiting lists and,  
14 for programs that do not have waiting lists, the  
15 reasons why not;

16 (C) the availability of programs to geo-  
17 graphically isolated communities;

18 (D) the impact of course enrollment poli-  
19 cies, including open enrollment, on the avail-  
20 ability of ESL instruction;

21 (E) the number individuals in the State  
22 and each participating locality;

23 (F) the effectiveness of the instruction in  
24 meeting the needs of individuals receiving in-  
25 struction and those needing instruction;

1           (G) as assessment of the need for pro-  
2           grams that integrate job training and ESL in-  
3           struction, to assist individuals to obtain better  
4           jobs; and

5           (H) the availability of ESL slots by State  
6           and locality;

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

10          (4) within 1 year of the date of enactment of  
11          this Act, issue a report to Congress that assesses the  
12          information collected in paragraphs (1), (2), and (3)  
13          and makes recommendations on steps that should be  
14          taken to progressively realize the goal of making  
15          ESL instruction available to all English language  
16          learners seeking instruction.

17          (f) AUTHORIZATION OF APPROPRIATIONS.—There  
18          are authorized to be appropriated to the Secretary of Edu-  
19          cation for each of fiscal years 2012 through 2015  
20          \$250,000,000 to carry out this section.

21          **SEC. 208. IMPLEMENTATION.**

22          (a) GENERAL PROVISIONS.—

23                 (1) A State shall not be immune under the  
24                 Eleventh Amendment of the Constitution of the  
25                 United States from suit in Federal court for failing

1 to provide the language access funded pursuant to  
2 this title.

3 (2) In a suit against a State for a violation of  
4 this title, remedies (including remedies at both at  
5 law and in equity) are available for such a violation  
6 to the same extent as such remedies are available for  
7 such a violation in the suit against any public or pri-  
8 vate entity other than a State.

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

14 **SEC. 209. LANGUAGE ACCESS SERVICES.**

15 (a) ESSENTIAL BENEFITS.—Section 1302(b)(1) of  
16 the Patient Protection and Affordable Care Act (42  
17 U.S.C. 18022(b)(1)) is amended by adding at the end the  
18 following:

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

21 (b) EMPLOYER-SPONSORED MINIMUM ESSENTIAL  
22 COVERAGE.—Section 36B(c)(2)(C) of the Internal Rev-  
23 enue Code of 1986 is amended by adding at the end the  
24 following:

1           “(v) COVERAGE MUST INCLUDE LAN-  
2           GUAGE ACCESS AND SERVICES.—Except as  
3           provided in clause (iii), an employee shall  
4           not be treated as eligible for minimum es-  
5           sential coverage if such coverage consists  
6           of an eligible employer-sponsored plan (as  
7           defined in section 5000A(f)(2)) and the  
8           plan does not provide coverage for lan-  
9           guage access services, including oral inter-  
10          pretation and written translations.”.

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

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

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

18           (3) by adding at the end the following new sub-  
19          paragraph:

20           “(E) reduce health disparities through the  
21          provision of language access services, including  
22          oral interpretation and written translations.”.

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

3 **SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE**  
4 **ACT.**

5 Title XXXIV of the Public Health Service Act, as  
6 added by section 202, is amended by adding at the end  
7 the following:

8 **“Subtitle A—Diversifying the**  
9 **Health Care Workplace**

10 **“SEC. 3411. REPORT ON WORKFORCE DIVERSITY.**

11 “(a) IN GENERAL.—Not later than July 1, 2012, and  
12 biannually thereafter, the Secretary, acting through the  
13 director of each entity within the Department of Health  
14 and Human Services, shall prepare and submit to the  
15 Committee on Health, Education, Labor, and Pensions of  
16 the Senate and the Committee on Energy and Commerce  
17 of the House of Representatives a report on health work-  
18 force diversity.

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

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

24 “(A) the number of grants made;

25 “(B) the purpose of the grants;

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

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

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

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

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

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

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

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

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



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

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

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

8           **“SEC. 3412. NATIONAL WORKING GROUP ON WORKFORCE**  
9           **DIVERSITY.**

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

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

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

20           “(A) The Health Resources and Services  
21           Administration.

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

24           “(C) The Office of Minority Health.

1           “(D) The Bureau of Labor Statistics of  
2 the Department of Labor.

3           “(E) The Public Health Practice Program  
4 Office—Office of Workforce Policy and Plan-  
5 ning.

6           “(F) The National Institute on Minority  
7 Health and Health Disparities.

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

10          “(H) The Institute of Medicine Study  
11 Committee for the 2004 workforce diversity re-  
12 port.

13          “(I) The Indian Health Service.

14          “(J) Minority-serving academic institu-  
15 tions.

16          “(K) Consumer organizations.

17          “(L) Health professional associations, in-  
18 cluding those that represent underrepresented  
19 minority populations.

20          “(M) Researchers in the area of health  
21 workforce.

22          “(N) Health workforce accreditation enti-  
23 ties.

24          “(O) Private foundations that have spon-  
25 sored workforce diversity initiatives.

1           “(2) The grantee shall ensure that, in addition  
2           to the representatives under paragraph (1), the  
3           group has not less than 5 health professions stu-  
4           dents representing various health profession fields  
5           and levels of training.

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

9           “(1) Review current public and private health  
10          workforce diversity initiatives.

11          “(2) Identify successful health workforce diver-  
12          sity programs and practices.

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

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

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

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

1           “(7) Develop curriculum guidelines for diversity  
2 training.

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

6           “(9) Other activities determined appropriate by  
7 the Secretary.

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

16           “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
17 is authorized to be appropriated to carry out this section  
18 such sums as may be necessary for each of fiscal years  
19 2012 through 2017.

20 **“SEC. 3413. TECHNICAL CLEARINGHOUSE FOR HEALTH**  
21 **WORKFORCE DIVERSITY.**

22           “(a) IN GENERAL.—The Secretary, acting through  
23 the Office of Minority Health, and in collaboration with  
24 the Bureau of Health Professions within the Health Re-  
25 sources and Services Administration, the National Insti-

1 tute on Minority Health and Health Disparities, shall es-  
2 tablish a technical clearinghouse on health workforce di-  
3 versity within the Office of Minority Health and coordi-  
4 nate current and future clearinghouses.

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

8 “(1) Information on the importance of health  
9 workforce diversity.

10 “(2) Statistical information relating to under-  
11 represented minority representation in health and al-  
12 lied health professions and occupations.

13 “(3) Model health workforce diversity practices  
14 and programs.

15 “(4) Admissions policies that promote health  
16 workforce diversity and are in compliance with Fed-  
17 eral and State laws.

18 “(5) Lists of scholarship, loan repayment, and  
19 loan cancellation grants as well as fellowship infor-  
20 mation for underserved populations for health pro-  
21 fessions schools.

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

24 “(c) CONSULTATION.—In carrying out this section,  
25 the Secretary shall consult with non-Federal entities which

1 may include minority health professional associations to  
2 ensure the adequacy and accuracy of information.

3 “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
4 is authorized to be appropriated to carry out this section  
5 such sums as may be necessary for each of fiscal years  
6 2012 through 2017.

7 **“SEC. 3414. SUPPORT FOR INSTITUTIONS COMMITTED TO**  
8 **WORKFORCE DIVERSITY.**

9 “(a) IN GENERAL.—The Secretary, acting through  
10 the Administrator of the Health Resources and Services  
11 Administration and the Centers for Disease Control and  
12 Prevention, shall award grants to eligible entities that  
13 demonstrate a commitment to health workforce diversity.

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

16 “(1) be an educational institution or entity that  
17 historically produces or trains meaningful numbers  
18 of underrepresented minority health professionals,  
19 including—

20 “(A) historically Black colleges and univer-  
21 sities;

22 “(B) Hispanic-serving health professions  
23 schools;

24 “(C) Hispanic-serving institutions;

25 “(D) tribal colleges and universities;

1           “(E) Asian-American, Native American,  
2           and Pacific Islander-serving institutions;

3           “(F) institutions that have programs to re-  
4           cruit and retain underrepresented minority  
5           health professionals, in which a significant  
6           number of the enrolled participants are under-  
7           represented minorities;

8           “(G) health professional associations,  
9           which may include underrepresented minority  
10          health professional associations; and

11          “(H) institutions—

12                  “(i) located in communities with pre-  
13                  dominantly underrepresented minority pop-  
14                  ulations;

15                  “(ii) with whom partnerships have  
16                  been formed for the purpose of increasing  
17                  workforce diversity; and

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

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

24          “(c) USE OF FUNDS.—Amounts received under a  
25          grant under subsection (a) shall be used to expand existing

1 workforce diversity programs, implement new workforce  
2 diversity programs, or evaluate existing or new workforce  
3 diversity programs, including with respect to mental  
4 health care professions. Such programs shall enhance di-  
5 versity by considering minority status as part of an indi-  
6 vidualized consideration of qualifications. Possible activi-  
7 ties may include—

8           “(1) educational outreach programs relating to  
9           opportunities in the health professions;

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

12           “(3) postbaccalaureate programs;

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

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

18           “(6) mentoring programs;

19           “(7) internship or rotation programs involving  
20           hospitals, health systems, health plans and other  
21           health entities;

22           “(8) community partnership development for  
23           purposes relating to workforce diversity; or

24           “(9) leadership training.



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

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

12           “(f) 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 2012 through 2017.

16 **“SEC. 3415. CAREER DEVELOPMENT FOR SCIENTISTS AND**  
17 **RESEARCHERS.**

18           “(a) IN GENERAL.—The Secretary, acting through  
19 the Director of the National Institutes of Health, the Di-  
20 rector of the Centers for Disease Control and Prevention,  
21 the Commissioner of Food and Drugs, and the Director  
22 of the Agency for Healthcare Research and Quality, shall  
23 award grants that expand existing opportunities for sci-  
24 entists and researchers and promote the inclusion of  
25 underrepresented minorities in the health professions.

1           “(b) RESEARCH FUNDING.—The head of each entity  
2 within the Department of Health and Human Services  
3 shall establish or expand existing programs to provide re-  
4 search funding to scientists and researchers in training.  
5 Under such programs, the head of each such entity shall  
6 give priority in allocating research funding to support  
7 health research in traditionally underserved communities,  
8 including underrepresented minority communities, and re-  
9 search classified as community or participatory.

10           “(c) DATA COLLECTION.—The head of each entity  
11 within the Department of Health and Human Services  
12 shall collect data on the number (expressed as an absolute  
13 number and a percentage) of underrepresented minority  
14 and nonminority applicants who receive and are denied  
15 agency funding at every stage of review. Such data shall  
16 be reported annually to the Secretary and the appropriate  
17 committees of Congress.

18           “(d) STUDENT LOAN REIMBURSEMENT.—The Sec-  
19 retary shall establish a student loan reimbursement pro-  
20 gram to provide student loan reimbursement assistance to  
21 researchers who focus on racial and ethnic disparities in  
22 health. The Secretary shall promulgate regulations to de-  
23 fine the scope and procedures for the program under this  
24 subsection.

1       “(e) STUDENT LOAN CANCELLATION.—The Sec-  
2 retary shall establish a student loan cancellation program  
3 to provide student loan cancellation assistance to research-  
4 ers who focus on racial and ethnic disparities in health.  
5 Students participating in the program shall make a min-  
6 imum 5-year commitment to work at an accredited health  
7 profession school. The Secretary shall promulgate addi-  
8 tional regulations to define the scope and procedures for  
9 the program under this subsection.

10       “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
11 is authorized to be appropriated to carry out this section,  
12 such sums as may be necessary for each of fiscal years  
13 2012 through 2017.

14 **“SEC. 3416. CAREER SUPPORT FOR NON-RESEARCH**  
15 **HEALTH PROFESSIONALS.**

16       “(a) IN GENERAL.—The Secretary, acting through  
17 the Director of the Centers for Disease Control and Pre-  
18 vention, the Administrator of the Substance Abuse and  
19 Mental Health Services Administration, the Administrator  
20 of the Health Resources and Services Administration, and  
21 the Administrator of the Centers for Medicare and Med-  
22 icaid Services shall establish a program to award grants  
23 to eligible individuals for career support in non-research-  
24 related health care.

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

3           “(1) be a student in a health professions school,  
4 a graduate of such a school who is working in a  
5 health profession, or a faculty member of such a  
6 school; and

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

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

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

15           “(2) support health-related career advancement  
16 activities;

17           “(3) to pay, or as reimbursement for payments  
18 of, student loans for individuals who are health pro-  
19 fessionals and are focused on health issues affecting  
20 underserved communities, including racial and eth-  
21 nic minority communities; and

22           “(4) to establish and promote leadership train-  
23 ing programs to decrease health disparities and to  
24 increase cultural competence with the goal of in-  
25 creasing diversity in leadership positions.

1       “(d) DEFINITION.—In this section, the term ‘career  
2 in non-research-related health care’ means employment or  
3 intended employment in the field of public health, health  
4 policy, health management, health administration, medi-  
5 cine, nursing, pharmacy, psychology, social work, psychi-  
6 atry, other mental and behavioral health, allied health,  
7 community health, social work, or other fields determined  
8 appropriate by the Secretary, other than in a position that  
9 involves research.

10       “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
11 is authorized to be appropriated to carry out this section,  
12 such sums as may be necessary for each of fiscal years  
13 2012 through 2017.

14       **“SEC. 3417. RESEARCH ON THE EFFECT OF WORKFORCE DI-  
15    VERSITY ON QUALITY.**

16       “(a) IN GENERAL.—The Director of the Agency for  
17 Healthcare Research and Quality, in collaboration with  
18 the Deputy Assistant Secretary for Minority Health and  
19 the Director of the National Institute on Minority Health  
20 and Health Disparities, shall award grants to eligible enti-  
21 ties to expand research on the link between health work-  
22 force diversity and quality health care.

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

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

4           “(2) 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.—Amounts received under a  
8           grant awarded under subsection (a) shall be used to sup-  
9           port research that investigates the effect of health work-  
10          force diversity on—

11           “(1) language access;

12           “(2) cultural competence;

13           “(3) patient satisfaction;

14           “(4) timeliness of care;

15           “(5) safety of care;

16           “(6) effectiveness of care;

17           “(7) efficiency of care;

18           “(8) patient outcomes;

19           “(9) community engagement;

20           “(10) resource allocation;

21           “(11) organizational structure;

22           “(12) compliance of care; or

23           “(13) other topics determined appropriate by  
24          the Director.

1       “(d) PRIORITY.—In awarding grants under sub-  
2 section (a), the Director shall give individualized consider-  
3 ation to all relevant aspects of the applicant’s background.  
4 Consideration of prior research experience involving the  
5 health of underserved communities shall be such a factor.

6       “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
7 is authorized to be appropriated to carry out this section,  
8 such sums as may be necessary for each of fiscal years  
9 2012 through 2017.

10 **“SEC. 3418. HEALTH DISPARITIES EDUCATION PROGRAM.**

11       “(a) ESTABLISHMENT.—The Secretary, acting  
12 through the National Institute on Minority Health and  
13 Health Disparities and in collaboration with the Office of  
14 Minority Health, the Office for Civil Rights, the Centers  
15 for Disease Control and Prevention, the Centers for Medi-  
16 care & Medicaid Services, the Health Resources and Serv-  
17 ices Administration, and other appropriate public and pri-  
18 vate entities, shall establish and coordinate a health and  
19 health care disparities education program to support, de-  
20 velop, and implement educational initiatives and outreach  
21 strategies that inform health care professionals and the  
22 public about the existence of and methods to reduce racial  
23 and ethnic disparities in health and health care.

24       “(b) ACTIVITIES.—The Secretary, through the edu-  
25 cation program established under subsection (a) shall,

1 through the use of public awareness and outreach cam-  
2 paigns targeting the general public and the medical com-  
3 munity at large—

4           “(1) disseminate scientific evidence for the ex-  
5           istence and extent of racial and ethnic disparities in  
6           health care, including disparities that are not other-  
7           wise attributable to known factors such as access to  
8           care, patient preferences, or appropriateness of  
9           intervention, as described in the 2002 Institute of  
10          Medicine Report entitled ‘Unequal Treatment: Con-  
11          fronting Racial and Ethnic Disparities in Health  
12          Care’, as well as the impact of disparities related to  
13          age, disability status, socioeconomic status, sex, gen-  
14          der identity, and sexual orientation on racial and  
15          ethnic minorities;

16          “(2) disseminate new research findings to  
17          health care providers and patients to assist them in  
18          understanding, reducing, and eliminating health and  
19          health care disparities;

20          “(3) disseminate information about the impact  
21          of linguistic and cultural barriers on health care  
22          quality and the obligation of health providers who  
23          receive Federal financial assistance to ensure that  
24          people with limited-English proficiency have access  
25          to language access services;



1 “(4) disseminate information about the impor-  
 2 tance and legality of racial, ethnic, disability status,  
 3 socioeconomic status, sex, gender identity, and sex-  
 4 ual orientation, and primary language data collec-  
 5 tion, analysis, and reporting;

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

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

13 “(c) AUTHORIZATION OF APPROPRIATIONS.—There  
 14 is authorized to be appropriated to carry out this section,  
 15 such sums as may be necessary for each of fiscal years  
 16 2012 through 2017.”.

17 **SEC. 302. HISPANIC-SERVING HEALTH PROFESSIONS**  
 18 **SCHOOLS.**

19 Part B of title VII of the Public Health Service Act  
 20 (42 U.S.C. 293 et seq.) is amended by adding at the end  
 21 the following:

22 **“SEC. 742. HISPANIC-SERVING HEALTH PROFESSIONS**  
 23 **SCHOOLS.**

24 “(a) IN GENERAL.—The Secretary, acting through  
 25 the Administrator of the Health Resources and Services

1 Administration, shall award grants to Hispanic-serving  
2 health professions schools for the purpose of carrying out  
3 programs to recruit Hispanic individuals to enroll in and  
4 graduate from such schools, which may include providing  
5 scholarships and other financial assistance as appropriate.

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

9 “(1) is a school or program under section  
10 799B;

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

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

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

19 “(5) has a significant number of graduates who  
20 are providing health services to medically under-  
21 served populations or to individuals in health profes-  
22 sional shortage areas; and

23 “(6) Regional Hispanic Centers of Excellence.”.

1 **SEC. 303. LOAN REPAYMENT PROGRAM OF CENTERS FOR**  
2 **DISEASE CONTROL AND PREVENTION.**

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

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

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

7 “\$750,000 for fiscal year 2012, and such sums as  
8 may be necessary for each of the fiscal years 2013  
9 through 2017.”.

10 **SEC. 304. COOPERATIVE AGREEMENTS FOR ONLINE DE-**  
11 **GREE PROGRAMS AT SCHOOLS OF PUBLIC**  
12 **HEALTH AND SCHOOLS OF ALLIED HEALTH.**

13 Part B of title VII of the Public Health Service Act  
14 (42 U.S.C. 293 et seq.), as amended by section 302, is  
15 further amended by adding at the end the following:

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

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

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

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

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

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

15       “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
16 are authorized to be appropriated to carry out this section,  
17 such sums as may be necessary for each of fiscal years  
18 2012 through 2017.”.

19 **SEC. 305. NATIONAL REPORT ON THE PREPAREDNESS OF**  
20 **HEALTH PROFESSIONALS TO CARE FOR DI-**  
21 **VERSE POPULATIONS.**

22       The Secretary of Health and Human Services, in col-  
23 laboration with the Bureau of Health Professions, the Of-  
24 fice of Minority Health and the National Institute on Mi-  
25 nority Health and Health Disparities, shall prepare and

1 disseminate a report that details and assesses the pre-  
2 paredness of health professionals to care for racially and  
3 ethnically diverse populations. Such information, which  
4 shall be collected by the Bureau of Health Professions,  
5 shall include—

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

10           (2) a description of the coursework involved in  
11           such education;

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

14           (4) a description of the types of exposure that  
15           students have during their education to minority pa-  
16           tient populations; and

17           (5) a description of model programs and prac-  
18           tices.

19 **SEC. 306. SCHOLARSHIP AND FELLOWSHIP PROGRAMS.**

20           Subtitle A of title XXXIV of the Public Health Serv-  
21           ice Act, as amended by section 301, is further amended  
22           by inserting after section 3418 the following:

1 **“SEC. 3419. DAVID SATCHER PUBLIC HEALTH AND HEALTH**  
2 **SERVICES CORPS.**

3 “(a) IN GENERAL.—The Administrator of the Health  
4 Resources and Services Administration and the Director  
5 of the Centers for Disease Control and Prevention, in col-  
6 laboration with the Deputy Assistant Secretary for Minor-  
7 ity Health, shall award grants to eligible entities to in-  
8 crease awareness among postprimary and postsecondary  
9 students of career opportunities in the health professions.

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

12 “(1) be a clinical, public health or health serv-  
13 ices organization, community-based or nonprofit en-  
14 tity, or other entity determined appropriate by the  
15 Director of the Centers for Disease Control and Pre-  
16 vention;

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

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

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

25 “(c) USE OF FUNDS.—Grant awards under sub-  
26 section (a) shall be used to support internships that will

1 increase awareness among students of non-research-based  
2 and career opportunities in the following health profes-  
3 sions:

4           “(1) Medicine.

5           “(2) Nursing.

6           “(3) Public Health.

7           “(4) Pharmacy.

8           “(5) Health administration and management.

9           “(6) Health policy.

10          “(7) Psychology.

11          “(8) Dentistry.

12          “(9) International health.

13          “(10) Social work.

14          “(11) Allied health.

15          “(12) Psychiatry.

16          “(13) Hospice care.

17          “(14) Other professions deemed appropriate by

18          the Director of the Centers for Disease Control and

19          Prevention.

20          “(d) PRIORITY.—In awarding grants under sub-

21          section (a), the Director of the Centers for Disease Con-

22          trol and Prevention shall give priority to those entities

23          that—

24                 “(1) serve a high proportion of individuals from

25          disadvantaged backgrounds;

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

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

5           “(4) provide counseling or other services de-  
6 signed to assist disadvantaged individuals in success-  
7 fully completing their education at the postsecondary  
8 level.

9           “(e) STIPENDS.—The Secretary may approve sti-  
10 pends under this section for individuals for any period of  
11 education in student-enhancement programs (other than  
12 regular courses) at health professions schools, programs,  
13 or entities, except that such a stipend may not be provided  
14 to an individual for more than 6 months, and such a sti-  
15 pend may not exceed \$20 per day (notwithstanding any  
16 other provision of law regarding the amount of stipends).

17           “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
18 is authorized to be appropriated to carry out this section,  
19 such sums as may be necessary for each of fiscal years  
20 2012 through 2017.

21 **“SEC. 3420. LOUIS STOKES PUBLIC HEALTH SCHOLARS**  
22 **PROGRAM.**

23           “(a) IN GENERAL.—The Director of the Centers for  
24 Disease Control and Prevention, in collaboration with the  
25 Deputy Assistant Secretary for Minority Health, shall



1 award scholarships to postsecondary students who seek a  
2 career in public health.

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

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

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

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

12 “(4) demonstrate promise for becoming a leader  
13 in public health;

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

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

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

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

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

1 “(1) are from disadvantaged backgrounds;

2 “(2) have secured admissions to a minority-  
3 serving institution; and

4 “(3) have identified a health professional as a  
5 mentor at their school or institution and an aca-  
6 demic advisor to assist in the completion of their  
7 baccalaureate degree.

8 “(e) SCHOLARSHIPS.—The Secretary may approve  
9 payment of scholarships under this section for such indi-  
10 viduals for any period of education in student under-  
11 graduate tenure, except that such a scholarship may not  
12 be provided to an individual for more than 4 years, and  
13 such scholarships may not exceed \$10,000 per academic  
14 year (notwithstanding any other provision of law regard-  
15 ing the amount of scholarship).

16 “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
17 is authorized to be appropriated to carry out this section,  
18 such sums as may be necessary for each of fiscal years  
19 2012 through 2017.

20 **“SEC. 3420A. PATSY MINK HEALTH AND GENDER RESEARCH**  
21 **FELLOWSHIP PROGRAM.**

22 “(a) IN GENERAL.—The Director of the Centers for  
23 Disease Control and Prevention, in collaboration with the  
24 Deputy Assistant Secretary for Minority Health, the Ad-  
25 ministrator of the Substance Abuse and Mental Health

1 Services Administration, and the Director of the Indian  
2 Health Services, shall award research fellowships to post-  
3 baccalaureate students to conduct research that will exam-  
4 ine gender and health disparities and to pursue a career  
5 in the health professions.

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

8 “(1) have experience in health research or pub-  
9 lic health practice;

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

12 “(3) have expressed an interest in the health  
13 professions;

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

16 “(5) secure admission to a health professions  
17 school or graduate program with an emphasis in  
18 gender studies;

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

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

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

1 the research base on the intersection between gender and  
2 health.

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

7 “(1) are from disadvantaged backgrounds; and

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

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

22 “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
23 is authorized to be appropriated to carry out this section,  
24 such sums as may be necessary for each of fiscal years  
25 2012 through 2017.

1 **“SEC. 3420B. PAUL DAVID WELLSTONE INTERNATIONAL**  
2 **HEALTH FELLOWSHIP PROGRAM.**

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

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

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

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

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

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

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

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

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

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

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

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

7 “(2) have identified a mentor at a health pro-  
8 fessions school or institution, an academic advisor to  
9 assist in the completion of their graduate or profes-  
10 sional degree, and an advisor from an international  
11 health non-governmental organization, private volun-  
12 teer organization, or other international institution  
13 or program that focuses on increasing health care  
14 access and quality for residents in developing coun-  
15 tries.

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

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

1 such sums as may be necessary for each of fiscal years  
2 2012 through 2017.

3 **“SEC. 3420C. EDWARD R. ROYBAL HEALTH CARE SCHOLAR**  
4 **PROGRAM.**

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

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

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

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

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

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

1       “(c) USE OF FUNDS.—Amounts received under a  
2 grant awarded under subsection (a) shall be used to sup-  
3 port opportunities that expose students to non-research-  
4 based health professions, including—

5               “(1) public health policy;

6               “(2) health care and pharmaceutical policy;

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

9               “(4) health economics; and

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

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

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

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

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

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



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

7 “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
8 is authorized to be appropriated to carry out this section  
9 such sums as may be necessary for each of fiscal years  
10 2012 through 2017.”.

11 **SEC. 307. ADVISORY COMMITTEE ON HEALTH PROFES-**  
12 **SIONS TRAINING FOR DIVERSITY.**

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

19 (b) COMPOSITION.—

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

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

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

18 (c) TERMS.—

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

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

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

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

3 (2) VACANCIES.—

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

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

13 (d) DUTIES.—

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

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

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

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

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

8 (e) MEETINGS AND DOCUMENTS.—

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

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

25 (f) COMPENSATION AND EXPENSES.—

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

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

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

20          **SEC. 308. MCNAIR POSTBACCALAUREATE ACHIEVEMENT**  
21    **PROGRAM.**

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

1       “(g) **COLLABORATION IN HEALTH PROFESSION DI-**  
2 **VERSITY TRAINING PROGRAMS.**—The Secretary shall co-  
3 ordinate with the Secretary of Health and Human Serv-  
4 ices to ensure that there is collaboration between the goals  
5 of the program under this section and programs of the  
6 Health Resources and Services Administration that pro-  
7 mote health workforce diversity. The Secretary of Edu-  
8 cation shall take such measures as may be necessary to  
9 encourage participants in programs under this section to  
10 consider health profession careers.

11       “(h) **FUNDING.**—From amounts appropriated pursu-  
12 ant to the authority of section 402A(g), the Secretary  
13 shall, to the extent practicable, allocate funds for projects  
14 authorized by this section in an amount which is not less  
15 than \$31,000,000 for each of the fiscal years 2012  
16 through 2018.”.

17 **SEC. 309. RULES FOR DETERMINATION OF FULL-TIME**  
18 **EQUIVALENT RESIDENTS FOR COST REPORT-**  
19 **ING PERIODS.**

20       (a) **DGME DETERMINATIONS.**—Section 1886(h)(4)  
21 of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B))  
22 is amended—

23               (1) in subparagraph (E), by striking “Subject  
24       to subparagraphs (J) and (K), such rules” and in-

1       serting “Subject to subparagraphs (J), (K), and (L),  
2       such rules”;

3           (2) in subparagraph (J), by striking “Such  
4       rules” and inserting “Subject to subparagraph (L),  
5       such rules”;

6           (3) in subparagraph (K), by striking “In deter-  
7       mining” and inserting “Subject to subparagraph  
8       (L), in determining”; and

9           (4) by adding at the end the following new sub-  
10       paragraph:

11           “(L) For purposes of cost-reporting peri-  
12       ods beginning on or after October 1, 2011, in  
13       determining the hospital’s number of full-time  
14       equivalent residents for purposes of this sub-  
15       paragraph, all the time spent by an intern or  
16       resident in an approved medical residency train-  
17       ing program shall be counted toward the deter-  
18       mination of full-time equivalency if the hos-  
19       pital—

20           “(i) is recognized as a subsection (d)  
21       hospital;

22           “(ii) is recognized as a subsection (d)  
23       Puerto Rico hospital;

1 “(iii) is reimbursed under a reim-  
2 bursement system authorized under section  
3 1814(b)(3); or

4 “(iv) is a provider-based hospital out-  
5 patient department.”.

6 (b) **IME DETERMINATIONS.**—Section 1886(d)(5)(B)  
7 of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended—

8 (1) in clause (x)(II), by striking “In deter-  
9 mining” and inserting “Subject to subclause (x)(IV),  
10 in determining”;

11 (2) in clause (x)(III), by striking “In deter-  
12 mining” and inserting “Subject to subclause (x)(IV),  
13 in determining”; and

14 (3) by adding at the end the following new sub-  
15 clause:

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

21 **SEC. 310. DEVELOPING AND IMPLEMENTING STRATEGIES**  
22 **FOR LOCAL HEALTH EQUITY.**

23 (a) **GRANTS.**—The Secretaries of Health and Human  
24 Services, Education, and Labor, acting jointly, shall make  
25 grants to academic institutions for the purposes of—



1           (1) in accordance with subsection (b), devel-  
2           oping capacity—

3                   (A) to build an evidence base for successful  
4                   strategies for increasing local health equity; and

5                   (B) to serve as national models of driving  
6                   local health equity;

7           (2) in accordance with subsection (c), devel-  
8           oping a strategic partnership with the community in  
9           which the academic institution is located; and

10           (3) collecting data on, and periodically evalu-  
11           ating, the effectiveness of the institution’s programs  
12           funded through this section to enable the institution  
13           to adapt accordingly for maximum efficiency and  
14           success.

15           (b) DEVELOPING CAPACITY FOR INCREASING LOCAL  
16 HEALTH EQUITY.—As a condition on receipt of a grant  
17 under subsection (a), an academic institution shall agree  
18 to use the grant to build an evidence base for successful  
19 strategies for increasing local health equity, and to serve  
20 as a national model of driving local health equity, by sup-  
21 porting—

22                   (1) resources to strengthen institutional metrics  
23                   and capacity to execute institutionwide health work-  
24                   force goals that can serve as models for increasing  
25                   health equity in communities across the country ;

1           (2) collaborations among a cohort of institu-  
2           tions in implementing systemic change, partnership  
3           development, and programmatic efforts supportive of  
4           health equity goals across disciplines and popu-  
5           lations; and

6           (3) enhanced or newly developed data systems  
7           and research infrastructure capable of informing  
8           current and future workforce efforts and building a  
9           foundation for a broader research agenda targeting  
10          urban health disparities.

11          (c) STRATEGIC PARTNERSHIPS.—As a condition on  
12          receipt of a grant under subsection (a), an academic insti-  
13          tution shall agree to use the grant to develop a strategic  
14          partnership with the community in which the institution  
15          is located for the purposes of—

16                (1) strengthening connections between the insti-  
17                tution and the community—

18                    (A) to improve evaluation of and address  
19                    the community's health and health workforce  
20                    needs; and

21                    (B) to engage the community in health  
22                    workforce development;

23                (2) developing, enhancing, or accelerating inno-  
24                vative undergraduate and graduate programs in the  
25                biomedical sciences and health professions; and

1           (3) strengthening the “birth to career” pipeline  
2           in the biomedical sciences and health professions, in-  
3           cluding by developing partnerships between institu-  
4           tions of higher education and elementary and sec-  
5           ondary schools to recruit the next generation of  
6           health professionals earlier in the pipeline to a  
7           health care career.

8   **SEC. 311. LOAN FORGIVENESS FOR MENTAL AND BEHAV-**  
9                           **IORAL HEALTH SOCIAL WORKERS.**

10          Section 455 of the Higher Education Act of 1965 (20  
11   U.S.C. 1087e) is amended by adding at the end the fol-  
12   lowing new subsection:

13          “(q) **REPAYMENT PLAN FOR MENTAL AND BEHAV-**  
14   **IORAL HEALTH SOCIAL WORKERS.—**

15               “(1) **IN GENERAL.—**The Secretary shall cancel  
16               the balance of interest and principal due on any eli-  
17               gible Federal Direct Loan not in default for a bor-  
18               rower who—

19                       “(A) has made 120 monthly payments on  
20                       the eligible Federal Direct Loan after October  
21                       1, 2012, pursuant to any one or a combination  
22                       of the following—

23                               “(i) payments under an income-based  
24                               repayment plan under section 493C;

1           “(ii) payments under a standard re-  
2           payment plan under subsection (d)(1)(A),  
3           based on a 10-year repayment period;

4           “(iii) monthly payments under a re-  
5           payment plan under subsection (d)(1) or  
6           (g) of not less than the monthly amount  
7           calculated under subsection (d)(1)(A),  
8           based on a 10-year repayment period; or

9           “(iv) payments under an income con-  
10          tingent repayment plan under subsection  
11          (d)(1)(D); and

12          “(B)(i) is employed as a mental health or  
13          behavioral health social worker, as defined by  
14          the Secretary by regulation, at the time of such  
15          forgiveness; and

16          “(ii) has been employed as such a mental  
17          health or behavioral health social worker during  
18          the period in which the borrower makes each of  
19          the 120 payments as described in subparagraph  
20          (A).

21          “(2) LOAN CANCELLATION AMOUNT.—After the  
22          conclusion of the employment period described in  
23          paragraph (1), the Secretary shall cancel the obliga-  
24          tion to repay the balance of principal and interest  
25          due as of the time of such cancellation, on the eligi-

1 ble Federal Direct Loans made to the borrower  
2 under this part.

3 “(3) DEFINITION OF ELIGIBLE FEDERAL DI-  
4 RECT LOAN.—In this subsection, the term ‘eligible  
5 Federal Direct Loan’ means a Federal Direct Staf-  
6 ford Loan, Federal Direct PLUS Loan, Federal Di-  
7 rect Unsubsidized Stafford Loan, or a Federal Di-  
8 rect Consolidation Loan.”.

9 **TITLE IV—IMPROVEMENT OF**  
10 **HEALTH CARE SERVICES**  
11 **Subtitle A—Health Empowerment**  
12 **Zones**

13 **SEC. 401. SHORT TITLE.**

14 This subtitle may be cited as the “Health Empower-  
15 ment Zone Act of 2011”.

16 **SEC. 402. FINDINGS.**

17 The Congress finds the following:

18 (1) Numerous studies and reports, including  
19 the National Healthcare Disparities Report and Un-  
20 equal Treatment, the 2002 Institute of Medicine Re-  
21 port, document the extensiveness to which health  
22 disparities exist across the country.

23 (2) These studies have found that, on average,  
24 racial and ethnic minorities are disproportionately  
25 afflicted with chronic and acute conditions—such as

1 cancer, diabetes, and hypertension—and suffer  
2 worse health outcomes, worse health status, and  
3 higher mortality rates than their White counter-  
4 parts.

5 (3) Several recent studies also show that health  
6 disparities are a function of not only access to health  
7 care, but also the social determinants of health—in-  
8 cluding the environment, the physical structure of  
9 communities, nutrition and food options, educational  
10 attainment, employment, race, ethnicity, geography,  
11 and language preference—that directly and indi-  
12 rectly affect the health, health care, and wellness of  
13 individuals and communities.

14 (4) Integrally involving and fully supporting the  
15 communities most affected by health inequities in  
16 the assessment, planning, launch, and evaluation of  
17 health disparity elimination efforts is among the  
18 leading recommendations made to adequately ad-  
19 dress and ultimately reduce health disparities.

20 (5) Recommendations also include supporting  
21 the efforts of community stakeholders from a broad  
22 crosssection—including, but not limited to local  
23 businesses, local departments of commerce, edu-  
24 cation, labor, urban planning, and transportation,  
25 and community-based and other nonprofit organiza-

1 tions—to find areas of common ground around  
2 health disparity elimination and collaborate to im-  
3 prove the overall health and wellness of a community  
4 and its residents.

5 **SEC. 403. DESIGNATION OF HEALTH EMPOWERMENT**  
6 **ZONES.**

7 (a) IN GENERAL.—At the request of an eligible com-  
8 munity partnership, the Secretary may designate an eligi-  
9 ble area as a health empowerment zone.

10 (b) ELIGIBILITY CRITERIA.—

11 (1) ELIGIBLE COMMUNITY PARTNERSHIP.—A  
12 community partnership is eligible to submit a re-  
13 quest under this section if the partnership—

14 (A) demonstrates widespread public sup-  
15 port from key individuals and entities in the eli-  
16 gible area, including State and local govern-  
17 ments, nonprofit organizations, and community  
18 and industry leaders, for designation of the eli-  
19 gible area as a health empowerment zone; and

20 (B) includes representatives of—

21 (i) a broad cross section of stake-  
22 holders and residents from communities in  
23 the eligible area experiencing dispropor-  
24 tionate disparities in health status and  
25 health care; and

1                   (ii) organizations, facilities, and insti-  
2                   tutions that have a history of working  
3                   within and serving such communities.

4                   (2) ELIGIBLE AREA.—An area is eligible to be  
5                   designated as a health empowerment zone under this  
6                   section if one or more communities in the area expe-  
7                   rience disproportionate disparities in health status  
8                   and health care. In determining whether a commu-  
9                   nity experiences such disparities, the Secretary shall  
10                  consider the data collected by the Department of  
11                  Health and Human Services focusing on the fol-  
12                  lowing areas:

13                   (A) Access to affordable high-quality  
14                   health services.

15                   (B) Arthritis, osteoporosis, and chronic  
16                   back conditions.

17                   (C) Cancer.

18                   (D) Chronic kidney disease.

19                   (E) Diabetes.

20                   (F) Injury and violence prevention.

21                   (G) Maternal, infant, and child health.

22                   (H) Medical product safety.

23                   (I) Mental health and mental disorders.

24                   (J) Nutrition and overweight.

25                   (K) Disability and secondary conditions.



1           (L) Educational and community-based  
2 health programs.

3           (M) Environmental health.

4           (N) Family planning.

5           (O) Food safety.

6           (P) Health communication.

7           (Q) Health disease and stroke.

8           (R) HIV/AIDS.

9           (S) Immunization and infectious diseases.

10          (T) Occupational safety and health.

11          (U) Oral health.

12          (V) Physical activity and fitness.

13          (W) Public health infrastructure.

14          (X) Respiratory diseases.

15          (Y) Sexually transmitted diseases.

16          (Z) Substance abuse.

17          (AA) Tobacco use.

18          (BB) Vision and hearing.

19          (CC) The degree to which those who have  
20 disabilities have access to health services, in-  
21 cluding physical activity and fitness, including  
22 the ability to physically access the locations  
23 where such services are provided.

24          (c) PROCEDURE.—

1           (1) REQUEST.—A request under subsection (a)  
2 shall—

3           (A) describe the bounds of the area to be  
4 designated as a health empowerment zone and  
5 the process used to select those bounds;

6           (B) demonstrate that the partnership sub-  
7 mitting the request is an eligible community  
8 partnership described in subsection (b)(1);

9           (C) demonstrate that the area is an eligible  
10 area described in subsection (b)(2);

11           (D) include a comprehensive assessment of  
12 disparities in health status and health care ex-  
13 perience by one or more communities in the  
14 area;

15           (E) set forth—

16           (i) a vision and a set of values for the  
17 area; and

18           (ii) a comprehensive and holistic set of  
19 goals to be achieved in the area through  
20 designation as a health empowerment zone;  
21 and

22           (F) include a strategic plan for achieving  
23 the goals described in subparagraph (E)(ii).

24           (2) APPROVAL.—Not later than 60 days after  
25 the receipt of a request for designation of an area

1 as a health empowerment zone under this section,  
2 the Secretary shall approve or disapprove the re-  
3 quest.

4 (d) MINIMUM NUMBER.—The Secretary—

5 (1) shall designate not more than 110 health  
6 empowerment zones under this section; and

7 (2) shall designate at least one health empower-  
8 ment zone in each of the several States, the District  
9 of Columbia, and each territory or possession of the  
10 United States.

11 **SEC. 404. ASSISTANCE TO THOSE SEEKING DESIGNATION.**

12 At the request of any organization or entity seeking  
13 to submit a request under section 403(a), the Secretary  
14 shall provide technical assistance, and may award a grant,  
15 to assist such organization or entity—

16 (1) to form an eligible community partnership  
17 described in section 403(b)(1);

18 (2) to complete a health assessment, including  
19 an assessment of health disparities under section  
20 403(c)(1)(D); or

21 (3) to prepare and submit a request, including  
22 a strategic plan, in accordance with section 403.

1 **SEC. 405. BENEFITS OF DESIGNATION.**

2 (a) PRIORITY.—In awarding any competitive grant,  
3 a Federal official shall give priority to any applicant  
4 that—

5 (1) meets the eligibility criteria for the grant;

6 (2) proposes to use the grant for activities in a  
7 health empowerment zone; and

8 (3) demonstrates that such activities will di-  
9 rectly and significantly further the goals of the stra-  
10 tegic plan approved for such zone under section 403.

11 (b) GRANTS FOR INITIAL IMPLEMENTATION OF  
12 STRATEGIC PLAN.—

13 (1) IN GENERAL.—Upon designating an eligible  
14 area as a health empowerment zone at the request  
15 of an eligible community partnership, the Secretary  
16 shall, subject to the availability of appropriations,  
17 make a grant to the community partnership for im-  
18 plementation of the strategic plan for such zone.

19 (2) GRANT PERIOD.—A grant under paragraph  
20 (1) for a health empowerment zone shall be for a pe-  
21 riod of 2 years and may be renewed, except that the  
22 total period of grants under paragraph (1) for such  
23 zone may not exceed 10 years.

24 (3) LIMITATION.—In awarding grants under  
25 this subsection, the Secretary shall not give less pri-  
26 ority to an applicant or reduce the amount of a

1 grant because the Secretary rendered technical as-  
2 sistance or made a grant to the same applicant  
3 under section 404.

4 (4) REPORTING.—The Secretary shall require  
5 each recipient of a grant under this subsection to re-  
6 port to the Secretary not less than every 6 months  
7 on the progress in implementing the strategic plan  
8 for the health empowerment zone.

9 **SEC. 406. DEFINITION.**

10 In this subtitle, the term “Secretary” means the Sec-  
11 retary of Health and Human Services, acting through the  
12 Administrator of the Health Resources and Services Ad-  
13 ministration and the Deputy Assistant Secretary for Mi-  
14 nority Health, and in cooperation with the Director of the  
15 Office of Community Services and the Director of the Na-  
16 tional Institute for Minority Health and Health Dispari-  
17 ties.

18 **SEC. 407. AUTHORIZATION OF APPROPRIATIONS.**

19 To carry out this subtitle, there is authorized to be  
20 appropriated \$100,000,000 for fiscal year 2012.

1 **Subtitle B—Other Improvements of**  
2 **Health Care Services**

3 **CHAPTER 1—EXPANSION OF COVERAGE**

4 **SEC. 411. AMENDMENT TO THE PUBLIC HEALTH SERVICE**  
5 **ACT.**

6 Title XXXIV of the Public Health Service Act, as  
7 amended by titles I, II, III, and IX of this Act, is further  
8 amended by inserting after subtitle C the following:

9 **“Subtitle D—Reconstruction and**  
10 **Improvement Grants for Public**  
11 **Health Care Facilities Serving**  
12 **Pacific Islanders and the Insu-**  
13 **lar Areas**

14 **“SEC. 3451. GRANT SUPPORT FOR QUALITY IMPROVEMENT**  
15 **INITIATIVES.**

16 “(a) IN GENERAL.—The Secretary, in collaboration  
17 with the Administrator of the Health Resources and Serv-  
18 ices Administration, the Director of the Agency for  
19 Healthcare Research and Quality, and the Administrator  
20 of the Centers for Medicare & Medicaid Services, shall  
21 award grants to eligible entities for the conduct of dem-  
22 onstration projects to improve the quality of and access  
23 to health care.

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

1           “(1) be a health center, hospital, health plan,  
2 health system, community clinic. or other health en-  
3 tity determined appropriate by the Secretary—

4           “(A) that, by legal mandate or explicitly  
5 adopted mission, provides patients with access  
6 to services regardless of their ability to pay;

7           “(B) that provides care or treatment for a  
8 substantial number of patients who are unin-  
9 sured, are receiving assistance under a State  
10 program under title XIX of the Social Security  
11 Act, or are members of vulnerable populations,  
12 as determined by the Secretary; and

13           “(C)(i) with respect to which, not less than  
14 50 percent of the entity’s patient population is  
15 made up of racial and ethnic minorities; or

16           “(ii) that—

17           “(I) serves a disproportionate percent-  
18 age of local, minority racial and ethnic pa-  
19 tients, or that has a patient population, at  
20 least 50 percent of which is limited-English  
21 proficient; and

22           “(II) provides an assurance that  
23 amounts received under the grant will be  
24 used only to support quality improvement

1 activities in the racial and ethnic popu-  
2 lation served; and

3 “(2) prepare and submit to the Secretary an  
4 application at such time, in such manner, and con-  
5 taining such information as the Secretary may re-  
6 quire.

7 “(c) PRIORITY.—In awarding grants under sub-  
8 section (a), the Secretary shall give priority to applicants  
9 under subsection (b)(2) that—

10 “(1) demonstrate an intent to operate as part  
11 of a health care partnership, network, collaborative,  
12 coalition, or alliance where each member entity con-  
13 tributes to the design, implementation, and evalua-  
14 tion of the proposed intervention; or

15 “(2) intend to use funds to carry out system-  
16 wide changes with respect to health care quality im-  
17 provement, including—

18 “(A) improved systems for data collection  
19 and reporting;

20 “(B) innovative collaborative or similar  
21 processes;

22 “(C) group programs with behavioral or  
23 self-management interventions;

24 “(D) case management services;



1           “(E) physician or patient reminder sys-  
2           tems;

3           “(F) educational interventions; or

4           “(G) other activities determined appro-  
5           priate by the Secretary.

6           “(d) USE OF FUNDS.—An entity shall use amounts  
7           received under a grant under subsection (a) to support  
8           the implementation and evaluation of health care quality  
9           improvement activities or minority health and health care  
10          disparity reduction activities that include—

11           “(1) with respect to health care systems, activi-  
12          ties relating to improving—

13           “(A) patient safety;

14           “(B) timeliness of care;

15           “(C) effectiveness of care;

16           “(D) efficiency of care;

17           “(E) patient centeredness; and

18           “(F) health information technology; and

19           “(2) with respect to patients, activities relating  
20          to—

21           “(A) staying healthy;

22           “(B) getting well;

23           “(C) living with illness or disability; and

24           “(D) coping with end-of-life issues.

1       “(e) COMMON DATA SYSTEMS.—The Secretary shall  
2 provide financial and other technical assistance to grant-  
3 ees under this section for the development of common data  
4 systems.

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

9       **“SEC. 3452. CENTERS OF EXCELLENCE.**

10       “(a) IN GENERAL.—The Secretary, acting through  
11 the Administrator of the Health Resources and Services  
12 Administration, shall designate centers of excellence at  
13 public hospitals, and other health systems serving large  
14 numbers of minority patients, that—

15               “(1) meet the requirements of section  
16               3451(b)(1);

17               “(2) demonstrate excellence in providing care to  
18               minority populations; and

19               “(3) demonstrate excellence in reducing dispari-  
20               ties in health and health care.

21       “(b) REQUIREMENTS.—A hospital or health system  
22 that serves as a Center of Excellence under subsection (a)  
23 shall—

24               “(1) design, implement, and evaluate programs  
25               and policies relating to the delivery of care in ra-

1 cially, ethnically, and linguistically diverse popu-  
2 lations;

3 “(2) provide training and technical assistance  
4 to other hospitals and health systems relating to the  
5 provision of quality health care to minority popu-  
6 lations; and

7 “(3) develop activities for graduate or con-  
8 tinuing medical education that institutionalize a  
9 focus on cultural competence training for health care  
10 providers.

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

15 **“SEC. 3453. RECONSTRUCTION AND IMPROVEMENT GRANTS**  
16 **FOR PUBLIC HEALTH CARE FACILITIES SERV-**  
17 **ING PACIFIC ISLANDERS AND THE INSULAR**  
18 **AREAS.**

19 “(a) IN GENERAL.—The Secretary shall provide di-  
20 rect financial assistance to designated health care pro-  
21 viders and community health centers in American Samoa,  
22 Guam, the Commonwealth of the Northern Mariana Is-  
23 lands, the United States Virgin Islands, Puerto Rico, and  
24 Hawaii for the purposes of reconstructing and improving  
25 health care facilities and services.

1       “(b) ELIGIBILITY.—To be eligible to receive direct fi-  
2 nancial assistance under subsection (a), an entity shall be  
3 a public health facility or community health center located  
4 in American Samoa, Guam, the Commonwealth of the  
5 Northern Mariana Islands, the United States Virgin Is-  
6 lands, Puerto Rico, or Hawaii that—

7               “(1) is owned or operated by—

8                       “(A) the Government of American Samoa,  
9                       Guam, the Commonwealth of the Northern  
10                      Mariana Islands, the United States Virgin Is-  
11                      lands, Puerto Rico, or Hawaii or a unit of local  
12                      government; or

13                     “(B) a nonprofit organization; and

14               “(2)(A) provides care or treatment for a sub-  
15               stantial number of patients who are uninsured, re-  
16               ceiving assistance under a State program under a  
17               title XVIII of the Social Security Act, or a State  
18               program under title XIX of such Act, or who are  
19               members of a vulnerable population, as determined  
20               by the Secretary; or

21               “(B) serves a disproportionate percentage of  
22               local, minority racial and ethnic patients.

23       “(c) REPORT.—Not later than 180 days after the  
24 date of enactment of this title and annually thereafter, the  
25 Secretary shall submit to the Congress and the President

1 a report that includes an assessment of health resources  
2 and facilities serving populations in American Samoa,  
3 Guam, the Commonwealth of the Northern Mariana Is-  
4 lands, the United States Virgin Islands, Puerto Rico, and  
5 Hawaii. In preparing such report, the Secretary shall—

6 “(1) consult with and obtain information on all  
7 health care facilities needs from the entities de-  
8 scribed in subsection (b);

9 “(2) include all amounts of Federal assistance  
10 received by each entity in the preceding fiscal year;

11 “(3) review the total unmet needs of each juris-  
12 diction for health care facilities, including needs for  
13 renovation and expansion of existing facilities; and

14 “(4) include a strategic plan for addressing the  
15 needs of each jurisdiction identified in the report.

16 “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
17 are authorized to be appropriated such sums as necessary  
18 to carry out this section.”.

19 **SEC. 412. REMOVING BARRIERS TO UNSUBSIDIZED PUR-**  
20 **CHASE OF PRIVATE INSURANCE IN AMER-**  
21 **ICAN HEALTH BENEFIT EXCHANGES.**

22 (a) IN GENERAL.—Section 1312(f) of the Patient  
23 Protection and Affordable Care Act (42 U.S.C.18032(f))  
24 is amended—

1           (1) in the subsection heading, by striking the  
2           semicolon and all that follows through “RESI-  
3           DENTS”; and

4           (2) by striking paragraph (3).

5           (b) CONFORMING AMENDMENT.—Section 1411(a)(1)  
6           of such Act (42 U.S.C. 18081(a)(1)) is amended by strik-  
7           ing “1312(f)(3),”.

8           **SEC. 413. STUDY ON THE UNINSURED.**

9           (a) IN GENERAL.—The Secretary of Health and  
10          Human Services shall—

11           (1) conduct a study on the demographic charac-  
12          teristics of the population of individuals who do not  
13          have health insurance coverage; and

14           (2) predict, based on such study, the demo-  
15          graphic characteristics of the population of individ-  
16          uals who will not have health insurance coverage  
17          after January 1, 2014.

18          (b) REPORTING REQUIREMENTS.—

19           (1) IN GENERAL.—Not later than 12 months  
20          after the date of the enactment of this Act, the Sec-  
21          retary shall submit to the Congress the results of  
22          the study under subsection (a)(1) and the prediction  
23          made under subsection (a)(2).

24           (2) REPORTING OF DEMOGRAPHIC CHARACTER-  
25          ISTICS.—The Secretary shall report the demographic

1 characteristics under paragraphs (1) and (2) of sub-  
2 section (a) on the basis of racial and ethnic group,  
3 and shall stratify the reporting on each racial and  
4 ethnic group by other demographic characteristics  
5 that can impact access to health insurance coverage,  
6 such as sexual orientation, gender identity, primary  
7 language, disability status, sex, socioeconomic sta-  
8 tus, and citizenship and immigration status, in a  
9 manner consistent with title I of this Act.

10 **SEC. 414. MEDICAID PAYMENT PARITY FOR THE TERRI-**  
11 **TORIES.**

12 (a) ELIMINATION OF FUNDING LIMITATIONS FOR  
13 PUERTO RICO, THE UNITED STATES VIRGIN ISLANDS,  
14 GUAM, THE COMMONWEALTH OF THE NORTHERN MAR-  
15 IANA ISLANDS, AND AMERICAN SAMOA.—

16 (1) IN GENERAL.—Section 1108 of the Social  
17 Security Act (42 U.S.C. 1308) is amended—

18 (A) in subsection (f), in the matter before  
19 paragraph (1), by striking “subsection (g)” and  
20 inserting “subsections (g) and (h)”;

21 (B) in subsection (g)(2), in the matter be-  
22 fore subparagraph (A), by inserting “and sub-  
23 section (h)” after “paragraphs (3) and (5)”;  
24 and

1 (C) by adding at the end the following new  
2 subsection:

3 “(h) SUNSET OF FUNDING LIMITATIONS FOR PUER-  
4 TO RICO, THE UNITED STATES VIRGIN ISLANDS, GUAM,  
5 THE COMMONWEALTH OF THE NORTHERN MARIANA IS-  
6 LANDS, AND AMERICAN SAMOA.—Subsections (f) and (g)  
7 shall not apply to Puerto Rico, the United States Virgin  
8 Islands, Guam, the Commonwealth of the Northern Mar-  
9 iana Islands, and American Samoa for any fiscal year  
10 after fiscal year 2011.”.

11 (2) CONFORMING AMENDMENT.—Section  
12 1903(u) of such Act (42 U.S.C. 1396c(u)) is amend-  
13 ed by striking paragraph (4).

14 (3) EFFECTIVE DATE.—The amendments made  
15 by this subsection shall apply beginning with fiscal  
16 year 2012.

17 (b) PARITY IN FMAP.—

18 (1) IN GENERAL.—Section 1905(b)(2) of such  
19 Act (42 U.S.C. 1396d(b)(2)) is amended by insert-  
20 ing after “50 per centum” the following: “(except  
21 that, beginning with fiscal year 2014, the Federal  
22 medical assistance percentage for Puerto Rico, the  
23 United States Virgin Islands, Guam, the Common-  
24 wealth of the Northern Mariana Islands, and Amer-  
25 ican Samoa shall be the Federal medical assistance



1 percentage determined by the Secretary in consulta-  
2 tion (for the United States Virgin Islands, Guam,  
3 the Commonwealth of the Northern Mariana Is-  
4 lands, and American Samoa) with the Secretary of  
5 the Interior”).

6 (2) 2-FISCAL-YEAR TRANSITION.—Notwith-  
7 standing any other provision of law, during fiscal  
8 years 2012 and 2013, the Federal medical assist-  
9 ance percentage established under section 1905(b) of  
10 the Social Security Act (42 U.S.C. 1396d(b)) for  
11 Puerto Rico, the United States Virgin Islands,  
12 Guam, the Commonwealth of the Northern Mariana  
13 Islands, and American Samoa shall be the highest  
14 such Federal medical assistance percentage applica-  
15 ble to any of the 50 States or the District of Colum-  
16 bia for the fiscal year involved, taking into account  
17 the application of subsections (a) and (b)(1) of 5001  
18 of division B of the American Recovery and Rein-  
19 vestment Act of 2009 (Public Law 111–5) to such  
20 States and District of Columbia for calendar quar-  
21 ters during such fiscal years for which such sub-  
22 sections apply respectively.

23 (3) PER CAPITA INCOME DATA.—

24 (A) REPORT TO CONGRESS.—Not later  
25 than October 1, 2012, the Secretary of Health

1 and Human Services shall submit to Congress  
2 a report that describes the per capita income  
3 data used to promulgate the Federal medical  
4 assistance percentage in the territories and how  
5 such data differ from the per capita income  
6 data used to promulgate Federal medical assist-  
7 ance percentages for the 50 States and the Dis-  
8 trict of Columbia. The report should include  
9 recommendations on how the Federal medical  
10 assistance percentages can be calculated for the  
11 territories to ensure parity with the 50 States  
12 and the District of Columbia.

13 (B) APPLICATION.—Section 1101(a)(8)(B)  
14 of the Social Security Act (42 U.S.C.  
15 1308(a)(8)(B)) is amended—

16 (i) by striking “(other than Puerto  
17 Rico, the United States Virgin Islands, and  
18 Guam)” and inserting “(including Puerto  
19 Rico, the United States Virgin Islands,  
20 Guam, the Commonwealth of the Northern  
21 Mariana Islands, and American Samoa)”;  
22 and

23 (ii) by inserting “(or, if such satisfac-  
24 tory data are not available in the case of  
25 the Virgin Islands, Guam, the Northern

1 Mariana Islands, or American Samoa, sat-  
2 isfactory data available from the Depart-  
3 ment of the Interior for the same period,  
4 or if such satisfactory data are not avail-  
5 able in the case of Puerto Rico, satisfac-  
6 tory data available from the government of  
7 the Commonwealth of Puerto Rico for the  
8 same period)” after “Department of Com-  
9 merce”.

10 (4) RELATION TO AMERICAN RECOVERY AND  
11 REINVESTMENT ACT OF 2009.—For any period and  
12 territory in which the provisions of this subsection  
13 apply to a territory, the provisions of section  
14 5001(b)(2) of division B of the American Recovery  
15 and Reinvestment Act of 2009 (Public Law 111–5)  
16 shall not apply (except as otherwise specifically pro-  
17 vided in paragraph (2)).

18 **SEC. 415. CLARIFICATION OF MEDICAID COVERAGE FOR**  
19 **CITIZENS OF FREELY ASSOCIATED STATES.**

20 (a) IN GENERAL.—Section 402(b)(2) of the Personal  
21 Responsibility and Work Opportunity Reconciliation Act  
22 of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at  
23 the end the following:

24 “(G) MEDICAID EXCEPTION FOR CITIZENS  
25 OF FREELY ASSOCIATED STATES.—With respect

1 to eligibility for benefits for the program de-  
2 fined in paragraph (3)(C) (relating to the Med-  
3 icaid program), paragraph (1) shall not apply  
4 to any individual who lawfully resides in the  
5 United States (including territories and posses-  
6 sions of the United States) in accordance with  
7 the Compacts of Free Association between the  
8 Government of the United States and the Gov-  
9 ernments of the Federated States of Micro-  
10 nesia, the Republic of the Marshall Islands, and  
11 the Republic of Palau.”.

12 (b) CONFORMING DEFINITION OF QUALIFIED  
13 ALIEN.—Section 431(b) of such Act (8 U.S.C. 1641(b))  
14 is amended—

15 (1) in paragraph (6), by striking “or” at the  
16 end;

17 (2) in paragraph (7), by striking the period at  
18 the end and inserting “; or”; and

19 (3) by adding at the end the following:

20 “(8) an individual who lawfully resides in the  
21 United States (including territories and possessions  
22 of the United States) in accordance with a Compact  
23 of Free Association referred to in section  
24 402(b)(2)(G), but only with respect to the program

1 defined in section 402(b)(3)(C) (relating to the Med-  
2 icaid program).”.

3 (c) **SETTING FMAP AT 100 PERCENT.**—The third  
4 sentence of section 1905(b) of the Social Security Act (42  
5 U.S.C. 1396d(b)) is amended by inserting before the pe-  
6 riod at the end the following: “; with respect to medical  
7 assistance for individuals described in section  
8 402(b)(2)(G) of the Personal Responsibility and Work Op-  
9 portunity Reconciliation Act of 1996”.

10 (d) **EFFECTIVE DATE.**—The amendments made by  
11 this Act take effect on October 1, 2011, and apply to bene-  
12 fits and assistance provided on or after that date.

13 **SEC. 416. EXTENSION OF MEDICARE SECONDARY PAYER.**

14 (a) **IN GENERAL.**—Section 1862(b)(1)(C) of the So-  
15 cial Security Act (42 U.S.C. 1395y(b)(1)(C)) is amend-  
16 ed—

17 (1) in the last sentence, by inserting “, and be-  
18 fore January 1, 2012” after “prior to such date”;  
19 and

20 (2) by adding at the end the following new sen-  
21 tence: “Effective for items and services furnished on  
22 or after January 1, 2012 (with respect to periods  
23 beginning on or after the date that is 42 months  
24 prior to such date), clauses (i) and (ii) shall be ap-

1       plied by substituting ‘42-month’ for ‘12-month’ each  
2       place it appears in the first sentence.”.

3       (b) **EFFECTIVE DATE.**—The amendments made by  
4 this subsection shall take effect on the date of enactment  
5 of this Act. For purposes of determining an individual’s  
6 status under section 1862(b)(1)(C) of the Social Security  
7 Act (42 U.S.C. 1395y(b)(1)(C)), as amended by para-  
8 graph (1), an individual who is within the coordinating  
9 period as of the date of enactment of this Act shall have  
10 that period extended to the full 42 months described in  
11 the last sentence of such section, as added by the amend-  
12 ment made by paragraph (1)(B).

13 **SEC. 417. BORDER HEALTH GRANTS.**

14       (a) **ELIGIBLE ENTITY DEFINED.**—In this section,  
15 the term “eligible entity” means a State, public institution  
16 of higher education, local government, tribal government,  
17 nonprofit health organization, community health center, or  
18 community clinic receiving assistance under section 330  
19 of the Public Health Service Act (42 U.S.C. 254b), that  
20 is located in the border area.

21       (b) **AUTHORIZATION.**—From funds appropriated  
22 under subsection (f), the Secretary of Health and Human  
23 Services (in this section referred to as the “Secretary”),  
24 acting through the United States members of the United  
25 States-Mexico Border Health Commission, shall award

1 grants to eligible entities to address priorities and rec-  
2 ommendations to improve the health of border area resi-  
3 dents that are established by—

4           (1) the United States members of the United  
5 States-Mexico Border Health Commission;

6           (2) the State border health offices; and

7           (3) the Secretary.

8           (c) APPLICATION.—An eligible entity that desires a  
9 grant under subsection (b) shall submit an application to  
10 the Secretary at such time, in such manner, and con-  
11 taining such information as the Secretary may require.

12           (d) USE OF FUNDS.—An eligible entity that receives  
13 a grant under subsection (b) shall use the grant funds  
14 for—

15           (1) programs relating to—

16                   (A) maternal and child health;

17                   (B) primary care and preventative health;

18                   (C) public health and public health infra-  
19 structure;

20                   (D) health education and promotion;

21                   (E) oral health;

22                   (F) mental and behavioral health;

23                   (G) substance abuse;

24                   (H) health conditions that have a high  
25 prevalence in the border area;

1 (I) medical and health services research;

2 (J) workforce training and development;

3 (K) community health workers or  
4 promotoras;

5 (L) health care infrastructure problems in  
6 the border area (including planning and con-  
7 struction grants);

8 (M) health disparities in the border area;

9 (N) environmental health; and

10 (O) outreach and enrollment services with  
11 respect to Federal programs (including pro-  
12 grams authorized under titles XIX and XXI of  
13 the Social Security Act (42 U.S.C. 1396 and  
14 1397aa)); and

15 (2) other programs determined appropriate by  
16 the Secretary.

17 (e) SUPPLEMENT, NOT SUPPLANT.—Amounts pro-  
18 vided to an eligible entity awarded a grant under sub-  
19 section (b) shall be used to supplement and not supplant  
20 other funds available to the eligible entity to carry out the  
21 activities described in subsection (d).

22 (f) AUTHORIZATION OF APPROPRIATIONS.—There  
23 are authorized to be appropriated to carry out this section,  
24 \$200,000,000 for fiscal year 2012, and such sums as may  
25 be necessary for each succeeding fiscal year.



1 **SEC. 418. REMOVING MEDICARE BARRIER TO HEALTH**  
2 **CARE.**

3 Section 1818(a)(3) of the Social Security Act (42  
4 U.S.C. 1395i-2(a)(3)) is amended by amending subpara-  
5 graph (B) to read as follows: “(B) an individual who is  
6 lawfully present in the United States”.

7 **SEC. 419. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**  
8 **PROVIDED BY URBAN INDIAN HEALTH CEN-**  
9 **TERS.**

10 (a) **IN GENERAL.**—Section 1905(b) of the Social Se-  
11 curity Act (42 U.S.C. 1396(b)), as amended by section  
12 415(c), is amended by inserting “or are received through  
13 a program operated by an urban Indian organization  
14 through a grant or contract under title V of such Act”.

15 (b) **EFFECTIVE DATE.**—The amendment made by  
16 this section shall apply to medical assistance provided on  
17 or after the date of enactment of this Act.

18 **SEC. 420. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**  
19 **PROVIDED TO A NATIVE HAWAIIAN THROUGH**  
20 **A FEDERALLY QUALIFIED HEALTH CENTER**  
21 **OR A NATIVE HAWAIIAN HEALTH CARE SYS-**  
22 **TEM UNDER THE MEDICAID PROGRAM.**

23 (a) **IN GENERAL.**—The third sentence of section  
24 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)),  
25 as amended by section 419, is amended by inserting “;  
26 and, with respect to medical assistance provided to a Na-

1 tive Hawaiian (as defined in section 12(2) of the Native  
 2 Hawaiian Health Care Improvement Act) through a feder-  
 3 ally qualified health center or a Native Hawaiian health  
 4 care system (as defined in section 12(6) of such Act),  
 5 whether directly, by referral, or under contract or other  
 6 arrangement between such federally qualified health cen-  
 7 ter or Native Hawaiian health care system and another  
 8 health care provider” before the period.

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 **CHAPTER 2—EXPANSION OF ACCESS**

### 13 **SEC. 421. GRANTS FOR RACIAL AND ETHNIC APPROACHES** 14 **TO COMMUNITY HEALTH.**

15 (a) PURPOSE.—It is the purpose of this section to  
 16 provide for the awarding of grants to assist communities  
 17 in mobilizing and organizing resources in support of effec-  
 18 tive and sustainable programs that will reduce or eliminate  
 19 disparities in health and health care experienced by racial  
 20 and ethnic minority individuals.

21 (b) AUTHORITY TO AWARD GRANTS.—The Sec-  
 22 retary, acting through the Centers for Disease Control and  
 23 Prevention, 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, cardiovascular dis-  
19 ease, diabetes, child and adult immunization  
20 levels, or other health priority areas as des-  
21 ignated by the Secretary; and

22 (C) a demonstration of a proven record of  
23 accomplishment of the coalition members in  
24 serving and working with the targeted commu-  
25 nity.

1           (d) SUSTAINABILITY.—The Secretary shall give pri-  
2 ority to an eligible entity under this section if the entity  
3 agrees that, with respect to the costs to be incurred by  
4 the entity in carrying out the activities for which the grant  
5 was awarded, the entity (and each of the participating  
6 partners in the coalition represented by the entity) will  
7 maintain its expenditures of non-Federal funds for such  
8 activities at a level that is not less than the level of such  
9 expenditures during the fiscal year immediately preceding  
10 the first fiscal year for which the grant is awarded.

11           (e) NONDUPLICATION.—Funds provided through this  
12 grant program should supplement, not supplant, existing  
13 Federal funding, and the funds should not be used to du-  
14 plicate the activities of the other health disparity grant  
15 programs in this Act.

16           (f) TECHNICAL ASSISTANCE.—The Secretary may,  
17 either directly or by grant or contract, provide any entity  
18 that receives a grant under this section with technical and  
19 other nonfinancial assistance necessary to meet the re-  
20 quirements of this section.

21           (g) DISSEMINATION.—The Secretary shall encourage  
22 and enable grantees to share best practices, evaluation re-  
23 sults, and reports with communities not affiliated with  
24 grantees using the Internet, conferences, and other perti-  
25 nent information regarding the projects funded by this

1 section, including the outreach efforts of the Office of Mi-  
2 nority Health and Health Disparity Elimination and the  
3 Centers for Disease Control and Prevention.

4 (h) ADMINISTRATIVE BURDENS.—The Secretary  
5 shall make every effort to minimize duplicative or unneces-  
6 sary administrative burdens on grantees.

7 (i) AUTHORIZATION OF APPROPRIATIONS.—There  
8 are authorized to be appropriated such sums as may be  
9 necessary to carry out this section.

10 **SEC. 422. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.**

11 (a) ELIMINATION OF ISOLATION TEST FOR COST-  
12 BASED AMBULANCE REIMBURSEMENT.—

13 (1) IN GENERAL.—Section 1834(l)(8) of the  
14 Social Security Act (42 U.S.C. 1395m(l)(8)) is  
15 amended—

16 (A) in subparagraph (B)—

17 (i) by striking “owned and”; and

18 (ii) by inserting “(including when  
19 such services are provided by the entity  
20 under an arrangement with the hospital)”  
21 after “hospital”; and

22 (B) by striking the comma at the end of  
23 subparagraph (B) and all that follows and in-  
24 serting a period.

1           (2) EFFECTIVE DATE.—The amendments made  
2           by this subsection shall apply to services furnished  
3           on or after January 1, 2012.

4           (b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE  
5 TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT  
6 REQUIREMENT.—

7           (1) IN GENERAL.—Section 1820(c)(2) of the  
8           Social Security Act (42 U.S.C. 1395i–4(c)(2)) is  
9           amended—

10           (A) in subparagraph (B)(iii), by striking  
11           “provides not more than” and inserting “sub-  
12           ject to subparagraph (F), provides not more  
13           than”; and

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

16           “(F) ALTERNATIVE TO 25 INPATIENT BED  
17           LIMIT REQUIREMENT.—

18           “(i) IN GENERAL.—A State may elect  
19           to treat a facility, with respect to the des-  
20           ignation of the facility for a cost reporting  
21           period, as satisfying the requirement of  
22           subparagraph (B)(iii) relating to a max-  
23           imum number of acute care inpatient beds  
24           if the facility elects, in accordance with a  
25           method specified by the Secretary and be-

1           fore the beginning of the cost reporting pe-  
2           riod, to meet the requirement under clause  
3           (ii).

4           “(ii) ALTERNATE REQUIREMENT.—  
5           The requirement under this clause, with  
6           respect to a facility and a cost reporting  
7           period, is that the total number of inpa-  
8           tient bed days described in subparagraph  
9           (B)(iii) during such period will not exceed  
10          7,300. For purposes of this subparagraph,  
11          an individual who is an inpatient in a bed  
12          in the facility for a single day shall be  
13          counted as one inpatient bed day.

14          “(iii) WITHDRAWAL OF ELECTION.—  
15          The option described in clause (i) shall not  
16          apply to a facility for a cost reporting pe-  
17          riod if the facility (for any two consecutive  
18          cost-reporting periods during the previous  
19          5 cost-reporting periods) was treated under  
20          such option and had a total number of in-  
21          patient bed days for each of such two cost-  
22          reporting periods that exceeded the num-  
23          ber specified in such clause.”.

24               (2) EFFECTIVE DATE.—The amendments made  
25               by paragraph (1) shall apply to cost-reporting peri-



1 ods beginning on or after the date of the enactment  
2 of this Act.

3 **SEC. 423. ESTABLISHMENT OF RURAL COMMUNITY HOS-**  
4 **PITAL (RCH) PROGRAM.**

5 (a) IN GENERAL.—Section 1861 of the Social Secu-  
6 rity Act (42 U.S.C. 1395x), as amended by section  
7 203(b)(1)(A), is amended by adding at the end of the fol-  
8 lowing new subsection:

9 “Rural Community Hospital; Rural Community Hospital  
10 Services

11 “(jjj)(1) The term ‘rural community hospital’ means  
12 a hospital (as defined in subsection (e)) that—

13 “(A) is located in a rural area (as defined in  
14 section 1886(d)(2)(D)) or treated as being so lo-  
15 cated pursuant to section 1886(d)(8)(E);

16 “(B) subject to paragraph (2), has less than 51  
17 acute care inpatient beds, as reported in its most re-  
18 cent cost report;

19 “(C) makes available 24-hour emergency care  
20 services;

21 “(D) subject to paragraph (3), has a provider  
22 agreement in effect with the Secretary and is open  
23 to the public as of January 1, 2010; and

24 “(E) applies to the Secretary for such designa-  
25 tion.

1       “(2) For purposes of paragraph (1)(B), beds in a  
2 psychiatric or rehabilitation unit of the hospital which is  
3 a distinct part of the hospital shall not be counted.

4       “(3) Paragraph (1)(D) shall not be construed to pro-  
5 hibit any of the following from qualifying as a rural com-  
6 munity hospital:

7           “(A) A replacement facility (as defined by the  
8 Secretary in regulations in effect on January 1,  
9 2012) with the same service area (as defined by the  
10 Secretary in regulations in effect on such date).

11          “(B) A facility obtaining a new provider num-  
12 ber pursuant to a change of ownership.

13          “(C) A facility which has a binding written  
14 agreement with an outside, unrelated party for the  
15 construction, reconstruction, lease, rental, or financ-  
16 ing of a building as of January 1, 2012.

17       “(4) Nothing in this subsection shall be construed as  
18 prohibiting a critical access hospital from qualifying as a  
19 rural community hospital if the critical access hospital  
20 meets the conditions otherwise applicable to hospitals  
21 under subsection (e) and section 1866.

22       “(5) Nothing in this subsection shall be construed as  
23 prohibiting a rural community hospital participating in  
24 the demonstration program under section 410A of the  
25 Medicare Prescription Drug, Improvement, and Mod-

1 ernization Act of 2003 (Public Law 108–173; 117 Stat.  
2 2313) from qualifying as a rural community hospital if  
3 the rural community hospital meets the conditions other-  
4 wise applicable to hospitals under subsection (e) and sec-  
5 tion 1866.”.

6 (b) PAYMENT.—

7 (1) INPATIENT HOSPITAL SERVICES.—Section  
8 1814 of the Social Security Act (42 U.S.C. 1395f)  
9 is amended by adding at the end the following new  
10 subsection:

11 “Payment for Inpatient Services Furnished in Rural  
12 Community Hospitals

13 “(m) The amount of payment under this part for in-  
14 patient hospital services furnished in a rural community  
15 hospital, other than such services furnished in a psy-  
16 chiatric or rehabilitation unit of the hospital which is a  
17 distinct part, is, at the election of the hospital in the appli-  
18 cation referred to in section 1861(jjj)(1)(E)—

19 “(1) 101 percent of the reasonable costs of pro-  
20 viding such services, without regard to the amount  
21 of the customary or other charge, or

22 “(2) the amount of payment provided for under  
23 the prospective payment system for inpatient hos-  
24 pital services under section 1886(d).”.

1           (2) OUTPATIENT SERVICES.—Section 1834 of  
2           such Act (42 U.S.C. 1395m) is amended by adding  
3           at the end the following new subsection:

4           “(p) PAYMENT FOR OUTPATIENT SERVICES FUR-  
5           NISHED IN RURAL COMMUNITY HOSPITALS.—The  
6           amount of payment under this part for outpatient services  
7           furnished in a rural community hospital is, at the election  
8           of the hospital in the application referred to in section  
9           1861(jjj)(1)(E)—

10           “(1) 101 percent of the reasonable costs of pro-  
11           viding such services, without regard to the amount  
12           of the customary or other charge and any limitation  
13           under section 1861(v)(1)(U), or

14           “(2) the amount of payment provided for under  
15           the prospective payment system for covered OPD  
16           services under section 1833(t).”.

17           (3) EXEMPTION FROM 30-PERCENT REDUCTION  
18           IN REIMBURSEMENT FOR BAD DEBT.—Section  
19           1861(v)(1)(T) of such Act (42 U.S.C.  
20           1395x(v)(1)(T)) is amended by inserting “(other  
21           than for a rural community hospital)” after “In de-  
22           termining such reasonable costs for hospitals”.

23           (c) BENEFICIARY COST-SHARING FOR OUTPATIENT  
24           SERVICES.—Section 1834(p) of such Act (as added by  
25           subsection (b)(2)) is amended—

1           (1) by redesignating paragraphs (1) and (2) as  
2           subparagraphs (A) and (B), respectively;

3           (2) by inserting “(1)” after “(p)”; and

4           (3) by adding at the end the following:

5           “(2) The amounts of beneficiary costsharing for out-  
6           patient services furnished in a rural community hospital  
7           under this part shall be as follows:

8           “(A) For items and services that would have  
9           been paid under section 1833(t) if provided by a  
10          hospital, the amount of costsharing determined  
11          under paragraph (8) of such section.

12          “(B) For items and services that would have  
13          been paid under section 1833(h) if furnished by a  
14          provider or supplier, no costsharing shall apply.

15          “(C) For all other items and services, the  
16          amount of costsharing that would apply to the item  
17          or service under the methodology that would be used  
18          to determine payment for such item or service if pro-  
19          vided by a physician, provider, or supplier, as the  
20          case may be.”.

21          (d) CONFORMING AMENDMENTS.—

22                 (1) PART A PAYMENT.—Section 1814(b) of  
23                 such Act (42 U.S.C. 1395f(b)) is amended in the  
24                 matter preceding paragraph (1) by inserting “other  
25                 than inpatient hospital services furnished by a rural

1 community hospital,” after “critical access hospital  
2 services,”.

3 (2) PART B PAYMENT.—Section 1833(a) of  
4 such Act (42 U.S.C. 1395l(a)), as amended by sec-  
5 tion 203(b)(2), is amended—

6 (A) in paragraph (2), in the matter before  
7 subparagraph (A), by striking “and (I)” and in-  
8 serting “(I), and (K)”;

9 (B) by striking “and” at the end of para-  
10 graph (9);

11 (C) by striking the period at the end of  
12 paragraph (10) and inserting “; and”; and

13 (D) by adding at the end the following:

14 “(11) in the case of outpatient services fur-  
15 nished by a rural community hospital, the amounts  
16 described in section 1834(p).”.

17 (3) TECHNICAL AMENDMENTS.—

18 (A) CONSULTATION WITH STATE AGEN-  
19 CIES.—Section 1863 of such Act (42 U.S.C.  
20 1395z) is amended by striking “and (dd)(2)”  
21 and inserting “(dd)(2), (mm)(1), and (jjj)(1)”.

22 (B) PROVIDER AGREEMENTS.—Section  
23 1866(a)(2)(A) of such Act (42 U.S.C.  
24 1395cc(a)(2)(A)) is amended by inserting “sec-  
25 tion 1834(p)(2),” after “section 1833(b),”.

1 (e) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to items and services furnished on  
3 or after October 1, 2011.

4 **SEC. 424. MEDICARE REMOTE MONITORING PILOT**  
5 **PROJECTS.**

6 (a) PILOT PROJECTS.—

7 (1) IN GENERAL.—Not later than 9 months  
8 after the date of enactment of this Act, the Sec-  
9 retary of Health and Human Services (in this sec-  
10 tion referred to as the “Secretary”) shall conduct  
11 pilot projects under title XVIII of the Social Secu-  
12 rity Act for the purpose of providing incentives to  
13 home health agencies to utilize home monitoring and  
14 communications technologies that—

15 (A) enhance health outcomes for Medicare  
16 beneficiaries; and

17 (B) reduce expenditures under such title.

18 (2) SITE REQUIREMENTS.—

19 (A) URBAN AND RURAL.—The Secretary  
20 shall conduct the pilot projects under this sec-  
21 tion in both urban and rural areas.

22 (B) SITE IN A SMALL STATE.—The Sec-  
23 retary shall conduct at least 3 of the pilot  
24 projects in a State with a population of less  
25 than 1,000,000.

1           (3) DEFINITION OF HOME HEALTH AGENCY.—

2           In this section, the term “home health agency” has  
3           the meaning given that term in section 1861(o) of  
4           the Social Security Act (42 U.S.C. 1395x(o)).

5           (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE  
6           OF PROJECTS.—The Secretary shall specify the criteria  
7           for identifying those Medicare beneficiaries who shall be  
8           considered within the scope of the pilot projects under this  
9           section for purposes of the application of subsection (c)  
10          and for the assessment of the effectiveness of the home  
11          health agency in achieving the objectives of this section.  
12          Such criteria may provide for the inclusion in the projects  
13          of Medicare beneficiaries who begin receiving home health  
14          services under title XVIII of the Social Security Act after  
15          the date of the implementation of the projects.

16          (c) INCENTIVES.—

17                 (1) PERFORMANCE TARGETS.—The Secretary  
18                 shall establish for each home health agency partici-  
19                 pating in a pilot project under this section a per-  
20                 formance target using one of the following meth-  
21                 odologies, as determined appropriate by the Sec-  
22                 retary:

23                         (A) ADJUSTED HISTORICAL PERFORMANCE  
24                         TARGET.—The Secretary shall establish for the  
25                         agency—



1 (i) a base expenditure amount equal  
2 to the average total payments made to the  
3 agency under parts A and B of title XVIII  
4 of the Social Security Act for Medicare  
5 beneficiaries determined to be within the  
6 scope of the pilot project in a base period  
7 determined by the Secretary; and

8 (ii) an annual per capita expenditure  
9 target for such beneficiaries, reflecting the  
10 base expenditure amount adjusted for risk  
11 and adjusted growth rates.

12 (B) COMPARATIVE PERFORMANCE TAR-  
13 GET.—The Secretary shall establish for the  
14 agency a comparative performance target equal  
15 to the average total payments under such parts  
16 A and B during the pilot project for comparable  
17 individuals in the same geographic area that  
18 are not determined to be within the scope of the  
19 pilot project.

20 (2) INCENTIVE.—Subject to paragraph (3), the  
21 Secretary shall pay to each participating home care  
22 agency an incentive payment for each year under the  
23 pilot project equal to a portion of the Medicare sav-  
24 ings realized for such year relative to the perform-  
25 ance target under paragraph (1).

1           (3) LIMITATION ON EXPENDITURES.—The Sec-  
2           retary shall limit incentive payments under this sec-  
3           tion in order to ensure that the aggregate expendi-  
4           tures under title XVIII of the Social Security Act  
5           (including incentive payments under this subsection)  
6           do not exceed the amount that the Secretary esti-  
7           mates would have been expended if the pilot projects  
8           under this section had not been implemented.

9           (d) WAIVER AUTHORITY.—The Secretary may waive  
10          such provisions of titles XI and XVIII of the Social Secu-  
11          rity Act as the Secretary determines to be appropriate for  
12          the conduct of the pilot projects under this section.

13          (e) REPORT TO CONGRESS.—Not later than 5 years  
14          after the date that the first pilot project under this section  
15          is implemented, the Secretary shall submit to Congress a  
16          report on the pilot projects. Such report shall contain a  
17          detailed description of issues related to the expansion of  
18          the projects under subsection (f) and recommendations for  
19          such legislation and administrative actions as the Sec-  
20          retary considers appropriate.

21          (f) EXPANSION.—If the Secretary determines that  
22          any of the pilot projects under this section enhance health  
23          outcomes for Medicare beneficiaries and reduce expendi-  
24          tures under title XVIII of the Social Security Act, the Sec-

1 retary may initiate comparable projects in additional  
2 areas.

3 (g) INCENTIVE PAYMENTS HAVE NO EFFECT ON  
4 OTHER MEDICARE PAYMENTS TO AGENCIES.—An incen-  
5 tive payment under this section—

6 (1) shall be in addition to the payments that a  
7 home health agency would otherwise receive under  
8 title XVIII of the Social Security Act for the provi-  
9 sion of home health services; and

10 (2) shall have no effect on the amount of such  
11 payments.

12 **SEC. 425. RURAL HEALTH QUALITY ADVISORY COMMISSION**  
13 **AND DEMONSTRATION PROJECTS.**

14 (a) RURAL HEALTH QUALITY ADVISORY COMMIS-  
15 SION.—

16 (1) ESTABLISHMENT.—Not later than 6  
17 months after the date of the enactment of this sec-  
18 tion, the Secretary of Health and Human Services  
19 (in this section referred to as the “Secretary”) shall  
20 establish a commission to be known as the Rural  
21 Health Quality Advisory Commission (in this section  
22 referred to as the “Commission”).

23 (2) DUTIES OF COMMISSION.—

24 (A) NATIONAL PLAN.—The Commission  
25 shall develop, coordinate, and facilitate imple-

1           mentation of a national plan for rural health  
2           quality improvement. The national plan shall—

3                   (i) identify objectives for rural health  
4                   quality improvement;

5                   (ii) identify strategies to eliminate  
6                   known gaps in rural health system capacity  
7                   and improve rural health quality; and

8                   (iii) provide for Federal programs to  
9                   identify opportunities for strengthening  
10                  and aligning policies and programs to im-  
11                  prove rural health quality.

12           (B) DEMONSTRATION PROJECTS.—The  
13           Commission shall design demonstration projects  
14           to test alternative models for rural health qual-  
15           ity improvement, including with respect to both  
16           personal and population health.

17           (C) MONITORING.—The Commission shall  
18           monitor progress toward the objectives identi-  
19           fied pursuant to paragraph (1)(A).

20           (3) MEMBERSHIP.—

21                   (A) NUMBER.—The Commission shall be  
22                   composed of 11 members appointed by the Sec-  
23                   retary.

24                   (B) SELECTION.—The Secretary shall se-  
25                   lect the members of the Commission from

1 among individuals with significant rural health  
2 care and health care quality expertise, including  
3 expertise in clinical health care, health care  
4 quality research, population or public health, or  
5 purchaser organizations.

6 (4) CONTRACTING AUTHORITY.—Subject to the  
7 availability of funds, the Commission may enter into  
8 contracts and make other arrangements, as may be  
9 necessary to carry out the duties described in para-  
10 graph (2).

11 (5) STAFF.—Upon the request of the Commis-  
12 sion, the Secretary may detail, on a reimbursable  
13 basis, any of the personnel of the Office of Rural  
14 Health Policy of the Health Resources and Services  
15 Administration, the Agency for Health care Quality  
16 and Research, or the Centers for Medicare & Med-  
17 icaid Services to the Commission to assist in car-  
18 rying out this subsection.

19 (6) REPORTS TO CONGRESS.—Not later than 1  
20 year after the establishment of the Commission, and  
21 annually thereafter, the Commission shall submit a  
22 report to the Congress on rural health quality. Each  
23 such report shall include the following:

1 (A) An inventory of relevant programs and  
2 recommendations for improved coordination and  
3 integration of policy and programs.

4 (B) An assessment of achievement of the  
5 objectives identified in the national plan devel-  
6 oped under paragraph (2) and recommenda-  
7 tions for realizing such objectives.

8 (C) Recommendations on Federal legisla-  
9 tion, regulations, or administrative policies to  
10 enhance rural health quality and outcomes.

11 (b) RURAL HEALTH QUALITY DEMONSTRATION  
12 PROJECTS.—

13 (1) IN GENERAL.—Not later than 270 days  
14 after the date of the enactment of this section, the  
15 Secretary, in consultation with the Rural Health  
16 Quality Advisory Commission, the Office of Rural  
17 Health Policy of the Health Resources and Services  
18 Administration, the Agency for Healthcare Research  
19 and Quality, and the Centers for Medicare & Med-  
20 icaid Services, shall make grants to eligible entities  
21 for 5 demonstration projects to implement and  
22 evaluate methods for improving the quality of health  
23 care in rural communities. Each such demonstration  
24 project shall include—

25 (A) alternative community models that—

1 (i) will achieve greater integration of  
2 personal and population health services;  
3 and

4 (ii) address safety, effectiveness,  
5 patient- or community-centeredness, timeli-  
6 ness, efficiency, and equity (the 6 aims  
7 identified by the Institute of Medicine of  
8 the National Academies in its report enti-  
9 tled “Crossing the Quality Chasm: A New  
10 Health System for the 21st Century” re-  
11 leased on March 1, 2001);

12 (B) innovative approaches to the financing  
13 and delivery of health services to achieve rural  
14 health quality goals; and

15 (C) development of quality improvement  
16 support structures to assist rural health sys-  
17 tems and professionals (such as workforce sup-  
18 port structures, quality monitoring and report-  
19 ing, clinical care protocols, and information  
20 technology applications).

21 (2) ELIGIBLE ENTITIES.—In this subsection,  
22 the term “eligible entity” means a consortium  
23 that—

24 (A) shall include—

1 (i) at least one health care provider or  
2 health care delivery system located in a  
3 rural area; and

4 (ii) at least one organization rep-  
5 resenting multiple community stakeholders;  
6 and

7 (B) may include other partners such as  
8 rural research centers.

9 (3) CONSULTATION.—In developing the pro-  
10 gram for awarding grants under this subsection, the  
11 Secretary shall consult with the Administrator of the  
12 Agency for Healthcare Research and Quality, rural  
13 health care providers, rural health care researchers,  
14 and private and nonprofit groups (including national  
15 associations) which are undertaking similar efforts.

16 (4) EXPEDITED WAIVERS.—The Secretary shall  
17 expedite the processing of any waiver that—

18 (A) is authorized under title XVIII or XIX  
19 of the Social Security Act (42 U.S.C. 1395 et  
20 seq.); and

21 (B) is necessary to carry out a demonstra-  
22 tion project under this subsection.

23 (5) DEMONSTRATION PROJECT SITES.—The  
24 Secretary shall ensure that the 5 demonstration  
25 projects funded under this subsection are conducted



1 at a variety of sites representing the diversity of  
2 rural communities in the Nation.

3 (6) DURATION.—Each demonstration project  
4 under this subsection shall be for a period of 4  
5 years.

6 (7) INDEPENDENT EVALUATION.—The Sec-  
7 retary shall enter into an arrangement with an enti-  
8 ty that has experience working directly with rural  
9 health systems for the conduct of an independent  
10 evaluation of the program carried out under this  
11 subsection.

12 (8) REPORT.—Not later than 1 year after the  
13 conclusion of all of the demonstration projects fund-  
14 ed under this subsection, the Secretary shall submit  
15 a report to the Congress on the results of such  
16 projects. The report shall include—

17 (A) an evaluation of patient access to care,  
18 patient outcomes, and an analysis of the cost  
19 effectiveness of each such project; and

20 (B) recommendations on Federal legisla-  
21 tion, regulations, or administrative policies to  
22 enhance rural health quality and outcomes.

23 (c) APPROPRIATION.—

24 (1) IN GENERAL.—Out of funds in the Treas-  
25 ury not otherwise appropriated, there are appro-

1        priated to the Secretary to carry out this section  
2        \$30,000,000 for the period of fiscal years 2012  
3        through 2016.

4            (2) AVAILABILITY.—

5            (A) IN GENERAL.—Funds appropriated  
6            under paragraph (1) shall remain available for  
7            expenditure through fiscal year 2016.

8            (B) REPORT.—For purposes of carrying  
9            out subsection (b)(8), funds appropriated under  
10           paragraph (1) shall remain available for ex-  
11           penditure through fiscal year 2017.

12           (3) RESERVATION.—Of the amount appro-  
13           priated under paragraph (1), the Secretary shall re-  
14           serve—

15                (A) \$5,000,000 to carry out subsection (a);

16                and

17                (B) \$25,000,000 to carry out subsection  
18                (b), of which—

19                        (i) 2 percent shall be for the provision  
20                        of technical assistance to grant recipients;  
21                        and

22                        (ii) 5 percent shall be for independent  
23                        evaluation under subsection (b)(7).

1 **SEC. 426. RURAL HEALTH CARE SERVICES.**

2 Section 330A of the Public Health Service Act (42  
3 U.S.C. 254c) is amended to read as follows:

4 **“SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH,**  
5 **RURAL HEALTH NETWORK DEVELOPMENT,**  
6 **DELTA RURAL DISPARITIES AND HEALTH**  
7 **SYSTEMS DEVELOPMENT, AND SMALL RURAL**  
8 **HEALTH CARE PROVIDER QUALITY IMPROVE-**  
9 **MENT GRANT PROGRAMS.**

10 “(a) PURPOSE.—The purpose of this section is to  
11 provide for grants—

12 “(1) under subsection (b), to promote rural  
13 health care services outreach;

14 “(2) under subsection (c), to provide for the  
15 planning and implementation of integrated health  
16 care networks in rural areas;

17 “(3) under subsection (d), to assist rural com-  
18 munities in the Delta Region to reduce health dis-  
19 parities and to promote and enhance health system  
20 development; and

21 “(4) under subsection (e), to provide for the  
22 planning and implementation of small rural health  
23 care provider quality improvement activities.

24 “(b) RURAL HEALTH CARE SERVICES OUTREACH  
25 GRANTS.—

1           “(1) GRANTS.—The Director of the Office of  
2 Rural Health Policy of the Health Resources and  
3 Services Administration may award grants to eligible  
4 entities to promote rural health care services out-  
5 reach by expanding the delivery of health care serv-  
6 ices to include new and enhanced services in rural  
7 areas. The Director may award the grants for peri-  
8 ods of not more than 3 years.

9           “(2) ELIGIBILITY.—To be eligible to receive a  
10 grant under this subsection for a project, an enti-  
11 ty—

12                   “(A) shall be a rural public or rural non-  
13 profit private entity, a facility that qualifies as  
14 a rural health clinic under title XVIII of the  
15 Social Security Act, a public or nonprofit entity  
16 existing exclusively to provide services to mi-  
17 grant and seasonal farm workers in rural areas,  
18 or a tribal government whose grant-funded ac-  
19 tivities will be conducted within federally recog-  
20 nized tribal areas;

21                   “(B) shall represent a consortium com-  
22 posed of members—

23                           “(i) that include 3 or more independ-  
24 ently owned health care entities; and

1                   “(ii) that may be nonprofit or for-  
2                   profit entities; and

3                   “(C) shall not previously have received a  
4                   grant under this subsection for the same or a  
5                   similar project, unless the entity is proposing to  
6                   expand the scope of the project or the area that  
7                   will be served through the project.

8                   “(3) APPLICATIONS.—To be eligible to receive a  
9                   grant under this subsection, an eligible entity shall  
10                  prepare and submit to the Director an application at  
11                  such time, in such manner, and containing such in-  
12                  formation as the Director may require, including—

13                  “(A) a description of the project that the  
14                  eligible entity will carry out using the funds  
15                  provided under the grant;

16                  “(B) a description of the manner in which  
17                  the project funded under the grant will meet  
18                  the health care needs of rural populations in  
19                  the local community or region to be served;

20                  “(C) a plan for quantifying how health  
21                  care needs will be met through identification of  
22                  the target population and benchmarks of service  
23                  delivery or health status, such as—

1           “(i) quantifiable measurements of  
2 health status improvement for projects fo-  
3 cusing on health promotion; or

4           “(ii) benchmarks of increased access  
5 to primary care, including tracking factors  
6 such as the number and type of primary  
7 care visits, identification of a medical  
8 home, or other general measures of such  
9 access;

10          “(D) a description of how the local com-  
11 munity or region to be served will be involved  
12 in the development and ongoing operations of  
13 the project;

14          “(E) a plan for sustaining the project after  
15 Federal support for the project has ended;

16          “(F) a description of how the project will  
17 be evaluated;

18          “(G) the administrative capacity to submit  
19 annual performance data electronically as speci-  
20 fied by the Director; and

21          “(H) other such information as the Direc-  
22 tor determines to be appropriate.

23          “(c) RURAL HEALTH NETWORK DEVELOPMENT  
24 GRANTS.—

25                 “(1) GRANTS.—

1           “(A) IN GENERAL.—The Director may  
2           award rural health network development grants  
3           to eligible entities to promote, through planning  
4           and implementation, the development of inte-  
5           grated health care networks that have combined  
6           the functions of the entities participating in the  
7           networks in order to—

8                   “(i) achieve efficiencies and economies  
9                   of scale;

10                   “(ii) expand access to, coordinate, and  
11                   improve the quality of the health care de-  
12                   livery system through development of orga-  
13                   nizational efficiencies;

14                   “(iii) implement health information  
15                   technology to achieve efficiencies, reduce  
16                   medical errors, and improve quality;

17                   “(iv) coordinate care and manage  
18                   chronic illness; and

19                   “(v) strengthen the rural health care  
20                   system as a whole in such a manner as to  
21                   show a quantifiable return on investment  
22                   to the participants in the network.

23           “(B) GRANT PERIODS.—The Director may  
24           award such a rural health network development  
25           grant—

1           “(i) for a period of 3 years for imple-  
2           mentation activities; or

3           “(ii) for a period of 1 year for plan-  
4           ning activities to assist in the initial devel-  
5           opment of an integrated health care net-  
6           work, if the proposed participants in the  
7           network do not have a history of collabo-  
8           rative efforts and a 3-year grant would be  
9           inappropriate.

10           “(2) ELIGIBILITY.—To be eligible to receive a  
11           grant under this subsection, an entity—

12           “(A) shall be a rural public or rural non-  
13           profit private entity, a facility that qualifies as  
14           a rural health clinic under title XVIII of the  
15           Social Security Act, a public or nonprofit entity  
16           existing exclusively to provide services to mi-  
17           grant and seasonal farm workers in rural areas,  
18           or a tribal government whose grant-funded ac-  
19           tivities will be conducted within federally recog-  
20           nized tribal areas;

21           “(B) shall represent a network composed  
22           of participants—

23           “(i) that include 3 or more independ-  
24           ently owned health care entities; and



1                   “(ii) that may be nonprofit or for-  
2                   profit entities; and

3                   “(C) shall not previously have received a  
4                   grant under this subsection (other than a 1-  
5                   year grant for planning activities) for the same  
6                   or a similar project.

7                   “(3) APPLICATIONS.—To be eligible to receive a  
8                   grant under this subsection, an eligible entity, in  
9                   consultation with the appropriate State office of  
10                  rural health or another appropriate State entity,  
11                  shall prepare and submit to the Director an applica-  
12                  tion at such time, in such manner, and containing  
13                  such information as the Director may require, in-  
14                  cluding—

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—

22                          “(i) the history of collaborative activi-  
23                          ties carried out by the participants in the  
24                          network;

1           “(ii) the degree to which the partici-  
2 pants are ready to integrate their func-  
3 tions; and

4           “(iii) how the local community or re-  
5 gion to be served will benefit from and be  
6 involved in the activities carried out by the  
7 network;

8           “(D) a description of how the local com-  
9 munity or region to be served will experience in-  
10 creased access to quality health care services  
11 across the continuum of care as a result of the  
12 integration activities carried out by the net-  
13 work, including a description of—

14           “(i) return on investment for the com-  
15 munity and the network members; and

16           “(ii) other quantifiable performance  
17 measures that show the benefit of the net-  
18 work activities;

19           “(E) a plan for sustaining the project after  
20 Federal support for the project has ended;

21           “(F) a description of how the project will  
22 be evaluated;

23           “(G) the administrative capacity to submit  
24 annual performance data electronically as speci-  
25 fied by the Director; and

1                   “(H) other such information as the Direc-  
2                   tor determines to be appropriate.

3                   “(d) DELTA RURAL DISPARITIES AND HEALTH SYS-  
4                   TEMS DEVELOPMENT GRANTS.—

5                   “(1) GRANTS.—The Director may award grants  
6                   to eligible entities to support reduction of health dis-  
7                   parities, improve access to health care, and enhance  
8                   rural health system development in the Delta Re-  
9                   gion.

10                  “(2) ELIGIBILITY.—To be eligible to receive a  
11                  grant under this subsection, an entity shall be a  
12                  rural public or rural nonprofit private entity, a facil-  
13                  ity that qualifies as a rural health clinic under title  
14                  XVIII of the Social Security Act, a public or non-  
15                  profit entity existing exclusively to provide services  
16                  to migrant and seasonal farm workers in rural  
17                  areas, or a tribal government whose grant-funded  
18                  activities will be conducted within federally recog-  
19                  nized tribal areas.

20                  “(3) APPLICATIONS.—To be eligible to receive a  
21                  grant under this subsection, an eligible entity shall  
22                  prepare and submit to the Director an application at  
23                  such time, in such manner, and containing such in-  
24                  formation as the Director may require, including—

1           “(A) a description of the project that the  
2 eligible entity will carry out using the funds  
3 provided under the grant;

4           “(B) an explanation of the reasons why  
5 Federal assistance is required to carry out the  
6 project;

7           “(C) a description of the manner in which  
8 the project funded under the grant will meet  
9 the health care needs of the Delta Region;

10           “(D) a description of how the local com-  
11 munity or region to be served will experience in-  
12 creased access to quality health care services as  
13 a result of the activities carried out by the enti-  
14 ty;

15           “(E) a description of how health dispari-  
16 ties will be reduced or the health system will be  
17 improved;

18           “(F) a plan for sustaining the project after  
19 Federal support for the project has ended;

20           “(G) a description of how the project will  
21 be evaluated including process and outcome  
22 measures related to the quality of care provided  
23 or how the health care system improves its per-  
24 formance;

1           “(H) a description of how the grantee will  
2           develop an advisory group made up of rep-  
3           resentatives of the communities to be served to  
4           provide guidance to the grantee to best meet  
5           community need; and

6           “(I) other such information as the Director  
7           determines to be appropriate.

8           “(e) SMALL RURAL HEALTH CARE PROVIDER QUAL-  
9           ITY IMPROVEMENT GRANTS.—

10           “(1) GRANTS.—The Director may award grants  
11           to provide for the planning and implementation of  
12           small rural health care provider quality improvement  
13           activities. The Director may award the grants for  
14           periods of 1 to 3 years.

15           “(2) ELIGIBILITY.—To be eligible for a grant  
16           under this subsection, an entity—

17           “(A) shall be—

18           “(i) a rural public or rural nonprofit  
19           private health care provider or provider of  
20           health care services, such as a rural health  
21           clinic; or

22           “(ii) another rural provider or net-  
23           work of small rural providers identified by  
24           the Director as a key source of local care;  
25           and

1           “(B) shall not previously have received a  
2           grant under this subsection for the same or a  
3           similar project.

4           “(3) PREFERENCE.—In awarding grants under  
5           this subsection, the Director shall give preference to  
6           facilities that qualify as rural health clinics under  
7           title XVIII of the Social Security Act.

8           “(4) APPLICATIONS.—To be eligible to receive a  
9           grant under this subsection, an eligible entity shall  
10          prepare and submit to the Director an application at  
11          such time, in such manner, and containing such in-  
12          formation as the Director may require, including—

13                  “(A) a description of the project that the  
14                  eligible entity will carry out using the funds  
15                  provided under the grant;

16                  “(B) an explanation of the reasons why  
17                  Federal assistance is required to carry out the  
18                  project;

19                  “(C) a description of the manner in which  
20                  the project funded under the grant will assure  
21                  continuous quality improvement in the provision  
22                  of services by the entity;

23                  “(D) a description of how the local com-  
24                  munity or region to be served will experience in-  
25                  creased access to quality health care services as

1 a result of the activities carried out by the enti-  
2 ty;

3 “(E) a plan for sustaining the project after  
4 Federal support for the project has ended;

5 “(F) a description of how the project will  
6 be evaluated including process and outcome  
7 measures related to the quality of care pro-  
8 vided; and

9 “(G) other such information as the Direc-  
10 tor determines to be appropriate.

11 “(f) GENERAL REQUIREMENTS.—

12 “(1) PROHIBITED USES OF FUNDS.—An entity  
13 that receives a grant under this section may not use  
14 funds provided through the grant—

15 “(A) to build or acquire real property; or

16 “(B) for construction.

17 “(2) COORDINATION WITH OTHER AGENCIES.—

18 The Director shall coordinate activities carried out  
19 under grant programs described in this section, to  
20 the extent practicable, with Federal and State agen-  
21 cies and nonprofit organizations that are operating  
22 similar grant programs, to maximize the effect of  
23 public dollars in funding meritorious proposals.

24 “(g) REPORT.—Not later than September 30, 2014,  
25 the Secretary shall prepare and submit to the appropriate

1 committees of Congress a report on the progress and ac-  
2 complishments of the grant programs described in sub-  
3 sections (b), (c), (d), and (e).

4 “(h) DEFINITIONS.—In this section:

5 “(1) The term ‘Delta Region’ has the meaning  
6 given to the term ‘region’ in section 382A of the  
7 Consolidated Farm and Rural Development Act (7  
8 U.S.C. 2009aa).

9 “(2) The term ‘Director’ means the Director of  
10 the Office of Rural Health Policy of the Health Re-  
11 sources and Services Administration.

12 “(i) AUTHORIZATION OF APPROPRIATIONS.—There  
13 are authorized to be appropriated to carry out this section  
14 \$40,000,000 for fiscal year 2012, and such sums as may  
15 be necessary for each of fiscal years 2013 through 2016.”.

16 **SEC. 427. COMMUNITY HEALTH CENTER COLLABORATIVE**  
17 **ACCESS EXPANSION.**

18 Section 330 of the Public Health Service Act (42  
19 U.S.C. 254b) is amended by adding at the end the fol-  
20 lowing:

21 “(t) MISCELLANEOUS PROVISIONS.—

22 “(1) RULE OF CONSTRUCTION WITH RESPECT  
23 TO RURAL HEALTH CLINICS.—

24 “(A) IN GENERAL.—Nothing in this sec-  
25 tion shall be construed to prevent a community



1 health center from contracting with a federally  
2 certified rural health clinic (as defined by sec-  
3 tion 1861(aa)(2) of the Social Security Act) for  
4 the delivery of primary health care services that  
5 are available at the rural health clinic to indi-  
6 viduals who would otherwise be eligible for free  
7 or reduced cost care if that individual were able  
8 to obtain that care at the community health  
9 center. Such services may be limited in scope to  
10 those primary health care services available in  
11 that rural health clinic.

12 “(B) ASSURANCES.—In order for a rural  
13 health clinic to receive funds under this section  
14 through a contract with a community health  
15 center under paragraph (1), such rural health  
16 clinic shall establish policies to ensure—

17 “(i) nondiscrimination based upon the  
18 ability of a patient to pay; and

19 “(ii) the establishment of a sliding fee  
20 scale for low-income patients.”.

21 **SEC. 428. FACILITATING THE PROVISION OF TELEHEALTH**  
22 **SERVICES ACROSS STATE LINES.**

23 (a) IN GENERAL.—For purposes of expediting the  
24 provision of telehealth services, for which payment is made  
25 under the Medicare program, across State lines, the Sec-

1 retary of Health and Human Services shall, in consulta-  
2 tion with representatives of States, physicians, health care  
3 practitioners, and patient advocates, encourage and facili-  
4 tate the adoption of provisions allowing for multistate  
5 practitioner practice across State lines.

6 (b) DEFINITIONS.—In subsection (a):

7 (1) TELEHEALTH SERVICE.—The term “tele-  
8 health service” has the meaning given that term in  
9 subparagraph (F) of section 1834(m)(4) of the So-  
10 cial Security Act (42 U.S.C. 1395m(m)(4)).

11 (2) PHYSICIAN, PRACTITIONER.—The terms  
12 “physician” and “practitioner” have the meaning  
13 given those terms in subparagraphs (D) and (E), re-  
14 spectively, of such section.

15 (3) MEDICARE PROGRAM.—The term “Medicare  
16 program” means the program of health insurance  
17 administered by the Secretary of Health and Human  
18 Services under title XVIII of the Social Security Act  
19 (42 U.S.C. 1395 et seq.).

20 **SEC. 429. SCORING OF PREVENTIVE HEALTH SAVINGS.**

21 Section 202 of the Congressional Budget and Im-  
22 poundment Control Act of 1974 (2 U.S.C. 602) is amend-  
23 ed by adding at the end the following new subsection:

24 “(h) SCORING OF PREVENTIVE HEALTH SAVINGS.—

1           “(1) DETERMINATION BY THE DIRECTOR.—

2           Upon a request by the chairman or ranking minority  
3           member of the Committee on the Budget of the Sen-  
4           ate, or by the chairman or ranking minority member  
5           of the Committee on the Budget of the House of  
6           Representatives, the Director shall determine if a  
7           proposed measure would result in reductions in  
8           budget outlays in budgetary outyears through the  
9           use of preventive health and preventive health serv-  
10          ices.

11          “(2) PROJECTIONS.—If the Director determines  
12          that a measure would result in substantial reduc-  
13          tions in budget outlays as described in paragraph  
14          (1), the Director—

15                 “(A) shall include, in any projection pre-  
16                 pared by the Director, a description and esti-  
17                 mate of the reductions in budget outlays in the  
18                 budgetary outyears and a description of the  
19                 basis for such conclusions; and

20                 “(B) may prepare a budget projection that  
21                 includes some or all of the budgetary outyears,  
22                 notwithstanding the time periods for projections  
23                 described in subsection (e) and sections 308,  
24                 402, and 424.

1           “(3) DEFINITIONS.—As used in this sub-  
2 section—

3           “(A) the term ‘preventive health’ means an  
4 action that focuses on the health of the public,  
5 individuals, and defined populations in order to  
6 protect, promote, and maintain health, wellness,  
7 and functional ability, and prevent disease, dis-  
8 ability, and premature death that is dem-  
9 onstrated by credible and publicly available epi-  
10 demiological projection models, incorporating  
11 clinical trials or observational studies in hu-  
12 mans, to avoid future health care costs; and

13           “(B) the term ‘budgetary outyears’ means  
14 the 2 consecutive 10-year periods beginning  
15 with the first fiscal year that is 10 years after  
16 the budget year provided for in the most re-  
17 cently agreed to concurrent resolution on the  
18 budget.”.

19 **SEC. 430. SENSE OF CONGRESS.**

20 It is the sense of the Congress that—

21           (1) the maintenance of effort (MOE) provisions  
22 added to sections 1902 and 2105(d) of the Social  
23 Security Act by sections 2001(b) and 2101(b) of the  
24 Patient Protection and Affordable Care Act were  
25 written to maintain the eligibility standards for the

1 Medicaid program and Children’s Health Insurance  
2 Program until the American Health Benefit Ex-  
3 changes in the States are fully operational;

4 (2) it is imperative that the MOE provisions are  
5 enforced to the strict standard intended by the Con-  
6 gress;

7 (3) waiving the MOE provisions should not be  
8 permitted, except in the case of a request for a waiv-  
9 er that meets the explicit nonapplication require-  
10 ments;

11 (4) the MOE provisions ensure the continued  
12 success of the Medicaid program and CHIP and  
13 were written deliberately to specifically protect vul-  
14 nerable and disabled individuals, children, and senior  
15 citizens, many of whom are also members of commu-  
16 nities of color; and

17 (5) the MOE provisions must be strictly en-  
18 forced and proposals to weaken the MOE provisions  
19 must not be considered in this time of recession.

20 **SEC. 431. REPEAL OF REQUIREMENT FOR DOCUMENTA-**  
21 **TION EVIDENCING CITIZENSHIP OR NATION-**  
22 **ALITY UNDER THE MEDICAID PROGRAM.**

23 (a) REPEAL.—Subsections (i)(22) and (x) of section  
24 1903 of the Social Security Act (42 U.S.C. 1396b), as

1 added by section 6036 of the Deficit Reduction Act of  
2 2005, are each repealed.

3 (b) CONFORMING AMENDMENTS.—

4 (1) Section 1903 of the Social Security Act (42  
5 U.S.C. 1396b) is amended—

6 (A) in subsection (i)—

7 (i) in paragraph (20), by adding “or”  
8 after the semicolon at the end; and

9 (ii) in paragraph (21), by striking “;  
10 or” and inserting a period;

11 (B) by redesignating subsection (y), as  
12 added by section 6043(b) of the Deficit Reduc-  
13 tion Act of 2005, as subsection (x); and

14 (C) by redesignating subsection (z), as  
15 added by section 6081(a) of the Deficit Reduc-  
16 tion Act of 2005, as subsection (y).

17 (2) Subsection (c) of section 6036 of the Deficit  
18 Reduction Act of 2005 is repealed.

19 (c) EFFECTIVE DATE.—The repeals and amend-  
20 ments made by this section shall take effect as if included  
21 in the enactment of the Deficit Reduction Act of 2005.

1 **SEC. 432. 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 **“§ 7309. 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  
9       cultural 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 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 **SEC. 433. ACCESS FOR NATIVE AMERICANS UNDER PPACA.**

4       (a) IN GENERAL.—Title I of the Patient Protection  
5 and Affordable Care Act is amended—

6           (1) in section 1311(c)(6)(D), by striking “(as  
7       defined in section 4 of the Indian Health Care Im-  
8       provement Act)” and inserting “(as defined in sec-  
9       tion 447.50(b)(1) of title 42 of the Code of Federal  
10      Regulations, as in effect on July 1, 2010)”; and

11          (2) in section 1402(d)(1), by striking “(as de-  
12      fined in section 4(d) of the Indian Self-Determina-  
13      tion and Education Assistance Act (25 U.S.C.  
14      450b(d))” and inserting (f) “(as defined in section  
15      447.50(b)(1) of title 42 of the Code of Federal Reg-  
16      ulations, as in effect on July 1, 2010)”.

17      (b) INDIVIDUAL MANDATE.—In section 5000A(e)(3)  
18 of the Internal Revenue Code of 1986, by striking “(as  
19 defined in section 45A(c)(6))” and inserting “(as defined  
20 in section 447.50(b)(1) of title 42 of the Code of Federal  
21 Regulations, as in effect on July 1, 2010)”.

1 **TITLE V—IMPROVING HEALTH**  
2 **OUTCOMES FOR WOMEN,**  
3 **CHILDREN, AND FAMILIES**

4 **SEC. 501. GRANTS TO PROMOTE POSITIVE HEALTH BEHAV-**  
5 **IORES IN WOMEN AND CHILDREN.**

6 Part Q of title III of the Public Health Service Act  
7 (42 U.S.C. 280g et seq.) is amended by adding at the end  
8 the following:

9 **“SEC. 399Z–2. GRANTS TO PROMOTE POSITIVE HEALTH BE-**  
10 **HAVIORS IN WOMEN AND CHILDREN.**

11 “(a) GRANTS AUTHORIZED.—The Secretary, in col-  
12 laboration with the Director of the Centers for Disease  
13 Control and Prevention and other Federal officials deter-  
14 mined appropriate by the Secretary, is authorized to  
15 award grants to eligible entities to promote positive health  
16 behaviors for women and children in target populations,  
17 especially racial and ethnic minority women and children  
18 in medically underserved communities.

19 “(b) USE OF FUNDS.—Grants awarded pursuant to  
20 subsection (a) may be used to support community health  
21 workers—

22 “(1) to educate and provide outreach regarding  
23 enrollment in health insurance including the State  
24 Children’s Health Insurance Program under title  
25 XXI of the Social Security Act, Medicare under title

1 XVIII of such Act, and Medicaid under title XIX of  
2 such Act;

3 “(2) to educate, guide, and provide outreach in  
4 a community setting regarding health problems prev-  
5 alent among women and children and especially  
6 among racial and ethnic minority women and chil-  
7 dren;

8 “(3) to educate, guide, and provide experiential  
9 learning opportunities that target behavioral risk  
10 factors including—

11 “(A) poor nutrition;

12 “(B) physical inactivity;

13 “(C) being overweight or obese;

14 “(D) tobacco use;

15 “(E) alcohol and substance use;

16 “(F) injury and violence;

17 “(G) risky sexual behavior;

18 “(H) mental health problems;

19 “(I) musculoskeletal health;

20 “(J) dental and oral health problems; and

21 “(K) understanding informed consent;

22 “(4) to educate and guide regarding effective  
23 strategies to promote positive health behaviors with-  
24 in the family;

1           “(5) to promote community wellness and aware-  
2           ness; and

3           “(6) to educate and refer target populations to  
4           appropriate health care agencies and community-  
5           based programs and organizations in order to in-  
6           crease access to quality health care services, includ-  
7           ing preventive health services.

8           “(c) APPLICATION.—

9           “(1) IN GENERAL.—Each eligible entity that  
10          desires to receive a grant under subsection (a) shall  
11          submit an application to the Secretary, at such time,  
12          in such manner, and accompanied by such additional  
13          information as the Secretary may require.

14          “(2) CONTENTS.—Each application submitted  
15          pursuant to paragraph (1) shall—

16                 “(A) describe the activities for which as-  
17                 sistance under this section is sought;

18                 “(B) contain an assurance that with re-  
19                 spect to each community health worker pro-  
20                 gram receiving funds under the grant awarded,  
21                 such program provides training and supervision  
22                 to community health workers to enable such  
23                 workers to provide authorized program services;

24                 “(C) contain an assurance that the appli-  
25                 cant will evaluate the effectiveness of commu-

1           nity health worker programs receiving funds  
2           under the grant;

3           “(D) contain an assurance that each com-  
4           munity health worker program receiving funds  
5           under the grant will provide services in the cul-  
6           tural context most appropriate for the individ-  
7           uals served by the program;

8           “(E) contain a plan to document and dis-  
9           seminate project description and results to  
10          other States and organizations as identified by  
11          the Secretary; and

12          “(F) describe plans to enhance the capac-  
13          ity of individuals to utilize health services and  
14          health-related social services under Federal,  
15          State, and local programs by—

16                  “(i) assisting individuals in estab-  
17                  lishing eligibility under the programs and  
18                  in receiving the services or other benefits  
19                  of the programs; and

20                  “(ii) providing other services as the  
21                  Secretary determines to be appropriate,  
22                  that may include transportation and trans-  
23                  lation services.

1       “(d) PRIORITY.—In awarding grants under sub-  
2 section (a), the Secretary shall give priority to those appli-  
3 cants—

4           “(1) who propose to target geographic areas—

5               “(A) with a high percentage of residents  
6 who are eligible for health insurance but are  
7 uninsured or underinsured; and

8               “(B) with a high percentage of families for  
9 whom English is not their primary language;

10          “(2) with experience in providing health or  
11 health-related social services to individuals who are  
12 underserved with respect to such services; and

13          “(3) with documented community activity and  
14 experience with community health workers.

15       “(e) COLLABORATION WITH ACADEMIC INSTITU-  
16 TIONS.—The Secretary shall encourage community health  
17 worker programs receiving funds under this section to col-  
18 laborate with academic institutions, including minority-  
19 serving institutions. Nothing in this section shall be con-  
20 strued to require such collaboration.

21       “(f)           QUALITY           ASSURANCE           AND  
22 COSTEFFECTIVENESS.—The Secretary shall establish  
23 guidelines for assuring the quality of the training and su-  
24 pervision of community health workers under the pro-

1 grams funded under this section and for assuring the  
2 costeffectiveness of such programs.

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           and

8           “(F) by providing referral and followup  
9           services.

10          “(2) COMMUNITY SETTING.—The term ‘commu-  
11          nity setting’ means a home or a community organi-  
12          zation located in the neighborhood in which a partic-  
13          ipant resides.

14          “(3) ELIGIBLE ENTITY.—The term ‘eligible en-  
15          tity’ means—

16                 “(A) a unit of State, territorial, local, or  
17                 tribal government (including a federally recog-  
18                 nized tribe or Alaska Native village); or

19                 “(B) a community-based organization.

20          “(4) MEDICALLY UNDERSERVED COMMUNITY.—  
21          The term ‘medically underserved community’ means  
22          a community—

23                 “(A) that has a substantial number of in-  
24                 dividuals who are members of a medically un-

1           derserved population, as defined by section  
2           330(b)(3); and

3           “(B) a significant portion of which is a  
4           health professional shortage area as designated  
5           under section 332.

6           “(5) SUPPORT.—The term ‘support’ means the  
7           provision of training, supervision, and materials  
8           needed to effectively deliver the services described in  
9           subsection (b), reimbursement for services, and  
10          other benefits.

11          “(6) TARGET POPULATION.—The term ‘target  
12          population’ means women of reproductive age, re-  
13          gardless of their current childbearing status and  
14          children under 21 years of age.

15          “(k) AUTHORIZATION OF APPROPRIATIONS.—There  
16          are authorized to be appropriated to carry out this section  
17          \$15,000,000 for each of fiscal years 2012 through 2016.”.

18       **SEC. 502. REMOVING BARRIERS TO HEALTH CARE AND NU-**  
19                               **TRITION ASSISTANCE FOR CHILDREN, PREG-**  
20                               **NANT WOMEN, AND LAWFULLY PRESENT IN-**  
21                               **DIVIDUALS.**

22          (a) MEDICAID.—Section 1903(v) of the Social Secu-  
23          rity Act (42 U.S.C. 1396b(v)) is amended by striking  
24          paragraph (4) and inserting the following new paragraph:

1           “(4)(A) Notwithstanding sections 401(a),  
2           402(b), 403, and 421 of the Personal Responsibility  
3           and Work Opportunity Reconciliation Act of 1996,  
4           payment shall be made under this section for care  
5           and services that are furnished to aliens, including  
6           those described in paragraph (1), if they otherwise  
7           meet the eligibility requirements for medical assist-  
8           ance under the State plan approved under this sub-  
9           chapter (other than the requirement of the receipt of  
10          aid or assistance under title IV, supplemental secu-  
11          rity income benefits under title XVI, or a State sup-  
12          plementary payment), and are—

13                   “(i) lawfully present in the United  
14                   States;

15                   “(ii) children under 21 years of age,  
16                   including any optional targeted low-income  
17                   child (as such term is defined in section  
18                   1905(u)(2)(B)); or

19                   “(iii) pregnant women during preg-  
20                   nancy and during the 60-day period begin-  
21                   ning on the last day of the pregnancy.

22           “(B) No debt shall accrue under an affidavit of  
23           support against any sponsor of such an alien on the  
24           basis of provision of assistance to such alien under

1       this paragraph and the cost of such assistance shall  
2       not be considered as an unreimbursed cost.”.

3       (b) SCHIP.—Section 2107(e)(1) of the Social Secu-  
4       rity Act (42 U.S.C. 1397gg(e)(1)) is amended by amend-  
5       ing subparagraph (J) to read as follows:

6                       “(J) Paragraph (4) of section 1903(v) (re-  
7       lating to individuals who, but for sections  
8       401(a), 403, and 421 of the Personal Responsi-  
9       bility and Work Opportunity Reconciliation Act  
10       of 1996, would be eligible for medical assistance  
11       under title XXI).”.

12       (c) SUPPLEMENTAL NUTRITION ASSISTANCE.—Not-  
13       withstanding sections 401(a), 402(a), and 403(a) of the  
14       Personal Responsibility and Work Opportunity Reconcili-  
15       ation Act of 1996 (8 U.S.C. 1611(a); 1612(a); 1613(a))  
16       and section 6(f) of the Food and Nutrition Act of 2008  
17       (7 U.S.C. 2015(f)), persons who are lawfully present in  
18       the United States shall be not be ineligible for benefits  
19       under the supplemental nutrition assistance program on  
20       the basis of their immigration status or date of entry into  
21       the United States.

22       (d) ELIGIBILITY FOR FAMILIES WITH CHILDREN.—  
23       Section of the 421(d)(3) of the Personal Responsibility  
24       and Work Opportunity Reconciliation Act of 1996 (8  
25       U.S.C. 1631(d)(3)) is amended by striking “to the extent

1 that a qualified alien is eligible under section  
2 402(a)(2)(J)” and inserting, “to the extent that a child  
3 is a member of a household under the supplemental nutri-  
4 tion assistance program”.

5 (e) ENSURING PROPER SCREENING.—Section  
6 11(e)(2)(B) of the Food and Nutrition Act of 2008 (7  
7 U.S.C. 2020(e)(2)(B)) is amended—

8 (1) by redesignating clauses (vi) and (vii) as  
9 clauses (vii) and (viii); and

10 (2) by inserting after clause (v) the following:

11 “(vi) shall provide a method for imple-  
12 menting section 421 of the Personal Re-  
13 sponsibility and Work Opportunity Rec-  
14 onciliation Act of 1996 (8 U.S.C. 1631)  
15 that does not require any unnecessary in-  
16 formation from persons who may be ex-  
17 empt from that provision;”.

18 **SEC. 503. REPEAL OF DENIAL OF BENEFITS.**

19 Section 115 of the Personal Responsibility and Work  
20 Opportunity Reconciliation Act of 1996 (21 U.S.C. 862a)  
21 is amended—

22 (1) in subsection (a) by striking paragraph (2);

23 (2) in subsection (b) by striking paragraph (2);

24 and

25 (3) in subsection (e) by striking paragraph (2).

1 **SEC. 504. BIRTH DEFECTS PREVENTION, RISK REDUCTION,**  
2 **AND AWARENESS.**

3 (a) IN GENERAL.—The Secretary shall establish and  
4 implement a birth defects prevention and public awareness  
5 program, consisting of the activities described in sub-  
6 sections (c) and (d).

7 (b) DEFINITIONS.—In this section:

8 (1) The term “pregnancy and breastfeeding in-  
9 formation services” includes only—

10 (A) information services to provide accu-  
11 rate, evidence-based, clinical information re-  
12 garding maternal exposures during pregnancy  
13 that may be associated with birth defects or  
14 other health risks, such as exposures to medica-  
15 tions, chemicals, infections, foodborne patho-  
16 gens, illnesses, nutrition, or lifestyle factors;

17 (B) information services to provide accu-  
18 rate, evidence-based, clinical information re-  
19 garding maternal exposures during breast-  
20 feeding that may be associated with health risks  
21 to a breast-fed infant, such as exposures to  
22 medications, chemicals, infections, foodborne  
23 pathogens, illnesses, nutrition, or lifestyle fac-  
24 tors;

25 (C) the provision of accurate, evidence-  
26 based information weighing risks of exposures

1 during breastfeeding against the benefits of  
2 breastfeeding; and

3 (D) the provision of information described  
4 in subparagraph (A), (B), or (C) through coun-  
5 selors, Web sites, fact sheets, telephonic or elec-  
6 tronic communication, community outreach ef-  
7 forts, or other appropriate means.

8 (2) The term “Secretary” means the Secretary  
9 of Health and Human Services, acting through the  
10 Director of the Centers for Disease Control and Pre-  
11 vention.

12 (c) NATIONWIDE MEDIA CAMPAIGN.—In carrying out  
13 subsection (a), the Secretary shall conduct or support a  
14 nationwide media campaign to increase awareness among  
15 health care providers and at-risk populations about preg-  
16 nancy and breastfeeding information services.

17 (d) GRANTS FOR PREGNANCY AND BREASTFEEDING  
18 INFORMATION SERVICES.—

19 (1) IN GENERAL.—In carrying out subsection  
20 (a), the Secretary shall award grants to State or re-  
21 gional agencies or organizations for any of the fol-  
22 lowing:

23 (A) INFORMATION SERVICES.—The provi-  
24 sion of, or campaigns to increase awareness



1 about, pregnancy and breastfeeding information  
2 services.

3 (B) SURVEILLANCE AND RESEARCH.—The  
4 conduct or support of—

5 (i) surveillance of or research on—

6 (I) maternal exposures and ma-  
7 ternal health conditions that may in-  
8 fluence the risk of birth defects, pre-  
9 maturity, or other adverse pregnancy  
10 outcomes; and

11 (II) maternal exposures that may  
12 influence health risks to a breastfed  
13 infant; or

14 (ii) networking to facilitate surveil-  
15 lance or research described in this sub-  
16 paragraph.

17 (2) PREFERENCE FOR CERTAIN STATES.—The  
18 Secretary, in making any grant under this sub-  
19 section, shall give preference to States, otherwise  
20 equally qualified, that have or had a pregnancy and  
21 breastfeeding information service in place on or after  
22 January 1, 2006.

23 (3) MATCHING FUNDS.—The Secretary may  
24 only award a grant under this subsection to a State  
25 or regional agency or organization that agrees, with

1 respect to the costs to be incurred in carrying out  
2 the grant activities, to make available (directly or  
3 through donations from public or private entities)  
4 non-Federal funds toward such costs in an amount  
5 equal to not less than 25 percent of the amount of  
6 the grant.

7 (4) COORDINATION.—The Secretary shall en-  
8 sure that activities funded through a grant under  
9 this subsection are coordinated, to the maximum ex-  
10 tent practicable, with other birth defects prevention  
11 and environmental health activities of the Federal  
12 Government, including with respect to pediatric envi-  
13 ronmental health specialty units and children’s envi-  
14 ronmental health centers.

15 (e) EVALUATION.—In furtherance of the program  
16 under subsection (a), the Secretary shall provide for an  
17 evaluation of pregnancy and breastfeeding information  
18 services to identify efficient and effective models of—

- 19 (1) providing information;  
20 (2) raising awareness and increasing knowledge  
21 about birth defects prevention measures;  
22 (3) modifying risk behaviors; or  
23 (4) other outcome measures as determined ap-  
24 propriate by the Secretary.

1 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry  
2 out this section, there are authorized to be appropriated  
3 \$5,000,000 for fiscal year 2012, \$6,000,000 for fiscal year  
4 2013, \$7,000,000 for fiscal year 2014, \$8,000,000 for fis-  
5 cal year 2015, and \$9,000,000 for fiscal year 2016.

6 **SEC. 505. UNIFORM STATE MATERNAL MORTALITY REVIEW**  
7 **COMMITTEES ON PREGNANCY-RELATED**  
8 **DEATHS.**

9 (a) CONDITION OF RECEIPT OF PAYMENTS FROM  
10 ALLOTMENT UNDER MATERNAL AND CHILD HEALTH  
11 SERVICE BLOCK GRANT.—Title V of the Social Security  
12 Act (42 U.S.C. 701 et seq.) is amended by adding at the  
13 end the following new section:

14 **“SEC. 514. UNIFORM STATE MATERNAL MORTALITY RE-**  
15 **VIEW COMMITTEES ON PREGNANCY-RE-**  
16 **LATED DEATHS.**

17 “(a) GRANTS.—

18 “(1) IN GENERAL.—Notwithstanding any other  
19 provision of this title, for each of fiscal years 2012  
20 through 2018, in addition to payments from allot-  
21 ments for States under section 502 for such year,  
22 the Secretary shall, subject to paragraph (3) and in  
23 accordance with the criteria established under para-  
24 graph (2), award grants to States to—

1           “(A) carry out the activities described in  
2 subsection (b)(1);

3           “(B) establish a State maternal mortality  
4 review committee, in accordance with subsection  
5 (b)(2), to carry out the activities described in  
6 subsection (b)(2)(A), and to establish the proc-  
7 esses described in subsection (b)(1);

8           “(C) ensure the State department of  
9 health carries out the applicable activities de-  
10 scribed in subsection (b)(3), with respect to  
11 pregnancy-related deaths occurring within the  
12 State during such fiscal year;

13           “(D) implement and use the comprehensive  
14 case abstraction form developed under sub-  
15 section (c), in accordance with such subsection;  
16 and

17           “(E) provide for public disclosure of infor-  
18 mation, in accordance with subsection (e).

19           “(2) CRITERIA.—The Secretary shall establish  
20 criteria for determining eligibility for and the  
21 amount of a grant awarded to a State under para-  
22 graph (1). Such criteria shall provide that in the  
23 case of a State that receives such a grant for a fiscal  
24 year and is determined by the Secretary to have not  
25 used such grant in accordance with this section,

1 such State shall not be eligible for such a grant for  
2 any subsequent fiscal year.

3 “(3) AUTHORIZATION OF APPROPRIATIONS.—

4 For purposes of carrying out the grant program  
5 under this section, including for administrative pur-  
6 poses, there is authorized to be appropriated  
7 \$10,000,000 for each of fiscal years 2012 through  
8 2018.

9 “(b) PREGNANCY-RELATED DEATH REVIEW.—

10 “(1) REVIEW OF PREGNANCY-RELATED DEATH  
11 AND PREGNANCY-ASSOCIATED DEATH CASES.—For  
12 purposes of subsection (a), with respect to a State  
13 that receives a grant under subsection (a), the fol-  
14 lowing shall apply:

15 “(A) MANDATORY REPORTING OF PREG-  
16 NANCY-RELATED DEATHS.—

17 “(i) IN GENERAL.—The State shall,  
18 through the State maternal mortality re-  
19 view committee, develop a process, sepa-  
20 rate from any reporting process established  
21 by the State department of health prior to  
22 the date of the enactment of this section,  
23 that provides for mandatory and confiden-  
24 tial case reporting by individuals and enti-  
25 ties described in clause (ii) of pregnancy-

1 related deaths to the State department of  
2 health.

3 “(ii) INDIVIDUALS AND ENTITIES DE-  
4 SCRIBED.—Individuals and entities de-  
5 scribed in this clause include each of the  
6 following:

7 “(I) Health care providers.

8 “(II) Medical examiners.

9 “(III) Medical coroners.

10 “(IV) Hospitals.

11 “(V) Free-standing birth centers.

12 “(VI) Other health care facilities.

13 “(VII) Any other individuals re-  
14 sponsible for completing death certifi-  
15 cates.

16 “(VIII) Any other appropriate in-  
17 dividuals or entities specified by the  
18 Secretary.

19 “(B) VOLUNTARY REPORTING OF PREG-  
20 NANCY-RELATED AND PREGNANCY-ASSOCIATED  
21 DEATHS.—

22 “(i) The State shall, through the  
23 State maternal mortality review committee,  
24 develop a process for and encourage, sepa-  
25 rate from any reporting process established

1 by the State department of health prior to  
2 the date of the enactment of this section,  
3 voluntary and confidential case reporting  
4 by individuals described in clause (ii) of  
5 pregnancy-associated deaths to the State  
6 department of health.

7 “(ii) The State shall, through the  
8 State maternal mortality review committee,  
9 develop a process for voluntary and con-  
10 fidential reporting by family members of  
11 the deceased and by other individuals on  
12 possible pregnancy-related and pregnancy-  
13 associated deaths to the State department  
14 of health. Such process shall include—

15 “(I) making publicly available on  
16 the Internet Web site of the State de-  
17 partment of health a telephone num-  
18 ber, Internet Web link, and email ad-  
19 dress for such reporting; and

20 “(II) publicizing to local profes-  
21 sional organizations, community orga-  
22 nizations, and social services agencies  
23 the availability of the telephone num-  
24 ber, Internet Web link, and email ad-

1 dress made available under subclause  
2 (I).

3 “(C) DEVELOPMENT OF CASE-FINDING.—  
4 The State, through the vital statistics unit of  
5 the State, shall annually identify pregnancy-re-  
6 lated and pregnancy-associated deaths occur-  
7 ring in such State during the year involved  
8 by—

9 “(i) matching all death records, with  
10 respect to such year, for women of child-  
11 bearing age to live birth certificates and in-  
12 fant death certificates to identify deaths of  
13 women that occurred during pregnancy  
14 and within one year after the end of a  
15 pregnancy;

16 “(ii) identifying deaths reported dur-  
17 ing such year as having an underlying or  
18 contributing cause of death related to  
19 pregnancy, regardless of the time that has  
20 passed between the end of the pregnancy  
21 and the death;

22 “(iii) collecting data from medical ex-  
23 aminer and coroner reports; and

24 “(iv) any other methods the States  
25 may devise to identify maternal deaths,



1           such as through review of a random sam-  
2           ple of reported deaths of women of child-  
3           bearing age to ascertain cases of preg-  
4           nancy-related and pregnancy-associated  
5           deaths that are not discernable from a re-  
6           view of death certificates alone.

7           When feasible and for purposes of effectively  
8           collecting and obtaining data on pregnancy-re-  
9           lated and pregnancy-associated deaths, the  
10          State shall adopt the most recent standardized  
11          birth and death certificates, as issued by the  
12          National Center for Vital Health Statistics, in-  
13          cluding the recommended checkbox section for  
14          pregnancy on the death certificates.

15                 “(D) CASE INVESTIGATION AND DEVELOP-  
16                 MENT OF CASE SUMMARIES.—Following receipt  
17                 of reports by the State department of health  
18                 pursuant to subparagraph (A) or (B) and col-  
19                 lection by the vital statistics unit of the State  
20                 of possible cases of pregnancy-related and preg-  
21                 nancy-associated deaths pursuant to subpara-  
22                 graph (C), the State, through the State mater-  
23                 nal mortality review committee established  
24                 under subsection (a), shall investigate each  
25                 case, utilizing the case abstraction form de-

1           scribed in subsection (c), and prepare de-identi-  
2           fied case summaries, which shall be reviewed by  
3           the committee and included in applicable re-  
4           ports. For purposes of subsection (a), under the  
5           processes established under subparagraphs (A),  
6           (B), and (C), a State department of health or  
7           vital statistics unit of a State shall provide to  
8           the State maternal mortality review committee  
9           access to information collected pursuant to such  
10          subparagraphs as necessary to carry out this  
11          subparagraph. Data and information collected  
12          for the case summary and review are for pur-  
13          poses of public health activities, in accordance  
14          with HIPAA privacy and security law (as de-  
15          fined in section 3009(a)(2) of the Public Health  
16          Service Act). Such case investigations shall in-  
17          clude data and information obtained through—

18                   “(i) medical examiner and autopsy re-  
19                   ports of the woman involved;

20                   “(ii) medical records of the woman,  
21                   including such records related to health  
22                   care prior to pregnancy, prenatal and post-  
23                   natal care, labor and delivery care, emer-  
24                   gency room care, hospital discharge  
25                   records, and any care delivered up until

1 the time of death of the woman for pur-  
 2 poses of public health activities, in accord-  
 3 ance with HIPAA privacy and security law  
 4 (as defined in section 3009(a)(2) of the  
 5 Public Health Service Act);

6 “(iii) oral and written interviews of in-  
 7 dividuals directly involved in the maternal  
 8 care of the woman during and immediately  
 9 following the pregnancy of the woman, in-  
 10 cluding health care, mental health, and so-  
 11 cial service providers, as applicable;

12 “(iv) optional oral or written inter-  
 13 views of the family of the woman;

14 “(v) socioeconomic and other relevant  
 15 background information about the woman;

16 “(vi) information collected in subpara-  
 17 graph (C)(i); and

18 “(vii) other information on the cause  
 19 of death of the woman, such as social serv-  
 20 ices and child welfare reports.

21 “(2) STATE MATERNAL MORTALITY REVIEW  
 22 COMMITTEES.—

23 “(A) DUTIES.—

24 “(i) REQUIRED COMMITTEE ACTIVI-  
 25 TIES.—For purposes of subsection (a), a

1 maternal mortality review committee estab-  
2 lished by a State pursuant to a grant  
3 under such subsection shall carry out the  
4 following pregnancy-related death and  
5 pregnancy-associated death review activi-  
6 ties and shall include all information rel-  
7 evant to the death involved on the case ab-  
8 straction form developed under subsection  
9 (d):

10 “(I) With respect to a case of  
11 pregnancy-related or pregnancy-asso-  
12 ciated death of a woman, review the  
13 case summaries prepared under sub-  
14 paragraphs (A), (B), (C), and (D) of  
15 paragraph (1).

16 “(II) Review aggregate statistical  
17 reports developed by the vital statis-  
18 tics unit of the State under paragraph  
19 (1)(C) regarding pregnancy-related  
20 and pregnancy-associated deaths to  
21 identify trends, patterns, and dispari-  
22 ties in adverse outcomes and address  
23 medical, non-medical, and system-re-  
24 lated factors that may have contrib-  
25 uted to such pregnancy-related and

1 pregnancy-associated deaths and dis-  
2 parities.

3 “(III) Develop recommendations,  
4 based on the review of the case sum-  
5 maries under paragraph (1)(D) and  
6 aggregate statistical reports under  
7 subclause (II), to improve maternal  
8 care, social and health services, and  
9 public health policy and institutions,  
10 including with respect to improving  
11 access to maternal care, improving the  
12 availability of social services, and  
13 eliminating disparities in maternal  
14 care and outcomes.

15 “(ii) OPTIONAL COMMITTEE ACTIVI-  
16 TIES.—For purposes of subsection (a), a  
17 maternal mortality review committee estab-  
18 lished by a State under such subsection  
19 may present findings and recommendations  
20 regarding a specific case or set of cir-  
21 cumstances directly to a health care facil-  
22 ity or its local or State professional organi-  
23 zation for the purpose of instituting policy  
24 changes, educational activities, or other-

1 wise improving the quality of care provided  
2 by the facilities.

3 “(B) COMPOSITION OF MATERNAL MOR-  
4 TALITY REVIEW COMMITTEES.—

5 “(i) IN GENERAL.—Each State mater-  
6 nal mortality review committee established  
7 pursuant to a grant under subsection (a)  
8 shall be multi-disciplinary, consisting of  
9 health care and social service providers,  
10 public health officials, other persons with  
11 professional expertise on maternal health  
12 and mortality, and patient and community  
13 advocates who represent those communities  
14 within such State that are the most af-  
15 fected by maternal mortality. Membership  
16 on such a committee of a State shall be re-  
17 viewed annually by the State department  
18 of health to ensure that membership rep-  
19 resentation requirements are being fulfilled  
20 in accordance with this paragraph.

21 “(ii) REQUIRED MEMBERSHIP.—Each  
22 such review committee shall include—

23 “(I) representatives from medical  
24 specialities providing care to pregnant  
25 and postpartum patients, including

1 obstetricians (including generalists  
2 and maternal fetal medicine special-  
3 ists), and family practice physicians;

4 “(II) certified nurse midwives,  
5 certified midwives, and advanced prac-  
6 tice nurses;

7 “(III) hospital-based nurses;

8 “(IV) representatives of the State  
9 department of health maternal and  
10 child health department;

11 “(V) social service providers or  
12 social workers;

13 “(VI) the chief medical exam-  
14 iners or designees;

15 “(VII) facility representatives,  
16 such as from hospitals or free-stand-  
17 ing birth centers; and

18 “(VIII) community or patient ad-  
19 vocates who represent those commu-  
20 nities within the State that are the  
21 most affected by maternal mortality.

22 “(iii) ADDITIONAL MEMBERS.—Each  
23 such review committee may also include  
24 representatives from other relevant aca-  
25 demic, health, social service, or policy pro-

1           fessions, or community organizations, on  
2           an ongoing basis, or as needed, as deter-  
3           mined beneficial by the review committee,  
4           including—

5                   “(I) anesthesiologists;

6                   “(II) emergency physicians;

7                   “(III) pathologists;

8                   “(IV) epidemiologists or biostat-  
9           isticians;

10                  “(V) intensivists;

11                  “(VI) vital statistics officers;

12                  “(VII) nutritionists;

13                  “(VIII) mental health profes-  
14           sionals;

15                  “(IX) substance abuse treatment  
16           specialists;

17                  “(X) representatives of relevant  
18           advocacy groups;

19                  “(XI) academics;

20                  “(XII) representatives of bene-  
21           ficiaries of the State plan under the  
22           Medicaid program under title XIX;

23                  “(XIII) paramedics;

24                  “(XIV) lawyers;



1                   “(XV) risk management special-  
2                   ists;

3                   “(XVI) representatives of the de-  
4                   partments of health or public health  
5                   of major cities in the State involved;  
6                   and

7                   “(XVII) policy makers.

8                   “(iv) DIVERSE COMMUNITY MEMBER-  
9                   SHIP.—The composition of such a com-  
10                  mittee, with respect to a State, shall in-  
11                  clude—

12                   “(I) representatives from diverse  
13                   communities, particularly those com-  
14                   munities within such State most se-  
15                   verely affected by pregnancy-related  
16                   deaths or pregnancy-associated deaths  
17                   and by a lack of access to relevant  
18                   maternal care services, from commu-  
19                   nity maternal child health organiza-  
20                   tions, and from minority advocacy  
21                   groups;

22                   “(II) members, including health  
23                   care providers, from different geo-  
24                   graphic regions in the State, including

1 any rural, urban, and tribal areas;  
2 and

3 “(III) health care and social serv-  
4 ice providers who work in commu-  
5 nities that are diverse with regard to  
6 race, ethnicity, immigration status,  
7 Indigenous status, and English pro-  
8 ficiency.

9 “(v) MATERNAL MORTALITY REVIEW  
10 STAFF.—Staff of each such review com-  
11 mittee shall include—

12 “(I) vital health statisticians, ma-  
13 ternal child health statisticians, or  
14 epidemiologists;

15 “(II) a coordinator of the State  
16 maternal mortality review committee,  
17 to be designated by the State; and

18 “(III) administrative staff.

19 “(C) OPTION FOR STATES TO FORM RE-  
20 GIONAL MATERNAL MORTALITY REVIEWS.—  
21 States with a low rate of occurrence of preg-  
22 nancy-associated or pregnancy-related deaths  
23 may choose to partner with one or more neigh-  
24 boring States to fulfill the activities described in  
25 paragraph (1)(C). In such a case, with respect

1 to States in such a partnership, any require-  
2 ment under this section relating to the report-  
3 ing of information related to such activities  
4 shall be deemed to be fulfilled by each such  
5 State if a single such report is submitted for  
6 the partnership.

7 “(3) STATE DEPARTMENT OF HEALTH ACTIVI-  
8 TIES.—For purposes of subsection (a), a State de-  
9 partment of health of a State receiving a grant  
10 under such subsection shall—

11 “(A) in consultation with the maternal  
12 mortality review committee of the State and in  
13 conjunction with relevant professional organiza-  
14 tions, develop a plan for ongoing health care  
15 provider education, based on the findings and  
16 recommendations of the committee, in order to  
17 improve the quality of maternal care; and

18 “(B) take steps to widely disseminate the  
19 findings and recommendations of the State ma-  
20 ternal mortality review committees of the State  
21 and to implement the recommendations of such  
22 committee.

23 “(c) CASE ABSTRACTION FORM.—

24 “(1) DEVELOPMENT.—The Director of the Cen-  
25 ters for Disease Control and Prevention shall de-

1       velop a uniform, comprehensive case abstraction  
2       form and make such form available to States for  
3       State maternal mortality review committees for use  
4       by such committees in order to—

5               “(A) ensure that the cases and information  
6               collected and reviewed by such committees can  
7               be pooled for review by the Department of  
8               Health and Human Services and its agencies;  
9               and

10              “(B) preserve the uniformity of the infor-  
11              mation and its use for Federal public health  
12              purposes.

13              “(2) PERMISSIBLE STATE MODIFICATION.—  
14       Each State may modify the form developed under  
15       paragraph (1) for implementation and use by such  
16       State or by the State maternal mortality review com-  
17       mittee of such State by including on such form addi-  
18       tional information to be collected, but may not alter  
19       the standard questions on such form, in order to en-  
20       sure that the information can be collected and re-  
21       viewed centrally at the Federal level.

22              “(d) TREATMENT AS PUBLIC HEALTH AUTHORITY  
23       FOR PURPOSES OF HIPAA.—For purposes of applying  
24       HIPAA privacy and security law (as defined in section  
25       3009(a)(2) of the Public Health Service Act), a State ma-

1 ternal mortality review committee of a State established  
2 pursuant to this section to carry out activities described  
3 in subsection (b)(2)(A) shall be deemed to be a public  
4 health authority described in section 164.501 (and ref-  
5 erenced in section 164.512(b)(1)(i)) of title 45, Code of  
6 Federal Regulations (or any successor regulation), car-  
7 rying out public health activities and purposes described  
8 in such section 164.512(b)(1)(i) (or any such successor  
9 regulation).

10 “(e) PUBLIC DISCLOSURE OF INFORMATION.—

11 “(1) IN GENERAL.—For fiscal year 2012 or a  
12 subsequent fiscal year, each State receiving a grant  
13 under this section for such year shall, subject to  
14 paragraph (3), provide for the public disclosure, and  
15 submission to the information clearinghouse estab-  
16 lished under paragraph (2), of the information in-  
17 cluded in the report of the State under section  
18 506(a)(2)(F) for such year (relating to the findings  
19 for such year of the State maternal mortality review  
20 committee established by the State under this sec-  
21 tion).

22 “(2) INFORMATION CLEARINGHOUSE.—The  
23 Secretary of Health and Human Services shall es-  
24 tablish an information clearinghouse, that shall be  
25 administered by the Director of the Centers for Dis-

1 ease Control and Prevention, that will maintain find-  
2 ings and recommendations submitted pursuant to  
3 paragraph (1) and provide such findings and rec-  
4 ommendations for public review and research pur-  
5 poses by State health departments, maternal mor-  
6 tality review committees, and health providers and  
7 institutions.

8 “(3) CONFIDENTIALITY OF INFORMATION.—In  
9 no case shall any individually identifiable health in-  
10 formation be provided to the public, or submitted to  
11 the information clearinghouse, under paragraph (1).

12 “(f) CONFIDENTIALITY OF REVIEW COMMITTEE  
13 PROCEEDINGS.—

14 “(1) IN GENERAL.—All proceedings and activi-  
15 ties of a State maternal mortality review committee  
16 under this section, opinions of members of such a  
17 committee formed as a result of such proceedings  
18 and activities, and records obtained, created, or  
19 maintained pursuant to this section, including  
20 records of interviews, written reports, and state-  
21 ments procured by the Department of Health and  
22 Human Services or by any other person, agency, or  
23 organization acting jointly with the Department, in  
24 connection with morbidity and mortality reviews  
25 under this section, shall be confidential, and not sub-

1       ject to discovery, subpoena, or introduction into evi-  
2       dence in any civil, criminal, legislative, or other pro-  
3       ceeding. Such records shall not be open to public in-  
4       spection.

5               “(2) TESTIMONY OF MEMBERS OF COM-  
6       MITTEE.—

7               “(A) IN GENERAL.—Members of a State  
8       maternal mortality review committee under this  
9       section may not be questioned in any civil,  
10      criminal, legislative, or other proceeding regard-  
11      ing information presented in, or opinions  
12      formed as a result of, a meeting or communica-  
13      tion of the committee.

14              “(B) CLARIFICATION.—Nothing in this  
15      subsection shall be construed to prevent a mem-  
16      ber of such a committee from testifying regard-  
17      ing information that was obtained independent  
18      of such member’s participation on the com-  
19      mittee, or that is public information.

20              “(3) AVAILABILITY OF INFORMATION FOR RE-  
21      SEARCH PURPOSES.—Nothing in this subsection  
22      shall prohibit the publishing by such a committee or  
23      the Department of Health and Human Services of  
24      statistical compilations and research reports that—

1           “(A) are based on confidential information,  
2 relating to morbidity and mortality review; and

3           “(B) do not contain identifying informa-  
4 tion or any other information that could be  
5 used to ultimately identify the individuals con-  
6 cerned.

7           “(g) DEFINITIONS.—For purposes of this section:

8           “(1) The term ‘pregnancy-associated death’  
9 means the death of a woman while pregnant or dur-  
10 ing the one-year period following the date of the end  
11 of pregnancy, irrespective of the cause of such death.

12           “(2) The term ‘pregnancy-related death’ means  
13 the death of a woman while pregnant or during the  
14 one-year period following the date of the end of  
15 pregnancy, irrespective of the duration or site of the  
16 pregnancy, from any cause related to or aggravated  
17 by the pregnancy or its management, but not from  
18 any accidental or incidental cause.

19           “(3) The term ‘woman of childbearing age’  
20 means a woman who is at least 10 years of age and  
21 not more than 54 years of age.”.

22           (b) INCLUSION OF FINDINGS OF REVIEW COMMIT-  
23 TEES IN REQUIRED REPORTS.—

24           (1) STATE TRIENNIAL REPORTS.—Paragraph

25           (2) of section 506(a) of such Act (42 U.S.C. 706(a))



1 is amended by inserting after subparagraph (E) the  
2 following new subparagraph:

3 “(F) In the case of a State receiving a  
4 grant under section 514, beginning for the first  
5 fiscal year beginning after 3 years after the  
6 date of establishment of the State maternal  
7 mortality review committee established by the  
8 State pursuant to such grant and once every 3  
9 years thereafter, information containing the  
10 findings and recommendations of such com-  
11 mittee and information on the implementation  
12 of such recommendations during the period in-  
13 volved.”.

14 (2) ANNUAL REPORTS TO CONGRESS.—Para-  
15 graph (3) of such section is amended—

16 (A) in subparagraph (D), at the end, by  
17 striking “and”;

18 (B) in subparagraph (E), at the end, by  
19 striking the period and inserting “; and”; and

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

22 “(F) For fiscal year 2012 and each subse-  
23 quent fiscal year, taking into account the find-  
24 ings, recommendations, and implementation in-  
25 formation submitted by States pursuant to

1 paragraph (2)(F), on the status of pregnancy-  
2 related deaths and pregnancy-associated deaths  
3 in the United States and including rec-  
4 ommendations on methods to prevent such  
5 deaths in the United States.”.

6 **SEC. 506. ELIMINATING DISPARITIES IN MATERNITY**  
7 **HEALTH OUTCOMES.**

8 Part B of title III of the Public Health Service Act  
9 is amended by inserting after section 317V, as added, the  
10 following new section:

11 **“SEC. 317W. ELIMINATING DISPARITIES IN MATERNITY**  
12 **HEALTH OUTCOMES.**

13 “(a) IN GENERAL.—The Secretary shall, in consulta-  
14 tion with relevant national stakeholder organizations, such  
15 as national medical specialty organizations, national ma-  
16 ternal child health organizations, and national health dis-  
17 parity organizations, carry out the following activities to  
18 eliminate disparities in maternal health outcomes:

19 “(1) Conduct research into the determinants  
20 and the distribution of disparities in maternal care,  
21 health risks, and health outcomes, and improve the  
22 capacity of the performance measurement infrastruc-  
23 ture to measure such disparities.

1           “(2) Expand access to services that have been  
2           demonstrated to improve the quality and outcomes  
3           of maternity care for vulnerable populations.

4           “(3) Establish a demonstration project to com-  
5           pare the effectiveness of interventions to reduce dis-  
6           parities in maternity services and outcomes, and im-  
7           plement and assess effective interventions.

8           “(b) SCOPE AND SELECTION OF STATES FOR DEM-  
9           ONSTRATION PROJECT.—The demonstration project  
10          under subsection (a)(3) shall be conducted in no more  
11          than 8 States, which shall be selected by the Secretary  
12          based on—

13           “(1) applications submitted by States, which  
14           specify which regions and populations the State in-  
15           volved will serve under the demonstration project;

16           “(2) criteria designed by the Secretary to en-  
17           sure that, as a whole, the demonstration project is,  
18           to the greatest extent possible, representative of the  
19           demographic and geographic composition of commu-  
20           nities most affected by disparities;

21           “(3) criteria designed by the Secretary to en-  
22           sure that a variety of type of models are tested  
23           through the demonstration project and that such  
24           models include interventions that have an existing  
25           evidence base for effectiveness; and

1           “(4) criteria designed by the Secretary to as-  
2           sure that the demonstration projects and models will  
3           be carried out in consultation with local and regional  
4           provider organizations, such as community health  
5           centers, hospital systems, and medical societies rep-  
6           resenting providers of maternity services.

7           “(c) DURATION OF DEMONSTRATION PROJECT.—  
8           The demonstration project under subsection (a)(3) shall  
9           begin on January 1, 2012, and end on December 31,  
10          2016.

11          “(d) GRANTS FOR EVALUATION AND MONITORING.—  
12          The Secretary may make grants to States and health care  
13          providers participating in the demonstration project under  
14          subsection (a)(3) for the purpose of collecting data nec-  
15          essary for the evaluation and monitoring of such project.

16          “(e) REPORTS.—

17                 “(1) STATE REPORTS.—Each State that par-  
18                 ticipates in the demonstration project under sub-  
19                 section (a)(3) shall report to the Secretary, in a  
20                 time, form, and manner specified by the Secretary,  
21                 the data necessary to—

22                         “(A) monitor the—

23                                 “(i) outcomes of the project;

24                                 “(ii) costs of the project; and

1                   “(iii) quality of maternity care pro-  
2                   vided under the project; and

3                   “(B) evaluate the rationale for the selec-  
4                   tion of the items and services included in any  
5                   bundled payment made by the State under the  
6                   project.

7                   “(2) FINAL REPORT.—Not later than December  
8                   31, 2017, the Secretary shall submit to Congress a  
9                   report on the results of the demonstration project  
10                  under subsection (a)(3).”.

11 **SEC. 507. DECREASING THE RISK FACTORS FOR SUDDEN**  
12                   **UNEXPECTED INFANT DEATH AND SUDDEN**  
13                   **UNEXPLAINED DEATH IN CHILDHOOD.**

14                  (a) ESTABLISHMENT.—The Secretary of Health and  
15                  Human Services acting through the Administrator of the  
16                  Health Resources and Services Administration and in con-  
17                  sultation with the Director of the Centers for Disease Con-  
18                  trol and Prevention and the Director of the National Insti-  
19                  tutes of Health (in this section referred to as the “Sec-  
20                  retary”) shall establish and implement a culturally com-  
21                  petent public health awareness and education campaign  
22                  to provide information that is focused on decreasing the  
23                  risk factors for sudden unexpected infant death and sud-  
24                  den unexplained death in childhood, including educating  
25                  individuals about safe sleep environments, sleep positions,

1 and reducing exposure to smoking during pregnancy and  
2 after birth.

3 (b) TARGETED POPULATIONS.—The campaign under  
4 subsection (a) shall be designed to reduce health dispari-  
5 ties through the targeting of populations with high rates  
6 of sudden unexpected infant death and sudden unex-  
7 plained death in childhood.

8 (c) CONSULTATION.—In establishing and imple-  
9 menting the campaign under subsection (a), the Secretary  
10 shall consult with national organizations representing  
11 health care providers, including nurses and physicians,  
12 parents, child care providers, children’s advocacy and safe-  
13 ty organizations, maternal and child health programs and  
14 women’s, infants, and children nutrition professionals, and  
15 other individuals and groups determined necessary by the  
16 Secretary for such establishment and implementation.

17 (d) GRANTS.—

18 (1) IN GENERAL.—In carrying out the cam-  
19 paign under subsection (a), the Secretary shall  
20 award grants to national organizations, State and  
21 local health departments, and community-based or-  
22 ganizations for the conduct of education and out-  
23 reach programs for nurses, parents, child care pro-  
24 viders, public health agencies, and community orga-  
25 nizations.

1           (2) APPLICATION.—To be eligible to receive a  
 2 grant under paragraph (1), an entity shall submit to  
 3 the Secretary an application at such time, in such  
 4 manner, and containing such information as the Sec-  
 5 retary may require.

6           (e) AUTHORIZATION OF APPROPRIATIONS.—There is  
 7 authorized to be appropriated to carry out this section  
 8 such sums as may be necessary for each of fiscal years  
 9 2012 through 2016.

10 **SEC. 508. REDUCING TEENAGE PREGNANCIES.**

11           Title III of the Public Health Service Act (42 U.S.C.  
 12 241 et seq.) is amended by adding at the end the following  
 13 new part:

14           **“PART W—YOUTH PREGNANCY PREVENTION**  
 15    **PROGRAMS**

16 **“SEC. 3990O. PURPOSE.**

17           “It is the purpose of this part to develop and carry  
 18 out research and demonstration projects on new and exist-  
 19 ing program interventions to provide youth in racial or  
 20 ethnic minority or immigrant communities the information  
 21 and skills needed to reduce teenage pregnancies, build  
 22 healthy relationships, and improve overall health and well-  
 23 being.

1 **“SEC. 39900-1. DEMONSTRATION GRANTS TO REDUCE**  
2 **TEENAGE PREGNANCIES.**

3 “(a) IN GENERAL.—The Secretary shall award com-  
4 petitive grants to eligible entities for establishing or ex-  
5 panding programs to provide youth in racial or ethnic mi-  
6 nority or immigrant communities the information and  
7 skills needed to avoid teenage pregnancy and develop  
8 healthy relationships.

9 “(b) PRIORITY.—In awarding grants under this sec-  
10 tion, the Secretary shall give priority to applicants—

11 “(1) proposing to carry out projects in racial or  
12 ethnic minority or immigrant communities;

13 “(2) that have a demonstrated history of effec-  
14 tively working with such targeted communities; or

15 “(3) that have a demonstrated history of engag-  
16 ing in a meaningful and significant partnership with  
17 such targeted communities.

18 “(c) PROGRAM SETTINGS.—Programs funded  
19 through a grant under subsection (a) shall be provided—

20 “(1) through classroom-based settings, such as  
21 school health education, humanities, language arts,  
22 or family and consumer science education; after-  
23 school programs; community-based programs; work-  
24 force development programs; and health care set-  
25 tings; or



1           “(2) in collaboration with systems that serve  
2           large numbers of at-risk youth such as juvenile jus-  
3           tice or foster care systems.

4           “(d) PROJECT REQUIREMENTS.—As a condition of  
5 receipt of a grant under this section, an entity shall agree  
6 that, with respect to information and skills provided  
7 through the grant—

8           “(1) such information and skills will be—

9                   “(A) age-appropriate;

10                   “(B) evidence-based or evidence-informed;

11                   “(C) provided in accordance with section  
12           39900–5(b); and

13                   “(D) culturally sensitive and relevant to  
14           the target populations; and

15           “(2) any information provided about contracep-  
16           tives shall include the health benefits and side ef-  
17           fects of all contraceptives and barrier methods.

18           “(e) EVALUATION.—Of the total amount made avail-  
19 able to carry out this section for a fiscal year, the Sec-  
20 retary, acting through the Director of the Centers for Dis-  
21 ease Control and Prevention and other agencies as appro-  
22 priate, shall allot up to 10 percent of such amount to carry  
23 out a rigorous, independent evaluation to determine the  
24 extent and the effectiveness of activities funded through  
25 this section during such fiscal year in changing attitudes

1 and behavior of teenagers with respect to healthy relation-  
2 ships and childbearing.

3 “(f) GRANTS FOR INDIAN TRIBES OR TRIBAL ORGA-  
4 NIZATIONS.—Of the total amount made available to carry  
5 out this section for a fiscal year, the Secretary shall re-  
6 serve 5 percent of such amount to award grants under  
7 this section to Indian tribes and tribal organizations in  
8 such manner, and subject to such requirements, as the  
9 Secretary, in consultation with Indian tribes and tribal or-  
10 ganizations, determines appropriate.

11 “(g) ELIGIBLE ENTITY DEFINED.—

12 “(1) IN GENERAL.—In this section, the term  
13 ‘eligible entity’ means a State, local, or tribal agen-  
14 cy; a school or postsecondary institution; an after-  
15 school program; a nonprofit organization; or a com-  
16 munity or faith-based organization.

17 “(2) PREVENTING EXCLUSION OF SMALLER  
18 COMMUNITY-BASED ORGANIZATIONS.—In carrying  
19 out this section, the Secretary shall ensure that the  
20 amounts and requirements of grants provided under  
21 this section do not preclude receipt of such grants  
22 by community-based organizations with a dem-  
23 onstrated history of effectively working with adoles-  
24 cents in racial or ethnic minority or immigrant com-

1 communities or engaged in meaningful and significant  
2 partnership with such communities.

3 **“SEC. 39900-2. MULTIMEDIA CAMPAIGNS TO REDUCE**  
4 **TEENAGE PREGNANCIES.**

5 “(a) IN GENERAL.—The Secretary shall award com-  
6 petitive grants to public and private entities to carry out  
7 multimedia campaigns to provide public education and in-  
8 crease public awareness regarding teenage pregnancy and  
9 related social and emotional issues, such as violence pre-  
10 vention.

11 “(b) PRIORITY.—In awarding grants under this sec-  
12 tion, the Secretary shall give priority to applicants pro-  
13 posing to carry out campaigns developed for racial or eth-  
14 nic minority or immigrant communities.

15 “(c) INFORMATION TO BE PROVIDED.—As a condi-  
16 tion of receipt of a grant under this section, an entity shall  
17 agree to use the grant to carry out multimedia campaigns  
18 described in subsection (a) that—

19 “(1) at a minimum, shall provide information  
20 on—

21 “(A) the prevention of teenage pregnancy;

22 and

23 “(B) healthy relationship development; and

24 “(2) may provide information on the prevention  
25 of dating violence.

1 **“SEC. 39900–3. RESEARCH ON REDUCING TEENAGE PREG-**  
2 **NANCIES AND TEENAGE DATING VIOLENCE**  
3 **AND IMPROVING HEALTHY RELATIONSHIPS.**

4 “(a) IN GENERAL.—The Secretary, acting through  
5 the Director of the Centers for Disease Control and Pre-  
6 vention, shall make grants to public and private entities  
7 to conduct, support, or coordinate research on teenage  
8 pregnancy, dating violence, and healthy relationships  
9 among racial or ethnic minority or immigrant communities  
10 that—

11 “(1) improves data collection on—

12 “(A) sexual and reproductive health, in-  
13 cluding teenage pregnancies and births, among  
14 all minority communities and subpopulations in  
15 which such data are not collected, including  
16 American Indian and Alaska Native youth;

17 “(B) sexual behavior, sexual or reproduc-  
18 tive coercion, and teenage contraceptive use  
19 patterns at the State level, as appropriate; and

20 “(C) teenage pregnancies among youth in  
21 and aging out of foster care or juvenile justice  
22 systems and the underlying factors that lead to  
23 teenage pregnancy among youth in foster care  
24 or juvenile justice systems;

25 “(2) investigates—

1           “(A) the variance in the rates of teenage  
2 pregnancy by—

3           “(i) racial and ethnic group (such as  
4 Hispanic, Asian-American, African-Amer-  
5 ican, Pacific Islander, American Indian,  
6 and Alaska Native); and

7           “(ii) socioeconomic status, including  
8 as based on the income of the family and  
9 education attainment;

10          “(B) factors affecting the risk for youth of  
11 teenage pregnancy or dating abuse, including  
12 the physical and social environment, level of ac-  
13 culturation, access to health care, aspirations  
14 for the future, and history of physical or sexual  
15 violence or abuse;

16          “(C) the role that violence and abuse play  
17 in teenage sex, pregnancy, and childbearing;

18          “(D) strategies to address the dispropor-  
19 tionate rates of teenage pregnancies and dating  
20 violence in racial or ethnic minority or immi-  
21 grant communities;

22          “(E) how effective interventions can be  
23 replicated or adapted in other settings to serve  
24 racial or ethnic minority or immigrant commu-  
25 nities; and

1           “(F) the effectiveness of media campaigns  
2           in addressing healthy relationship development,  
3           dating violence prevention, and teenage preg-  
4           nancy; and

5           “(3) tests research-based strategies for address-  
6           ing high rates of unintended teenage pregnancy  
7           through programs that emphasize healthy relation-  
8           ships and violence prevention.

9           “(b) PRIORITY.—In carrying out this section, the  
10          Secretary shall give priority to research that incor-  
11          porates—

12           “(1) interdisciplinary approaches;

13           “(2) a strong emphasis on community-based  
14          participatory research; or

15           “(3) translational research.

16          **“SEC. 39900-4. HHS ADOLESCENT HEALTH WORK GROUP.**

17           “(a) PURPOSE.—Not later than 30 days after the  
18          date of the enactment of this part, the Secretary shall di-  
19          rect the interagency adolescent health workgroup within  
20          the Office of Adolescent Health of the Department of  
21          Health and Human Services to—

22           “(1) include in the work of the group strategies  
23          for teenage dating violence prevention and healthy  
24          teenage relationships with a particular focus among

1 racial or ethnic minority or immigrant communities;  
2 and

3 “(2) with respect to including such strategies,  
4 consult, to the greatest extent possible, with the  
5 Federal Interagency Workgroup on Teen Dating Vi-  
6 olence formed under the leadership of the National  
7 Institute of Justice of the Department of Justice.

8 “(b) REPORT REQUIREMENT.—The Secretary,  
9 through the Office of Adolescent Health, shall periodically  
10 submit to Congress a report that—

11 “(1) includes a review of the evidence-based  
12 programs on preventing teenage pregnancy, which  
13 are carried out and identified by the Office; and

14 “(2) identifies the programs of the Department  
15 of Health and Human Services that include teenage  
16 dating violence prevention and the promotion of  
17 healthy teenage relationships as part of a strategy to  
18 prevent teenage pregnancy.

19 **“SEC. 39900-5. GENERAL GRANT PROVISIONS.**

20 “(a) APPLICATIONS.—To seek a grant under this  
21 part, an entity shall submit an application to the Secretary  
22 in such form, in such manner, and containing such agree-  
23 ments, assurances, and information as the Secretary may  
24 require.

1       “(b) ADDITIONAL REQUIREMENTS.—A grant may be  
2 made under this part only if the applicant involved agrees  
3 that information, activities, and services provided under  
4 the grant—

5           “(1) will be evidence-based or evidence in-  
6 formed;

7           “(2) will be factually and medically accurate  
8 and complete; and

9           “(3) if directed to a particular population  
10 group, will be provided in an appropriate language  
11 and cultural context.

12       “(c) TRAINING AND TECHNICAL ASSISTANCE.—

13           “(1) IN GENERAL.—Of the total amount made  
14 available to carry out this part for a fiscal year, the  
15 Secretary shall use 10 percent to provide, directly or  
16 through a competitive grant process, training and  
17 technical assistance to the grant recipients under  
18 this part, including by disseminating research and  
19 information regarding effective and promising prac-  
20 tices, providing consultation and resources on a  
21 broad array of teenage and unintended pregnancy  
22 and violence prevention strategies, and developing  
23 resources and materials.

24           “(2) COLLABORATION.—In carrying out this  
25 subsection, the Secretary shall collaborate with enti-



1 ties that have expertise in the prevention of teenage  
2 pregnancy, healthy relationship development, minor-  
3 ity health and health disparities, and violence pre-  
4 vention.

5 **“SEC. 39900-6. DEFINITIONS.**

6 “In this part:

7 “(1) **MEDICALLY ACCURATE AND COMPLETE.**—

8 The term ‘medically accurate and complete’ means,  
9 with respect to information, activities, or services,  
10 verified or supported by the weight of research con-  
11 ducted in compliance with accepted scientific meth-  
12 ods and—

13 “(A) published in peer-reviewed journals,  
14 where applicable; or

15 “(B) comprising information that leading  
16 professional organizations and agencies with  
17 relevant expertise in the field recognize as accu-  
18 rate, objective, and complete.

19 “(2) **RACIAL OR ETHNIC MINORITY OR IMMI-**  
20 **GRANT COMMUNITIES.**—The term ‘racial or ethnic  
21 minority or immigrant communities’ means commu-  
22 nities with a substantial number of residents who  
23 are members of racial or ethnic minority groups or  
24 who are immigrants.

1           “(3) REPRODUCTIVE COERCION.—The term ‘re-  
2           productive coercion’ means, with respect to a person,  
3           coercive behavior that interferes with the ability of  
4           such person to control the reproductive decision-  
5           making of such person, such as intentionally expos-  
6           ing such person to sexually transmitted infections; in  
7           the case such person is a female, attempting to im-  
8           pregnate such person against her will; intentionally  
9           interfering with the person’s birth control; or threat-  
10          ening or acting violent if the person does not comply  
11          with the perpetrator’s wishes regarding contracep-  
12          tion or the decision whether to terminate or continue  
13          a pregnancy.

14           “(4) YOUTH.—The term ‘youth’ means individ-  
15          uals who are 11 to 19 years of age.

16   **“SEC. 39900-7. REPORTS.**

17           “(a) REPORT ON USE OF FUNDS.—Not later than  
18          1 year after the date of the enactment of this part, the  
19          Secretary shall submit to Congress a report on the use  
20          of funds provided pursuant to this part.

21           “(b) REPORT ON IMPACT OF PROGRAMS.—Not later  
22          than March 1, 2016, the Secretary shall submit to Con-  
23          gress a report on the impact that the programs under this  
24          part had on reducing teenage pregnancies.

1 **“SEC. 39900–8. AUTHORIZATION OF APPROPRIATIONS.**

2 “(a) IN GENERAL.—There are authorized to be ap-  
3 propriated to carry out this part such sums as may be  
4 necessary for each of the fiscal years 2012 through 2016.

5 “(b) AVAILABILITY.—Amounts appropriated pursu-  
6 ant to subsection (a)—

7 “(1) are authorized to remain available until ex-  
8 pended; and

9 “(2) are in addition to amounts otherwise made  
10 available for such purposes.”.

11 **SEC. 509. GESTATIONAL DIABETES.**

12 Part B of title III of the Public Health Service Act  
13 (42 U.S.C. 243 et seq.) is amended by adding after section  
14 317H the following:

15 **“SEC. 317H–1. GESTATIONAL DIABETES.**

16 “(a) UNDERSTANDING AND MONITORING GESTA-  
17 TIONAL DIABETES.—

18 “(1) IN GENERAL.—The Secretary, acting  
19 through the Director of the Centers for Disease  
20 Control and Prevention, in consultation with the Di-  
21 abetes Mellitus Interagency Coordinating Committee  
22 established under section 429 and representatives of  
23 appropriate national health organizations, shall de-  
24 velop a multisite gestational diabetes research  
25 project within the diabetes program of the Centers  
26 for Disease Control and Prevention to expand and

1 enhance surveillance data and public health research  
2 on gestational diabetes.

3 “(2) AREAS TO BE ADDRESSED.—The research  
4 project developed under paragraph (1) shall ad-  
5 dress—

6 “(A) procedures to establish accurate and  
7 efficient systems for the collection of gestational  
8 diabetes data within each State and common-  
9 wealth, territory, or possession of the United  
10 States;

11 “(B) the progress of collaborative activities  
12 with the National Vital Statistics System, the  
13 National Center for Health Statistics, and  
14 State health departments with respect to the  
15 standard birth certificate, in order to improve  
16 surveillance of gestational diabetes;

17 “(C) postpartum methods of tracking  
18 women with gestational diabetes after delivery  
19 as well as targeted interventions proven to  
20 lower the incidence of type 2 diabetes in that  
21 population;

22 “(D) variations in the distribution of diag-  
23 nosed and undiagnosed gestational diabetes,  
24 and of impaired fasting glucose tolerance and

1           impaired fasting glucose, within and among  
2           groups of women; and

3           “(E) factors and culturally sensitive inter-  
4           ventions that influence risks and reduce the in-  
5           cidence of gestational diabetes and related com-  
6           plications during childbirth, including cultural,  
7           behavioral, racial, ethnic, geographic, demo-  
8           graphic, socioeconomic, and genetic factors.

9           “(3) REPORT.—Not later than 2 years after the  
10          date of the enactment of this section, and annually  
11          thereafter, the Secretary shall generate a report on  
12          the findings and recommendations of the research  
13          project including prevalence of gestational diabetes  
14          in the multisite area and disseminate the report to  
15          the appropriate Federal and non-Federal agencies.

16          “(b) EXPANSION OF GESTATIONAL DIABETES RE-  
17          SEARCH.—

18                 “(1) IN GENERAL.—The Secretary shall expand  
19                 and intensify public health research regarding gesta-  
20                 tional diabetes. Such research may include—

21                         “(A) developing and testing novel ap-  
22                         proaches for improving postpartum diabetes  
23                         testing or screening and for preventing type 2  
24                         diabetes in women with a history of gestational  
25                         diabetes; and

1           “(B) conducting public health research to  
2           further understanding of the epidemiologic,  
3           socioenvironmental, behavioral, translation, and  
4           biomedical factors and health systems that in-  
5           fluence the risk of gestational diabetes and the  
6           development of type 2 diabetes in women with  
7           a history of gestational diabetes.

8           “(2) AUTHORIZATION OF APPROPRIATIONS.—  
9           There is authorized to be appropriated to carry out  
10          this subsection \$5,000,000 for each of fiscal years  
11          2012 through 2016.

12          “(c) DEMONSTRATION GRANTS TO LOWER THE  
13          RATE OF GESTATIONAL DIABETES.—

14                 “(1) IN GENERAL.—The Secretary, acting  
15                 through the Director of the Centers for Disease  
16                 Control and Prevention, shall award grants, on a  
17                 competitive basis, to eligible entities for demonstra-  
18                 tion projects that implement evidence-based inter-  
19                 ventions to reduce the incidence of gestational diabe-  
20                 tes, the recurrence of gestational diabetes in subse-  
21                 quent pregnancies, and the development of type 2 di-  
22                 abetes in women with a history of gestational diabe-  
23                 tes.

1           “(2) PRIORITY.—In making grants under this  
2 subsection, the Secretary shall give priority to  
3 projects focusing on—

4           “(A) helping women who have 1 or more  
5 risk factors for developing gestational diabetes;

6           “(B) working with women with a history of  
7 gestational diabetes during a previous preg-  
8 nancy;

9           “(C) providing postpartum care for women  
10 with gestational diabetes;

11           “(D) tracking cases where women with a  
12 history of gestational diabetes developed type 2  
13 diabetes;

14           “(E) educating mothers with a history of  
15 gestational diabetes about the increased risk of  
16 their child developing diabetes;

17           “(F) working to prevent gestational diabe-  
18 tes and prevent or delay the development of  
19 type 2 diabetes in women with a history of ges-  
20 tational diabetes; and

21           “(G) achieving outcomes designed to assess  
22 the efficacy and cost-effectiveness of interven-  
23 tions that can inform decisions on long-term  
24 sustainability, including third-party reimburse-  
25 ment.

1           “(3) APPLICATION.—An eligible entity desiring  
2           to receive a grant under this subsection shall submit  
3           to the Secretary—

4                   “(A) an application at such time, in such  
5                   manner, and containing such information as the  
6                   Secretary may require; and

7                   “(B) a plan to—

8                           “(i) lower the rate of gestational dia-  
9                           betes during pregnancy; or

10                           “(ii) develop methods of tracking  
11                           women with a history of gestational diabe-  
12                           tes and develop effective interventions to  
13                           lower the incidence of the recurrence of  
14                           gestational diabetes in subsequent preg-  
15                           nancies and the development of type 2 dia-  
16                           betes.

17           “(4) USES OF FUNDS.—An eligible entity re-  
18           ceiving a grant under this subsection shall use the  
19           grant funds to carry out demonstration projects de-  
20           scribed in paragraph (1), including—

21                   “(A) expanding community-based health  
22                   promotion education, activities, and incentives  
23                   focused on the prevention of gestational diabe-  
24                   tes and development of type 2 diabetes in  
25                   women with a history of gestational diabetes;



1           “(B) aiding State- and tribal-based diabe-  
2           tes prevention and control programs to collect,  
3           analyze, disseminate, and report surveillance  
4           data on women with, and at risk for, gesta-  
5           tional diabetes, the recurrence of gestational di-  
6           abetes in subsequent pregnancies, and, for  
7           women with a history of gestational diabetes,  
8           the development of type 2 diabetes; and

9           “(C) training and encouraging health care  
10          providers—

11               “(i) to promote risk assessment, high-  
12               quality care, and self-management for ges-  
13               tational diabetes and the recurrence of ges-  
14               tational diabetes in subsequent preg-  
15               nancies; and

16               “(ii) to prevent the development of  
17               type 2 diabetes in women with a history of  
18               gestational diabetes, and its complications  
19               in the practice settings of the health care  
20               providers.

21           “(5) REPORT.—Not later than 4 years after the  
22           date of the enactment of this section, the Secretary  
23           shall prepare and submit to the Congress a report  
24           concerning the results of the demonstration projects

1 conducted through the grants awarded under this  
2 subsection.

3 “(6) DEFINITION OF ELIGIBLE ENTITY.—In  
4 this subsection, the term ‘eligible entity’ means a  
5 nonprofit organization (such as a nonprofit academic  
6 center or community health center) or a State, trib-  
7 al, or local health agency.

8 “(7) AUTHORIZATION OF APPROPRIATIONS.—  
9 There is authorized to be appropriated to carry out  
10 this subsection \$5,000,000 for each of fiscal years  
11 2012 through 2016.

12 “(d) POSTPARTUM FOLLOW-UP REGARDING GESTA-  
13 TIONAL DIABETES.—The Secretary, acting through the  
14 Director of the Centers for Disease Control and Preven-  
15 tion, shall work with the State- and tribal-based diabetes  
16 prevention and control programs assisted by the Centers  
17 to encourage postpartum follow-up after gestational diabe-  
18 tes, as medically appropriate, for the purpose of reducing  
19 the incidence of gestational diabetes, the recurrence of  
20 gestational diabetes in subsequent pregnancies, the devel-  
21 opment of type 2 diabetes in women with a history of ges-  
22 tational diabetes, and related complications.”.

1 **SEC. 510. EMERGENCY CONTRACEPTION EDUCATION AND**  
2 **INFORMATION PROGRAMS.**

3 (a) EMERGENCY CONTRACEPTION PUBLIC EDU-  
4 CATION PROGRAM.—

5 (1) IN GENERAL.—The Secretary, acting  
6 through the Director of the Centers for Disease  
7 Control and Prevention, shall develop and dissemi-  
8 nate to the public information on emergency contra-  
9 ception.

10 (2) DISSEMINATION.—The Secretary may dis-  
11 seminate information under paragraph (1) directly  
12 or through arrangements with nonprofit organiza-  
13 tions, consumer groups, institutions of higher edu-  
14 cation, clinics, the media, and Federal, State, and  
15 local agencies.

16 (3) INFORMATION.—The information dissemi-  
17 nated under paragraph (1) shall include, at a min-  
18 imum, a description of emergency contraception and  
19 an explanation of the use, safety, efficacy, and avail-  
20 ability of such contraception.

21 (b) EMERGENCY CONTRACEPTION INFORMATION  
22 PROGRAM FOR HEALTH CARE PROVIDERS.—

23 (1) IN GENERAL.—The Secretary, acting  
24 through the Administrator of the Health Resources  
25 and Services Administration and in consultation  
26 with major medical and public health organizations,

1 shall develop and disseminate to health care pro-  
2 viders information on emergency contraception.

3 (2) INFORMATION.—The information dissemi-  
4 nated under paragraph (1) shall include, at a min-  
5 imum—

6 (A) information describing the use, safety,  
7 efficacy, and availability of emergency contra-  
8 ception;

9 (B) a recommendation regarding the use of  
10 such contraception in appropriate cases; and

11 (C) information explaining how to obtain  
12 copies of the information developed under sub-  
13 section (a) for distribution to the patients of  
14 the providers.

15 (c) DEFINITIONS.—In this section:

16 (1) EMERGENCY CONTRACEPTION.—The term  
17 “emergency contraception” means a drug or device  
18 (as the terms are defined in section 201 of the Fed-  
19 eral Food, Drug, and Cosmetic Act (21 U.S.C. 321))  
20 or a drug regimen that—

21 (A) is used postcoitally;

22 (B) prevents pregnancy primarily by pre-  
23 venting or delaying ovulation, and does not ter-  
24 minate an established pregnancy; and

1 (C) is approved by the Food and Drug Ad-  
2 ministration.

3 (2) HEALTH CARE PROVIDER.—The term  
4 “health care provider” means an individual who is li-  
5 censed or certified under State law to provide health  
6 care services and who is operating within the scope  
7 of such license. Such term shall include a phar-  
8 macist.

9 (3) INSTITUTION OF HIGHER EDUCATION.—The  
10 term “institution of higher education” has the same  
11 meaning given such term in section 101(a) of the  
12 Higher Education Act of 1965 (20 U.S.C. 1001(a)).

13 (4) SECRETARY.—The term “Secretary” means  
14 the Secretary of Health and Human Services.

15 (d) AUTHORIZATION OF APPROPRIATIONS.—There  
16 are authorized to be appropriated to carry out this section  
17 such sums as may be necessary for each of the fiscal years  
18 2012 through 2016.

19 **SEC. 511. SUPPORTING HEALTHY ADOLESCENT DEVELOP-**  
20 **MENT.**

21 (a) IN GENERAL.—The Secretary may award a grant  
22 to each eligible State to conduct programs of sex education  
23 described in subsection (b), including education on both  
24 abstinence and contraception for the prevention of teenage

1 pregnancy and sexually transmitted diseases, including  
2 HIV/AIDS.

3 (b) REQUIREMENTS FOR SEX EDUCATION PRO-  
4 GRAMS.—A program of sex education described in this  
5 subsection is a program that—

6 (1) is age appropriate and medically accurate;

7 (2) stresses the value of abstinence while not ig-  
8 noring those young people who have been or are sex-  
9 ually active;

10 (3) provides information about the health bene-  
11 fits and side effects of contraceptive and barrier  
12 methods used—

13 (A) as a means to prevent pregnancy; and

14 (B) to reduce the risk of contracting sexu-  
15 ally transmitted disease, including HIV/AIDS;

16 (4) encourages family communication between  
17 parent and child about sexuality;

18 (5) cultivates a respectful dialogue about sexu-  
19 ality, including sexual orientation and gender iden-  
20 tity, and embraces the principles of nondiscrimina-  
21 tion based on sexual orientation and gender identity;

22 (6) counters the perpetuation of narrow gender  
23 roles, including the sexualization of female children,  
24 adolescents, and adults;

1           (7) teaches young people the skills to make re-  
2           sponsible decisions about sexuality, including how to  
3           avoid unwanted verbal, physical, and sexual ad-  
4           vances and how to avoid making verbal, physical,  
5           and sexual advances that are not wanted by the  
6           other party;

7           (8) develops healthy relationships, including the  
8           prevention of dating and sexual violence;

9           (9) teaches young people how alcohol and drug  
10          use can affect responsible decisionmaking; and

11          (10) does not teach or promote religion.

12          (c) **ADDITIONAL ACTIVITIES.**—In carrying out a pro-  
13          gram of sex education, a State may expend grant funds  
14          awarded under subsection (a) to carry out educational and  
15          motivational activities that help young people—

16               (1) gain knowledge about the physical, emo-  
17               tional, biological, and hormonal changes of adoles-  
18               cence and subsequent stages of human maturation;

19               (2) develop the knowledge and skills necessary  
20               to ensure and protect their sexual and reproductive  
21               health from unintended pregnancy and sexually  
22               transmitted disease, including HIV/AIDS, through-  
23               out their lifespan;

1           (3) gain knowledge about the specific involve-  
2           ment and responsibility of each individual in sexual  
3           decisionmaking;

4           (4) develop healthy attitudes and values about  
5           adolescent growth and development, body image,  
6           gender roles, racial and ethnic diversity, sexual ori-  
7           entation and gender identity, and other subjects;

8           (5) develop and practice healthy life skills in-  
9           cluding goal-setting, decisionmaking, negotiation,  
10          communication, and stress management; and

11          (6) promote self-esteem and positive inter-  
12          personal skills focusing on relationship dynamics, in-  
13          cluding friendships, dating, romantic involvement,  
14          marriage, and family interactions.

15          (d) MATCHING FUNDS.—The Secretary may not  
16          make payments to a State under this section in an amount  
17          exceeding Federal medical assistance percentage for such  
18          State (as such term is defined in section 1905(b) of the  
19          Social Security Act (42 U.S.C. 1396d(b))) of the costs of  
20          the programs conducted by the State under this section.

21          (e) EVALUATION OF PROGRAMS.—

22                 (1) IN GENERAL.—For the purpose of evalu-  
23                 ating the effectiveness of programs of sex education  
24                 carried out with a grant under this section, evalua-



1 tions shall be carried out in accordance with para-  
2 graphs (2) and (3).

3 (2) NATIONAL EVALUATION.—

4 (A) METHOD.—The Secretary shall pro-  
5 vide for a national evaluation of a representa-  
6 tive sample of programs of sex education car-  
7 ried out with grants under this section to deter-  
8 mine—

9 (i) the effectiveness of such programs  
10 in helping to delay the initiation of sexual  
11 intercourse and other high-risk behaviors;

12 (ii) the effectiveness of such programs  
13 in preventing adolescent pregnancy;

14 (iii) the effectiveness of such pro-  
15 grams in preventing sexually transmitted  
16 disease, including HIV/AIDS;

17 (iv) the effectiveness of such programs  
18 in increasing contraceptive knowledge and  
19 contraceptive behaviors when sexual inter-  
20 course occurs; and

21 (v) a list of best practices based upon  
22 essential programmatic components of  
23 evaluated programs that have led to suc-  
24 cess described in clauses (i) through (iv).

1 (B) GRANT CONDITION.—A condition for  
2 the receipt of a grant to a State under this sec-  
3 tion is that the State cooperate with the evalua-  
4 tion under subparagraph (A).

5 (C) REPORT.—The Secretary shall submit  
6 to the Congress—

7 (i) not later than the end of each fis-  
8 cal year during the 5-year period beginning  
9 with fiscal year 2012, an interim report on  
10 the national evaluation under subpara-  
11 graph (A); and

12 (ii) not later than March 31, 2017, a  
13 final report providing the results of such  
14 national evaluation.

15 (3) INDIVIDUAL STATE EVALUATIONS.—A con-  
16 dition for the receipt of a grant under this section  
17 is that the State evaluate of the programs of sex  
18 education funded through such grant in accordance  
19 with the following requirements:

20 (A) The evaluation will be conducted by an  
21 external, independent entity.

22 (B) The purposes of the evaluation will be  
23 the determination of—

1 (i) the effectiveness of such programs  
2 in helping to delay the initiation of sexual  
3 intercourse and other high-risk behaviors;

4 (ii) the effectiveness of such programs  
5 in preventing adolescent pregnancy;

6 (iii) the effectiveness of such pro-  
7 grams in preventing sexually transmitted  
8 disease, including HIV/AIDS; and

9 (iv) the effectiveness of such programs  
10 in increasing contraceptive and barrier  
11 method knowledge and contraceptive be-  
12 haviors when sexual intercourse occurs.

13 (f) LIMITATIONS ON USE OF FUNDS.—

14 (1) LIMITATIONS ON SECRETARY.—Of the  
15 amounts appropriated for a fiscal year for purposes  
16 of this section, the Secretary may not use more  
17 than—

18 (A) 7 percent of such amounts for admin-  
19 istrative expenses related to carrying out this  
20 section for that fiscal year; and

21 (B) 10 percent of such amounts for the  
22 national evaluation under subsection (e)(2).

23 (2) LIMITATIONS TO STATES.—Of amounts pro-  
24 vided to an eligible State under this subsection, the  
25 State may not use more than 10 percent of the

1 grant to conduct any evaluation under subsection  
2 (e)(3).

3 (g) NONDISCRIMINATION REQUIRED.—Programs  
4 funded under this section shall not discriminate on the  
5 basis of sex, race, ethnicity, national origin, disability, reli-  
6 gion, marital status, familial status, sexual orientation, or  
7 gender identity. Nothing in this section shall be construed  
8 to invalidate or limit rights, remedies, procedures, or legal  
9 standards available to victims of discrimination under any  
10 other Federal law or any law of a State or a political sub-  
11 division of a State, including title VI of the Civil Rights  
12 Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the  
13 Education Amendments of 1972 (20 U.S.C. 1681 et seq.),  
14 section 504 of the Rehabilitation Act of 1973 (29 U.S.C.  
15 794), and the Americans with Disabilities Act of 1990 (42  
16 U.S.C. 12101 et seq.).

17 (h) DEFINITIONS.—For purposes of this section:

18 (1) The term “age appropriate” means, with re-  
19 spect to topics, messages, and teaching methods,  
20 those suitable to particular ages or age groups of  
21 children, adolescents, and adults, based on devel-  
22 oping cognitive, emotional, and behavioral capacity  
23 typical for the age or age group.

24 (2) The term “eligible State” means a State  
25 that submits to the Secretary an application for a

1 grant under this section that is in such form, is  
2 made in such manner, and contains such agree-  
3 ments, assurances, and information as the Secretary  
4 determines to be necessary to carry out this section.

5 (3) The term “HIV/AIDS” means the human  
6 immunodeficiency virus, and includes acquired im-  
7 mune deficiency syndrome.

8 (4) The term “medically accurate”, with respect  
9 to information, means information that is supported  
10 by research, recognized as accurate and objective by  
11 leading medical, psychological, psychiatric, and pub-  
12 lic health organizations and agencies, and, published  
13 in journals that are peer reviewed.

14 (5) The term “State” means the 50 States, the  
15 District of Columbia, the Commonwealth of Puerto  
16 Rico, the Commonwealth of the Northern Mariana  
17 Islands, American Samoa, Guam, the United States  
18 Virgin Islands, and any other territory or possession  
19 of the United States.

20 (i) AUTHORIZATION OF APPROPRIATIONS.—For the  
21 purpose of carrying out this section, there is authorized  
22 to be appropriated \$50,000,000 for each of the fiscal years  
23 2012 through 2016.

**TITLE VI—MENTAL HEALTH****SEC. 601. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES UNDER PART B OF THE MEDICARE PROGRAM.**

(a) COVERAGE OF SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (EE), by striking

“and” at the end;

(B) in subparagraph (FF), by inserting

“and” at the end; and

(C) by adding at the end the following new

subparagraph:

“(GG) marriage and family therapist services

(as defined in subsection (kkk)(1)) and mental

health counselor services (as defined in subsection

(kkk)(3));”.

(2) DEFINITIONS.—Section 1861 of such Act

(42 U.S.C. 1395x), as amended by sections

202(b)(1)(A) and 423(a), is amended by adding at

the end the following new subsection:

1 “Marriage and Family Therapist Services; Marriage and  
2 Family Therapist; Mental Health Counselor Serv-  
3 ices; Mental Health Counselor

4 “(kkk)(1) The term ‘marriage and family therapist  
5 services’ means services performed by a marriage and  
6 family therapist (as defined in paragraph (2)) for the diag-  
7 nosis and treatment of mental illnesses, which the mar-  
8 riage and family therapist is legally authorized to perform  
9 under State law (or the State regulatory mechanism pro-  
10 vided by State law) of the State in which such services  
11 are performed, as would otherwise be covered if furnished  
12 by a physician or as an incident to a physician’s profes-  
13 sional service, but only if no facility or other provider  
14 charges or is paid any amounts with respect to the fur-  
15 nishing of such services.

16 “(2) The term ‘marriage and family therapist’ means  
17 an individual who—

18 “(A) possesses a master’s or doctoral degree  
19 which qualifies for licensure or certification as a  
20 marriage and family therapist pursuant to State  
21 law;

22 “(B) after obtaining such degree has performed  
23 at least 2 years of clinical supervised experience in  
24 marriage and family therapy; and

1           “(C) in the case of an individual performing  
2           services in a State that provides for licensure or cer-  
3           tification of marriage and family therapists, is li-  
4           censed or certified as a marriage and family thera-  
5           pist in such State.

6           “(3) The term ‘mental health counselor services’  
7           means services performed by a mental health counselor (as  
8           defined in paragraph (4)) for the diagnosis and treatment  
9           of mental illnesses which the mental health counselor is  
10          legally authorized to perform under State law (or the  
11          State regulatory mechanism provided by the State law) of  
12          the State in which such services are performed, as would  
13          otherwise be covered if furnished by a physician or as inci-  
14          dent to a physician’s professional service, but only if no  
15          facility or other provider charges or is paid any amounts  
16          with respect to the furnishing of such services.

17          “(4) The term ‘mental health counselor’ means an  
18          individual who—

19                 “(A) possesses a master’s or doctor’s degree in  
20                 mental health counseling or a related field;

21                 “(B) after obtaining such a degree has per-  
22                 formed at least 2 years of supervised mental health  
23                 counselor practice; and

24                 “(C) in the case of an individual performing  
25                 services in a State that provides for licensure or cer-



1 tification of mental health counselors or professional  
2 counselors, is licensed or certified as a mental health  
3 counselor or professional counselor in such State.”.

4 (3) PROVISION FOR PAYMENT UNDER PART  
5 B.—Section 1832(a)(2)(B) of such Act (42 U.S.C.  
6 1395k(a)(2)(B)) is amended by adding at the end  
7 the following new clause:

8 “(v) marriage and family therapist  
9 services and mental health counselor serv-  
10 ices;”.

11 (4) AMOUNT OF PAYMENT.—Section 1833(a)(1)  
12 of such Act (42 U.S.C. 1395l(a)(1)) is amended—

13 (A) by striking “and (Z)” and inserting  
14 “(Z)”; and

15 (B) by inserting before the semicolon at  
16 the end the following: “, and (AA) with respect  
17 to marriage and family therapist services and  
18 mental health counselor services under section  
19 1861(s)(2)(GG), the amounts paid shall be 80  
20 percent of the lesser of the actual charge for  
21 the services or 75 percent of the amount deter-  
22 mined for payment of a psychologist under sub-  
23 paragraph (L)”.

24 (5) EXCLUSION OF MARRIAGE AND FAMILY  
25 THERAPIST SERVICES AND MENTAL HEALTH COUN-

1 SELOR SERVICES FROM SKILLED NURSING FACILITY  
2 PROSPECTIVE PAYMENT SYSTEM.—Section  
3 1888(e)(2)(A)(ii) of such Act (42 U.S.C.  
4 1395yy(e)(2)(A)(ii)) is amended by inserting “mar-  
5 riage and family therapist services (as defined in  
6 section 1861(kkk)(1)), mental health counselor serv-  
7 ices (as defined in section 1861(kkk)(3)),” after  
8 “qualified psychologist services.”

9 (6) INCLUSION OF MARRIAGE AND FAMILY  
10 THERAPISTS AND MENTAL HEALTH COUNSELORS AS  
11 PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Sec-  
12 tion 1842(b)(18)(C) of such Act (42 U.S.C.  
13 1395u(b)(18)(C)) is amended by adding at the end  
14 the following new clauses:

15 “(vii) A marriage and family therapist (as de-  
16 fined in section 1861(kkk)(2)).

17 “(viii) A mental health counselor (as defined in  
18 section 1861(kkk)(4)).”

19 (b) COVERAGE OF CERTAIN MENTAL HEALTH SERV-  
20 ICES PROVIDED IN CERTAIN SETTINGS.—

21 (1) RURAL HEALTH CLINICS AND FEDERALLY  
22 QUALIFIED HEALTH CENTERS.—Section  
23 1861(aa)(1)(B) of the Social Security Act (42  
24 U.S.C. 1395x(aa)(1)(B)) is amended by striking “or  
25 by a clinical social worker (as defined in subsection

1 (hh)(1)),” and inserting “, by a clinical social worker  
2 (as defined in subsection (hh)(1)), by a marriage  
3 and family therapist (as defined in subsection  
4 (kkk)(2)), or by a mental health counselor (as de-  
5 fined in subsection (kkk)(4)),”.

6 (2) HOSPICE PROGRAMS.—Section  
7 1861(dd)(2)(B)(i)(III) of such Act (42 U.S.C.  
8 1395x(dd)(2)(B)(i)(III)) is amended by inserting “or  
9 one marriage and family therapist (as defined in  
10 subsection (kkk)(2))” after “social worker”.

11 (c) AUTHORIZATION OF MARRIAGE AND FAMILY  
12 THERAPISTS TO DEVELOP DISCHARGE PLANS FOR POST-  
13 HOSPITAL SERVICES.—Section 1861(ee)(2)(G) of the So-  
14 cial Security Act (42 U.S.C. 1395x(ee)(2)(G)) is amended  
15 by inserting “marriage and family therapist (as defined  
16 in subsection (kkk)(2)),” after “social worker,”.

17 (d) EFFECTIVE DATE.—The amendments made by  
18 this section shall apply with respect to services furnished  
19 on or after January 1, 2012.

20 **SEC. 602. COMMUNITY MENTAL HEALTH AND ADDICTION**  
21 **SAFETY NET EQUITY ACT.**

22 (a) FEDERALLY QUALIFIED BEHAVIORAL HEALTH  
23 CENTERS.—Section 1913 of the Public Health Service Act  
24 (42 U.S.C. 300x-3) is amended—

1           (1) in subsection (a)(2)(A), by striking “com-  
2           munity mental health services” and inserting “be-  
3           havioral health services (of the type offered by feder-  
4           ally qualified behavioral health centers consistent  
5           with subsection (c)(3))”;

6           (2) in subsection (b)—

7                   (A) by striking paragraph (1) and insert-  
8           ing the following:

9           “(1) services under the plan will be provided  
10          only through appropriate, qualified community pro-  
11          grams (which may include federally qualified behav-  
12          ioral health centers, child mental health programs,  
13          psychosocial rehabilitation programs, mental health  
14          peer-support programs, and mental health primary  
15          consumer-directed programs); and”;

16                   (B) in paragraph (2), by striking “commu-  
17          nity mental health centers” and inserting “fed-  
18          erally qualified behavioral health centers”; and

19          (3) by striking subsection (c) and inserting the  
20          following:

21          “(c) CRITERIA FOR FEDERALLY QUALIFIED BEHAV-  
22          IORAL HEALTH CENTERS.—

23                   “(1) IN GENERAL.—The Administrator shall  
24          certify, and recertify at least every 5 years, federally

1 qualified behavioral health centers as meeting the  
2 criteria specified in this subsection.

3 “(2) REGULATIONS.—Not later than 18 months  
4 after the date of the enactment of this section, the  
5 Administrator shall issue final regulations for certi-  
6 fying nonprofit or local government centers as cen-  
7 ters under paragraph (1).

8 “(3) CRITERIA.—The criteria referred to in  
9 subsection (b)(2) are that the center performs each  
10 of the following:

11 “(A) Provide services in locations that en-  
12 sure services will be promptly available, be  
13 physically accessible, provide reasonable policy  
14 modifications, and be provided in a manner  
15 which preserves human dignity and assures con-  
16 tinuity of care.

17 “(B) Provide services in a mode of service  
18 delivery appropriate for the target population.

19 “(C) Provide individuals with a choice of  
20 service options where there is more than one ef-  
21 ficacious treatment.

22 “(D) Employ a core staff of clinical staff  
23 that is multidisciplinary and culturally and lin-  
24 guistically competent.

1           “(E) Provide services, within the limits of  
2 the capacities of the center, to any individual  
3 residing or employed in the service area of the  
4 center, regardless of the ability of the individual  
5 to pay.

6           “(F) Provide, directly or through contract,  
7 to the extent covered for adults in the State  
8 Medicaid plan under title XIX of the Social Se-  
9 curity Act and for children in accordance with  
10 section 1905(r) of such Act regarding early and  
11 periodic screening, diagnosis, and treatment,  
12 each of the following services:

13                 “(i) Screening, assessment, and diag-  
14 nosis, including risk assessment.

15                 “(ii) Person-centered treatment plan-  
16 ning or similar processes, including risk as-  
17 sessment and crisis planning.

18                 “(iii) Outpatient clinic mental health  
19 services, including screening, assessment,  
20 diagnosis, psychotherapy, substance abuse  
21 counseling, medication management, and  
22 integrated treatment for mental illness and  
23 substance abuse which shall be evidence-  
24 based (including cognitive behavioral ther-

1 apy and other such therapies which are  
2 evidence-based).

3 “(iv) Outpatient clinic primary care  
4 services, including screening and moni-  
5 toring of key health indicators and health  
6 risk (including screening for diabetes, hy-  
7 pertension, and cardiovascular disease and  
8 monitoring of weight, height, body mass  
9 index (BMI), blood pressure, blood glucose  
10 or HbA1C, and lipid profile).

11 “(v) Crisis mental health services, in-  
12 cluding 24-hour mobile crisis teams, emer-  
13 gency crisis intervention services, and cri-  
14 sis stabilization.

15 “(vi) Targeted case management  
16 (services to assist individuals gaining ac-  
17 cess to needed medical, social, educational,  
18 and other home- and community-based  
19 services and applying for income security  
20 and other benefits to which they may be  
21 entitled).

22 “(vii) Psychiatric rehabilitation serv-  
23 ices including skills training, assertive com-  
24 munity treatment, family psychoeducation,  
25 disability self-management, supported em-

1           employment, supported housing services,  
2           therapeutic foster care services, and such  
3           other evidence-based practices as the Sec-  
4           retary may require.

5           “(viii) Peer support and counselor  
6           services and family supports.

7           “(G) Maintain linkages, and where possible  
8           enter into formal contracts with the following:

9           “(i) Inpatient psychiatric facilities and  
10          substance abuse detoxification and residen-  
11          tial programs.

12          “(ii) Adult and youth peer support  
13          and counselor services.

14          “(iii) Family support services for fam-  
15          ilies of children with serious mental dis-  
16          orders.

17          “(iv) Other home- and community-  
18          based or regional services, supports, and  
19          providers, including schools, child welfare  
20          agencies, juvenile and criminal justice  
21          agencies and facilities, housing agencies  
22          and programs, employers, and other social  
23          services.

24          “(v) Onsite or offsite access to pri-  
25          mary care services.



1 “(vi) Enabling services, including out-  
2 reach, transportation, and translation.

3 “(vii) Health and wellness services, in-  
4 cluding services for tobacco cessation.”.

5 (b) MEDICAID COVERAGE AND PAYMENT FOR FED-  
6 ERALLY QUALIFIED BEHAVIORAL HEALTH CENTER  
7 SERVICES.—

8 (1) PAYMENT FOR SERVICES PROVIDED BY  
9 FEDERALLY QUALIFIED BEHAVIORAL HEALTH CEN-  
10 TERS.—Section 1902(bb) of the Social Security Act  
11 (42 U.S.C. 1396a(bb)) is amended—

12 (A) in the heading, by striking “AND  
13 RURAL HEALTH CLINICS” and inserting “,  
14 FEDERALLY QUALIFIED BEHAVIORAL HEALTH  
15 CENTERS, AND RURAL HEALTH CLINICS”;

16 (B) in paragraph (1), by inserting “(and  
17 beginning with fiscal year 2012 with respect to  
18 services furnished on or after January 1, 2012,  
19 and each succeeding fiscal year, for services de-  
20 scribed in section 1905(a)(2)(D) furnished by a  
21 federally qualified behavioral health center)”  
22 after “by a rural health clinic”;

23 (C) in paragraph (2)—

24 (i) by striking the heading and insert-  
25 ing “INITIAL FISCAL YEAR”;

1           (ii) by inserting “(or, in the case of  
2           services described in section 1905(a)(2)(D)  
3           furnished by a federally qualified behav-  
4           ioral health center, for services furnished  
5           on and after January 1, 2012, during fis-  
6           cal year 2012)” after “January 1, 2001,  
7           during fiscal year 2001”;

8           (iii) by inserting “(or, in the case of  
9           services described in section 1905(a)(2)(D)  
10          furnished by a federally qualified behav-  
11          ioral health center, during fiscal years  
12          2010 and 2011)” after “1999 and 2000”;  
13          and

14          (iv) by inserting “(or, in the case of  
15          services described in section 1905(a)(2)(D)  
16          furnished by a federally qualified behav-  
17          ioral health center, during fiscal year  
18          2012)” before the period;

19          (D) in paragraph (3)—

20               (i) in the heading, by striking “FIS-  
21               CAL YEAR 2002 AND SUCCEEDING” and in-  
22               serting “SUCCEEDING”; and

23               (ii) by inserting “(or, in the case of  
24               services described in section 1905(a)(2)(D)  
25               furnished by a federally qualified behav-

1 ioral health center, for services furnished  
2 during fiscal year 2013 or a succeeding fis-  
3 cal year)” after “2002 or a succeeding fis-  
4 cal year”;

5 (E) in paragraph (4)—

6 (i) by inserting “(or as a federally  
7 qualified behavioral health center after fis-  
8 cal year 2011” after “or rural health clinic  
9 after fiscal year 2000”;

10 (ii) by striking “furnished by the cen-  
11 ter or” and inserting “furnished by the  
12 federally qualified health center, services  
13 described in section 1905(a)(2)(D) fur-  
14 nished by the federally qualified behavioral  
15 health center, or”;

16 (iii) in the second sentence, by strik-  
17 ing “or rural health clinic” and inserting  
18 “, federally qualified behavioral health cen-  
19 ter, or rural health clinic”;

20 (F) in paragraph (5), in each of subpara-  
21 graphs (A) and (B), by striking “or rural  
22 health clinic” and inserting “, federally quali-  
23 fied behavioral health center, or rural health  
24 clinic”; and

1 (G) in paragraph (6), by striking “or to a  
2 rural health clinic” and inserting “, to a feder-  
3 ally qualified behavioral health center for serv-  
4 ices described in section 1905(a)(2)(D), or to a  
5 rural health clinic”.

6 (2) INCLUSION OF FEDERALLY QUALIFIED BE-  
7 HAVIORAL HEALTH CENTER SERVICES IN THE TERM  
8 MEDICAL ASSISTANCE.—Section 1905(a)(2) of the  
9 Social Security Act (42 U.S.C. 1396d(a)(2)) is  
10 amended—

11 (A) by striking “and” before “(C)”; and

12 (B) by inserting before the semicolon at  
13 the end the following: “, and (D) federally  
14 qualified behavioral health center services (as  
15 defined in subsection (l)(4))”.

16 (3) DEFINITION OF FEDERALLY QUALIFIED BE-  
17 HAVIORAL HEALTH CENTER SERVICES.—Section  
18 1905(l) of the Social Security Act (42 U.S.C.  
19 1396d(l)) is amended by adding at the end the fol-  
20 lowing paragraph:

21 “(4)(A) The term ‘federally qualified behavioral  
22 health center services’ means services furnished to  
23 an individual at a federally qualified behavioral  
24 health center (as defined by subparagraph (B)).

1           “(B) The term ‘federally qualified behavioral  
2 health center’ means an entity that is certified under  
3 section 1913(c) of the Public Health Service Act as  
4 meeting the criteria described in paragraph (3) of  
5 such section.”.

6           (c) MENTAL HEALTH AND ADDICTION SAFETY NET  
7 STUDIES.—

8           (1) PAPERWORK REDUCTION STUDY.—

9           (A) IN GENERAL.—Not later than 12  
10 months after the date of the enactment of this  
11 Act, the Institute of Medicine shall submit to  
12 the appropriate committees of Congress a re-  
13 port that evaluates the combined paperwork  
14 burden of federally qualified behavioral health  
15 centers certified section 1913(c) of the Public  
16 Health Service Act, as inserted by subsection  
17 (a).

18           (B) SCOPE.—In preparing the report  
19 under subparagraph (A), the Institute of Medi-  
20 cine shall examine licensing, certification, serv-  
21 ice definitions, claims payment, billing codes,  
22 and financial auditing requirements utilized by  
23 the Office of Management and Budget, the  
24 Centers for Medicare & Medicaid Services, the  
25 Health Resources and Services Administration,

1 the Substance Abuse and Mental Health Serv-  
2 ices Administration, the Office of the Inspector  
3 General, State Medicaid agencies, State depart-  
4 ments of health, State departments of edu-  
5 cation, and State and local juvenile justice and  
6 social services agencies to—

7 (i) establish an estimate of the com-  
8 bined nationwide cost of complying with  
9 the requirements described in this subpara-  
10 graph, in terms of both administrative  
11 funding and staff time;

12 (ii) establish an estimate of the per  
13 capita cost to each federally qualified be-  
14 havioral health center certified under sec-  
15 tion 1913(c) of the Public Health Service  
16 Act to comply with the requirements de-  
17 scribed in this subparagraph, in terms of  
18 both administrative funding and staff time;  
19 and

20 (iii) make administrative and statu-  
21 tory recommendations to Congress, which  
22 may include a uniform methodology, to re-  
23 duce the paperwork burden experienced by  
24 such federally qualified behavioral health  
25 centers.

1           (C) AUTHORIZATION OF APPROPRIA-  
2 TIONS.—There are authorized to be appro-  
3 priated to carry out this subsection \$550,000  
4 for each of the fiscal years 2012 and 2013.

5           (2) WAGE STUDY.—

6           (A) IN GENERAL.—Not later than 12  
7 months after the date of the enactment of this  
8 Act, the Institute of Medicine shall conduct a  
9 nationwide analysis, and submit a report to the  
10 appropriate committees of Congress, concerning  
11 the compensation structure of professional and  
12 paraprofessional personnel employed by feder-  
13 ally qualified behavioral health centers certified  
14 under section 1913(e) of the Public Health  
15 Service Act, as inserted by subsection (a), as  
16 compared with the compensation structure of  
17 comparable health safety net providers and rel-  
18 evant private sector health care employers.

19           (B) SCOPE.—In preparing the report  
20 under subparagraph (A), the Institute of Medi-  
21 cine shall examine compensation disparities, if  
22 such disparities are determined to exist, by type  
23 of personnel, type of provider or private sector  
24 employer, and by geographic region.

1                   (C) AUTHORIZATION OF APPROPRIA-  
2                   TIONS.—There are authorized to be appro-  
3                   priated to carry out this paragraph, \$550,000  
4                   for each of the fiscal years 2012 and 2013.

5 **SEC. 603. MINORITY FELLOWSHIP PROGRAM.**

6           Title V of the Public Health Service Act is amended  
7 by inserting after section 506B of such Act (42 U.S.C.  
8 290aa–5b) the following:

9 **“SEC. 506C. MINORITY FELLOWSHIP PROGRAM.**

10           “(a) FELLOWSHIPS.—The Administrator shall main-  
11 tain a program, to be known as the Minority Fellowship  
12 Program, under which the Administrator awards grants  
13 or contracts to national associations or other appropriate  
14 entities for the financial support of graduate students,  
15 postdoctoral fellows, and residents in the professions of  
16 psychology, psychiatry, social work, psychiatric advance-  
17 practice nursing, and marriage and family therapy to stu-  
18 dents who demonstrate a commitment to clinical or re-  
19 search careers focused on racial and ethnic minority popu-  
20 lations.

21           “(b) TERM OF FINANCIAL SUPPORT.—Financial sup-  
22 port provided to an individual pursuant to subsection (a)  
23 shall be for a term of not more than 12 months and may  
24 be renewed thereafter.



1       “(c) AUTHORIZATION OF APPROPRIATIONS.—To  
2 carry out this section, there is authorized to be appro-  
3 priated \$10,000,000 for each of fiscal years 2012 through  
4 2016”.

5 **SEC. 604. INTEGRATED HEALTH CARE DEMONSTRATION**  
6 **PROGRAM.**

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:

10 **“SEC. 544. INTERPROFESSIONAL HEALTH CARE TEAMS FOR**  
11 **PROVISION OF BEHAVIORAL HEALTH CARE**  
12 **IN PRIMARY CARE SETTINGS.**

13       “(a) GRANTS.—The Secretary, acting through the  
14 Director of the Office of Minority Health of the Adminis-  
15 tration, shall award grants to eligible entities for the pur-  
16 pose of providing technical assistance and training regard-  
17 ing the effective development and implementation of inte-  
18 grated interprofessional health care teams that provide be-  
19 havioral health care.

20       “(b) ELIGIBLE ENTITIES.—To be eligible to receive  
21 a grant under this section, an entity shall be a federally  
22 qualified health center (as defined in section 1861(aa) of  
23 the Social Security Act) serving a high proportion of indi-  
24 viduals from racial and ethnic minority groups (as defined  
25 in section 1707(g)).

1       “(c) AUTHORIZATION OF APPROPRIATIONS.—To  
2 carry out this section, there is authorized to be appro-  
3 priated \$20,000,000 for each of fiscal years 2012 through  
4 2014.”.

5 **SEC. 605. ADDRESSING RACIAL AND ETHNIC MINORITY**  
6                   **MENTAL HEALTH DISPARITIES RESEARCH**  
7                   **GAPS.**

8       Not later than 6 months after the date of the enact-  
9 ment of this Act, the Director of the National Institute  
10 on Minority Health and Health Disparities shall enter into  
11 an arrangement with the Institute of Medicine (or, if the  
12 Institute declines to enter into such an arrangement, an-  
13 other appropriate entity)—

14           (1) to conduct a study with respect to mental  
15       and behavioral health disparities in racial and ethnic  
16       minority groups (as defined in section 1707(g) of  
17       the Public Health Service Act (42 U.S.C. 300u-  
18       6(g)); and

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

21                   (A) a compilation of information on the dy-  
22       namics of mental disorders in such racial and  
23       ethnic minority groups;

24                   (B) an identification of gaps in knowledge  
25       and research needs; and

1 (C) recommendations for an interprofes-  
2 sional research agenda at the National Insti-  
3 tutes of Health aimed at reducing and ulti-  
4 mately eliminating mental and behavioral health  
5 disparities in such racial and ethnic minority  
6 groups.

7 **TITLE VII—ADDRESSING HIGH**  
8 **IMPACT MINORITY DISEASES**  
9 **Subtitle A—Cancer**

10 **SEC. 701. LUNG CANCER MORTALITY REDUCTION.**

11 (a) **SHORT TITLE.**—This section may be cited as the  
12 “Lung Cancer Mortality Reduction Act of 2011”.

13 (b) **FINDINGS.**—Congress makes the following find-  
14 ings:

15 (1) Lung cancer is the leading cause of cancer  
16 death for both men and women, accounting for 28  
17 percent of all cancer deaths.

18 (2) Lung cancer kills more people annually  
19 than breast cancer, prostate cancer, colon cancer,  
20 liver cancer, melanoma, and kidney cancer combined.

21 (3) Since the National Cancer Act of 1971  
22 (Public Law 92–218; 85 Stat. 778), coordinated and  
23 comprehensive research has raised the 5-year sur-  
24 vival rates for breast cancer to 88 percent, for pros-

1       tate cancer to 99 percent, and for colon cancer to  
2       64 percent.

3           (4) However, the 5-year survival rate for lung  
4       cancer is still only 15 percent and a similar coordi-  
5       nated and comprehensive research effort is required  
6       to achieve increases in lung cancer survivability  
7       rates.

8           (5) Sixty percent of lung cancer cases are now  
9       diagnosed nonsmokers or former smokers.

10          (6) Two-thirds of nonsmokers diagnosed with  
11       lung cancer are women.

12          (7) Certain minority populations, such as Afri-  
13       can-American males, have disproportionately high  
14       rates of lung cancer incidence and mortality, not-  
15       withstanding their similar smoking rate.

16          (8) Members of the baby boomer generation are  
17       entering their sixties, the most common age at which  
18       people develop lung cancer.

19          (9) Tobacco addiction and exposure to other  
20       lung cancer carcinogens such as Agent Orange and  
21       other herbicides and battlefield emissions are serious  
22       problems among military personnel and war vet-  
23       erans.

24          (10) Significant and rapid improvements in  
25       lung cancer mortality can be expected through great-

1 er use and access to lung cancer screening tests for  
2 at-risk individuals.

3 (11) Additional strategies are necessary to fur-  
4 ther enhance the existing tests and therapies avail-  
5 able to diagnose and treat lung cancer in the future.

6 (12) The August 2001 Report of the Lung  
7 Cancer Progress Review Group of the National Can-  
8 cer Institute stated that funding for lung cancer re-  
9 search was “far below the levels characterized for  
10 other common malignancies and far out of propor-  
11 tion to its massive health impact”.

12 (13) The Report of the Lung Cancer Progress  
13 Review Group identified as its “highest priority” the  
14 creation of integrated, multidisciplinary, multi-insti-  
15 tutional research consortia organized around the  
16 problem of lung cancer rather than around specific  
17 research disciplines.

18 (14) The United States must enhance its re-  
19 sponse to the issues raised in the Report of the  
20 Lung Cancer Progress Review Group, and this can  
21 be accomplished through the establishment of a co-  
22 ordinated effort designed to reduce the lung cancer  
23 mortality rate by 50 percent by 2015 and targeted  
24 funding to support this coordinated effort.

1 (c) SENSE OF CONGRESS CONCERNING INVESTMENT  
2 IN LUNG CANCER RESEARCH.—It is the sense of the Con-  
3 gress that—

4 (1) lung cancer mortality reduction should be  
5 made a national public health priority; and

6 (2) a comprehensive mortality reduction pro-  
7 gram coordinated by the Secretary of Health and  
8 Human Services is justified and necessary to ade-  
9 quately address and reduce lung cancer mortality.

10 (d) LUNG CANCER MORTALITY REDUCTION PRO-  
11 GRAM.—

12 (1) IN GENERAL.—Subpart 1 of part C of title  
13 IV of the Public Health Service Act (42 U.S.C. 285  
14 et seq.) is amended by adding at the end the fol-  
15 lowing:

16 **“SEC. 417H. LUNG CANCER MORTALITY REDUCTION PRO-**  
17 **GRAM.**

18 “(a) IN GENERAL.—Not later than 6 months after  
19 the date of the enactment of this section, the Secretary,  
20 in consultation with the Secretary of Defense, the Sec-  
21 retary of Veterans Affairs, the Director of the National  
22 Institutes of Health, the Director of the Centers for Dis-  
23 ease Control and Prevention, the Commissioner of Food  
24 and Drugs, the Administrator of the Centers for Medicare  
25 & Medicaid Services, the Director of the National Institute

1 on Minority Health and Health Disparities, and other  
2 members of the Lung Cancer Advisory Board established  
3 under section 546 of the Lung Cancer Mortality Reduc-  
4 tion Act of 2011, shall implement a comprehensive pro-  
5 gram, to be known as the Lung Cancer Mortality Reduc-  
6 tion Program, to achieve a reduction of at least 25 percent  
7 in the mortality rate of lung cancer by 2017.

8 “(b) REQUIREMENTS.—The Program shall include at  
9 least the following:

10 “(1) With respect to the National Institutes of  
11 Health—

12 “(A) a strategic review and prioritization  
13 by the National Cancer Institute of research  
14 grants to achieve the goal of the Lung Cancer  
15 Mortality Reduction Program in reducing lung  
16 cancer mortality;

17 “(B) the provision of funds to enable the  
18 Airway Biology and Disease Branch of the Na-  
19 tional Heart, Lung, and Blood Institute to ex-  
20 pand its research programs to include pre-  
21 dispositions to lung cancer, the interrelationship  
22 between lung cancer and other pulmonary and  
23 cardiac disease, and the diagnosis and treat-  
24 ment of these interrelationships;

1           “(C) the provision of funds to enable the  
2           National Institute of Biomedical Imaging and  
3           Bioengineering to expedite the development of  
4           computer assisted diagnostic, surgical, treat-  
5           ment, and drug-testing innovations to reduce  
6           lung cancer mortality, such as through expan-  
7           sion of the Institute’s Quantum Grant Program  
8           and Image-Guided Interventions programs; and

9           “(D) the provision of funds to enable the  
10          National Institute of Environmental Health  
11          Sciences to implement research programs rel-  
12          ative to the lung cancer incidence.

13          “(2) With respect to the Food and Drug Ad-  
14          ministration—

15                 “(A) activities under section 529 of the  
16                 Federal Food, Drug, and Cosmetic Act; and

17                 “(B) activities under section 561 of the  
18                 Federal Food, Drug, and Cosmetic Act to ex-  
19                 pand access to investigational drugs and devices  
20                 for the diagnosis, monitoring, or treatment of  
21                 lung cancer.

22          “(3) With respect to the Centers for Disease  
23          Control and Prevention, the establishment of an  
24          early disease research and management program  
25          under section 1511.



1           “(4) With respect to the Agency for Healthcare  
2           Research and Quality, the conduct of a biannual re-  
3           view of lung cancer screening, diagnostic, and treat-  
4           ment protocols, and the issuance of updated guide-  
5           lines.

6           “(5) The cooperation and coordination of all  
7           minority and health disparity programs within the  
8           Department of Health and Human Services to en-  
9           sure that all aspects of the Lung Cancer Mortality  
10          Reduction Program under this section adequately  
11          address the burden of lung cancer on minority and  
12          rural populations.

13          “(6) The cooperation and coordination of all to-  
14          bacco control and cessation programs within agen-  
15          cies of the Department of Health and Human Serv-  
16          ices to achieve the goals of the Lung Cancer Mor-  
17          tality Reduction Program under this section with  
18          particular emphasis on the coordination of drug and  
19          other cessation treatments with early detection pro-  
20          tocols.”.

21          (2) FEDERAL FOOD, DRUG, AND COSMETIC  
22          ACT.—Subchapter B of chapter V of the Federal  
23          Food, Drug, and Cosmetic Act (21 U.S.C. 360aaa et  
24          seq.) is amended by adding at the end the following:

1 “DRUGS RELATING TO LUNG CANCER

2 “SEC. 529. (a) IN GENERAL.—The provisions of this  
3 subchapter shall apply to a drug described in subsection  
4 (b) to the same extent and in the same manner as such  
5 provisions apply to a drug for a rare disease or condition.

6 “(b) QUALIFIED DRUGS.—A drug described in this  
7 subsection is—

8 “(1) a chemoprevention drug for precancerous  
9 conditions of the lung;

10 “(2) a drug for targeted therapeutic treat-  
11 ments, including any vaccine, for lung cancer; and

12 “(3) a drug to curtail or prevent nicotine addic-  
13 tion.

14 “(c) BOARD.—The Board established under the Lung  
15 Cancer Mortality Reduction Act of 2011 shall monitor the  
16 program implemented under this section.”.

17 (3) ACCESS TO UNAPPROVED THERAPIES.—Sec-  
18 tion 561(e) of the Federal Food, Drug, and Cos-  
19 metic Act (21 U.S.C. 360bbb(e)) is amended by in-  
20 sserting before the period the following: “and shall  
21 include expanding access to drugs under section  
22 529, with substantial consideration being given to  
23 whether the totality of information available to the  
24 Secretary regarding the safety and effectiveness of  
25 an investigational drug, as compared to the risk of

1 morbidity and death from the disease, indicates that  
2 a patient may obtain more benefit than risk if treat-  
3 ed with the drug”.

4 (4) CDC.—Title XV of the Public Health Serv-  
5 ice Act (42 U.S.C. 300k et seq.) is amended by add-  
6 ing at the end the following:

7 **“SEC. 1511. EARLY DISEASE RESEARCH AND MANAGEMENT**  
8 **PROGRAM.**

9 “The Secretary shall establish and implement an  
10 early disease research and management program targeted  
11 at the high incidence and mortality rates of lung cancer  
12 among minority and low-income populations.”.

13 (e) DEPARTMENT OF DEFENSE AND THE DEPART-  
14 MENT OF VETERANS AFFAIRS.—The Secretary of Defense  
15 and the Secretary of Veterans Affairs shall coordinate  
16 with the Secretary of Health and Human Services—

17 (1) in the development of the Lung Cancer  
18 Mortality Reduction Program under section 417H;

19 (2) in the implementation within the Depart-  
20 ment of Defense and the Department of Veterans  
21 Affairs of an early detection and disease manage-  
22 ment research program for military personnel and  
23 veterans whose smoking history and exposure to car-  
24 cinogens during active duty service has increased  
25 their risk for lung cancer; and

1           (3) in the implementation of coordinated care  
2 programs for military personnel and veterans diag-  
3 nosed with lung cancer.

4 (f) LUNG CANCER ADVISORY BOARD.—

5           (1) IN GENERAL.—The Secretary of Health and  
6 Human Services shall convene a Lung Cancer Advi-  
7 sory Board (referred to in this section as the  
8 “Board”)—

9           (A) to monitor the programs established  
10 under this section (and the amendments made  
11 by this section); and

12           (B) to provide annual reports to the Con-  
13 gress concerning benchmarks, expenditures,  
14 lung cancer statistics, and the public health im-  
15 pact of such programs.

16           (2) COMPOSITION.—The Board shall be com-  
17 posed of—

18           (A) the Secretary of Health and Human  
19 Services;

20           (B) the Secretary of Defense;

21           (C) the Secretary of Veterans Affairs; and

22           (D) two representatives each from the  
23 fields of clinical medicine focused on lung can-  
24 cer, lung cancer research, imaging, drug devel-  
25 opment, and lung cancer advocacy, to be ap-

1           pointed by the Secretary of Health and Human  
2           Services.

3           (g) AUTHORIZATION OF APPROPRIATIONS.—

4           (1) IN GENERAL.—To carry out this section  
5           (and the amendments made by this section), there  
6           are authorized to be appropriated such sums as may  
7           be necessary for each of fiscal years 2012 through  
8           2016.

9           (2) LUNG CANCER MORTALITY REDUCTION PRO-  
10          GRAM.—Of the amounts authorized to be appro-  
11          priated by subsection (a), there are authorized to be  
12          appropriated—

13                 (A) \$25,000,000 for fiscal year 2012, and  
14                 such sums as may be necessary for each of fis-  
15                 cal years 2013 through 2016, for the activities  
16                 described in section 417H(b)(1)(B) of the Pub-  
17                 lic Health Service Act, as added by subsection  
18                 (d)(1);

19                 (B) \$25,000,000 for fiscal year 2012, and  
20                 such sums as may be necessary for each of fis-  
21                 cal years 2013 through 2016, for the activities  
22                 described in section 417H(b)(1)(C) of such Act;

23                 (C) \$10,000,000 for fiscal year 2012, and  
24                 such sums as may be necessary for each of fis-  
25                 cal years 2013 through 2016, for the activities

1 described in section 417H(b)(1)(D) of such Act;  
2 and

3 (D) \$15,000,000 for fiscal year 2012, and  
4 such sums as may be necessary for each of fis-  
5 cal years 2013 through 2016, for the activities  
6 described in section 417H(b)(3) of such Act.

7 **SEC. 702. EXPANDING PROSTATE CANCER RESEARCH, OUT-**  
8 **REACH, SCREENING, TESTING, ACCESS, AND**  
9 **TREATMENT EFFECTIVENESS.**

10 (a) **SHORT TITLE.**—This section may be cited as the  
11 “Prostate Research, Outreach, Screening, Testing, Access,  
12 and Treatment Effectiveness Act of 2011” or the “PROS-  
13 TATE Act”.

14 (b) **FINDINGS.**—Congress makes the following find-  
15 ings:

16 (1) Prostate cancer is the second leading cause  
17 of cancer death among men.

18 (2) In 2010, more than 217,730 new patients  
19 were diagnosed with prostate cancer and more than  
20 32,000 men died from this disease.

21 (3) Roughly 2,000,000 Americans are living  
22 with a diagnosis of prostate cancer and its con-  
23 sequences.

24 (4) While prostate cancer generally affects older  
25 individuals, younger men are also at risk for the dis-

1 ease, and when prostate cancer appears in early  
2 middle age it frequently takes on a more aggressive  
3 form.

4 (5) There are significant racial and ethnic dis-  
5 parities that demand attention, namely African-  
6 Americans have prostate cancer mortality rates that  
7 are more than double those in the White population.

8 (6) Underserved rural populations have higher  
9 rates of mortality compared to their urban counter-  
10 parts, and innovative and cost-efficient methods to  
11 improve rural access to high quality care should take  
12 advantage of advances in telehealth to diagnose and  
13 treat prostate cancer when appropriate.

14 (7) Certain veterans populations may have  
15 nearly twice the incidence of prostate cancer as the  
16 general population of the United States.

17 (8) Urologists may constitute the specialists  
18 who diagnose and treat the vast majority of prostate  
19 cancer patients.

20 (9) Although much basic and translational re-  
21 search has been completed and much is currently  
22 known, there are still many unanswered questions.  
23 For example, it is not fully understood how much of  
24 known disparities are attributable to disease eti-

1 ology, access to care, or education and awareness in  
2 the community.

3 (10) Causes of prostate cancer are not known.  
4 There is not good information regarding how to dif-  
5 ferentiate accurately, early on, between aggressive  
6 and indolent forms of the disease. As a result, there  
7 is significant overtreatment in prostate cancer.  
8 There are no treatments that can durably arrest  
9 growth or cure prostate cancer once it has metasta-  
10 sized.

11 (11) A significant proportion (roughly 23 to 54  
12 percent) of cases may be clinically indolent and  
13 “overdiagnosed”, resulting in significant overtreat-  
14 ment. More accurate tests will allow men and their  
15 families to face less physical, psychological, financial,  
16 and emotional trauma and billions of dollars could  
17 be saved in private and public health care systems  
18 in an area that has been identified by the Medicare  
19 program as one of eight high-volume, high-cost areas  
20 in the Resource Utilization Report program author-  
21 ized by Congress under the Medicare Improvements  
22 for Patients and Providers Act of 2008.

23 (12) Prostate cancer research and health care  
24 programs across Federal agencies should be coordi-  
25 nated to improve accountability and actively encour-



1 age the translation of research into practice, to iden-  
2 tify and implement best practices, in order to foster  
3 an integrated and consistent focus on effective pre-  
4 vention, diagnosis, and treatment of this disease.

5 (c) PROSTATE CANCER COORDINATION AND EDU-  
6 CATION.—

7 (1) INTERAGENCY PROSTATE CANCER COORDI-  
8 NATION AND EDUCATION TASK FORCE.—Not later  
9 than 180 days after the date of the enactment of  
10 this section, the Secretary of Veterans Affairs, in co-  
11 operation with the Secretary of Defense and the Sec-  
12 retary of Health and Human Services, shall estab-  
13 lish an Interagency Prostate Cancer Coordination  
14 and Education Task Force (in this section referred  
15 to as the “Prostate Cancer Task Force”).

16 (2) DUTIES.—The Prostate Cancer Task Force  
17 shall—

18 (A) develop a summary of advances in  
19 prostate cancer research supported or con-  
20 ducted by Federal agencies relevant to the diag-  
21 nosis, prevention, and treatment of prostate  
22 cancer, including psychosocial impairments re-  
23 lated to prostate cancer treatment, and compile  
24 a list of best practices that warrant broader  
25 adoption in health care programs;

1 (B) consider establishing, and advocating  
2 for, a guidance to enable physicians to allow  
3 screening of men who are over age 74, on a  
4 case-by-case basis, taking into account quality  
5 of life and family history of prostate cancer;

6 (C) share and coordinate information on  
7 Federal research and health care program ac-  
8 tivities, including activities related to—

9 (i) determining how to improve re-  
10 search and health care programs, including  
11 psychosocial impairments related to pros-  
12 tate cancer treatment;

13 (ii) identifying any gaps in the overall  
14 research inventory and in health care pro-  
15 grams;

16 (iii) identifying opportunities to pro-  
17 mote translation of research into practice;  
18 and

19 (iv) maximizing the effects of Federal  
20 efforts by identifying opportunities for col-  
21 laboration and leveraging of resources in  
22 research and health care programs that  
23 serve those susceptible to or diagnosed  
24 with prostate cancer;

1 (D) develop a comprehensive interagency  
2 strategy and advise relevant Federal agencies in  
3 the solicitation of proposals for collaborative,  
4 multidisciplinary research and health care pro-  
5 grams, including proposals to evaluate factors  
6 that may be related to the etiology of prostate  
7 cancer, that would—

8 (i) result in innovative approaches to  
9 study emerging scientific opportunities or  
10 eliminate knowledge gaps in research to  
11 improve the prostate cancer research port-  
12 folio of the Federal Government;

13 (ii) outline key research questions,  
14 methodologies, and knowledge gaps; and

15 (iii) ensure consistent action, as out-  
16 lined by section 402(b) of the Public  
17 Health Service Act;

18 (E) develop a coordinated message related  
19 to screening and treatment for prostate cancer  
20 to be reflected in educational and beneficiary  
21 materials for Federal health programs as such  
22 documents are updated; and

23 (F) not later than 2 years after the date  
24 of the establishment of the Prostate Cancer  
25 Task Force, submit to the Expert Advisory

1 Panel to be reviewed and returned within 30  
2 days, and then within 90 days submitted to  
3 Congress recommendations—

4 (i) regarding any appropriate changes  
5 to research and health care programs, in-  
6 cluding recommendations to improve the  
7 research portfolio of the Department of  
8 Veterans Affairs, Department of Defense,  
9 National Institutes of Health, and other  
10 Federal agencies to ensure that scientif-  
11 ically based strategic planning is imple-  
12 mented in support of research and health  
13 care program priorities;

14 (ii) designed to ensure that the re-  
15 search and health care programs and ac-  
16 tivities of the Department of Veterans Af-  
17 fairs, the Department of Defense, the De-  
18 partment of Health and Human Services,  
19 and other Federal agencies are free of un-  
20 necessary duplication;

21 (iii) regarding public participation in  
22 decisions relating to prostate cancer re-  
23 search and health care programs to in-  
24 crease the involvement of patient advo-  
25 cates, community organizations, and med-

1 ical associations representing a broad geo-  
2 graphical area;

3 (iv) on how to best disseminate infor-  
4 mation on prostate cancer research and  
5 progress achieved by health care programs;

6 (v) about how to expand partnerships  
7 between public entities, including Federal  
8 agencies, and private entities to encourage  
9 collaborative, cross-cutting research and  
10 health care delivery;

11 (vi) assessing any cost savings and ef-  
12 ficiencies realized through the efforts iden-  
13 tified and supported in this section and  
14 recommending expansion of those efforts  
15 that have proved most promising while also  
16 ensuring against any conflicts in directives  
17 from other congressional or statutory man-  
18 dates or enabling statutes;

19 (vii) identifying key priority action  
20 items from among the recommendations;  
21 and

22 (viii) with respect to the level of fund-  
23 ing needed by each agency to implement  
24 the recommendations contained in the re-  
25 port.

1           (3) MEMBERS OF THE PROSTATE CANCER TASK  
2           FORCE.—The Prostate Cancer Task Force described  
3           in subsection (a) shall be composed of representa-  
4           tives from such Federal agencies, as each Secretary  
5           determines necessary, to coordinate a uniform mes-  
6           sage relating to prostate cancer screening and treat-  
7           ment where appropriate, including representatives of  
8           the following:

9                   (A) The Department of Veterans Affairs,  
10           including representatives of each relevant pro-  
11           gram areas of the Department of Veterans Af-  
12           fairs.

13                   (B) The Prostate Cancer Research Pro-  
14           gram of the Congressionally Directed Medical  
15           Research Program of the Department of De-  
16           fense.

17                   (C) The Department of Health and  
18           Human Services, including at a minimum rep-  
19           resentatives of the following:

20                           (i) The National Institutes of Health.

21                           (ii) National research institutes and  
22           centers, including the National Cancer In-  
23           stitute, the National Institute of Allergy  
24           and Infectious Diseases, and the Office of  
25           Minority Health.

1 (iii) The Centers for Medicare & Med-  
2 icaid Services.

3 (iv) The Food and Drug Administra-  
4 tion.

5 (v) The Centers for Disease Control  
6 and Prevention.

7 (vi) The Agency for Healthcare Re-  
8 search and Quality.

9 (vii) The Health Resources and Serv-  
10 ices Administration.

11 (4) APPOINTING EXPERT ADVISORY PANELS.—

12 The Prostate Cancer Task Force shall appoint ex-  
13 pert advisory panels, as determined appropriate, to  
14 provide input and concurrence from individuals and  
15 organizations from the medical, prostate cancer pa-  
16 tient and advocate, research, and delivery commu-  
17 nities with expertise in prostate cancer diagnosis,  
18 treatment, and research, including practicing urolo-  
19 gists, primary care providers, and others and indi-  
20 viduals with expertise in education and outreach to  
21 underserved populations affected by prostate cancer.

22 (5) MEETINGS.—The Prostate Cancer Task  
23 Force shall convene not less than twice a year, or  
24 more frequently as the Secretary determines to be  
25 appropriate.

1           (6) SUBMISSION OF RECOMMENDATIONS TO  
2 CONGRESS.—The Secretary of Veterans Affairs shall  
3 submit to Congress any recommendations submitted  
4 to the Secretary under paragraph (2)(E).

5           (7) FEDERAL ADVISORY COMMITTEE ACT.—

6           (A) IN GENERAL.—Except as provided in  
7 subparagraph (B), the Federal Advisory Com-  
8 mittee Act (5 U.S.C. App.) shall apply to the  
9 Prostate Cancer Task Force.

10          (B) EXCEPTION.—Section 14(a)(2)(B) of  
11 such Act (relating to the termination of advi-  
12 sory committees) shall not apply to the Prostate  
13 Cancer Task Force.

14          (8) SUNSET DATE.—The Prostate Cancer Task  
15 Force shall terminate at the end of fiscal year 2016.

16          (d) PROSTATE CANCER RESEARCH.—

17          (1) RESEARCH COORDINATION.—The Secretary  
18 of Veterans Affairs, in coordination with the Secre-  
19 taries of Defense and of Health and Human Serv-  
20 ices, shall establish and carry out a program to co-  
21 ordinate and intensify prostate cancer research as  
22 needed. Specifically, such research program shall—

23           (A) develop advances in diagnostic and  
24 prognostic methods and tests, including bio-  
25 markers and an improved prostate cancer



1 screening blood test, including improvements or  
2 alternatives to the prostate specific antigen test  
3 and additional tests to distinguish indolent from  
4 aggressive disease;

5 (B) better understand the etiology of the  
6 disease (including an analysis of lifestyle factors  
7 proven to be involved in higher rates of prostate  
8 cancer, such as obesity and diet, and in dif-  
9 ferent ethnic, racial, and socioeconomic groups,  
10 such as the African-American, Latin-American,  
11 and American Indian populations and men with  
12 a family history of prostate cancer) to improve  
13 prevention efforts;

14 (C) expand basic research into prostate  
15 cancer, including studies of fundamental molec-  
16 ular and cellular mechanisms;

17 (D) identify and provide clinical testing of  
18 novel agents for the prevention and treatment  
19 of prostate cancer;

20 (E) establish clinical registries for prostate  
21 cancer;

22 (F) use the National Institute of Bio-  
23 medical Imaging and Bioengineering and the  
24 National Cancer Institute for assessment of ap-  
25 propriate imaging modalities; and

1           (G) address such other matters relating to  
2           prostate cancer research as may be identified by  
3           the Federal agencies participating in the pro-  
4           gram under this section.

5           (2) PROSTATE CANCER ADVISORY BOARD.—

6           There is established in the Office of the Chief Sci-  
7           entist of the Food and Drug Administration a Pros-  
8           tate Cancer Scientific Advisory Board. Such board  
9           shall be responsible for accelerating real-time shar-  
10          ing of the latest research data and accelerating  
11          movement of new medicines to patients.

12          (3) UNDERSERVED MINORITY GRANT PRO-  
13          GRAM.—In carrying out such program, the Secretary  
14          shall—

15                (A) award grants to eligible entities to  
16                carry out components of the research outlined  
17                in paragraph (1);

18                (B) integrate and build upon existing  
19                knowledge gained from comparative effective-  
20                ness research; and

21                (C) recognize and address—

22                       (i) the racial and ethnic disparities in  
23                       the incidence and mortality rates of pros-  
24                       tate cancer and men with a family history  
25                       of prostate cancer;

1 (ii) any barriers in access to care and  
2 participation in clinical trials that are spe-  
3 cific to racial, ethnic, and other under-  
4 served minorities and men with a family  
5 history of prostate cancer;

6 (iii) needed outreach and educational  
7 efforts to raise awareness in these commu-  
8 nities; and

9 (iv) appropriate access and utilization  
10 of imaging modalities.

11 (e) TELEHEALTH AND RURAL ACCESS PILOT  
12 PROJECT.—

13 (1) IN GENERAL.—The Secretary of Veterans  
14 Affairs, the Secretary of Defense, and the Secretary  
15 of Health and Human Services (in this section re-  
16 ferred to as the “Secretaries”) shall establish 4-year  
17 telehealth pilot projects for the purpose of analyzing  
18 the clinical outcomes and cost effectiveness associ-  
19 ated with telehealth services in a variety of geo-  
20 graphic areas that contain high proportions of medi-  
21 cally underserved populations, including African-  
22 Americans, Latin-Americans, American Indians, and  
23 those in rural areas. Such projects shall promote ef-  
24 ficient use of specialist care through better coordina-  
25 tion of primary care and physician extender teams

1 in underserved areas and more effectively employ  
2 tumor boards to better counsel patients.

3 (2) ELIGIBLE ENTITIES.—

4 (A) IN GENERAL.—The Secretaries shall  
5 select eligible entities to participate in the pilot  
6 projects under this section.

7 (B) PRIORITY.—In selecting eligible enti-  
8 ties to participate in the pilot projects under  
9 this section, the Secretaries shall give priority  
10 to such entities located in medically under-  
11 served areas, particularly those that include Af-  
12 rican-Americans, Latin-Americans, and facili-  
13 ties of the Indian Health Service, and those in  
14 rural areas.

15 (3) EVALUATION.—The Secretaries shall,  
16 through the pilot projects, evaluate—

17 (A) the effective and economic delivery of  
18 care in diagnosing and treating prostate cancer  
19 with the use of telehealth services in medically  
20 underserved and tribal areas including collabo-  
21 rative uses of health professionals and integra-  
22 tion of the range of telehealth and other tech-  
23 nologies;

24 (B) the effectiveness of improving the ca-  
25 pacity of nonmedical providers and nonspecial-

1            ized medical providers to provide health services  
2            for prostate cancer in medically underserved  
3            and tribal areas, including the exploration of in-  
4            novative medical home models with collabora-  
5            tion between urologists, other relevant medical  
6            specialists, including oncologists, radiologists,  
7            and primary care teams and coordination of  
8            care through the efficient use of primary care  
9            teams and physician extenders; and

10            (C) the effectiveness of using telehealth  
11            services to provide prostate cancer treatment in  
12            medically underserved areas, including the use  
13            of tumor boards to facilitate better patient  
14            counseling.

15            (4) REPORT.—Not later than 12 months after  
16            the completion of the pilot projects under this sub-  
17            section, the Secretaries shall submit to Congress a  
18            report describing the outcomes of such pilot projects,  
19            including any cost savings and efficiencies realized,  
20            and providing recommendations, if any, for expand-  
21            ing the use of telehealth services.

22            (f) EDUCATION AND AWARENESS.—

23            (1) IN GENERAL.—The Secretary of Veterans  
24            Affairs shall develop a national education campaign  
25            for prostate cancer. Such campaign shall involve the

1 use of written educational materials and public serv-  
2 ice announcements consistent with the findings of  
3 the Prostate Cancer Task Force under subsection  
4 (c), that are intended to encourage men to seek  
5 prostate cancer screening when appropriate.

6 (2) RACIAL DISPARITIES AND THE POPULATION  
7 OF MEN WITH A FAMILY HISTORY OF PROSTATE  
8 CANCER.—In developing the national campaign  
9 under paragraph (1), the Secretary shall ensure that  
10 such educational materials and public service an-  
11 nouncements are more readily available in commu-  
12 nities experiencing racial disparities in the incidence  
13 and mortality rates of prostate cancer and by men  
14 of any race classification with a family history of  
15 prostate cancer.

16 (3) GRANTS.—In carrying out the national  
17 campaign under this section, the Secretary shall  
18 award grants to nonprofit private entities to enable  
19 such entities to test alternative outreach and edu-  
20 cation strategies.

21 (g) AUTHORIZATION OF APPROPRIATIONS.—

22 (1) IN GENERAL.—There is authorized to be  
23 appropriated to carry out this section for the period  
24 of fiscal years 2012 through 2016 an amount equal  
25 to the savings described in paragraph (2).

1           (2)     CORRESPONDING     REDUCTION.—The  
2     amount authorized to be appropriated by provisions  
3     of law other than this section for the period of fiscal  
4     years 2012 through 2016 for Federal research and  
5     health care program activities related to prostate  
6     cancer is reduced by the amount of Federal savings  
7     projected to be achieved over such period by imple-  
8     mentation of subsection (c)(2)(C) of this section.

9     **SEC. 703. IMPROVED MEDICAID COVERAGE FOR CERTAIN**  
10                   **BREAST AND CERVICAL CANCER PATIENTS**  
11                   **IN THE TERRITORIES.**

12     (a) ELIMINATION OF FUNDING LIMITATIONS.—

13           (1) IN GENERAL.—Section 1108(g)(4) of the  
14     Social Security Act (42 U.S.C. 1308(g)(4)) is  
15     amended by adding at the end the following: “With  
16     respect to fiscal years beginning with fiscal year  
17     2012, payment for medical assistance for individuals  
18     who are eligible for such assistance only on the basis  
19     of section 1902(a)(10)(A)(ii)(XVIII) shall not be  
20     taken into account in applying subsection (f) (as in-  
21     creased in accordance with paragraphs (1), (2), and  
22     (3) of this subsection) to such commonwealth or ter-  
23     ritory for such fiscal year.”.

1           (2) TECHNICAL AMENDMENT.—Such section is  
2 further amended by striking “(3), and (4)” and in-  
3 sserting “and (3)”.

4           (b) APPLICATION OF ENHANCED FMAP FOR HIGH-  
5 EST STATE.—Section 1905(b) of such Act (42 U.S.C.  
6 1396d(b)) is amended by adding at the end the following:  
7 “Notwithstanding the first sentence of this subsection,  
8 with respect to medical assistance described in clause (4)  
9 of such sentence that is furnished in Puerto Rico, the  
10 United States Virgin Islands, Guam, the Commonwealth  
11 of the Northern Mariana Islands, or American Samoa in  
12 a fiscal year, the Federal medical assistance percentage  
13 is equal to the highest such percentage applied under such  
14 clause for such fiscal year for any of the 50 States or the  
15 District of Columbia that provides such medical assistance  
16 for any portion of such fiscal year.”

17           (c) EFFECTIVE DATE.—The amendments made by  
18 this section shall apply to payment for medical assistance  
19 for items and services furnished on or after October 1,  
20 2011.

21 **SEC. 704. CANCER PREVENTION AND TREATMENT DEM-**  
22 **ONSTRATION FOR ETHNIC AND RACIAL MI-**  
23 **NORITIES.**

24           (a) DEMONSTRATION.—



1           (1) IN GENERAL.—The Secretary of Health and  
2           Human Services (in this section referred to as the  
3           “Secretary”) shall conduct demonstration projects  
4           (in this section referred to as “demonstration  
5           projects”) for the purpose of developing models and  
6           evaluating methods that—

7                   (A) improve the quality of items and serv-  
8                   ices provided to target individuals in order to  
9                   facilitate reduced disparities in early detection  
10                  and treatment of cancer;

11                  (B) improve clinical outcomes, satisfaction,  
12                  quality of life, and appropriate use of Medicare-  
13                  covered services and referral patterns among  
14                  those target individuals with cancer;

15                  (C) eliminate disparities in the rate of pre-  
16                  ventive cancer screening measures, such as Pap  
17                  smears, prostate cancer screenings, and CT  
18                  scans for lung cancer among target individuals;

19                  (D) promote collaboration with community-  
20                  based organizations to ensure cultural com-  
21                  petency of health care professionals and lin-  
22                  guistic access for persons with limited-English  
23                  proficiency; and

24                  (E) encourage the incorporation of commu-  
25                  nity health workers to increase the efficiency

1           and appropriateness of cervical cancer pro-  
2           grams.

3           (2) COMMUNITY HEALTH WORKER DEFINED.—

4           In this section, the term “community health worker”  
5           includes a community health advocate, a lay health  
6           worker, a community health representative, a peer  
7           health promotor, a community health outreach work-  
8           ers, and promotores de salud, who promotes health  
9           or nutrition within the community in which the indi-  
10          vidual resides.

11          (3) TARGET INDIVIDUAL DEFINED.—In this

12          section, the term “target individual” means an indi-  
13          vidual of a racial and ethnic minority group, as de-  
14          fined in section 1707(g)(1) of the Public Health  
15          Service Act (42 U.S.C. 300u–6(g)(1)), who is enti-  
16          tled to benefits under part A, and enrolled under  
17          part B, of title XVIII of the Social Security Act.

18          (b) PROGRAM DESIGN.—

19          (1) INITIAL DESIGN.—Not later than 1 year  
20          after the date of the enactment of this Act, the Sec-  
21          retary shall evaluate best practices in the private  
22          sector, community programs, and academic research  
23          of methods that reduce disparities among individuals  
24          of racial and ethnic minority groups in the preven-

1       tion and treatment of cancer and shall design the  
2       demonstration projects based on such evaluation.

3               (2) NUMBER AND PROJECT AREAS.—Not later  
4       than 2 years after the date of the enactment of this  
5       Act, the Secretary shall implement at least nine  
6       demonstration projects, including the following:

7               (A) Two projects for each of the four fol-  
8       lowing major racial and ethnic minority groups:

9                       (i) American Indians and Alaska Na-  
10                      tives, Eskimos and Aleuts.

11                     (ii) Asian-Americans.

12                     (iii) Blacks/African-Americans.

13                     (iv) Hispanic/Latin-Americans.

14                     (v) Native Hawaiians and other Pa-  
15                      cific Islanders.

16       The two projects must target different ethnic  
17       subpopulations.

18               (B) One project within the Pacific Islands  
19       or United States insular areas.

20               (C) At least one project each in a rural  
21       area and inner-city area.

22               (3) EXPANSION OF PROJECTS; IMPLEMENTA-  
23       TION OF DEMONSTRATION PROJECT RESULTS.—If  
24       the initial report under subsection (c) contains an  
25       evaluation that demonstration projects—

1 (A) reduce expenditures under the Medi-  
2 care program under title XVIII of the Social  
3 Security Act; or

4 (B) do not increase expenditures under the  
5 Medicare program and reduce racial and ethnic  
6 health disparities in the quality of health care  
7 services provided to target individuals and in-  
8 crease satisfaction of beneficiaries and health  
9 care providers;

10 the Secretary shall continue the existing demonstra-  
11 tion projects and may expand the number of dem-  
12 onstration projects.

13 (c) REPORT TO CONGRESS.—

14 (1) IN GENERAL.—Not later than 2 years after  
15 the date the Secretary implements the initial dem-  
16 onstration projects, and biannually thereafter, the  
17 Secretary shall submit to Congress a report regard-  
18 ing the demonstration projects.

19 (2) CONTENTS OF REPORT.—Each report under  
20 paragraph (1) shall include the following:

21 (A) A description of the demonstration  
22 projects.

23 (B) An evaluation of—

24 (i) the cost effectiveness of the dem-  
25 onstration projects;

1 (ii) the quality of the health care serv-  
2 ices provided to target individuals under  
3 the demonstration projects; and

4 (iii) beneficiary and health care pro-  
5 vider satisfaction under the demonstration  
6 projects.

7 (C) Any other information regarding the  
8 demonstration projects that the Secretary de-  
9 termines to be appropriate.

10 (d) WAIVER AUTHORITY.—The Secretary shall waive  
11 compliance with the requirements of title XVIII of the So-  
12 cial Security Act to such extent and for such period as  
13 the Secretary determines is necessary to conduct dem-  
14 onstration projects.

15 **SEC. 705. REDUCING CANCER DISPARITIES WITHIN MEDI-**  
16 **CARE.**

17 (a) DEVELOPMENT OF MEASURES OF DISPARITIES  
18 IN QUALITY OF CANCER CARE.—

19 (1) DEVELOPMENT OF MEASURES.—The Sec-  
20 retary of Health and Human Services (in this sec-  
21 tion referred to as the “Secretary”) shall enter into  
22 an agreement with the National Quality Forum  
23 under which the National Quality Forum shall de-  
24 velop a uniform set of measures to evaluate dispari-  
25 ties in the quality of cancer care, endorse such set

1 of measures through its multistakeholder consensus  
2 development process, and annually update such set  
3 of measures.

4 (2) MEASURES TO BE INCLUDED.—Such set of  
5 measures shall include, with respect to the treatment  
6 of cancer, measures of patient outcomes, the process  
7 for delivering medical care related to such treat-  
8 ment, patient counseling and engagement in deci-  
9 sionmaking, patient experience of care, resource use,  
10 and practice capabilities, such as care coordination.

11 (b) ESTABLISHMENT OF REPORTING PROCESS.—

12 (1) IN GENERAL.—The Secretary shall establish  
13 a reporting process that provides for a method for  
14 health care providers specified under paragraph (2)  
15 to submit to the Secretary and make public data on  
16 the performance of such providers during each re-  
17 porting period through use of the measures devel-  
18 oped pursuant to subsection (a). Such data shall be  
19 submitted in a form and manner and at a time spec-  
20 ified by the Secretary.

21 (2) SPECIFICATION OF PROVIDERS TO REPORT  
22 ON MEASURES.—The Secretary shall specify the  
23 classes of Medicare providers of services and sup-  
24 pliers, including hospitals, cancer centers, physi-  
25 cians, primary care providers, and specialty pro-

1       viders, that will be required under such process to  
2       publicly report on the measures specified under sub-  
3       section (a).

4               (3) ASSESSMENT OF CHANGES.—Within this re-  
5       porting process, the Secretary shall also establish a  
6       format that assesses changes in both the absolute  
7       and relative disparities over time. These measures  
8       shall be presented in an easily comprehensible for-  
9       mat, such as those presented in the final publica-  
10      tions relating to Healthy People 2010 or the Na-  
11      tional Healthcare Disparities Report.

12              (4) INITIAL IMPLEMENTATION.—The Secretary  
13      shall implement the reporting process under this  
14      subsection for reporting periods beginning not later  
15      than 6 months after the date that measures are first  
16      established under subsection (a).

17      **Subtitle B—Viral Hepatitis and**  
18      **Liver Cancer Control and Pre-**  
19      **vention**

20      **SEC. 711. VIRAL HEPATITIS AND LIVER CANCER CONTROL**  
21                                      **AND PREVENTION.**

22              (a) SHORT TITLE.—This subtitle may be cited as the  
23      “Viral Hepatitis and Liver Cancer Control and Prevention  
24      Act of 2011”.

25              (b) FINDINGS.—Congress finds the following:

1           (1) Approximately 5,300,000 Americans are  
2 chronically infected with the hepatitis B virus (re-  
3 ferred to in this section as “HBV”), the hepatitis C  
4 virus (referred to in this section as “HCV”), or  
5 both.

6           (2) In the United States, chronic HBV and  
7 HCV are the most common cause of liver cancer,  
8 one of the most lethal and fastest growing cancers  
9 in this country. It is the most common cause of  
10 chronic liver disease, liver cirrhosis, and the most  
11 common indication for liver transplantation. It is  
12 also a leading cause of death in Americans living  
13 with HIV/AIDS, many of whom are coinfecting with  
14 chronic HBV, chronic HCV, or both. At least 15,000  
15 deaths per year in the United States can be attrib-  
16 uted to chronic HBV and HCV.

17           (3) According to the Centers for Disease Con-  
18 trol and Prevention (referred to in this section as  
19 the “CDC” “”), approximately 2 percent of the pop-  
20 ulation of the United States is living with chronic  
21 HBV, chronic HCV, or both. The CDC has recog-  
22 nized HCV as the Nation’s most common chronic  
23 bloodborne virus infection and HBV as the deadliest  
24 vaccine-preventable disease.



1           (4) HBV is easily transmitted and is 100 times  
2 more infectious than HIV. According to the CDC,  
3 HBV is transmitted through percutaneous (i.e.,  
4 puncture through the skin) or mucosal contact with  
5 infectious blood or body fluids. HCV is transmitted  
6 by percutaneous exposures to infectious blood.

7           (5) The CDC conservatively estimates that in  
8 2008 approximately 18,000 Americans were newly  
9 infected with HCV and more than 38,000 Americans  
10 were newly infected with HBV.

11           (6) There were 6 outbreaks reported to CDC  
12 for investigation in 2008 related to health care ac-  
13 quired infection of HBV and HCV, potentially ex-  
14 posing more than 52,000 Americans to the viruses,  
15 in 2009–2010 there were 15 outbreaks in which  
16 more than 30,000 people were potentially exposed.

17           (7) Chronic HBV and chronic HCV usually do  
18 not cause symptoms early in the course of the dis-  
19 ease, but after many years of a clinically “silent”  
20 phase, more than 50 percent of infected individuals  
21 will develop cirrhosis, end-stage liver disease, or liver  
22 cancer. Since most of those with chronic HBV and  
23 HCV are unaware of their infection, they do not  
24 know to take precautions to prevent the spread of

1 their infection and can unknowingly exacerbate their  
2 own disease progression.

3 (8) HBV and HCV disproportionately affect  
4 certain populations in the United States. Although  
5 representing only 5 percent of the population, Asian-  
6 Americans and Pacific Islanders account for over  
7 half of the 1,400,000 domestic chronic HBV cases.  
8 Baby boomers (those born between 1946 and 1964)  
9 account for more than half of domestic chronic hepa-  
10 titis C cases. In addition, African-Americans, Latin-  
11 Americans, and American Indian/Alaskan Natives  
12 are among the groups which have disproportionately  
13 high rates of HBV and/or HCV infections in the  
14 United States.

15 (9) For both chronic HBV and chronic HCV,  
16 behavioral changes can slow disease progression if  
17 diagnosis is made early. Early diagnosis, which is  
18 determined through simple blood tests, can reduce  
19 the risk of transmission and disease progression  
20 through education and vaccination of household  
21 members and other susceptible persons at risk.

22 (10) For those chronically infected with HBV  
23 or HCV, regular monitoring can lead to the early de-  
24 tection of liver cancer at a stage where cure is still  
25 possible. Liver cancer is the third deadliest cancer in

1 the United States however, liver cancer has received  
2 little funding for research, prevention, or treatment.

3 (11) Treatment for chronic HCV can eradicate  
4 the disease in approximately 75 percent of those cur-  
5 rently treated. The treatment of chronic HBV can  
6 effectively suppress viral replication in the over-  
7 whelming majority (>80%) of those treated thereby  
8 reducing the risk of transmission and progression to  
9 liver scarring or liver cancer even though a complete  
10 cure is much less common than for HCV.

11 (12) To combat the HBV and HCV epidemics  
12 in the United States, in May 2011, the Department  
13 of Health and Human Services released Combating  
14 the Silent Epidemic of Viral Hepatitis: Action Plan  
15 for the Prevention, Care & Treatment of Viral Hepa-  
16 titis (hereafter referred to as the HHS Action Plan).  
17 The Institute of Medicine (IOM) of the National  
18 Academies 2010 reported on the Federal response to  
19 HBV and HCV titled: Hepatitis and Liver Cancer:  
20 A National Strategy for Prevention and Control of  
21 Hepatitis B and C. These recommendations and  
22 guidelines provide a framework for HBV and HCV  
23 prevention, education, control, research, and medical  
24 management programs.

1           (13) The annual health care costs attributable  
2           to HBV and HCV in the United States are signifi-  
3           cant. For HBV, it is estimated to be approximately  
4           \$1,000,000,000 to 2,000,000,000 (\$1,000 to \$2,000  
5           per infected person). More than \$1,000,000,000 is  
6           spent each year for HBV-related hospitalizations.  
7           The indirect costs of chronic HBV infection are  
8           harder to measure, but include reduced physical and  
9           emotional quality of life, reduced economic produc-  
10          tivity, long-term disability, and premature death.  
11          For HCV, medical costs for patients are expected to  
12          increase from \$30,000,000,000 in 2009 to over  
13          \$85,000,000,000 in 2024. Avoiding these costs by  
14          screening and diagnosing individuals earlier—and  
15          connecting them to appropriate treatment and care  
16          will save lives and critical health care dollars. Cur-  
17          rently, without a comprehensive screening, testing  
18          and diagnosis program, most patients are diagnosed  
19          too late when they need a liver transplant costing at  
20          least \$314,000 for uncomplicated cases or when they  
21          have liver cancer or end stage liver disease which  
22          costs \$30,980 to \$110,576 per hospital admission.  
23          As health care costs continue to grow, it is critical  
24          that the Federal Government invests in effective  
25          mechanisms to avoid documented cost drivers.

1           (14) According to the IOM report in 2010,  
2           chronic HBV and HCV infections cause substantial  
3           morbidity and mortality despite being preventable  
4           and treatable. Deficiencies in the implementation of  
5           established guidelines for the prevention, diagnosis,  
6           and medical management of chronic HBV and HCV  
7           infections perpetuate personal and economic bur-  
8           dens. Existing grants are not sufficient for the scale  
9           of the health burden presented by HBV and HCV.

10           (15) Screening and testing for HBV and HCV  
11           is aligned with the Healthy People 2020 goal; In-  
12           crease immunization rates and reduce preventable  
13           infectious diseases. Awareness of disease and access  
14           to prevention and treatment remain essential compo-  
15           nents for reducing infectious disease transmission.

16           (16) Federal support is necessary to increase  
17           knowledge and awareness of HBV and HCV and to  
18           assist State and local prevention and control efforts  
19           in reducing the morbidity and mortality of these  
20           epidemics.

21           (c) BIENNIAL ASSESSMENT OF HHS HEPATITIS B  
22           AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH,  
23           AND MEDICAL MANAGEMENT PLAN.—Title III of the  
24           Public Health Service Act (42 U.S.C. 241 et seq.) is  
25           amended—

1           (1) by striking section 317N (42 U.S.C. 247b–  
2           15); and

3           (2) by adding at the end the following:

4   **“PART X—BIENNIAL ASSESSMENT OF HHS HEPA-**  
5       **TITIS B AND HEPATITIS C PREVENTION, EDU-**  
6       **CATION, RESEARCH, AND MEDICAL MANAGE-**  
7       **MENT PLAN**

8   **“SEC. 399NN. BIENNIAL UPDATE OF THE PLAN.**

9           “(a) IN GENERAL.—The Secretary shall conduct a bi-  
10       ennial assessment of the Secretary’s plan for the preven-  
11       tion, control, and medical management of, and education  
12       and research relating to, hepatitis B and hepatitis C, for  
13       the purposes of—

14           “(1) incorporating into such plan new knowl-  
15       edge or observations relating to hepatitis B and hep-  
16       atitis C (such as knowledge and observations that  
17       may be derived from clinical, laboratory, and epide-  
18       miological research and disease detection, preven-  
19       tion, and surveillance outcomes);

20           “(2) addressing gaps in the coverage or effec-  
21       tiveness of the plan; and

22           “(3) evaluating and, if appropriate, updating  
23       recommendations, guidelines, or educational mate-  
24       rials of the Centers for Disease Control and Preven-  
25       tion or the National Institutes of Health for health

1 care providers or the public on viral hepatitis in  
2 order to be consistent with the plan.

3 “(b) PUBLICATION OF NOTICE OF ASSESSMENTS.—

4 Not later than October 1 of the first even-numbered year  
5 beginning after the date of the enactment of this part,  
6 and October 1 of each even-numbered year thereafter, the  
7 Secretary shall publish in the Federal Register a notice  
8 of the results of the assessments conducted under para-  
9 graph (1). Such notice shall include—

10 “(1) a description of any revisions to the plan  
11 referred to in subsection (a) as a result of the as-  
12 sessment;

13 “(2) an explanation of the basis for any such  
14 revisions, including the ways in which such revisions  
15 can reasonably be expected to further promote the  
16 original goals and objectives of the plan; and

17 “(3) in the case of a determination by the Sec-  
18 retary that the plan does not need revision, an expla-  
19 nation of the basis for such determination.

20 **“SEC. 399NN-1. ELEMENTS OF PROGRAM.**

21 “(a) EDUCATION AND AWARENESS PROGRAMS.—The  
22 Secretary, acting through the Director of the Centers for  
23 Disease Control and Prevention, the Administrator of the  
24 Health Resources and Services Administration, and the  
25 Administrator of the Substance Abuse and Mental Health

1 Services Administration, and in accordance with the plan  
2 referred to in section 399NN(a), shall implement pro-  
3 grams to increase awareness and enhance knowledge and  
4 understanding of hepatitis B and hepatitis C. Such pro-  
5 grams shall include—

6           “(1) the conduct of culturally and language ap-  
7           propriate health education in primary and secondary  
8           schools, college campuses, public awareness cam-  
9           paigns, and community outreach activities (especially  
10          to the ethnic communities with high rates of chronic  
11          hepatitis B and chronic hepatitis C and other high-  
12          risk groups) to promote public awareness and knowl-  
13          edge about the value of hepatitis A and hepatitis B  
14          immunization, risk factors, the transmission and  
15          prevention of hepatitis B and hepatitis C, the value  
16          of screening for the early detection of hepatitis B  
17          and hepatitis C, and options available for the treat-  
18          ment of chronic hepatitis B and chronic hepatitis C;

19           “(2) the promotion of immunization programs  
20          that increase awareness and access to hepatitis A  
21          and hepatitis B vaccines for susceptible adults and  
22          children;

23           “(3) the training of health care professionals  
24          regarding the importance of vaccinating individuals  
25          infected with hepatitis C and individuals who are at



1 risk for hepatitis C infection against hepatitis A and  
2 hepatitis B;

3 “(4) the training of health care professionals  
4 regarding the importance of vaccinating individuals  
5 chronically infected with hepatitis B and individuals  
6 who are at risk for chronic hepatitis B infection  
7 against the hepatitis A virus;

8 “(5) the training of health care professionals  
9 and health educators to make them aware of the  
10 high rates of chronic hepatitis B and chronic hepa-  
11 titis C in certain adult ethnic populations, and the  
12 importance of prevention, detection, and medical  
13 management of hepatitis B and hepatitis C and of  
14 liver cancer screening;

15 “(6) the development and distribution of health  
16 education curricula (including information relating  
17 to the special needs of individuals infected with hep-  
18 atitis B and hepatitis C, such as the importance of  
19 prevention and early intervention, regular moni-  
20 toring, the recognition of psychosocial needs, appro-  
21 priate treatment, and liver cancer screening) for in-  
22 dividuals providing hepatitis B and hepatitis C coun-  
23 seling; and

1           “(7) support for the implementation curricula  
2           described in paragraph (6) by State and local public  
3           health agencies.

4           “(b) IMMUNIZATION, PREVENTION, AND CONTROL  
5 PROGRAMS.—

6           “(1) IN GENERAL.—The Secretary, acting  
7           through the Director of the Centers for Disease  
8           Control and Prevention, shall support the integra-  
9           tion of activities described in paragraph (2) into ex-  
10          isting clinical and public health programs at State,  
11          local, territorial, and tribal levels (including commu-  
12          nity health clinics, programs for the prevention and  
13          treatment of HIV/AIDS, sexually transmitted dis-  
14          eases, and substance abuse, and programs for indi-  
15          viduals in correctional settings).

16          “(2) ACTIVITIES.—

17                  “(A) VOLUNTARY TESTING PROGRAMS.—

18                          “(i) IN GENERAL.—The Secretary  
19                          shall establish a mechanism by which to  
20                          support and promote the development of  
21                          State, local, territorial, and tribal vol-  
22                          untary hepatitis B and hepatitis C testing  
23                          programs to screen the high-prevalence  
24                          populations to aid in the early identifica-  
25                          tion of chronically infected individuals.

1           “(ii) CONFIDENTIALITY OF THE TEST  
2 RESULTS.—The Secretary shall prohibit  
3 the use of the results of a hepatitis B or  
4 hepatitis C test conducted by a testing pro-  
5 gram developed or supported under this  
6 subparagraph for any of the following:

7                   “(I) Issues relating to health in-  
8 surance.

9                   “(II) To screen or determine  
10 suitability for employment.

11                   “(III) To discharge a person  
12 from employment.

13           “(B) COUNSELING REGARDING VIRAL HEP-  
14 ATITIS.—The Secretary shall support State,  
15 local, territorial, and tribal programs in a wide  
16 variety of settings, including those providing  
17 primary and specialty health care services in  
18 nonprofit private and public sectors, to—

19                   “(i) provide individuals with ongoing  
20 risk factors for hepatitis B and hepatitis C  
21 infection with client-centered education  
22 and counseling which concentrates on—

23                   “(I) promoting testing of individ-  
24 uals that have been exposed to their

1 blood, family members, and their sex-  
2 ual partners; and

3 “(II) changing behaviors that  
4 place individuals at risk for infection;

5 “(ii) provide individuals chronically in-  
6 fected with hepatitis B or hepatitis C with  
7 education, health information, and coun-  
8 seling to reduce their risk of—

9 “(I) dying from end-stage liver  
10 disease and liver cancer; and

11 “(II) transmitting viral hepatitis  
12 to others; and

13 “(iii) provide women chronically in-  
14 fected with hepatitis B or hepatitis C who  
15 are pregnant or of childbearing age with  
16 culturally and language appropriate health  
17 information, such as how to prevent hepa-  
18 titis B perinatal infection, and to alleviate  
19 fears associated with pregnancy or raising  
20 a family.

21 “(C) IMMUNIZATION.—The Secretary shall  
22 support State, local, territorial, and tribal ef-  
23 forts to expand the current vaccination pro-  
24 grams to protect every child in the country and  
25 all susceptible adults, particularly those infected

1 with hepatitis C and high-prevalence ethnic  
2 populations and other high-risk groups, from  
3 the risks of acute and chronic hepatitis B infec-  
4 tion by—

5 “(i) ensuring continued funding for  
6 hepatitis B vaccination for all children 19  
7 years of age or younger through the Vac-  
8 cines for Children Program;

9 “(ii) ensuring that the recommenda-  
10 tions of the Advisory Committee on Immu-  
11 nization Practices are followed regarding  
12 the birth dose of hepatitis B vaccinations  
13 for newborns;

14 “(iii) requiring proof of hepatitis B  
15 vaccination for entry into public or private  
16 daycare, preschool, elementary school, sec-  
17 ondary school, and institutions of higher  
18 education;

19 “(iv) expanding the availability of  
20 hepatitis B vaccination for all susceptible  
21 adults to protect them from becoming  
22 acutely or chronically infected, including  
23 ethnic and other populations with high  
24 prevalence rates of chronic hepatitis B in-  
25 fection;

1           “(v) expanding the availability of hep-  
2           atitis B vaccination for all susceptible  
3           adults, particularly those in their reproduc-  
4           tive age (women and men less than 45  
5           years of age), to protect them from the  
6           risk of hepatitis B infection;

7           “(vi) ensuring the vaccination of indi-  
8           viduals infected, or at risk for infection,  
9           with hepatitis C against hepatitis A, hepa-  
10          titis B, and other infectious diseases, as  
11          appropriate, for which such individuals  
12          may be at increased risk; and

13          “(vii) ensuring the vaccination of indi-  
14          viduals infected, or at risk for infection,  
15          with hepatitis B against hepatitis A virus  
16          and other infectious diseases, as appro-  
17          priate, for which such individuals may be  
18          at increased risk.

19          “(D) MEDICAL REFERRAL.—The Secretary  
20          shall support State, local, territorial, and tribal  
21          programs that support—

22                 “(i) referral of persons chronically in-  
23                 fected with hepatitis B or hepatitis C—

24                         “(I) for medical evaluation to de-  
25                         termine the appropriateness for

1           antiviral treatment to reduce the risk  
2           of progression to cirrhosis and liver  
3           cancer; and

4                   “(II) for ongoing medical man-  
5           agement including regular monitoring  
6           of liver function and screening for  
7           liver cancer; and

8                   “(ii) referral of persons infected with  
9           acute or chronic hepatitis B infection or  
10          acute or chronic hepatitis C infection for  
11          drug and alcohol abuse treatment where  
12          appropriate.

13                   “(3) INCREASED SUPPORT FOR ADULT VIRAL  
14          HEPATITIS COORDINATORS.—The Secretary, acting  
15          through the Director of the Centers for Disease  
16          Control and Prevention, shall provide increased sup-  
17          port to Adult Viral Hepatitis Coordinators in State,  
18          local, territorial, and tribal health departments in  
19          order to enhance the additional management, net-  
20          working, and technical expertise needed to ensure  
21          successful integration of hepatitis B and hepatitis C  
22          prevention and control activities into existing public  
23          health programs.

24                   “(c) EPIDEMIOLOGICAL SURVEILLANCE.—

1           “(1) IN GENERAL.—The Secretary, acting  
2 through the Director of the Centers for Disease  
3 Control and Prevention, shall support the establish-  
4 ment and maintenance of a national chronic and  
5 acute hepatitis B and hepatitis C surveillance pro-  
6 gram, in order to identify—

7           “(A) trends in the incidence of acute and  
8 chronic hepatitis B and acute and chronic hepa-  
9 titis C;

10           “(B) trends in the prevalence of acute and  
11 chronic hepatitis B and acute and chronic hepa-  
12 titis C infection among groups that may be dis-  
13 proportionately affected; and

14           “(C) trends in liver cancer and end-stage  
15 liver disease incidence and deaths, caused by  
16 chronic hepatitis B and chronic hepatitis C in  
17 the high-risk ethnic populations.

18           “(2) SEROPREVALENCE AND LIVER CANCER  
19 STUDIES.—The Secretary, acting through the Direc-  
20 tor of the Centers for Disease Control and Preven-  
21 tion, shall prepare a report outlining the population-  
22 based seroprevalence studies currently underway, fu-  
23 ture planned studies, the criteria involved in deter-  
24 mining which seroprevalence studies to conduct,  
25 defer, or suspend, and the scope of those studies, the



1 economic and clinical impact of hepatitis B and hep-  
2 atitis C, and the impact of chronic hepatitis B and  
3 chronic hepatitis C infections on the quality of life.  
4 Not later than one year after the date of the enact-  
5 ment of this part, the Secretary shall submit the re-  
6 port to the Committee on Energy and Commerce of  
7 the House of Representatives and the Committee on  
8 Health, Education, Labor, and Pensions of the Sen-  
9 ate.

10 “(3) CONFIDENTIALITY.—The Secretary shall  
11 not disclose any individually identifiable information  
12 identified under paragraph (1) or derived through  
13 studies under paragraph (2).

14 “(d) RESEARCH.—The Secretary, acting through the  
15 Director of the Centers for Disease Control and Preven-  
16 tion, the Director of the National Cancer Institute, and  
17 the Director of the National Institutes of Health, shall—

18 “(1) conduct epidemiologic and community-  
19 based research to develop, implement, and evaluate  
20 best practices for hepatitis B and hepatitis C pre-  
21 vention especially in the ethnic populations with high  
22 rates of chronic hepatitis B and chronic hepatitis C  
23 and other high-risk groups;

24 “(2) conduct research on hepatitis B and hepa-  
25 titis C natural history, pathophysiology, improved

1 treatments and prevention (such as the hepatitis C  
2 vaccine), and noninvasive tests that help to predict  
3 the risk of progression to liver cirrhosis and liver  
4 cancer;

5 “(3) conduct research that will lead to better  
6 noninvasive or blood tests to screen for liver cancer,  
7 and more effective treatments of liver cancer caused  
8 by chronic hepatitis B and chronic hepatitis C; and

9 “(4) conduct research comparing the effective-  
10 ness of screening, diagnostic, management, and  
11 treatment approaches for chronic hepatitis B, chron-  
12 ic hepatitis C, and liver cancer in the affected com-  
13 munities.

14 “(e) UNDERSERVED AND DISPROPORTIONATELY AF-  
15 FECTED POPULATIONS.—In carrying out this section, the  
16 Secretary shall provide expanded support for individuals  
17 with limited access to health education, testing, and health  
18 care services and groups that may be disproportionately  
19 affected by hepatitis B and hepatitis C.

20 “(f) EVALUATION OF PROGRAM.—The Secretary  
21 shall develop benchmarks for evaluating the effectiveness  
22 of the programs and activities conducted under this sec-  
23 tion and make determinations as to whether such bench-  
24 marks have been achieved.

1 **“SEC. 399NN-2. GRANTS.**

2       “(a) IN GENERAL.—The Secretary may award grants  
3 to, or enter into contracts or cooperative agreements with,  
4 States, political subdivisions of States, territories, Indian  
5 tribes, or nonprofit entities that have special expertise re-  
6 lating to hepatitis B, hepatitis C, or both, to carry out  
7 activities under this part.

8       “(b) APPLICATION.—To be eligible for a grant, con-  
9 tract, or cooperative agreement under subsection (a), an  
10 entity shall prepare and submit to the Secretary an appli-  
11 cation at such time, in such manner, and containing such  
12 information as the Secretary may require.

13 **“SEC. 399NN-3. AUTHORIZATION OF APPROPRIATIONS.**

14       “There are authorized to be appropriated to carry out  
15 this part \$90,000,000 for fiscal year 2012, \$90,000,000  
16 for fiscal year 2013, \$110,000,000 for fiscal year 2014,  
17 \$130,000,000 for fiscal year 2015, and \$150,000,000 for  
18 fiscal year 2016.”.

19       (d) ENHANCING SAMHSA’S ROLE IN HEPATITIS AC-  
20 TIVITIES.—Paragraph (6) of section 501(d) of the Public  
21 Health Service Act (42 U.S.C. 290aa(d)) is amended by  
22 striking “HIV or tuberculosis” and inserting “HIV, tuber-  
23 culosis, or hepatitis”.

1 **Subtitle C—Acquired Bone Marrow**  
2 **Failure Diseases**

3 **SEC. 721. ACQUIRED BONE MARROW FAILURE DISEASES.**

4 (a) **SHORT TITLE.**—This subtitle may be cited as the  
5 “Bone Marrow Failure Disease Research and Treatment  
6 Act of 2011”.

7 (b) **FINDINGS.**—The Congress finds the following:

8 (1) Between 20,000 and 30,000 Americans are  
9 diagnosed each year with myelodysplastic syndromes,  
10 aplastic anemia, paroxysmal nocturnal hemo-  
11 globinuria, and other acquired bone marrow failure  
12 diseases.

13 (2) Acquired bone marrow failure diseases have  
14 a debilitating and often fatal impact on those diag-  
15 nosed with these diseases.

16 (3) While some treatments for acquired bone  
17 marrow failure diseases can prolong and improve the  
18 quality of patients’ lives, there is no single cure for  
19 these diseases.

20 (4) The prevalence of acquired bone marrow  
21 failure diseases in the United States will continue to  
22 grow as the general public ages.

23 (5) Evidence exists suggesting that acquired  
24 bone marrow failure diseases occur more often in

1 minority populations, particularly in Asian-American  
2 and Hispanic/Latin-American populations.

3 (6) The National Heart, Lung, and Blood Insti-  
4 tute and the National Cancer Institute have con-  
5 ducted important research into the causes of and  
6 treatments for acquired bone marrow failure dis-  
7 eases.

8 (7) The National Marrow Donor Program Reg-  
9 istry has made significant contributions to the fight  
10 against bone marrow failure diseases by connecting  
11 millions of potential marrow donors with individuals  
12 and families suffering from these conditions.

13 (8) Despite these advances, a more comprehen-  
14 sive Federal strategic effort among numerous Fed-  
15 eral agencies is needed to discover a cure for ac-  
16 quired bone marrow failure disorders.

17 (9) Greater Federal surveillance of acquired  
18 bone marrow failure diseases is needed to gain a bet-  
19 ter understanding of the causes of acquired bone  
20 marrow failure diseases.

21 (10) The Federal Government should increase  
22 its research support for and engage with public and  
23 private organizations in developing a comprehensive  
24 approach to combat and cure acquired bone marrow  
25 failure diseases.

1 (c) NATIONAL ACQUIRED BONE MARROW FAILURE  
2 DISEASE REGISTRY.—Part B of the Public Health Service  
3 Act (42 U.S.C. 311 et seq.) is amended by inserting after  
4 section 317W, as added, the following:

5 **“SEC. 317X. NATIONAL ACQUIRED BONE MARROW FAILURE**  
6 **DISEASE REGISTRY.**

7 “(a) ESTABLISHMENT OF REGISTRY.—

8 “(1) IN GENERAL.—Not later than 6 months  
9 after the date of the enactment of this section, the  
10 Secretary, acting through the Director of the Cen-  
11 ters for Disease Control and Prevention, shall—

12 “(A) develop a system to collect data on  
13 acquired bone marrow failure diseases; and

14 “(B) establish and maintain a national and  
15 publicly available registry, to be known as the  
16 National Acquired Bone Marrow Failure Dis-  
17 ease Registry, in accordance with paragraph  
18 (3).

19 “(2) RECOMMENDATIONS OF ADVISORY COM-  
20 MITTEE.—In carrying out this subsection, the Sec-  
21 retary shall take into consideration the recommenda-  
22 tions of the Advisory Committee on Acquired Bone  
23 Marrow Failure Diseases established under sub-  
24 section (b).

1           “(3) PURPOSES OF REGISTRY.—The National  
2 Acquired Bone Marrow Failure Disease Registry—

3           “(A) shall identify the incidence and preva-  
4 lence of acquired bone marrow failure diseases  
5 in the United States;

6           “(B) shall be used to collect and store data  
7 on acquired bone marrow failure diseases, in-  
8 cluding data concerning—

9           “(i) the age, race or ethnicity, general  
10 geographic location, sex, and family history  
11 of individuals who are diagnosed with ac-  
12 quired bone marrow failure diseases, and  
13 any other characteristics of such individ-  
14 uals determined appropriate by the Sec-  
15 retary;

16           “(ii) the genetic and environmental  
17 factors that may be associated with devel-  
18 oping acquired bone marrow failure dis-  
19 eases;

20           “(iii) treatment approaches for deal-  
21 ing with acquired bone marrow failure dis-  
22 eases;

23           “(iv) outcomes for individuals treated  
24 for acquired bone marrow failure diseases,  
25 including outcomes for recipients of stem

1 cell therapeutic products as contained in  
2 the database established pursuant to sec-  
3 tion 379A; and

4 “(v) any other factors pertaining to  
5 acquired bone marrow failure diseases de-  
6 termined appropriate by the Secretary; and

7 “(C) shall be made available—

8 “(i) to the general public; and

9 “(ii) to researchers to facilitate fur-  
10 ther research into the causes of, and treat-  
11 ments for, acquired bone marrow failure  
12 diseases in accordance with standard prac-  
13 tices of the Centers for Disease Control  
14 and Preventions.

15 “(b) ADVISORY COMMITTEE.—

16 “(1) ESTABLISHMENT.—Not later than 6  
17 months after the date of the enactment of this sec-  
18 tion, the Secretary, acting through the Director of  
19 the Centers for Disease Control and Prevention,  
20 shall establish an advisory committee, to be known  
21 as the Advisory Committee on Acquired Bone Mar-  
22 row Failure Diseases.

23 “(2) MEMBERS.—The members of the Advisory  
24 Committee on Acquired Bone Marrow Failure Dis-  
25 eases shall be appointed by the Secretary, acting



1 through the Director of the Centers for Disease  
2 Control and Prevention, and shall include at least  
3 one representative from each of the following:

4 “(A) A national patient advocacy organiza-  
5 tion with experience advocating on behalf of pa-  
6 tients suffering from acquired bone marrow  
7 failure diseases.

8 “(B) The National Institutes of Health, in-  
9 cluding at least one representative from each  
10 of—

11 “(i) the National Cancer Institute;

12 “(ii) the National Heart, Lung, and  
13 Blood Institute; and

14 “(iii) the Office of Rare Diseases.

15 “(C) The Centers for Disease Control and  
16 Prevention.

17 “(D) Clinicians with experience in—

18 “(i) diagnosing or treating acquired  
19 bone marrow failure diseases; and

20 “(ii) medical data registries.

21 “(E) Epidemiologists who have experience  
22 with data registries.

23 “(F) Publicly or privately funded research-  
24 ers who have experience researching acquired  
25 bone marrow failure diseases.

1           “(G) The entity operating the C.W. Bill  
2           Young Cell Transplantation Program estab-  
3           lished pursuant to section 379 and the entity  
4           operating the C.W. Bill Young Cell Transplan-  
5           tation Program Outcomes Database.

6           “(3) RESPONSIBILITIES.—The Advisory Com-  
7           mittee on Acquired Bone Marrow Failure Diseases  
8           shall provide recommendations to the Secretary on  
9           the establishment and maintenance of the National  
10          Acquired Bone Marrow Failure Disease Registry, in-  
11          cluding recommendations on the collection, mainte-  
12          nance, and dissemination of data.

13          “(4) PUBLIC AVAILABILITY.—The Secretary  
14          shall make the recommendations of the Advisory  
15          Committee on Acquired Bone Marrow Failure Dis-  
16          ease publicly available.

17          “(c) GRANTS.—The Secretary, acting through the  
18          Director of the Centers for Disease Control and Preven-  
19          tion, may award grants to, and enter into contracts and  
20          cooperative agreements with, public or private nonprofit  
21          entities for the management of, as well as the collection,  
22          analysis, and reporting of data to be included in, the Na-  
23          tional Acquired Bone Marrow Failure Disease Registry.

24          “(d) DEFINITION.—In this section, the term ‘ac-  
25          quired bone marrow failure disease’ means—

- 1           “(1) myelodysplastic syndromes (MDS);  
2           “(2) aplastic anemia;  
3           “(3) paroxysmal nocturnal hemoglobinuria  
4           (PNH);  
5           “(4) pure red cell aplasia;  
6           “(5) acute myeloid leukemia that has pro-  
7           gressed from myelodysplastic syndromes; or  
8           “(6) large granular lymphocytic leukemia.

9           “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
10 is authorized to be appropriated to carry out this section  
11 \$3,000,000 for each of fiscal years 2012 through 2016.”.

12           (d) PILOT STUDIES THROUGH THE AGENCY FOR  
13 TOXIC SUBSTANCES AND DISEASE REGISTRY.—

14           (1) PILOT STUDIES.—The Secretary of Health  
15 and Human Services, acting through the Adminis-  
16 trator of the Agency for Toxic Substances and Dis-  
17 ease Registry, shall conduct pilot studies to deter-  
18 mine which environmental factors, including expo-  
19 sure to toxins, may cause acquired bone marrow fail-  
20 ure diseases.

21           (2) COLLABORATION WITH THE RADIATION IN-  
22 JURY TREATMENT NETWORK.—In carrying out the  
23 directives of this section, the Secretary may collabo-  
24 rate with the Radiation Injury Treatment Network  
25 of the C.W. Bill Young Cell Transplantation Pro-

1       gram established pursuant to section 379 of the  
2       Public Health Service Act (42 U.S.C. 274j) to—

3               (A) augment data for the pilot studies au-  
4               thorized by this section;

5               (B) access technical assistance that may be  
6               provided by the Radiation Injury Treatment  
7               Network; or

8               (C) perform joint research projects.

9               (3) AUTHORIZATION OF APPROPRIATIONS.—

10       There is authorized to be appropriated to carry out  
11       this section \$1,000,000 for each of fiscal years 2012  
12       through 2016.

13       (e) MINORITY-FOCUSED PROGRAMS ON ACQUIRED  
14       BONE MARROW FAILURE DISEASES.—Title XVII of the  
15       Public Health Service Act (42 U.S.C. 300u et seq.) is  
16       amended by inserting after section 1707A the following:

17       “MINORITY-FOCUSED PROGRAMS ON ACQUIRED BONE  
18                               MARROW FAILURE DISEASES

19       “SEC. 1707B. (a) INFORMATION AND REFERRAL  
20       SERVICES.—

21               “(1) IN GENERAL.—Not later than 6 months  
22       after the date of the enactment of this section, the  
23       Secretary, acting through the Deputy Assistant Sec-  
24       retary for Minority Health, shall establish and co-  
25       ordinate outreach and informational programs tar-

1       geted to minority populations affected by acquired  
2       bone marrow failure diseases.

3               “(2) PROGRAM REQUIREMENTS.—Minority-fo-  
4       cused outreach and informational programs author-  
5       ized by this section—

6                       “(A) shall make information about treat-  
7       ment options and clinical trials for acquired  
8       bone marrow failure diseases publicly available,  
9       and

10                      “(B) shall provide referral services for  
11       treatment options and clinical trials,  
12       at the national minority health resource center sup-  
13       ported under section 1707(b)(8) (including by means  
14       of the center’s Web site, through appropriate loca-  
15       tions such as the center’s knowledge center, and  
16       through appropriate programs such as the center’s  
17       resource persons network) and through minority  
18       health consultants located at each Department of  
19       Health and Human Services regional office.

20               “(b) HISPANIC AND ASIAN-AMERICAN AND PACIFIC  
21 ISLANDER OUTREACH.—

22                      “(1) IN GENERAL.—The Secretary, acting  
23       through the Deputy Assistant Secretary for Minority  
24       Health, shall undertake a coordinated outreach ef-  
25       fort to connect Hispanic, Asian-American, and Pa-

1       cific Islander communities with comprehensive serv-  
2       ices focused on treatment of, and information about,  
3       acquired bone marrow failure diseases.

4           “(2) COLLABORATION.—In carrying out this  
5       subsection, the Secretary may collaborate with public  
6       health agencies, nonprofit organizations, community  
7       groups, and online entities to disseminate informa-  
8       tion about treatment options and clinical trials for  
9       acquired bone marrow failure diseases.

10       “(c) GRANTS AND COOPERATIVE AGREEMENTS.—

11           “(1) IN GENERAL.—Not later than 6 months  
12       after the date of the enactment of this section, the  
13       Secretary, acting through the Deputy Assistant Sec-  
14       retary for Minority Health, shall award grants to, or  
15       enter into cooperative agreements with, entities to  
16       perform research on acquired bone marrow failure  
17       diseases.

18           “(2) REQUIREMENT.—Grants and cooperative  
19       agreements authorized by this subsection shall be  
20       awarded or entered into on a competitive, peer-re-  
21       viewed basis.

22           “(3) SCOPE OF RESEARCH.—Research funded  
23       under this section shall examine factors affecting the  
24       incidence of acquired bone marrow failure diseases  
25       in minority populations.

1       “(d) DEFINITION.—In this section, the term ‘ac-  
2       quired bone marrow failure disease’ has the meaning given  
3       to such term in section 317X(d).

4       “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
5       is authorized to be appropriated to carry out this section  
6       \$2,000,000 for each of fiscal years 2012 through 2016.”.

7       (f) DIAGNOSIS AND QUALITY OF CARE FOR AC-  
8       QUIRED BONE MARROW FAILURE DISEASES.—

9               (1) GRANTS.—The Secretary of Health and  
10       Human Services, acting through the Director of the  
11       Agency for Healthcare Research and Quality, shall  
12       award grants to entities to improve diagnostic prac-  
13       tices and quality of care with respect to patients  
14       with acquired bone marrow failure diseases.

15              (2) AUTHORIZATION OF APPROPRIATIONS.—  
16       There is authorized to be appropriated to carry out  
17       this section \$2,000,000 for each of fiscal years 2012  
18       through 2016.

19       (g) DEFINITION.—In this section, the term “acquired  
20       bone marrow failure disease” means—

- 21               (1) myelodysplastic syndromes (MDS);
- 22               (2) aplastic anemia;
- 23               (3) paroxysmal nocturnal hemoglobinuria  
24               (PNH);
- 25               (4) pure red cell aplasia;

1 (5) acute myeloid leukemia that progressed  
2 from myelodysplastic syndromes; or

3 (6) large granular lymphocytic leukemia.

4 **Subtitle D—Cardiovascular Dis-**  
5 **ease, Chronic Disease, and**  
6 **Other Disease Issues**

7 **SEC. 731. GUIDELINES FOR DISEASE SCREENING FOR MI-**  
8 **NORITY PATIENTS.**

9 (a) IN GENERAL.—The Secretary, acting through the  
10 Director of the Agency for Healthcare Research and Qual-  
11 ity, shall convene a series of meetings to develop guidelines  
12 for disease screening for minority patient populations  
13 which have a higher than average risk for many chronic  
14 diseases and cancers.

15 (b) PARTICIPANTS.—In convening meetings under  
16 subsection (a), the Secretary shall ensure that meeting  
17 participants include representatives of—

18 (1) professional societies and associations;

19 (2) minority health organizations;

20 (3) health care researchers and providers, in-  
21 cluding those with expertise in minority health;

22 (4) Federal health agencies, including the Of-  
23 fice of Minority Health, the National Institute on  
24 Minority Health and Health Disparities, and the  
25 National Institutes of Health; and



1           (5) other experts determined appropriate by the  
2       Secretary.

3       (c) DISEASES.—Screening guidelines for minority  
4       populations shall be developed as appropriate under sub-  
5       section (a) for—

6           (1) hypertension;

7           (2) hypercholesterolemia;

8           (3) diabetes;

9           (4) cardiovascular disease;

10          (5) cancers, including breast, prostate, colon,  
11       cervical, and lung cancer;

12          (6) asthma;

13          (7) diabetes;

14          (8) kidney diseases;

15          (9) eye diseases and disorders, including glau-  
16       coma;

17          (10) HIV/AIDS and sexually transmitted dis-  
18       eases;

19          (11) uterine fibroids;

20          (12) autoimmune disease;

21          (13) mental health conditions;

22          (14) dental health conditions and oral diseases;

23          (15) environmental and related health illnesses  
24       and conditions;

25          (16) Sickle cell disease;

- 1           (17) violence and injury prevention and control;  
2           (18) genetic and related conditions;  
3           (19) heart disease and stroke;  
4           (20) tuberculosis;  
5           (21) chronic obstructive pulmonary disease; and  
6           (22) other diseases determined appropriate by  
7           the Secretary.

8           (d) DISSEMINATION.—Not later than 24 months  
9 after the date of enactment of this title, the Secretary  
10 shall publish and disseminate to health care provider orga-  
11 nizations the guidelines developed under subsection (a).

12           (e) AUTHORIZATION OF APPROPRIATIONS.—There  
13 are authorized to be appropriated to carry out this section,  
14 such sums as may be necessary for each of fiscal years  
15 2012 through 2016.

16 **SEC. 732. COVERAGE OF THE SHINGLES VACCINE UNDER**  
17 **THE MEDICARE PROGRAM.**

18           (a) IN GENERAL.—Section 1861 of the Social Secu-  
19 rity Act (42 U.S.C. 1395x) is amended—

20           (1) in subsection (s)(10)(A), by inserting “,  
21 shingles vaccine and its administration,” before  
22 “and, subject to”; and

23           (2) in subsection (ww)(2)(A), by inserting  
24 “shingles,” after “Pneumococcal,”.

1 (b) EFFECTIVE DATE.—The amendments made by  
2 subsection (a) shall apply to shingles vaccine furnished on  
3 or after January 1 of the first calendar year beginning  
4 more than 60 days after the date of the enactment of this  
5 Act.

6 **SEC. 733. CDC WISEWOMAN SCREENING PROGRAM.**

7 Section 1509 of the Public Health Service Act (42  
8 U.S.C. 300n–4a) is amended—

9 (1) in subsection (a)—

10 (A) by striking the heading and inserting  
11 “IN GENERAL.—”; and

12 (B) in the matter preceding paragraph (1),  
13 by striking “may make grants” and all that fol-  
14 lows through “purpose” and inserting the fol-  
15 lowing: “may make grants to such States for  
16 the purpose”; and

17 (2) in subsection (d)(1), by striking “there are  
18 authorized” and all that follows through the period  
19 and inserting “there are authorized to be appro-  
20 priated \$23,000,000 for fiscal year 2012,  
21 \$25,300,000 for fiscal year 2013, \$27,800,000 for  
22 fiscal year 2014, \$30,800,000 for fiscal year 2015,  
23 and \$34,000,000 for fiscal year 2016.”.

1 **SEC. 734. 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.) is amended by adding at the end  
5 the following:

6 **“SEC. 399V-5. REPORT ON CARDIOVASCULAR CARE FOR**  
7 **WOMEN AND MINORITIES.**

8 “Not later than September 30, 2014, 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. 735. COVERAGE OF COMPREHENSIVE TOBACCO CES-**  
19 **SATION SERVICES IN MEDICAID.**

20 (a) REQUIRING COVERAGE OF COUNSELING AND  
21 PHARMACOTHERAPY FOR CESSATION OF TOBACCO  
22 USE.—Section 1905 of the Social Security Act (42 U.S.C.  
23 1396d) is amended—

24 (1) in subsection (a)(4)(D) is amended by strik-  
25 ing “by pregnant women”; and

26 (2) in subsection (bb)—

1 (A) by striking “by pregnant women” each  
2 place it appears;

3 (B) in paragraph (1), in the matter before  
4 subparagraph (A), by inserting “by individuals”  
5 before “who use tobacco”; and

6 (C) in paragraph (2)(A), by striking “with  
7 respect to pregnant women”.

8 (b) EXCEPTION FROM OPTIONAL RESTRICTION  
9 UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—  
10 Section 1927(d)(2)(F) of the Social Security Act (42  
11 U.S.C. 1396r–8(d)(2)(F)) is amended by striking “in the  
12 case of pregnant women”.

13 (c) REMOVAL OF COST SHARING FOR COUNSELING  
14 AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO  
15 USE.—

16 (1) GENERAL COST SHARING LIMITATIONS.—  
17 Section 1916 of the Social Security Act (42 U.S.C.  
18 1396o) is amended—

19 (A) in subsections (a)(2)(B) and (b)(2)(B),  
20 by striking “and counseling and pharmacothe-  
21 rapy for cessation of tobacco use by pregnant  
22 women (as defined in section 1905(bb)) and  
23 covered outpatient drugs (as defined in sub-  
24 section (k)(2) of section 1927 and including  
25 nonprescription drugs described in subsection

1 (d)(2) of such section) that are prescribed for  
2 purposes of promoting, and when used to pro-  
3 mote, tobacco cessation by pregnant women in  
4 accordance with the Guideline referred to in  
5 section 1905(bb)(2)(A)” each place it appears;  
6 and

7 (B) in each of subsections (a)(2)(D) and  
8 (b)(2)(D) by inserting “and counseling and  
9 pharmacotherapy for cessation of tobacco use  
10 (as defined in section 1905(bb)) and covered  
11 outpatient drugs (as defined in subsection  
12 (k)(2) of section 1927 and including non-  
13 prescription drugs described in subsection  
14 (d)(2) of such section) that are prescribed for  
15 purposes of promoting, and when used to pro-  
16 mote, tobacco cessation in accordance with the  
17 Guideline referred to in section  
18 1905(bb)(2)(A),” after “section  
19 1905(a)(4)(C),”.

20 (2) APPLICATION TO ALTERNATIVE  
21 COSTSHARING.—Section 1916A(b)(3)(B) of such Act  
22 (42 U.S.C. 1396o–1(b)(3)(B)) is amended—

23 (A) in clause (iii), by striking “, and coun-  
24 seling and pharmacotherapy for cessation of to-

1           bacco use by pregnant women (as defined in  
2           section 1905(bb))”); and

3           (B) by adding at the end the following:

4                   “(xi)           Counseling           and  
5                   pharmacotherapy for cessation of tobacco  
6                   use (as defined in section 1905(bb)) and  
7                   covered outpatient drugs (as defined in  
8                   subsection (k)(2) of section 1927 and in-  
9                   cluding nonprescription drugs described in  
10                  subsection (d)(2) of such section) that are  
11                  prescribed for purposes of promoting, and  
12                  when used to promote, tobacco cessation in  
13                  accordance with the Guideline referred to  
14                  in section 1905(bb)(2)(A).”.

15          (d) EFFECTIVE DATE.—The amendments made by  
16 this section shall take effect on October 1, 2012.

17 **SEC. 736. CLINICAL RESEARCH FUNDING FOR ORAL**  
18 **HEALTH.**

19          (a) IN GENERAL.—The Secretary of Health and  
20 Human Services shall expand and intensify the conduct  
21 and support of the research activities of the National In-  
22 stitutes of Health and the National Institute of Dental  
23 and Craniofacial Research to improve the oral health of  
24 the population through the prevention and management  
25 of oral diseases and conditions.

1 (b) INCLUDED RESEARCH ACTIVITIES.—Research  
2 activities under subsection (a) shall include—

3 (1) comparative effectiveness research and clin-  
4 ical disease management research addressing early  
5 childhood caries and oral cancer; and

6 (2) awarding of grants and contracts to support  
7 the training and development of health services re-  
8 searchers, comparative effectiveness researchers, and  
9 clinical researchers whose research improves the oral  
10 health of the population.

## 11 **Subtitle E—HIV/AIDS**

### 12 **SEC. 741. FINDINGS.**

13 The Congress finds the following:

14 (1) Over one million people are estimated to be  
15 living with HIV in the United States according to  
16 the Centers for Disease Control and Prevention.

17 (2) Annually there are over 17,000 deaths in  
18 people with an HIV diagnoses in 40 States and 5  
19 dependent areas of the United States.

20 (3) The Centers for Disease Control and Pre-  
21 vention estimates that in 2009 there were approxi-  
22 mately 48,100 people newly infected with HIV.  
23 Though this number seems to be staying relatively  
24 stable, the number of new infections is rapidly in-  
25 creasing among certain populations especially among



1 young African-American men who have sex with men  
2 who had an overall 48 percent increase in new infec-  
3 tions from 2006 to 2009.

4 (4) HIV disproportionately affects certain popu-  
5 lations in the United States. Though African-Ameri-  
6 cans represent less than 13 percent of the popu-  
7 lation, African-Americans account for almost half  
8 (46 percent) of all people living with HIV in the  
9 United States. Men who have sex with men (MSM)  
10 make up approximately 2 percent of the population,  
11 but account for over half (53 percent) of individuals  
12 living with HIV and are the only risk group in which  
13 HIV infections continue to increase.

14 (5) Disparities exist among Latin-Americans;  
15 they make up 15 percent of US population and 17  
16 percent of new infections (2006).

17 (6) Though American Indians/Alaska Natives  
18 represent less than 1 percent of the total number of  
19 HIV/AIDS cases, American Indians and Alaska Na-  
20 tives rank third in rates of HIV/AIDS diagnosis,  
21 after African-Americans and Latin-Americans.

22 (7) While Asian-Americans, Native Hawaiians,  
23 and Pacific Islanders HIV/AIDS cases account for  
24 approximately 1 percent of cases nationally, Asian  
25 Americans and Pacific Islanders were the only ra-

1 cial/ethnic groups with a statistically significant in-  
2 crease in new HIV diagnoses between 2001 and  
3 2008.

4 (8) The limited data available on transgender  
5 individuals point to a disproportionate burden of  
6 HIV infection.

7 (9) Stigma and discrimination contribute to  
8 these disparities.

9 (10) For HIV, early detection and treatment  
10 can have huge effects. New research suggests that  
11 treatment of individuals not only slows disease pro-  
12 gression, but can also greatly reduce the risk of  
13 transmission to other individuals.

14 (11) To combat the HIV epidemic in the United  
15 States, the National HIV/AIDS Strategy (NHAS)  
16 from the White House Office of National AIDS Pol-  
17 icy provides a framework of increasing access to  
18 care, reducing new infections, and eliminating HIV-  
19 related health disparities. The vision of NHAS is  
20 “The United States will become a place where new  
21 HIV infections are rare and when they do occur,  
22 every person, regardless of age, gender, race/eth-  
23 nicity, sexual orientation, gender identity, or socio-  
24 economic circumstance, will have unfettered access

1 to high quality, life extending care, free from stigma  
2 and discrimination.”.

3 (12) Although the cost of education, treatment  
4 and care, and research are not inconsequential, they  
5 are substantially less than the annual health care  
6 cost attributable to HIV in the United States. The  
7 lifetime cost of HIV care and treatment in 2004 was  
8 estimated to be \$405,000 to \$648,000 dollars annu-  
9 ally. Preventing 40,000 new infections in the United  
10 States each year would save \$12.8 billion annually.

11 **SEC. 742. ADDRESSING HIV/AIDS IN COMMUNITIES OF**  
12 **COLOR.**

13 (a) NATIONAL OBSERVANCE DAYS.—It is the sense  
14 of the Congress that national observance days highlighting  
15 the impact of HIV/AIDS on communities of color include  
16 the following:

17 (1) National Black HIV/AIDS Awareness Day.

18 (2) National Latino AIDS Awareness Day.

19 (3) National Asian and Pacific Islander HIV/  
20 AIDS Awareness Day.

21 (4) National Native HIV/AIDS Awareness Day.

22 (5) Caribbean American HIV/AIDS Awareness  
23 Day.

1 (b) CALL TO ACTION.—It is the sense of the Con-  
2 gress that the President should call on members of com-  
3 munities of color—

4 (1) to become involved at the local community  
5 level in HIV/AIDS testing, policy, and advocacy;

6 (2) to become aware, engaged, and empowered  
7 on the HIV/AIDS epidemic within their commu-  
8 nities; and

9 (3) to urge members of their communities to re-  
10 duce risk factors, practice safe sex and other preven-  
11 tive measures, be tested for HIV/AIDS, and seek  
12 care when appropriate.

13 **SEC. 743. HIV/AIDS REDUCTION IN RACIAL AND ETHNIC MI-**  
14 **NORITY COMMUNITIES.**

15 (a) EXPANDED FUNDING.—The Secretary, in col-  
16 laboration with the Deputy Assistant Secretary for Minor-  
17 ity Health, the Director of the Centers for Disease Control  
18 and Prevention, the Administrator of the Health Re-  
19 sources and Services Administration, and the Adminis-  
20 trator of the Substance Abuse and Mental Health Services  
21 Administration, shall provide funds and carry out activi-  
22 ties to expand the Minority HIV/AIDS Initiative.

23 (b) USE OF FUNDS.—The additional funds made  
24 available under this section may be used, through the Mi-  
25 nority AIDS Initiative, to support the following activities:

1           (1) Providing technical assistance and infra-  
2           structure support to reduce HIV/AIDS in minority  
3           populations.

4           (2) Increasing minority populations' access to  
5           HIV/AIDS prevention and care services.

6           (3) Building strong community programs and  
7           partnerships to address HIV prevention and the  
8           health care needs of specific racial and ethnic minor-  
9           ity populations.

10          (c) PRIORITY INTERVENTIONS.—Within the racial  
11          and ethnic minority populations referred to in subsection  
12          (b), priority in conducting intervention services shall be  
13          given to—

14                 (1) women;

15                 (2) youth;

16                 (3) men who have sex with men;

17                 (4) persons who engage in intravenous drug  
18          abuse;

19                 (5) homeless individuals; and

20                 (6) individuals incarcerated or in the penal sys-  
21          tem.

22          (d) AUTHORIZATION OF APPROPRIATIONS.—For car-  
23          rying out this section, there are authorized to be appro-  
24          priated \$610,000,000 for fiscal year 2012 and such sums

1 as may be necessary for each of fiscal years 2013 through  
2 2016.

3 **SEC. 744. REPEALING INEFFECTIVE AND INCOMPLETE AB-**  
4 **STINENCE-ONLY EDUCATION PROGRAM.**

5 (a) IN GENERAL.—Title V of the Social Security Act  
6 (42 U.S.C. 701 et seq.) is amended by striking section  
7 510.

8 (b) RESCISSION.—Amounts appropriated for each of  
9 fiscal years 2010 and 2011 under section 510(d) of the  
10 Social Security Act (42 U.S.C. 710(d)) (as in effect on  
11 the day before the date of enactment of this Act) that are  
12 unobligated as of the date of enactment of this Act are  
13 rescinded.

14 (c) REPROGRAM OF ELIMINATED ABSTINENCE-ONLY  
15 FUNDS FOR THE PERSONAL RESPONSIBILITY EDUCATION  
16 PROGRAM (PREP).—Section 513(f) of the Social Security  
17 Act (42 U.S.C. 713(f)) is amended by striking “for each  
18 of fiscal years 2010 through 2014” and inserting “for fis-  
19 cal year 2010, \$75,000,000 increased by an amount equal  
20 to the unobligated portion of funds appropriated for each  
21 of fiscal years 2010 and 2011 under section 510(d) that  
22 are rescinded under subsection (b), and \$125,000,000 for  
23 each of fiscal years 2012 through 2014”.

1 **SEC. 745. 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) The term “dental education loan”—

9                 (A) means a loan that is incurred for the  
10 cost of attendance (including tuition, other rea-  
11 sonable educational expenses, and reasonable  
12 living costs) at a school of dentistry; and

13                 (B) includes only the portion of the loan  
14 that is outstanding on the date the dentist in-  
15 volved begins the service specified in the agree-  
16 ment under subsection (a).

17           (2) The term “dentist” means a graduate of a  
18 school of dentistry who has completed postgraduate  
19 training in general or pediatric dentistry.

20           (3) The term “HIV/AIDS” means human im-  
21 munodeficiency virus and acquired immune defi-  
22 ciency syndrome.

23           (4) The term “school of dentistry” has the  
24 meaning given to that term in section 799B of the  
25 Public Health Service Act (42 U.S.C. 295p).

1           (5) The term “Secretary” means the Secretary  
2           of Health and Human Services.

3           (f) AUTHORIZATION OF APPROPRIATIONS.—To carry  
4           out this section, there are authorized to be appropriated  
5           such sums as may be necessary for each of fiscal years  
6           2012 through 2016.

7           **SEC. 746. REPORT ON THE IMPLEMENTATION OF THE NA-**  
8                                 **TIONAL HIV/AIDS STRATEGY.**

9           (a) REPORT REQUIRED.—Not later than 6 months  
10          after the date of the enactment of this Act, the President,  
11          in consultation with the heads of all relevant agencies in-  
12          cluding the Department of Education, the Department of  
13          Health and Human Services, the Department of Housing  
14          and Urban Development, the Department of Justice, the  
15          Department of Labor, the Department of Veterans Af-  
16          fairs, and the Social Security Administration, shall trans-  
17          mit to the Congress and make publicly available a report  
18          on the status of the implementation of the National HIV/  
19          AIDS Strategy.

20          (b) CONTENTS.—The report required by subsection  
21          (a) shall include a description, analysis, and evaluation  
22          of—

23                         (1) key steps taken by the Federal Government  
24                         towards the achievement of the goals of the National  
25                         HIV/AIDS Strategy, including the goals of—

1           (A) reducing the number of people who be-  
2           come infected with HIV;

3           (B) increasing access to care and opti-  
4           mizing health outcomes for people living with  
5           HIV; and

6           (C) reducing HIV-related health dispari-  
7           ties;

8           (2) the extent to which the National HIV/AIDS  
9           Strategy has improved coordination of efforts to  
10          maximize the effective delivery of HIV/AIDS preven-  
11          tion, care, and treatment services at the community  
12          level, including coordination—

13           (A) within and among Federal agencies  
14           and departments;

15           (B) between the Federal Government and  
16           State and local governments and health depart-  
17           ments;

18           (C) between the Federal Government and  
19           nonprofit foundations and civil society organiza-  
20           tions, including community- and faith-based or-  
21           ganizations focused on addressing the issue of  
22           HIV/AIDS; and

23           (D) between the Federal Government and  
24           private businesses;

1           (3) efforts by the Federal Government to edu-  
2           cate, involve, and establish and strengthen partner-  
3           ships with civil society organizations, including  
4           community- and faith-based organizations, in order  
5           to implement the National HIV/AIDS Strategy and  
6           achieve its goals;

7           (4) how Federal resources are being deployed to  
8           implement the Strategy, including—

9                   (A) the amount of funding used to date, by  
10                  each Federal agency and department, to imple-  
11                  ment the National HIV/AIDS Strategy;

12                  (B) a brief summary for each Federal  
13                  agency and department of the number and  
14                  function of all Federal employees assisting in  
15                  implementing the Strategy; and

16                  (C) an estimate of the amount of funding  
17                  necessary to implement the National HIV/AIDS  
18                  Strategy, by each Federal agency and depart-  
19                  ment, for the next fiscal year; and

20           (5) what additional steps, if any, are necessary  
21           to fully implement the National HIV/AIDS Strategy,  
22           including—

23                   (A) whether any existing statutory laws,  
24                  policies, or regulations are impeding the imple-  
25                  mentation of the National HIV/AIDS Strategy,

1 at the Federal, State, or local level, and wheth-  
2 er any changes to such laws, policies, or regula-  
3 tions are necessary or recommended; and

4 (B) whether any Federal agencies or de-  
5 partments require additional statutory authority  
6 to effectively carry out their duties as part of  
7 the National HIV/AIDS Strategy.

8 (c) USE OF PREVIOUSLY APPROPRIATED FUNDS.—  
9 Funding for the report required under subsection (a) shall  
10 derive from discretionary funds of the departments and  
11 agencies specified in such subsection.

12 **SEC. 747. ADDRESSING HIV/AIDS IN THE AFRICAN-AMER-**  
13 **ICAN COMMUNITY.**

14 (a) SENSE OF CONGRESS ON NATIONAL BLACK  
15 CLERGY HIV/AIDS AWARENESS SUNDAY.—It is the  
16 sense of Congress that—

17 (1) there should be established a National  
18 Black Clergy HIV/AIDS Awareness Sunday on  
19 which the Congress and the President call on mem-  
20 bers of the Black clergy—

21 (A) to become involved at the local commu-  
22 nity level in HIV/AIDS testing, policy, and ad-  
23 vocacy;

1 (B) to discuss the HIV/AIDS epidemic  
2 with their congregations and the community at-  
3 large; and

4 (C) to urge members of their congregations  
5 to reduce risk factors, practice safe sex and  
6 other preventive measures, be tested for HIV/  
7 AIDS, and seek care when appropriate; and

8 (2) an appropriate Sunday should be selected  
9 for this occasion.

10 (b) SENSE OF CONGRESS ON FEDERAL AGENCIES  
11 WITH RESPONSIBILITY FOR PREVENTING, TESTING FOR,  
12 AND TREATING HIV/AIDS.—It is the sense of Congress  
13 that all Federal agencies with a responsibility for pre-  
14 venting, testing for, and treating HIV/AIDS should—

15 (1) adopt policies for prevention, testing, and  
16 treatment that are consistent with the guidelines  
17 issued in 2006 by the Centers for Disease Control  
18 and Prevention, entitled “Revised Recommendations  
19 for HIV Testing of Adults, Adolescents, and Preg-  
20 nant Women in Health-Care Settings”; and

21 (2) begin a systemic, aggressive approach to im-  
22 plementing voluntary, routine testing as part of all  
23 health exams, including in emergency rooms, clinics,  
24 and private physician offices.

1 (c) SENSE OF CONGRESS ON FEDERAL BUREAU OF  
2 PRISONS PROCEDURES FOR INMATES WITH HIV.—It is  
3 the sense of Congress that the Federal Bureau of Prisons  
4 should implement procedures for—

5 (1) voluntary HIV testing as a routine compo-  
6 nent of inmate care; and

7 (2) referral to care as a routine component of  
8 release planning for inmates with HIV/AIDS, includ-  
9 ing referral to community-based care and faith-based  
10 institutions.

11 **SEC. 748. NATIONAL BLACK CLERGY FOR THE ELIMI-**  
12 **NATION OF HIV/AIDS.**

13 (a) SHORT TITLE.—This section may be cited as the  
14 “National Black Clergy for the Elimination of HIV/AIDS  
15 Act of 2011”.

16 (b) FINDINGS.—Congress finds the following:

17 (1) It has been estimated that more than  
18 1,200,000 people in the United States are living  
19 with HIV/AIDS, and approximately 500,000 of them  
20 are Black. Blacks are 8 times more likely to have  
21 AIDS than their White counterparts. Within the  
22 Black community, the subpopulation most dispropor-  
23 tionately impacted by HIV/AIDS is Black men who  
24 have sex with men (MSM) with prevalence rates  
25 twice those of White MSM. Black women account

1 for the majority of new AIDS cases among women  
2 and are 23 times more likely to be living with AIDS  
3 than White women and 4 times more likely than  
4 Latinas.

5 (2) On October 7–8, 2007, 186 Black clergy,  
6 consisting of Baptist, COGIC, Methodist, Protes-  
7 tant, AME, and Pentecostal, together with, medical,  
8 policy, and AIDS leaders, were brought together by  
9 the National Black Leadership Commission on  
10 AIDS (NBLCA), the oldest and largest Black AIDS  
11 organization of its kind in America, hosted by Time  
12 Warner, Inc., with other foundation support, to par-  
13 ticipate in the National Black Clergy Conclave On  
14 HIV/AIDS Policy.

15 (3) The attendees included faith leaders across  
16 traditional, mega, and activist churches representing  
17 millions of congregants: the National Medical Asso-  
18 ciation (NMA) representing 30,000 African-Amer-  
19 ican physicians; the National Conference of Black  
20 Mayors; the National Caucus of Black State Legisla-  
21 tors; and the Health Brain Trust of the Congres-  
22 sional Black Caucus and key African-American HIV/  
23 AIDS advocates from across the United States. This  
24 group developed a plan of action that has become  
25 the National Black Clergy for the Elimination of



1 HIV/AIDS Act of 2011 to respond to the “on the  
2 ground” emergency in prevention, care, and treat-  
3 ment for AIDS in Black America.

4 (4) In August 2007, the NMA, the oldest and  
5 largest organization representing 30,000 African-  
6 American physicians, released a consensus report en-  
7 titled “Addressing The HIV/AIDS Crisis In The Af-  
8 rican American Community: Fact, Fiction and Pol-  
9 icy”; and specifically called on the next President of  
10 the United States to declare HIV/AIDS in African-  
11 American communities a public health emergency  
12 and worked with NBLCA to organize clergy to advo-  
13 cate for the specific needs of Black physicians, their  
14 patients, and those at risk in African-American com-  
15 munities; and have pledged to advocate and work  
16 with clergy to develop, execute, and implement these  
17 initiatives as a part of their rightful role of leader-  
18 ship in African-American communities and culture.

19 (5) The National Conference of Black Mayors  
20 has pledged to work with clergy, medical, and com-  
21 munity leaders to develop and support these initia-  
22 tives on a local level and to help them to continue  
23 to develop a policy agenda leading to the elimination  
24 of HIV/AIDS.

1           (6) The National Caucus of Black State Legis-  
2           lators pledged to take the initiatives herein to their  
3           body and develop plans of action for Black State  
4           Legislators to work with local clergy, health depart-  
5           ments, and CBOs to adopt and implement these ini-  
6           tiatives on a national level.

7           (7) At their April 2008 annual meeting, the  
8           National Policy Alliance (NPA), consisting of the  
9           Joint Center For Political and Economic Studies  
10          (secretariat) and the National Black Caucus of  
11          School Board Members, National Black Caucus of  
12          Local Elected Officials; the Judicial Council of the  
13          National Bar Association; the National Association  
14          of Black County Officials; Blacks in Government  
15          and the CBC; NCBM; WCM, voted unanimously to  
16          support, endorse, and encourage the passage of the  
17          National Black Clergy for the Elimination of HIV/  
18          AIDS Act of 2011 and to organize their respective  
19          members to endorse and support the passage of this  
20          bill.

21          (8) The World Conference of Black Mayors has  
22          ratified its support of these initiatives and legisla-  
23          tion, and pledged to assist the clergy to take them  
24          internationally.

1           (9) The National Black Leadership Commission  
2           on AIDS, the Balm in Gilead, and the Black AIDS  
3           Institute have been recognized by the clergy for their  
4           tradition and history of service and will work with  
5           clergy to conduct community and policy develop-  
6           ment, linkages to local departments of health and  
7           other services, infrastructure development, education  
8           media, and fund development activities.

9           (10) Bishop T.D. Jakes of the Potters House  
10          in Dallas, Texas, and Rev. Calvin O. Butts of the  
11          Abyssinian Baptist Church in Harlem, New York,  
12          and chairman of the National Black Leadership  
13          Commission on AIDS have been recognized as the  
14          organizers of this group and will help guide and lead  
15          the development efforts of fellow clergy through this  
16          process.

17          (11) The National Conclave on HIV/AIDS for  
18          Black Clergy calls upon the President, Congress,  
19          and corporate America to declare the HIV/AIDS cri-  
20          sis in the African-American community a “public  
21          health emergency”.

22          (12) The Black clergy will aggressively seek to  
23          have every person under the sphere of their influence  
24          tested for HIV in order to know the person’s status.

1           (13) The Black clergy will promote HIV/AIDS  
2 awareness to ensure that all Black clergy serving in  
3 their denominations and other congregations are  
4 equipped to address issues related to this disease in  
5 a factual and scientifically sound manner.

6           (14) The Black clergy will use the ABC/D  
7 model as a behavioral guideline for prevention initia-  
8 tives:

9                   (A) A—Abstain.

10                   (B) B—Be Faithful.

11                   (C) C—Use Condoms.

12                   (D) D—Don't Engage in Risky Behaviors.

13           (c) DEFINITIONS APPLICABLE THROUGHOUT SEC-  
14 TION.—In this section—

15                   (1) the terms “HIV” and “HIV/AIDS” have  
16 the meanings given to such terms in section 2689 of  
17 the Public Health Service Act (42 U.S.C. 300ff–88);  
18 and

19                   (2) the term “Secretary” means the Secretary  
20 of Health and Human Services.

21           (d) SERVICES TO REDUCE HIV/AIDS IN THE AFRI-  
22 CAN-AMERICAN COMMUNITY.—

23                   (1) IN GENERAL.—For the purpose of reducing  
24 HIV/AIDS in the African-American community, the  
25 Secretary, acting through the Deputy Assistant Sec-

1       retary for Minority Health, may make grants to  
2       public health agencies and faith-based organizations  
3       to conduct—

4               (A) outreach activities related to HIV/  
5       AIDS prevention and testing activities;

6               (B) HIV/AIDS prevention activities; and

7               (C) HIV/AIDS testing activities.

8               (2) AUTHORIZATION OF APPROPRIATIONS.—To  
9       carry out this section, there are authorized to be ap-  
10      propriated \$50,000,000 for fiscal year 2012, and  
11      such sums as may be necessary for fiscal years 2013  
12      through 2016.

13      (e) GRANTS FOR SUBSTANCE ABUSE AND MENTAL  
14      HEALTH SERVICES TO PUBLIC HEALTH AGENCIES AND  
15      FAITH-BASED ORGANIZATIONS.—

16              (1) IN GENERAL.—The Secretary, acting  
17      through the Administrator of the Substance Abuse  
18      and Mental Health Services Administration, may  
19      make grants to public health agencies and faith-  
20      based organizations to—

21              (A) conduct HIV/AIDS and sexually trans-  
22      mitted disease outreach, prevention, and testing  
23      activities that are targeted to the African-Amer-  
24      ican community; and

1 (B) in connection with such activities, pro-  
2 vide substance abuse testing and mental health  
3 services to members of such community.

4 (2) AUTHORIZATION OF APPROPRIATIONS.—To  
5 carry out this section, there are authorized to be ap-  
6 propriated \$90,000,000 for fiscal year 2012 and  
7 such sums as may be necessary for fiscal years 2013  
8 through 2016.

9 (f) SERVICES FOR HIV/AIDS AFFECTED YOUTH  
10 WHO ARE SEPARATED FROM THEIR FAMILIES.—

11 (1) IN GENERAL.—The Secretary, acting  
12 through the Administrator of the Substance Abuse  
13 and Mental Health Services Administration, may  
14 make grants to faith- and community-based organi-  
15 zations to provide family reunification services, men-  
16 tal health counseling, HIV/AIDS and sexually trans-  
17 mitted disease testing, and substance abuse testing  
18 and treatment to youth who—

19 (A)(i) have run away from home;

20 (ii) are homeless; or

21 (iii) reside in a detention center or foster  
22 care; and

23 (B) are HIV positive or at risk for HIV/  
24 AIDS, including young men who have sex with  
25 men.

1           (2) AUTHORIZATION OF APPROPRIATIONS.—To  
2 carry out this section, there are authorized to be ap-  
3 propriated \$5,000,000 for fiscal year 2012, and such  
4 sums as may be necessary for fiscal years 2013  
5 through 2016.

6           (g) PUBLIC HEALTH INTERVENTION AND PREVEN-  
7 TION ACTIVITIES.—

8           (1) IN GENERAL.—For the purpose of reducing  
9 HIV/AIDS, sexually transmitted diseases, tuber-  
10 culosis, and viral hepatitis in African-American com-  
11 munities, the Secretary, acting through the Director  
12 of the Centers for Disease Control and Prevention,  
13 may make grants to faith-based organizations for  
14 public health intervention and prevention activities,  
15 including the use of rapid testing in traditional and  
16 nontraditional settings to increase the number of in-  
17 dividuals who know their status at the point of care  
18 and are put into treatment.

19           (2) PARTNERSHIPS.—In carrying out this sec-  
20 tion, the Secretary shall encourage grantees to enter  
21 into partnerships with public health agencies.

22           (3) AUTHORIZATION OF APPROPRIATIONS.—To  
23 carry out this section, there are authorized to be ap-  
24 propriated \$100,000,000 for fiscal year 2012, and

1 such sums as may be necessary for fiscal years 2013  
2 through 2016.

3 (h) HIV/AIDS PREVENTION AND EDUCATION.—

4 (1) PREVENTION ACTIVITIES.—The Secretary,  
5 acting through the Director of the Centers for Dis-  
6 ease Control and Prevention, shall expand and inten-  
7 sify HIV/AIDS prevention activities in African-  
8 American communities. Such activities—

9 (A) shall be targeted to specific popu-  
10 lations;

11 (B) shall be comprehensive and accurately  
12 based on science and research; and

13 (C) shall include information on absti-  
14 nence, the proper use of condoms, risks associ-  
15 ated with unprotected sex, and the value of sex-  
16 ual delay particularly among young adolescents  
17 and teenagers.

18 (2) EDUCATION.—The Secretary, acting  
19 through the Director of the Centers for Disease  
20 Control and Prevention, shall expand and intensify  
21 HIV/AIDS educational activities targeting Black  
22 women, youth, and men who have sex with men.

23 (3) COORDINATION.—The Secretary shall carry  
24 out this section in coordination with public schools  
25 of all levels, Black organizations, historically Black



1 colleges and universities, and faith-based organiza-  
2 tions and institutions.

3 (4) AUTHORIZATION OF APPROPRIATIONS.—To  
4 carry out this section, there are authorized to be ap-  
5 propriated \$90,000,000 for fiscal year 2012, and  
6 such sums as may be necessary for fiscal years 2013  
7 through 2016.

8 (i) BUILDING CAPACITY OF COMMUNITIES.—

9 (1) IN GENERAL.—The Secretary, acting  
10 through the Director of the Centers for Disease  
11 Control and Prevention, shall expand funding to eli-  
12 gible entities to build the capacity of African-Amer-  
13 ican communities to respond to HIV/AIDS.

14 (2) EMPHASIS.—In carrying out this section,  
15 the Secretary shall emphasize the provision of fund-  
16 ing for policy development, education, technical as-  
17 sistance, and training—

18 (A) to national and local faith-based orga-  
19 nizations; and

20 (B) to organizations with a significant his-  
21 tory of working within the African-American  
22 community on HIV/AIDS issues, an inter-  
23 denominational center of seminaries specializing  
24 in the training of African-American clergy, and  
25 historically Black colleges and universities.

1           (3) DEFINITION.—In this section, the term “el-  
2           igible entity” means a national or community-based  
3           organization with a history and tradition of service  
4           to African-American communities.

5           (4) AUTHORIZATION OF APPROPRIATIONS.—To  
6           carry out this section, there are authorized to be ap-  
7           propriated \$25,000,000 for fiscal year 2012, and  
8           such sums as may be necessary for fiscal years 2013  
9           through 2016.

10          (j) NATIONAL MEDIA OUTREACH CAMPAIGN.—

11           (1) IN GENERAL.—The Secretary, acting  
12           through the Director of the Centers for Disease  
13           Control and Prevention, shall implement a national  
14           media outreach campaign that urges all sexually ac-  
15           tive individuals to be tested for and know their HIV/  
16           AIDS status.

17           (2) REQUIREMENTS.—The national media out-  
18           reach campaign under this subsection shall—

19                   (A) be science-driven and targeted to Afri-  
20                   can-American men, women, and youth; and

21                   (B) give special emphasis to Black women  
22                   and men who have sex with men.

23           (3) COORDINATION; CONSULTATION.—The Sec-  
24           retary shall carry out this subsection—

1 (A) in coordination with Black media out-  
2 lets for print, electronic, and Web-based media  
3 and Black media associations, including the Na-  
4 tional Association of Black Owned Broadcasters  
5 and the National Newspaper Publishers Asso-  
6 ciation; and

7 (B) in consultation with an advisory board  
8 including representatives of the National Med-  
9 ical Association, faith leaders, elected and ap-  
10 pointed officials, social marketing experts, and  
11 business and community stakeholders.

12 (4) AUTHORIZATION OF APPROPRIATIONS.—To  
13 carry out this subsection, there are authorized to be  
14 appropriated \$10,000,000 for fiscal year 2012, and  
15 such sums as may be necessary for fiscal years 2013  
16 through 2016.

17 (k) RESEARCH TO DEVELOP BEHAVIORAL STRATE-  
18 GIES TO REDUCE TRANSMISSION OF HIV/AIDS.—

19 (1) IN GENERAL.—The Secretary, acting  
20 through the Director of the National Institutes of  
21 Health, may conduct or support culturally competent  
22 research to develop evidence-based behavioral strate-  
23 gies to reduce the transmission of HIV/AIDS within  
24 the African-American community.

1           (2) PRIORITY.—In carrying out this section, the  
2 Secretary shall prioritize research that focuses on  
3 populations within the African-American community  
4 that are at increased risk for HIV/AIDS, includ-  
5 ing—

6                   (A) men who have sex with men; and

7                   (B) women.

8           (3) AUTHORIZATION OF APPROPRIATIONS.—To  
9 carry out this section, there are authorized to be ap-  
10 propriated \$10,000,000 for fiscal year 2012, and  
11 such sums as may be necessary for fiscal years 2013  
12 through 2016.

13           (1) STUDY OF BIOLOGICAL AND BEHAVIORAL FAC-  
14 TORS.—

15                   (1) IN GENERAL.—The Secretary, acting  
16 through the Director of the National Institute on  
17 Minority Health and Health Disparities, may make  
18 grants for—

19                           (A) the study of biological and behavioral  
20 factors that lead to increased HIV/AIDS preva-  
21 lence in the African-American community, to be  
22 conducted by researchers with a history and  
23 tradition of service to Black communities; and

24                           (B) behavioral and structural network re-  
25 search and interventions, in collaboration with

1 other institutes and centers of the National In-  
2 stitutes of Health, indigenous faith and national  
3 and community-based organizations with a his-  
4 tory and tradition of conducting such research  
5 for Black communities, with a special emphasis  
6 on Black women and Black men who have sex  
7 with men.

8 (2) AUTHORIZATION OF APPROPRIATIONS.—To  
9 carry out this subsection, there are authorized to be  
10 appropriated \$100,000,000 for fiscal year 2012, and  
11 such sums as may be necessary for fiscal years 2013  
12 through 2016.

13 (m) HEALTH CARE PROFESSIONALS TREATING INDI-  
14 VIDUALS WITH HIV/AIDS.—Part E of title VII of the  
15 Public Health Service Act (42 U.S.C. 294n et seq.) is  
16 amended by adding at the end the following:

17 **“Subpart 4—Health Care Professionals Treating**  
18 **Individuals With HIV/AIDS**

19 **“SEC. 781. BETTER CARE FOR INDIVIDUALS WITH HIV/AIDS.**

20 “(a) IN GENERAL.—The Secretary, acting through  
21 the Administrator of the Health Resources and Services  
22 Administration and in consultation with the African-  
23 American church community, may award grants for any  
24 of the following:

1           “(1) Development of curricula for training pri-  
2           mary care providers in HIV/AIDS prevention and  
3           care.

4           “(2) Training health care professionals with ex-  
5           pertise in HIV/AIDS to provide care to individuals  
6           with HIV/AIDS.

7           “(3) Development by grant recipients under  
8           title XXVI and other persons of policies for pro-  
9           viding culturally relevant and sensitive treatment to  
10          individuals with HIV/AIDS, with particular empha-  
11          sis on treatment to African-Americans and children  
12          with HIV/AIDS.

13          “(4) Development and implementation of pro-  
14          grams to increase the use of telemedicine to respond  
15          to HIV/AIDS-specific health care needs in rural and  
16          minority communities, with particular emphasis  
17          given to medically underserved communities and the  
18          southern States.

19          “(5) Creation of faith- and community-based  
20          certification programs for providers in HIV/AIDS  
21          care and support services.

22          “(6) Establishment of comfort care centers that  
23          provide mental, emotional, and psychosocial coun-  
24          seling for people with HIV/AIDS and implement ad-  
25          ditional protocols to be carried out in the centers

1 that address the needs of children and young adults  
2 who are infected with the disease and are  
3 transitioning from childhood to adulthood.

4 “(7) Incentive payments to health care pro-  
5 viders supported by the Health Resources and Serv-  
6 ices Administration to implement HIV/AIDS testing  
7 consistent with the guidelines issued in 2006 by the  
8 Centers for Disease Control and Prevention entitled  
9 ‘Revised Recommendations for HIV Testing of  
10 Adults, Adolescents, and Pregnant Women in  
11 Health-Care Settings’.

12 “(b) DEFINITION.—In this section, the term ‘HIV/  
13 AIDS’ has the meaning given to such term in section  
14 2689.

15 “(c) AUTHORIZATION OF APPROPRIATIONS.—To  
16 carry out this section, there are authorized to be appro-  
17 priated \$100,000,000 for fiscal year 2012, and such sums  
18 as may be necessary for fiscal years 2013 through 2016.”.

19 (n) REPORT ON IMPACT OF HIV/AIDS IN THE AFRI-  
20 CAN-AMERICAN COMMUNITY.—

21 (1) IN GENERAL.—The Secretary shall submit  
22 to Congress and the President an annual report on  
23 the impact of HIV/AIDS in the African-American  
24 community.

1           (2) CONTENTS.—The report under subsection  
2           (a) shall include information on the—

3                   (A) progress that has been made in reduc-  
4           ing the impact of HIV/AIDS in such commu-  
5           nity;

6                   (B) opportunities that exist to make addi-  
7           tional progress in reducing the impact of HIV/  
8           AIDS in such community;

9                   (C) challenges that may impede such addi-  
10          tional progress; and

11                   (D) Federal funding necessary to achieve  
12          substantial reductions in HIV/AIDS in the Afri-  
13          can-American community.

14 **SEC. 749. REDUCING THE SPREAD OF SEXUALLY TRANS-**  
15 **MITTED INFECTIONS IN CORRECTIONAL FA-**  
16 **CILITIES.**

17           (a) SHORT TITLE.—This section may be cited as the  
18 “Justice for the Unprotected Against Sexually Trans-  
19 mitted Infections among the Confined and Exposed Act”  
20 or the “JUSTICE Act”.

21           (b) FINDINGS.—The Congress makes the following  
22 findings:

23                   (1) According to the Bureau of Justice Statis-  
24          tics (BJS), 2,292,133 persons were incarcerated in  
25          the United States as of the end of 2009. Between



1 1998 and 2008, the number of persons incarcerated  
2 in Federal or State correctional facilities increased  
3 by an average of 2.4 percent per year. One in every  
4 32 United States residents was on probation, in jail  
5 or prison, or on parole at the end of 2009.

6 (2) As of 2009, 66.8 percent of incarcerated  
7 persons were racial or ethnic minorities. Based on  
8 current incarceration rates, BJS estimates that Afri-  
9 can-American males are 6 times more likely to be  
10 held in custody than White males, while Hispanic  
11 males are a little more than 2 times more likely to  
12 be held in custody. Across all age categories, Afri-  
13 can-American males were incarcerated at higher  
14 rates than Hispanic or White males.

15 (3) There is a disproportionately high rate of  
16 HIV/AIDS among incarcerated persons, especially  
17 among minorities. Approximately 25 percent of the  
18 HIV-positive population of the United States passes  
19 through correctional facilities each year. BJS has  
20 determined that the rate of confirmed AIDS cases is  
21 2.4 times higher among incarcerated persons than in  
22 the general population. Minorities account for the  
23 majority of AIDS-related deaths among incarcerated  
24 persons, with African-American incarcerated persons  
25 2.8 times more likely than White incarcerated per-

1        sons and 1.4 times more likely than Hispanic incar-  
2        cerated persons to die from AIDS-related causes.  
3        Nearly two-thirds of AIDS-related deaths are among  
4        Black, non-Hispanic males.

5            (4) Studies suggest that other sexually trans-  
6        mitted infections (STIs), such as gonorrhea,  
7        chlamydia, syphilis, genital herpes, viral hepatitis,  
8        and human papillomavirus, also exist at a higher  
9        rate among incarcerated persons than in the general  
10       population. For instance, researchers have estimated  
11       that the rate of hepatitis C (HCV) infection among  
12       incarcerated persons is somewhere between 8 and 20  
13       times higher than that of the general population.

14           (5) Correctional facilities lack a uniform system  
15       of STI testing and reporting. Establishing a uniform  
16       data collection system would assist in developing and  
17       targeting counseling and treatment programs for in-  
18       carcerated persons. Better developed and targeted  
19       programs may reduce the spread of STIs.

20           (6) Although Congress has acted to reduce the  
21       spread of sexual violence in correctional facilities by  
22       enacting the National Prison Rape Elimination Act  
23       (PREA) of 2003, BJS reported that approximately  
24       4.4 percent of incarcerated persons in prisons and  
25       3.1 percent of persons in jail reported experiencing

1 one or more incidents of sexual victimization by an-  
2 other incarcerated person or correctional facility  
3 staff in the previous year.

4 (7) Approximately 95 percent of all incarcer-  
5 ated persons eventually return to society. According  
6 to one study, every year approximately 100,000 per-  
7 sons infected with both HIV and HCV are released  
8 from correctional facilities. These individuals com-  
9 prise approximately 50 percent of all persons with  
10 both infections in the United States.

11 (8) According to the Centers for Disease Con-  
12 trol and Prevention (CDC), latex condoms, when  
13 used consistently and correctly, are highly effective  
14 in preventing the transmission of HIV. Latex  
15 condoms also reduce the risk of other STIs. Despite  
16 the effectiveness of condoms in reducing the spread  
17 of STIs, the Bureau of Prisons does not recommend  
18 their use in correctional facilities.

19 (9) The distribution of condoms in correctional  
20 facilities is currently legal in certain parts of the  
21 United States and the world. The States of Vermont  
22 and Mississippi and the District of Columbia allow  
23 condom distribution programs in their correctional  
24 facilities. The cities of New York, San Francisco,  
25 Los Angeles, Washington DC, and Philadelphia also

1 allow condom distribution in their correctional facili-  
2 ties. However, these States and cities operate fewer  
3 than 1 percent of all correctional facilities.

4 (10) A 2007 report by the Massachusetts Gen-  
5 eral Hospital Division of Infectious Diseases and the  
6 University of California, San Francisco, found that  
7 the proportion of European prison systems allowing  
8 condoms rose from 53 percent in 1989 to 81 percent  
9 in 1997. The same report also found that no prison  
10 system allowing the distribution of condoms had re-  
11 versed their decision, and no prison system reported  
12 an increase in sexual activity among incarcerated  
13 persons as a result of a decision to allow condom  
14 distribution.

15 (11) In 2000 and 2001, researchers surveyed  
16 300 incarcerated persons and 100 correctional offi-  
17 cers at the Central Detention Facility, a correctional  
18 facility operated by the District of Columbia at  
19 which condoms are available. Researchers found that  
20 both incarcerated persons and correctional officers  
21 generally supported the condom distribution pro-  
22 gram and considered it to be important. Further-  
23 more, the researchers determined that the program  
24 had not caused any major security infractions. In  
25 Canada, the Expert Committee on AIDS and Pris-

1       ons surveyed more than 400 correctional officers in  
2       the Federal prison system of Canada in 1995 and  
3       reported that 82 percent of those responding indi-  
4       cated that the availability of condoms had created no  
5       problems at their facility.

6           (12) The American Public Health Association,  
7       the United Nations Joint Program on HIV/AIDS,  
8       and the World Health Organization have endorsed  
9       the effectiveness of condom distribution programs in  
10      correctional facilities.

11          (13) Many correctional facilities in the United  
12      States do not provide comprehensive testing and  
13      treatment programs to reduce the spread of STIs.  
14      According to BJS surveys from 2005, only 996 of  
15      the 1,821 Federal and State correctional facilities  
16      (i.e. 54.7 percent) provided HIV/AIDS counseling  
17      programs.

18          (14) Individuals who are enrolled in Medicaid  
19      prior to incarceration face a suspension of their ben-  
20      efits upon incarceration, and in some States a termi-  
21      nation of their Medicaid eligibility. The Federal Gov-  
22      ernment encourages States to automatically re-enroll  
23      incarcerated persons on Medicaid upon their release  
24      from a correctional facility, unless the State reaches

1 a determination that the individual is no longer eligi-  
2 ble for reasons other than their prior incarceration.

3 (15) Formerly incarcerated individuals who are  
4 newly released from correctional facilities often face  
5 delays in the resumption of their Medicaid benefits  
6 which may exacerbate any health issues which they  
7 face.

8 (16) Incarcerated individuals living with HIV/  
9 AIDS who are eligible for Medicaid would benefit  
10 from prompt and automatic enrollment upon their  
11 release in order to ensure their continued ability to  
12 access health services, including antiretroviral treat-  
13 ment.

14 (c) AUTHORITY TO ALLOW COMMUNITY ORGANIZA-  
15 TIONS TO PROVIDE STI COUNSELING, STI PREVENTION  
16 EDUCATION, AND SEXUAL BARRIER PROTECTION DE-  
17 VICES IN FEDERAL CORRECTIONAL FACILITIES.—

18 (1) DIRECTIVE TO ATTORNEY GENERAL.—Not  
19 later than 30 days after the date of enactment of  
20 this Act, the Attorney General shall direct the Bu-  
21 reau of Prisons to allow community organizations to  
22 distribute sexual barrier protection devices and to  
23 engage in STI counseling and STI prevention edu-  
24 cation in Federal correctional facilities. These activi-  
25 ties shall be subject to all relevant Federal laws and

1 regulations which govern visitation in correctional  
2 facilities.

3 (2) INFORMATION REQUIREMENT.—Any com-  
4 munity organization permitted to distribute sexual  
5 barrier protection devices under paragraph (1) must  
6 ensure that the persons to whom the devices are dis-  
7 tributed are informed about the proper use and dis-  
8 posal of sexual barrier protection devices in accord-  
9 ance with established public health practices. Any  
10 community organization conducting STI counseling  
11 or STI prevention education under paragraph (1)  
12 must offer comprehensive sexuality education.

13 (3) POSSESSION OF DEVICE PROTECTED.—No  
14 Federal correctional facility may, because of the pos-  
15 session or use of a sexual barrier protection device—

16 (A) take adverse action against an incar-  
17 cerated person; or

18 (B) consider possession or use as evidence  
19 of prohibited activity for the purpose of any  
20 Federal correctional facility administrative pro-  
21 ceeding.

22 (4) IMPLEMENTATION.—The Attorney General  
23 and Bureau of Prisons shall implement this section  
24 according to established public health practices in a  
25 manner that protects the health, safety, and privacy

1 of incarcerated persons and of correctional facility  
2 staff.

3 (d) SENSE OF CONGRESS REGARDING DISTRIBUTION  
4 OF SEXUAL BARRIER PROTECTION DEVICES IN STATE  
5 PRISON SYSTEMS.—It is the sense of Congress that States  
6 should allow for the legal distribution of sexual barrier  
7 protection devices in State correctional facilities to reduce  
8 the prevalence and spread of STIs in those facilities.

9 (e) AUTOMATIC REINSTATEMENT OF MEDICAID BEN-  
10 EFITS.—

11 (1) IN GENERAL.—Section 1902(e) of the So-  
12 cial Security Act (42 U.S.C. 1396a(e)) is amended  
13 by adding at the end the following:

14 “(15) ENROLLMENT OF EX-OFFENDERS.—

15 “(A) AUTOMATIC ENROLLMENT OR REIN-  
16 STATEMENT.—

17 “(i) IN GENERAL.—The State plan  
18 shall provide for the automatic enrollment  
19 or reinstatement of enrollment of an eligi-  
20 ble individual if—

21 “(I) such individual is scheduled  
22 to be released from a public institu-  
23 tion due to the completion of sen-  
24 tence, not less than 30 days prior to  
25 the scheduled date of the release; and



1                   “(II) such individual is to be re-  
2                   leased from a public institution on pa-  
3                   role or on probation, as soon as pos-  
4                   sible after the date on which the de-  
5                   termination to release such individual  
6                   was made, and before the date such  
7                   individual is released.

8                   “(ii) EXCEPTION.—If a State makes a  
9                   determination that an individual is not eli-  
10                  gible to be enrolled under the State plan—

11                   “(I) on or before the date by  
12                   which the individual would be enrolled  
13                   under clause (i), such clause shall not  
14                   apply to such individual; or

15                   “(II) after such date, the State  
16                   may terminate the enrollment of such  
17                   individual.

18                   “(B) RELATIONSHIP OF ENROLLMENT TO  
19                   PAYMENT FOR SERVICES.—

20                   “(i) IN GENERAL.—Subject to sub-  
21                   paragraph (A)(ii), an eligible individual  
22                   who is enrolled, or whose enrollment is re-  
23                   instated under subparagraph (A), shall be  
24                   eligible for medical assistance that is pro-  
25                   vided after the date that the eligible indi-

1           vidual is released from the public institu-  
2           tion

3           “(ii) RELATIONSHIP TO PAYMENT  
4           PROHIBITION FOR INMATES.—No provision  
5           of this paragraph may be construed to per-  
6           mit payment for care or services for which  
7           payment is excluded under the subpara-  
8           graph (A), following paragraph (29), of  
9           section 1905(a).

10          “(C) TREATMENT OF CONTINUOUS ELIGI-  
11          BILITY.—

12           “(i) SUSPENSION FOR INMATES.—Any  
13           period of continuous eligibility under this  
14           title shall be suspended on the date an in-  
15           dividual enrolled under this title becomes  
16           an inmate of a public institution (except as  
17           a patient of a medical institution).

18           “(ii) DETERMINATION OF REMAINING  
19           PERIOD.—Notwithstanding any changes to  
20           State law related to continuous eligibility  
21           during the time that an individual is an in-  
22           mate of a public institution (except as a  
23           patient of a medical institution), subject to  
24           clause (iii), with respect to an eligible indi-  
25           vidual who was subject to a suspension

1 under subclause (I), on the date that such  
2 individual is released from a public institu-  
3 tion the suspension of continuous eligibility  
4 under such subclause shall be lifted for a  
5 period that is equal to the time remaining  
6 in the period of continuous eligibility for  
7 such individual on the date that such pe-  
8 riod was suspended under such subclause.

9 “(iii) EXCEPTION.—If a State makes  
10 a determination that an individual is not  
11 eligible to be enrolled under the State  
12 plan—

13 “(I) on or before the date that  
14 the suspension of continuous eligibility  
15 is lifted under clause (ii), such clause  
16 shall not apply to such individual; or

17 “(II) after such date, the State  
18 may terminate the enrollment of such  
19 individual.

20 “(D) AUTOMATIC ENROLLMENT OR REIN-  
21 STATEMENT OF ENROLLMENT DEFINED.—For  
22 purposes of this paragraph, the term ‘automatic  
23 enrollment or reinstatement of enrollment’  
24 means that the State determines eligibility for  
25 medical assistance under the State plan without

1 a program application from, or on behalf of, the  
2 eligible individual, but an individual can only be  
3 automatically enrolled in the State Medicaid  
4 plan if the individual affirmatively consents to  
5 being enrolled through affirmation in writing,  
6 by telephone, orally, through electronic signa-  
7 ture, or through any other means specified by  
8 the Secretary.

9 “(E) ELIGIBLE INDIVIDUAL DEFINED.—  
10 For purposes of this paragraph, the term ‘eligi-  
11 ble individual’ means an individual who is an  
12 inmate of a public institution (except as a pa-  
13 tient in a medical institution)—

14 “(i) who was enrolled under the State  
15 plan for medical assistance immediately be-  
16 fore becoming an inmate of such an insti-  
17 tution; or

18 “(ii) is diagnosed with human im-  
19 munodeficiency virus.”.

20 (2) SUPPLEMENTAL FUNDING FOR STATE IM-  
21 PLEMENTATION OF AUTOMATIC REINSTATEMENT OF  
22 MEDICAID BENEFITS.—

23 (A) IN GENERAL.—Subject to paragraph  
24 (6), for each State for which the Secretary of  
25 Health and Human Services has approved an

1 application under paragraph (3), the Federal  
2 matching payments (including payments based  
3 on the Federal medical assistance percentage)  
4 made to such State under section 1903 of the  
5 Social Security Act (42 U.S.C. 1396b) shall be  
6 increased by 5.0 percentage points for pay-  
7 ments to the State for the activities permitted  
8 under paragraph (2) for a period of one year.

9 (B) USE OF FUNDS.—A State may only  
10 use increased matching payments authorized  
11 under paragraph (1)—

12 (i) to strengthen the State’s enroll-  
13 ment and administrative resources for the  
14 purpose of improving processes for enroll-  
15 ing (or reinstating the enrollment of) eligi-  
16 ble individuals (as such term is defined in  
17 section 1902(e)(15)(E) of the Social Secu-  
18 rity Act); and

19 (ii) for medical assistance (as such  
20 term is defined in section 1905(a) of the  
21 Social Security Act) provided to such eligi-  
22 ble individuals.

23 (C) APPLICATION AND AGREEMENT.—The  
24 Secretary may only make payments to a State  
25 in the increased amount if—

1 (i) the State has amended the State  
2 plan under section 1902 of the Social Se-  
3 curity Act to incorporate the requirements  
4 of subsection (e)(15) of such section;

5 (ii) the State has submitted an appli-  
6 cation to the Secretary that includes a plan  
7 for implementing the requirements of sec-  
8 tion 1902(e)(15) of the Social Security Act  
9 under the State's amended State plan be-  
10 fore the end of the 90-day period begin-  
11 ning on the date that the State receives in-  
12 creased matching payments under para-  
13 graph (1);

14 (iii) the State's application meets the  
15 satisfaction of the Secretary; and

16 (iv) the State enters an agreement  
17 with the Secretary that states that—

18 (I) the State will only use the in-  
19 creased matching funds for the uses  
20 permitted under paragraph (2); and

21 (II) at the end of the period  
22 under paragraph (1), the State will  
23 submit to the Secretary, and make  
24 publicly available, a report that con-

1                   tains the information required under  
2                   paragraph (4).

3                   (D) REQUIRED REPORT INFORMATION.—

4                   The information that is required in the report  
5                   under paragraph (3)(D)(ii) includes—

6                   (i) the results of an evaluation of the  
7                   impact of the implementation of the re-  
8                   quirements of section 1902(e)(15) of the  
9                   Social Security Act on improving the  
10                  State’s processes for enrolling of individ-  
11                  uals who are released for public institu-  
12                  tions into the Medicaid program;

13                  (ii) the number of individuals who  
14                  were automatically enrolled (or whose en-  
15                  rollment is reinstated) under such section  
16                  1902(e)(15) during the period under para-  
17                  graph (1); and

18                  (iii) any other information that is re-  
19                  quired by the Secretary.

20                  (E) INCREASE IN CAP ON MEDICAID PAY-

21                  MENTS TO TERRITORIES.—Subject to para-  
22                  graph (6), the amounts otherwise determined  
23                  for Puerto Rico, the United States Virgin Is-  
24                  lands, Guam, the Commonwealth of the North-  
25                  ern Mariana Islands, and American Samoa

1 under subsections (f) and (g) of section 1108 of  
2 the Social Security Act (42 U.S.C. 1308) shall  
3 each be increased by the necessary amount to  
4 allow for the increase in the Federal matching  
5 payments under paragraph (1), but only for the  
6 period under such paragraph for such State. In  
7 the case of such an increase for a territory, sub-  
8 section (a)(1) of such section 1108 shall be ap-  
9 plied without regard to any increase in payment  
10 made to the territory under part E of title IV  
11 of such Act that is attributable to the increase  
12 in Federal medical assistance percentage ef-  
13 fected under paragraph (1) for the territory.

14 (F) LIMITATIONS.—

15 (i) TIMING.—With respect to a State,  
16 at the end of the period under paragraph  
17 (1), no increased matching payments may  
18 be made to such State under this sub-  
19 section.

20 (ii) MAINTENANCE OF ELIGIBILITY.—

21 (I) IN GENERAL.—Subject to  
22 clause (ii), a State is not eligible for  
23 an increase in its Federal matching  
24 payments under paragraph (1), or an  
25 increase in a cap amount under para-



1 graph (5), if eligibility standards,  
2 methodologies, or procedures under its  
3 State plan under title XIX of the So-  
4 cial Security Act (including any waiv-  
5 er under such title or under section  
6 1115 of such Act (42 U.S.C. 1315))  
7 are more restrictive than the eligibility  
8 standards, methodologies, or proce-  
9 dures, respectively, under such plan  
10 (or waiver) as in effect on the date of  
11 enactment of this Act.

12 (II) STATE REINSTATEMENT OF  
13 ELIGIBILITY PERMITTED.—A State  
14 that has restricted eligibility stand-  
15 ards, methodologies, or procedures  
16 under its State plan under title XIX  
17 of the Social Security Act (including  
18 any waiver under such title or under  
19 section 1115 of such Act (42 U.S.C.  
20 1315)) after the date of enactment of  
21 this Act, is no longer ineligible under  
22 clause (i) beginning with the first cal-  
23 endar quarter in which the State has  
24 reinstated eligibility standards, meth-  
25 odologies, or procedures that are no

1 more restrictive than the eligibility  
2 standards, methodologies, or proce-  
3 dures, respectively, under such plan  
4 (or waiver) as in effect on such date.

5 (iii) NO WAIVER AUTHORITY.—The  
6 Secretary may not waive the application of  
7 this subsection under section 1115 of the  
8 Social Security Act or otherwise.

9 (iv) LIMITATION OF MATCHING PAY-  
10 MENTS TO 100 PERCENT.—In no case shall  
11 an increase in Federal matching payments  
12 under this subsection result in Federal  
13 matching payments that exceed 100 per-  
14 cent.

15 (3) EFFECTIVE DATE.—

16 (A) IN GENERAL.—Except as provided in  
17 paragraph (2), the amendments made by sub-  
18 section (a) shall take effect 180 days after the  
19 date of the enactment of this Act and shall  
20 apply to services furnished on or after such  
21 date.

22 (B) RULE FOR CHANGES REQUIRING  
23 STATE LEGISLATION.—In the case of a State  
24 plan for medical assistance under title XIX of  
25 the Social Security Act which the Secretary of

1 Health and Human Services determines re-  
2 quires State legislation (other than legislation  
3 appropriating funds) in order for the plan to  
4 meet the additional requirement imposed by the  
5 amendments made by this subsection, the State  
6 plan shall not be regarded as failing to comply  
7 with the requirements of such title solely on the  
8 basis of its failure to meet this additional re-  
9 quirement before the first day of the first cal-  
10 endar quarter beginning after the close of the  
11 first regular session of the State legislature that  
12 begins after the date of the enactment of this  
13 Act. For purposes of the previous sentence, in  
14 the case of a State that has a 2-year legislative  
15 session, each year of such session shall be  
16 deemed to be a separate regular session of the  
17 State legislature.

18 (f) SURVEY OF AND REPORT ON CORRECTIONAL FA-  
19 CILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF  
20 STIs.—

21 (1) SURVEY.—The Attorney General, after con-  
22 sulting with the Secretary of Health and Human  
23 Services, State officials, and community organiza-  
24 tions, shall, to the maximum extent practicable, con-  
25 duct a survey of all Federal and State correctional

1 facilities, no later than 180 days after the date of  
2 enactment of this Act and annually thereafter for 5  
3 years, to determine the following:

4 (A) PREVENTION EDUCATION OFFERED.—

5 The type of prevention education, information,  
6 or training offered to incarcerated persons and  
7 correctional facility staff regarding sexual vio-  
8 lence and the spread of STIs, including whether  
9 such education, information, or training—

10 (i) constitutes comprehensive sexuality  
11 education;

12 (ii) is compulsory for new incarcerated  
13 persons and for new staff; and

14 (iii) is offered on an ongoing basis.

15 (B) ACCESS TO SEXUAL BARRIER PROTEC-  
16 TION DEVICES.—Whether incarcerated persons  
17 can—

18 (i) possess sexual barrier protection  
19 devices;

20 (ii) purchase sexual barrier protection  
21 devices;

22 (iii) purchase sexual barrier protection  
23 devices at a reduced cost; and

24 (iv) obtain sexual barrier protection  
25 devices without cost.

1 (C) INCIDENCE OF SEXUAL VIOLENCE.—

2 The incidence of sexual violence and assault  
3 committed by incarcerated persons and by cor-  
4 rectional facility staff.

5 (D) COUNSELING, TREATMENT, AND SUP-

6 PORTIVE SERVICES.—Whether the correctional  
7 facility requires incarcerated persons to partici-  
8 pate in counseling, treatment, and supportive  
9 services related to STIs, or whether it offers  
10 such programs to incarcerated persons.

11 (E) STI TESTING.—Whether the correc-

12 tional facility tests incarcerated persons for  
13 STIs or gives them the option to undergo such  
14 testing—

15 (i) at intake;

16 (ii) on a regular basis; and

17 (iii) prior to release.

18 (F) STI TEST RESULTS.—The number of

19 incarcerated persons who are tested for STIs  
20 and the outcome of such tests at each correc-  
21 tional facility, disaggregated to include results  
22 for—

23 (i) the type of sexually transmitted in-  
24 fection tested for;

1 (ii) the race and/or ethnicity of indi-  
2 viduals tested;

3 (iii) the age of individuals tested; and

4 (iv) the gender of individuals tested.

5 (G) PRE-RELEASE REFERRAL POLICY.—

6 Whether incarcerated persons are informed  
7 prior to release about STI-related services or  
8 other health services in their communities, in-  
9 cluding free and low-cost counseling and treat-  
10 ment options.

11 (H) PRE-RELEASE REFERRALS MADE.—

12 The number of referrals to community-based  
13 organizations or public health facilities offering  
14 STI-related or other health services provided to  
15 incarcerated persons prior to release, and the  
16 type of counseling or treatment for which the  
17 referral was made.

18 (I) REINSTATEMENT OF MEDICAID BENE-

19 FITS.—Whether the correctional facility assists  
20 incarcerated persons that were enrolled in the  
21 State Medicaid program prior to their incarcer-  
22 ation, in reinstating their enrollment upon re-  
23 lease and whether such individuals receive refer-  
24 rals as provided by paragraph (8) to entities

1           that accept the State Medicaid program, includ-  
2           ing if applicable—

3                   (i) the number of such individuals, in-  
4                   cluding those diagnosed with the human  
5                   immunodeficiency virus, that have been re-  
6                   instated;

7                   (ii) a list of obstacles to reinstating  
8                   enrollment or to making determinations of  
9                   eligibility for reinstatement, if any; and

10                  (iii) the number of individuals denied  
11                  enrollment.

12           (J) OTHER ACTIONS TAKEN.—Whether the  
13           correctional facility has taken any other action,  
14           in conjunction with community organizations or  
15           otherwise, to reduce the prevalence and spread  
16           of STIs in that facility.

17           (2) PRIVACY.—In conducting the survey, the  
18           Attorney General shall not request or retain the  
19           identity of any person who has sought or been of-  
20           fered counseling, treatment, testing, or prevention  
21           education information regarding an STI (including  
22           information about sexual barrier protection devices),  
23           or who has tested positive for an STI.

24           (3) REPORT.—The Attorney General shall  
25           transmit to Congress and make publicly available

1 the results of the survey required under paragraph  
2 (1), both for the Nation as a whole and  
3 disaggregated as to each State and each correctional  
4 facility. To the maximum extent possible, the Attor-  
5 ney General shall issue the first report no later than  
6 1 year after the date of enactment of this Act and  
7 shall issue reports annually thereafter for 5 years.

8 (g) STRATEGY.—

9 (1) DIRECTIVE TO ATTORNEY GENERAL.—The  
10 Attorney General, in consultation with the Secretary  
11 of Health and Human Services, State officials, and  
12 community organizations, shall develop and imple-  
13 ment a 5-year strategy to reduce the prevalence and  
14 spread of STIs in Federal and State correctional fa-  
15 cilities. To the maximum extent possible, the strat-  
16 egy shall be developed, transmitted to Congress, and  
17 made publicly available no later than 180 days after  
18 the transmission of the first report required under  
19 subsection (h)(3).

20 (2) CONTENTS OF STRATEGY.—The strategy  
21 shall include the following:

22 (A) PREVENTION EDUCATION.—A plan for  
23 improving prevention education, information,  
24 and training offered to incarcerated persons  
25 and correctional facility staff, including infor-



1 mation and training on sexual violence and the  
2 spread of STIs, and comprehensive sexuality  
3 education.

4 (B) SEXUAL BARRIER PROTECTION DEVICE  
5 ACCESS.—A plan for expanding access to sexual  
6 barrier protection devices in correctional facili-  
7 ties.

8 (C) SEXUAL VIOLENCE REDUCTION.—A  
9 plan for reducing the incidence of sexual vio-  
10 lence among incarcerated persons and correc-  
11 tional facility staff, developed in consultation  
12 with the National Prison Rape Elimination  
13 Commission.

14 (D) COUNSELING AND SUPPORTIVE SERV-  
15 ICES.—A plan for expanding access to coun-  
16 seling and supportive services related to STIs in  
17 correctional facilities.

18 (E) TESTING.—A plan for testing incarcer-  
19 ated persons for STIs during intake, during  
20 regular health exams, and prior to release, and  
21 that—

22 (i) is conducted in accordance with  
23 guidelines established by the Centers for  
24 Disease Control and Prevention;

25 (ii) includes pre-test counseling;

1 (iii) requires that incarcerated persons  
2 are notified of their option to decline test-  
3 ing at any time;

4 (iv) requires that incarcerated persons  
5 are confidentially notified of their test re-  
6 sults in a timely manner; and

7 (v) ensures that incarcerated persons  
8 testing positive for STIs receive post-test  
9 counseling, care, treatment, and supportive  
10 services.

11 (F) TREATMENT.—A plan for ensuring  
12 that correctional facilities have the necessary  
13 medicine and equipment to treat and monitor  
14 STIs and for ensuring that incarcerated per-  
15 sons living with or testing positive for STIs re-  
16 ceive and have access to care and treatment  
17 services.

18 (G) STRATEGIES FOR DEMOGRAPHIC  
19 GROUPS.—A plan for developing and imple-  
20 menting culturally appropriate, sensitive, and  
21 specific strategies to reduce the spread of STIs  
22 among demographic groups heavily impacted by  
23 STIs.

24 (H) LINKAGES WITH COMMUNITIES AND  
25 FACILITIES.—A plan for establishing and

1 strengthening linkages to local communities and  
2 health facilities that—

3 (i) provide counseling, testing, care,  
4 and treatment services;

5 (ii) may receive persons recently re-  
6 leased from incarceration who are living  
7 with STIs; and

8 (iii) accept payment through the State  
9 Medicaid program.

10 (I) ENROLLMENT IN STATE MEDICAID  
11 PROGRAMS.—Plans to ensure that incarcerated  
12 persons who were—

13 (i) enrolled in their State Medicaid  
14 program prior to incarceration in a correc-  
15 tional facility are automatically re-enrolled  
16 in such program upon their release; and

17 (ii) not enrolled in their State Med-  
18 icaid program prior to incarceration, but  
19 who are diagnosed with the human im-  
20 munodeficiency virus while incarcerated in  
21 a correctional facility, are automatically  
22 enrolled in such program upon their re-  
23 lease.

24 (J) OTHER PLANS.—Any other plans de-  
25 veloped by the Attorney General for reducing

1 the spread of STIs or improving the quality of  
2 health care in correctional facilities.

3 (K) MONITORING SYSTEM.—A monitoring  
4 system that establishes performance goals re-  
5 lated to reducing the prevalence and spread of  
6 STIs in correctional facilities and which, where  
7 feasible, expresses such goals in quantifiable  
8 form.

9 (L) MONITORING SYSTEM PERFORMANCE  
10 INDICATORS.—Performance indicators that  
11 measure or assess the achievement of the per-  
12 formance goals described in subparagraph (I).

13 (M) COST ESTIMATE.—A detailed estimate  
14 of the funding necessary to implement the  
15 strategy at the Federal and State levels for all  
16 5 years, including the amount of funds required  
17 by community organizations to implement the  
18 parts of the strategy in which they take part.

19 (3) REPORT.—The Attorney General shall  
20 transmit to Congress and make publicly available an  
21 annual progress report regarding the implementation  
22 and effectiveness of the strategy described in sub-  
23 section (a). The progress report shall include an  
24 evaluation of the implementation of the strategy  
25 using the monitoring system and performance indi-

1 cators provided for in subparagraphs (I) and (J) of  
2 paragraph (2).

3 (h) APPROPRIATIONS.—

4 (1) IN GENERAL.—There are authorized to be  
5 appropriated such sums as may be necessary to  
6 carry out this section for each of the fiscal years  
7 2012 through 2018.

8 (2) AVAILABILITY OF FUNDS.—Amounts made  
9 available under subsection (a) are authorized to re-  
10 main available until expended.

11 (i) DEFINITIONS.—For the purposes of this section:

12 (1) COMMUNITY ORGANIZATION.—The term  
13 “community organization” means a public health  
14 care facility or a nonprofit organization which pro-  
15 vides health- or STI-related services according to es-  
16 tablished public health standards.

17 (2) COMPREHENSIVE SEXUALITY EDUCATION.—  
18 The term “comprehensive sexuality education”  
19 means sexuality education that includes information  
20 about abstinence and about the proper use and dis-  
21 posal of sexual barrier protection devices and which  
22 is—

23 (A) evidence-based;

24 (B) medically accurate;

25 (C) age and developmentally appropriate;

1 (D) gender and identity sensitive;

2 (E) culturally and linguistically appro-  
3 priate; and

4 (F) structured to promote critical thinking,  
5 self-esteem, respect for others, and the develop-  
6 ment of healthy attitudes and relationships.

7 (3) CORRECTIONAL FACILITY.—The term “cor-  
8 rectional facility” means any prison, penitentiary,  
9 adult detention facility, juvenile detention facility,  
10 jail, or other facility to which persons may be sent  
11 after conviction of a crime or act of juvenile delin-  
12 quency within the United States.

13 (4) INCARCERATED PERSON.—The term “incar-  
14 cerated person” means any person who is serving a  
15 sentence in a correctional facility after conviction of  
16 a crime.

17 (5) SEXUALLY TRANSMITTED INFECTION.—The  
18 term “sexually transmitted infection” or “STI”  
19 means any disease or infection that is commonly  
20 transmitted through sexual activity, including HIV/  
21 AIDS, gonorrhea, chlamydia, syphilis, genital her-  
22 pes, viral hepatitis, and human papillomavirus.

23 (6) SEXUAL BARRIER PROTECTION DEVICE.—  
24 The term “sexual barrier protection device” means  
25 any FDA-approved physical device which has not

1       been tampered with and which reduces the prob-  
2       ability of STI transmission or infection between sex-  
3       ual partners, including female condoms, male  
4       condoms, and dental dams.

5               (7) STATE.—The term “State” includes the  
6       District of Columbia, American Samoa, the Com-  
7       monwealth of the Northern Mariana Islands, Guam,  
8       Puerto Rico, and the United States Virgin Islands.

9       **SEC. 750. STOP AIDS IN PRISON.**

10       (a) SHORT TITLE.—This section may be cited as the  
11       “Stop AIDS in Prison Act of 2011”.

12       (b) COMPREHENSIVE HIV/AIDS POLICY.—

13               (1) IN GENERAL.—The Bureau of Prisons  
14       (hereinafter in this section referred to as the “Bu-  
15       reau”) shall develop a comprehensive policy to pro-  
16       vide HIV testing, treatment, and prevention for in-  
17       mates within the correctional setting and upon re-  
18       entry.

19               (2) PURPOSE.—The purposes of such policy are  
20       the following:

21                       (A) To stop the spread of HIV/AIDS  
22                       among inmates.

23                       (B) To protect prison guards and other  
24                       personnel from HIV/AIDS infection.

1           (C) To provide comprehensive medical  
2           treatment to inmates who are living with HIV/  
3           AIDS.

4           (D) To promote HIV/AIDS awareness and  
5           prevention among inmates.

6           (E) To encourage inmates to take personal  
7           responsibility for their health.

8           (F) To reduce the risk that inmates will  
9           transmit HIV/AIDS to other persons in the  
10          community following their release from prison.

11          (3) CONSULTATION.—The Bureau shall consult  
12          with appropriate officials of the Department of  
13          Health and Human Services, the Office of National  
14          Drug Control Policy, the Office of National AIDS  
15          Policy, and the Centers for Disease Control regard-  
16          ing the development of such policy.

17          (4) TIME LIMIT.—The Bureau shall draft ap-  
18          propriate regulations to implement such policy not  
19          later than 1 year after the date of the enactment of  
20          this Act.

21          (c) REQUIREMENTS FOR POLICY.—The policy cre-  
22          ated under subsection (b) shall provide for the following:

23                  (1) TESTING AND COUNSELING UPON IN-  
24                  TAKE.—



1           (A)(i) Subject to clause (ii), health care  
2           personnel shall provide routine HIV testing to  
3           all inmates as a part of a comprehensive med-  
4           ical examination immediately following admis-  
5           sion to a facility.

6           (ii) Health care personnel shall not be re-  
7           quired to provide routine HIV testing to an in-  
8           mate who is transferred to a facility from an-  
9           other facility if the inmate's medical records are  
10          transferred with the inmate and indicate that  
11          the inmate has been tested previously.

12          (B) To all inmates admitted to a facility  
13          prior to the effective date of this policy, health  
14          care personnel shall provide routine HIV testing  
15          within no more than 6 months. HIV testing for  
16          these inmates may be performed in conjunction  
17          with other health services provided to these in-  
18          mates by health care personnel.

19          (C) All HIV tests under this paragraph  
20          shall comply with paragraph (9).

21          (2) PRE-TEST AND POST-TEST COUNSELING.—  
22          Health care personnel shall provide confidential pre-  
23          test and post-test counseling to all inmates who are  
24          tested for HIV. Counseling may be included with

1 other general health counseling provided to inmates  
2 by health care personnel.

3 (3) HIV/AIDS PREVENTION EDUCATION.—

4 (A) Health care personnel shall improve  
5 HIV/AIDS awareness through frequent edu-  
6 cational programs for all inmates. HIV/AIDS  
7 educational programs may be provided by com-  
8 munity based organizations, local health depart-  
9 ments, and inmate peer educators. Such HIV/  
10 AIDS educational programs shall include infor-  
11 mation on modes of transmission, including  
12 transmission through tattooing, sexual contact,  
13 and intravenous drug use; prevention methods;  
14 treatment; and disease progression. HIV/AIDS  
15 educational programs shall be culturally sen-  
16 sitive, conducted in a variety of languages, and  
17 present scientifically accurate information in a  
18 clear and understandable manner.

19 (B) HIV/AIDS educational materials shall  
20 be made available to all inmates at orientation,  
21 at health care clinics, at regular educational  
22 programs, and prior to release. Both written  
23 and audio-visual materials shall be made avail-  
24 able to all inmates. These materials shall be

1 culturally sensitive, written for low literacy lev-  
2 els, and available in a variety of languages.

3 (4) HIV TESTING UPON REQUEST.—

4 (A) Health care personnel shall allow in-  
5 mates to obtain HIV tests upon request once  
6 per year or whenever an inmate has a reason to  
7 believe the inmate may have been exposed to  
8 HIV. Health care personnel shall, both orally  
9 and in writing, inform inmates, during orienta-  
10 tion and periodically throughout incarceration,  
11 of their right to obtain HIV tests.

12 (B) Health care personnel shall encourage  
13 inmates to request HIV tests if the inmate is  
14 sexually active, has been raped, uses intra-  
15 venous drugs, receives a tattoo, or if the inmate  
16 is concerned that the inmate may have been ex-  
17 posed to HIV/AIDS.

18 (C) An inmate's request for an HIV test  
19 shall not be considered an indication that the  
20 inmate has put himself or herself at risk of in-  
21 fection or committed a violation of prison rules.

22 (5) HIV TESTING OF PREGNANT WOMAN.—

23 (A) Health care personnel shall provide  
24 routine HIV testing to all inmates who become  
25 pregnant.

1 (B) All HIV tests under this paragraph  
2 shall comply with paragraph (9).

3 (6) COMPREHENSIVE TREATMENT.—

4 (A) Health care personnel shall provide all  
5 inmates who test positive for HIV—

6 (i) timely, comprehensive medical  
7 treatment;

8 (ii) confidential counseling on man-  
9 aging their medical condition and pre-  
10 venting its transmission to other persons;  
11 and

12 (iii) voluntary partner notification  
13 services.

14 (B) Medical care provided under this para-  
15 graph shall be consistent with current Depart-  
16 ment of Health and Human Services guidelines  
17 and standard medical practice. Health care per-  
18 sonnel shall discuss treatment options, the im-  
19 portance of adherence to antiretroviral therapy,  
20 and the side effects of medications with inmates  
21 receiving treatment.

22 (C) Health care personnel and pharmacy  
23 personnel shall ensure that the facility for-  
24 mulary contains all Food and Drug Administra-  
25 tion-approved medications necessary to provide

1 comprehensive treatment for inmates living with  
2 HIV/AIDS, and that the facility maintains ade-  
3 quate supplies of such medications to meet in-  
4 mates' medical needs. Health care personnel  
5 and pharmacy personnel shall also develop and  
6 implement automatic renewal systems for these  
7 medications to prevent interruptions in care.

8 (D) Correctional staff, health care per-  
9 sonnel, and pharmacy personnel shall develop  
10 and implement distribution procedures to en-  
11 sure timely and confidential access to medica-  
12 tions.

13 (7) PROTECTION OF CONFIDENTIALITY.—

14 (A) Health care personnel shall develop  
15 and implement procedures to ensure the con-  
16 fidentiality of inmate tests, diagnoses, and  
17 treatment. Health care personnel and correc-  
18 tional staff shall receive regular training on the  
19 implementation of these procedures. Penalties  
20 for violations of inmate confidentiality by health  
21 care personnel or correctional staff shall be  
22 specified and strictly enforced.

23 (B) HIV testing, counseling, and treat-  
24 ment shall be provided in a confidential setting  
25 where other routine health services are provided

1           and in a manner that allows the inmate to re-  
2           quest and obtain these services as routine med-  
3           ical services.

4           (8) TESTING, COUNSELING, AND REFERRAL  
5           PRIOR TO REENTRY.—

6                   (A)(i) Subject to clauses (ii) and (iii),  
7           health care personnel shall provide routine HIV  
8           testing to all inmates no more than 3 months  
9           prior to their release and reentry into the com-  
10          munity.

11                   (ii) Inmates who are already known to be  
12          infected shall not be required to be tested  
13          again.

14                   (iii) The requirement under clause (i) may  
15          be waived if an inmate's release occurs without  
16          sufficient notice to the Bureau to allow health  
17          care personnel to perform a routine HIV test  
18          and notify the inmate of the results.

19                   (B) All HIV tests under this paragraph  
20          shall comply with paragraph (9).

21                   (C) To all inmates who test positive for  
22          HIV and all inmates who already are known to  
23          have HIV/AIDS, health care personnel shall  
24          provide—

1 (i) confidential prerelease counseling  
2 on managing their medical condition in the  
3 community, accessing appropriate treat-  
4 ment and services in the community, and  
5 preventing the transmission of their condi-  
6 tion to family members and other persons  
7 in the community;

8 (ii) referrals to appropriate health  
9 care providers and social service agencies  
10 in the community that meet the inmate's  
11 individual needs, including voluntary part-  
12 ner notification services and prevention  
13 counseling services for people living with  
14 HIV/AIDS; and

15 (iii) a 30-day supply of any medically  
16 necessary medications the inmate is cur-  
17 rently receiving.

18 (9) OPT-OUT PROVISION.—Inmates shall have  
19 the right to refuse routine HIV testing. Inmates  
20 shall be informed both orally and in writing of this  
21 right. Oral and written disclosure of this right may  
22 be included with other general health information  
23 and counseling provided to inmates by health care  
24 personnel. If an inmate refuses a routine test for  
25 HIV, health care personnel shall make a note of the

1 inmate's refusal in the inmate's confidential medical  
2 records. However, the inmate's refusal shall not be  
3 considered a violation of prison rules or result in dis-  
4 ciplinary action.

5 (10) EXCLUSION OF TESTS PERFORMED UNDER  
6 SECTION 4014(b) FROM THE DEFINITION OF ROU-  
7 TINE HIV TESTING.—HIV testing of an inmate  
8 under section 4014(b) of title 18, United States  
9 Code, is not routine HIV testing for the purposes of  
10 paragraph (9). Health care personnel shall document  
11 the reason for testing under section 4014(b) of title  
12 18, United States Code, in the inmate's confidential  
13 medical records.

14 (11) TIMELY NOTIFICATION OF TEST RE-  
15 SULTS.—Health care personnel shall provide timely  
16 notification to inmates of the results of HIV tests.

17 (d) CHANGES IN EXISTING LAW.—

18 (1) SCREENING IN GENERAL.—Section 4014(a)  
19 of title 18, United States Code, is amended—

20 (A) by striking “for a period of 6 months  
21 or more”;

22 (B) by striking “, as appropriate,”; and

23 (C) by striking “if such individual is deter-  
24 mined to be at risk for infection with such virus  
25 in accordance with the guidelines issued by the



1 Bureau of Prisons relating to infectious disease  
2 management” and inserting “unless the indi-  
3 vidual declines. The Attorney General shall also  
4 cause such individual to be so tested before re-  
5 lease unless the individual declines.”.

6 (2) INADMISSIBILITY OF HIV TEST RESULTS IN  
7 CIVIL AND CRIMINAL PROCEEDINGS.—Section  
8 4014(d) of title 18, United States Code, is amended  
9 by inserting “or under the Stop AIDS in Prison Act  
10 of 2011” after “under this section”.

11 (3) SCREENING AS PART OF ROUTINE SCREEN-  
12 ING.—Section 4014(e) of title 18, United States  
13 Code, is amended by adding at the end the fol-  
14 lowing: “Such rules shall also provide that the initial  
15 test under this section be performed as part of the  
16 routine health screening conducted at intake.”.

17 (e) REPORTING REQUIREMENTS.—

18 (1) REPORT ON HEPATITIS AND OTHER DIS-  
19 EASES.—Not later than 1 year after the date of the  
20 enactment of this Act, the Bureau shall provide a re-  
21 port to the Congress on Bureau policies and proce-  
22 dures to provide testing, treatment, and prevention  
23 education programs for hepatitis and other diseases  
24 transmitted through sexual activity and intravenous  
25 drug use. The Bureau shall consult with appropriate

1 officials of the Department of Health and Human  
2 Services, the Office of National Drug Control Policy,  
3 the Office of National AIDS Policy, and the Centers  
4 for Disease Control and Prevention regarding the  
5 development of this report.

6 (2) ANNUAL REPORTS.—

7 (A) GENERALLY.—Not later than 2 years  
8 after the date of the enactment of this Act, and  
9 then annually thereafter, the Bureau shall re-  
10 port to Congress on the incidence among in-  
11 mates of diseases transmitted through sexual  
12 activity and intravenous drug use.

13 (B) MATTERS PERTAINING TO VARIOUS  
14 DISEASES.—Reports under subparagraph (A)  
15 shall discuss—

16 (i) the incidence among inmates of  
17 HIV/AIDS, hepatitis, and other diseases  
18 transmitted through sexual activity and in-  
19 travenous drug use; and

20 (ii) updates on Bureau testing, treat-  
21 ment, and prevention education programs  
22 for these diseases.

23 (C) MATTERS PERTAINING TO HIV/AIDS  
24 ONLY.—Reports under subparagraph (A) shall  
25 also include—

1 (i) the number of inmates who tested  
2 positive for HIV upon intake;

3 (ii) the number of inmates who tested  
4 positive prior to reentry;

5 (iii) the number of inmates who were  
6 not tested prior to reentry because they  
7 were released without sufficient notice;

8 (iv) the number of inmates who opted-  
9 out of taking the test;

10 (v) the number of inmates who were  
11 tested under section 4014(b) of title 18,  
12 United States Code; and

13 (vi) the number of inmates under  
14 treatment for HIV/AIDS.

15 (D) CONSULTATION.—The Bureau shall  
16 consult with appropriate officials of the Depart-  
17 ment of Health and Human Services, the Office  
18 of National Drug Control Policy, the Office of  
19 National AIDS Policy, and the Centers for Dis-  
20 ease Control and Prevention regarding the de-  
21 velopment of reports under subparagraph (A).

22 **SEC. 751. SERVICES TO REDUCE HIV/AIDS IN RACIAL AND**  
23 **ETHNIC MINORITY COMMUNITIES.**

24 (a) IN GENERAL.—For the purpose of reducing HIV/  
25 AIDS in racial and ethnic minority communities, the Sec-

1 retary, acting through the Deputy Assistant Secretary for  
2 Minority Health, may make grants to public health agen-  
3 cies and faith-based organizations to conduct—

4 (1) outreach activities related to HIV/AIDS  
5 prevention and testing activities;

6 (2) HIV/AIDS prevention activities; and

7 (3) HIV/AIDS testing activities.

8 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry  
9 out this section, there are authorized to be appropriated  
10 \$50,000,000 for fiscal year 2012, and such sums as may  
11 be necessary for fiscal years 2013 through 2016.

12 **SEC. 752. HEALTH CARE PROFESSIONALS TREATING INDI-**  
13 **VIDUALS WITH HIV/AIDS.**

14 Part E of title VII of the Public Health Service Act  
15 (42 U.S.C. 294n et seq.) is amended by adding at the end  
16 the following:

17 **“Subpart 5—Health Care Professionals Treating**  
18 **Individuals With HIV/AIDS**

19 **“SEC. 785. HEALTH CARE PROFESSIONALS TREATING INDI-**  
20 **VIDUALS WITH HIV/AIDS.**

21 “(a) IN GENERAL.—The Secretary, acting through  
22 the Administrator of the Health Resources and Services  
23 Administration and in consultation with racial and ethnic  
24 minority community organizations, may award grants for  
25 any of the following:

1           “(1) Development of curricula for training pri-  
2           mary care providers in HIV/AIDS prevention and  
3           care.

4           “(2) Training health care professionals with ex-  
5           pertise in HIV/AIDS to provide care to individuals  
6           with HIV/AIDS.

7           “(3) Development by grant recipients under  
8           title XXVI and other persons of policies for pro-  
9           viding culturally relevant and sensitive treatment to  
10          individuals with HIV/AIDS, with particular empha-  
11          sis on treatment to racial and ethnic minorities, men  
12          who have sex with men, and women and children  
13          with HIV/AIDS.

14          “(4) Development and implementation of pro-  
15          grams to increase the use of telemedicine to respond  
16          to HIV/AIDS-specific health care needs in rural and  
17          minority communities, with particular emphasis  
18          given to medically underserved communities and in-  
19          sular areas.

20          “(5) Creation of faith- and community-based  
21          certification programs for providers in HIV/AIDS  
22          care and support services.

23          “(6) Establishment of comfort care centers that  
24          provide mental, emotional, and psychosocial coun-  
25          seling for people with HIV/AIDS and implement ad-

1       ditional protocols to be carried out in the centers  
2       that address the needs of children and young adults  
3       who are infected with the disease and are  
4       transitioning from childhood to adulthood.

5               “(7) Incentive payments to health care pro-  
6       viders supported by the Health Resources and Serv-  
7       ices Administration to implement HIV/AIDS testing  
8       consistent with the guidelines issued in 2006 by the  
9       Centers for Disease Control and Prevention entitled  
10      ‘Revised Recommendations for HIV Testing of  
11      Adults, Adolescents, and Pregnant Women in  
12      Health-Care Settings’.

13              “(b) DEFINITION.—In this section, the term ‘HIV/  
14      AIDS’ has the meaning given to such term in section  
15      2689.

16              “(c) AUTHORIZATION OF APPROPRIATIONS.—To  
17      carry out this section, there are authorized to be appro-  
18      priated \$100,000,000 for fiscal year 2012, and such sums  
19      as may be necessary for fiscal years 2013 through 2016.”.

20      **SEC. 753. REPORT ON IMPACT OF HIV/AIDS IN RACIAL AND**  
21                                      **ETHNIC MINORITY COMMUNITIES.**

22              (a) IN GENERAL.—The Secretary shall submit to the  
23      Congress and the President an annual report on the im-  
24      pact of HIV/AIDS in racial and ethnic minority commu-  
25      nities.

1 (b) CONTENTS.—The report under subsection (a)  
2 shall include information on the—

3 (1) progress that has been made in reducing  
4 the impact of HIV/AIDS in such communities;

5 (2) opportunities that exist to make additional  
6 progress in reducing the impact of HIV/AIDS in  
7 such communities;

8 (3) challenges that may impede such additional  
9 progress; and

10 (4) Federal funding necessary to achieve sub-  
11 stantial reductions in HIV/AIDS in racial and ethnic  
12 minority communities.

13 **SEC. 754. STUDY ON STATUS OF HIV/AIDS EPIDEMIC AMONG**  
14 **AFRICAN-AMERICANS.**

15 (a) IN GENERAL.—The Secretary shall—

16 (1) seek to enter into an agreement with the In-  
17 stitute of Medicine to document, in collaboration  
18 with an academic organization which specializes in  
19 the identification and reduction of health disparities  
20 within the African-American community, all aspects  
21 of the HIV/AIDS epidemic among African-Ameri-  
22 cans, including the role that historical racial or eth-  
23 nic barriers play in sustaining the epidemic among  
24 African-Americans;

1           (2) submit a report to the President, the Direc-  
2           tor of the Office of National AIDS Policy Coordina-  
3           tion, the Director of the White House Domestic Pol-  
4           icy Council, the Director of White House Office of  
5           Faith-Based and Neighborhood Partnerships, key  
6           Federal agencies, and the relevant committees of the  
7           Congress on the status of the HIV/AIDS epidemic  
8           among African-Americans in the United States; and

9           (3) include in such report—

10           (A) specific recommendations on the imple-  
11           mentation of Federal policies to reduce the bur-  
12           den of HIV/AIDS in the African-American com-  
13           munity; and

14           (B) a special focus on the Black clergy and  
15           the church as a unique resource in the African-  
16           American community.

17           (b) AUTHORIZATION OF APPROPRIATIONS.—

18           (1) IN GENERAL.—To carry out this section,  
19           there is authorized to be appropriated \$2,000,000  
20           for each of fiscal years 2012 and 2013.

21           (2) SPECIAL RULE.—Of the amount of funds  
22           appropriated to carry out this section for a fiscal  
23           year—



1 (A) 45 percent shall be allocated to the In-  
 2 stitutes of Medicine pursuant to the agreement  
 3 entered into under subsection (a)(1);

4 (B) 45 percent shall be allocated to an  
 5 academic organization which specializes in the  
 6 identification and reduction of health disparities  
 7 within the African-American community pursu-  
 8 ant to such agreement; and

9 (C) 10 percent shall be allocated for ad-  
 10 ministrative costs and other activities under  
 11 this subsection.

## 12 **Subtitle F—Diabetes**

### 13 **SEC. 755. TREATMENT OF DIABETES IN MINORITY COMMU-** 14 **NITIES.**

15 (a) **SHORT TITLE.**—This subtitle may be cited as the  
 16 “Minority Diabetes Initiative Act”.

17 (b) **GRANTS REGARDING TREATMENT OF DIABETES**  
 18 **IN MINORITY COMMUNITIES.**—Part D of title III of the  
 19 Public Health Service Act (42 U.S.C. 254b et seq.) is  
 20 amended by inserting after section 330L the following:

### 21 **“SEC. 330M. GRANTS REGARDING TREATMENT OF DIABE-** 22 **TES IN MINORITY COMMUNITIES.**

23 “(a) **IN GENERAL.**—The Secretary may make grants  
 24 to public and nonprofit private health care providers for

1 the purpose of providing treatment for diabetes in minor-  
2 ity communities.

3 “(b) RECIPIENTS OF GRANTS.—The public and non-  
4 profit private health care providers to whom grants may  
5 be made under subsection (a) include physicians, podia-  
6 trists, community-based organizations, health care organi-  
7 zations, community health centers, and State, local, and  
8 tribal health departments.

9 “(c) SCOPE OF TREATMENT ACTIVITIES.—The Sec-  
10 retary shall ensure that grants under subsection (a) cover  
11 a variety of diabetes-related health care services, including  
12 routine care for diabetic patients, public education on dia-  
13 betes prevention and control, eye care, foot care, and  
14 treatment for kidney disease and other complications of  
15 diabetes.

16 “(d) APPROPRIATE CULTURAL CONTEXT.—A condi-  
17 tion for the receipt of a grant under subsection (a) is that  
18 the applicant involved agrees that, in the program carried  
19 out with the grant, services will be provided in the lan-  
20 guages most appropriate for, and with consideration for  
21 the cultural backgrounds of, the individuals for whom the  
22 services are provided.

23 “(e) OUTREACH SERVICES.—A condition for the re-  
24 ceipt of a grant under subsection (a) is that the applicant  
25 involved agrees to provide outreach activities to inform the

1 public of the services of the program, and to provide offsite  
2 information on diabetes.

3 “(f) APPLICATION FOR GRANT.—A grant may be  
4 made under subsection (a) only if an application for the  
5 grant is submitted to the Secretary and the application  
6 is in such form, is made in such manner, and contains  
7 such agreements, assurances, and information as the Sec-  
8 retary determines to be necessary to carry out this section.

9 “(g) AUTHORIZATION OF APPROPRIATIONS.—For the  
10 purpose of carrying out this section, there are authorized  
11 to be appropriated such sums as may be necessary for  
12 each of the fiscal years 2012 through 2017.”.

13 **SEC. 756. ELIMINATING DISPARITIES IN DIABETES PREVEN-**  
14 **TION ACCESS AND CARE.**

15 (a) RESEARCH, TREATMENT, AND EDUCATION.—

16 (1) IN GENERAL.—Subpart 3 of part C of title  
17 IV of the Public Health Service Act (42 U.S.C. 285c  
18 et seq.) is amended by adding at the end the fol-  
19 lowing new section:

20 **“SEC. 434B. DIABETES IN MINORITY POPULATIONS.**

21 “(a) IN GENERAL.—The Director of the National In-  
22 stitutes of Health shall expand, intensify, and support on-  
23 going research and other activities with respect to pre-dia-  
24 betes and diabetes, particularly type 2, in minority popu-  
25 lations, including research to identify clinical, socio-

1 economic, geographical, cultural, and organizational fac-  
2 tors that contribute to type 2 diabetes in such populations.

3 “(b) CERTAIN ACTIVITIES.—Activities under sub-  
4 section (a) regarding type 2 diabetes in minority popu-  
5 lations shall include the following:

6 “(1) Continuing research on behavior and obe-  
7 sity, including through the obesity research center  
8 that is sponsored by the National Institutes of  
9 Health.

10 “(2) Research on environmental factors that  
11 may contribute to the increase in type 2 diabetes.

12 “(3) Support for new methods to identify envi-  
13 ronmental triggers and genetic interactions that lead  
14 to the development of type 2 diabetes in minority  
15 newborns. Such research should follow the newborns  
16 through puberty, an increasingly high-risk period for  
17 developing type 2 diabetes.

18 “(4) Research to identify genes that predispose  
19 individuals to the onset of developing type 1 and  
20 type 2 diabetes and to the development of complica-  
21 tions.

22 “(5) Research to prevent complications in indi-  
23 viduals who have already developed diabetes, such as  
24 research that attempts to identify the genes that

1 predispose individuals with diabetes to the develop-  
2 ment of complications.

3 “(6) Research methods and alternative thera-  
4 pies to control blood glucose.

5 “(7) Support of ongoing research efforts exam-  
6 ining the level of glycemia at which adverse out-  
7 comes develop during pregnancy and to address the  
8 many clinical issues associated with minority moth-  
9 ers and fetuses during diabetic and gestational dia-  
10 betic pregnancies.

11 “(c) EDUCATION.—The Director of the National In-  
12 stitutes of Health shall—

13 “(1) through the National Institute on Minority  
14 Health and Health Disparities and the National Di-  
15 abetes Education Program—

16 “(A) make grants to programs funded  
17 under section 485F (relating to centers of ex-  
18 cellence) for the purpose of establishing a men-  
19 toring program for health care professionals to  
20 be more involved in weight counseling, obesity  
21 research, and nutrition; and

22 “(B) provide for the participation of mi-  
23 nority health professionals in diabetes-focused  
24 research programs; and

1           “(2) make grants for programs to establish a  
2 pipeline from high school to professional school that  
3 will increase minority representation in diabetes-fo-  
4 cused health fields by expanding Minority Access to  
5 Research Careers (MARC) program internships and  
6 mentoring opportunities for recruitment.

7           “(d) DEFINITION.—For purposes of this section, the  
8 term ‘minority population’ means a racial and ethnic mi-  
9 nority group, as defined in section 1707(g).

10          “(e) AUTHORIZATION OF APPROPRIATIONS.—For the  
11 purpose of carrying out this section, there are authorized  
12 to be appropriated such sums as are necessary for fiscal  
13 year 2012 and each subsequent fiscal year.”.

14           (2) DIABETES MELLITUS INTERAGENCY CO-  
15 ORDINATING COMMITTEE.—Section 429 of the Pub-  
16 lic Health Service Act (42 U.S.C. 285c–3) is amend-  
17 ed by adding at the end the following new sub-  
18 section:

19          “(c)(1) The Diabetes Mellitus Interagency Coordi-  
20 nating Committee shall submit to the Secretary a biennial  
21 report that shall include an assessment of the Federal ac-  
22 tivities and programs related to diabetes in minority popu-  
23 lations. Such assessment shall—

24           “(A) compile the current activities of all current  
25 Federal health programs to allow for the assessment

1 of their adequacy as a systemic method of address-  
2 ing the impact of diabetes mellitus on minority popu-  
3 lations;

4 “(B) develop strategic planning activities to de-  
5 velop an effective and comprehensive Federal plan to  
6 address diabetes mellitus within minority popu-  
7 lations which will involve all appropriate Federal  
8 health programs and shall—

9 “(i) include steps to address issues includ-  
10 ing type 1 and type 2 diabetes in children and  
11 the disproportionate impact of diabetes mellitus  
12 on minority populations; and

13 “(ii) remain consistent with the programs  
14 and activities identified in section 3990, as well  
15 as remaining consistent with the intent of the  
16 Eliminating Disparities in Diabetes Prevention  
17 Access and Care Act of 2010; and

18 “(C) assess the implementation of such a plan  
19 throughout Federal health programs.

20 “(2) For the purposes of this subsection, the term  
21 ‘minority population’ means a racial and ethnic minority  
22 group, as defined in section 1707(g).

23 “(3) For the purpose of carrying out this subsection,  
24 there are authorized to be appropriated such sums as are

1 necessary for fiscal year 2012 and each subsequent fiscal  
2 year.”.

3 (b) RESEARCH, EDUCATION, AND OTHER ACTIVI-  
4 TIES.—Part B of title III of the Public Health Service  
5 Act (42 U.S.C. 243 et seq.) is amended by inserting after  
6 section 317T the following section:

7 **“SEC. 317U. DIABETES IN MINORITY POPULATIONS.**

8 “(a) RESEARCH AND OTHER ACTIVITIES.—

9 “(1) IN GENERAL.—The Secretary, acting  
10 through the Director of the Centers for Disease  
11 Control and Prevention, shall conduct and support  
12 research and other activities with respect to diabetes  
13 in minority populations.

14 “(2) CERTAIN ACTIVITIES.—Activities under  
15 paragraph (1) regarding diabetes in minority popu-  
16 lations shall include the following:

17 “(A) Expanding the National Diabetes  
18 Laboratory capacity for translational research  
19 and the identification of genetic and  
20 immunological risk factors associated with dia-  
21 betes.

22 “(B) Improving the understanding of dia-  
23 betes prevalence among Asian-American, Native  
24 Hawaiian and other Pacific Islanders by en-  
25 hancing data in the National Health and Nutri-



1           tion Examination Survey by oversampling these  
2           populations in appropriate geographic areas, or  
3           by another method determined appropriate to  
4           collect this data.

5           “(C) Within the Division of Diabetes  
6           Translation, providing for prevention research  
7           to better understand how to influence health  
8           care systems changes to improve quality of care  
9           being delivered to such populations, and within  
10          the Division of Diabetes Translation, carrying  
11          out model demonstration projects to design, im-  
12          plement, and evaluate effective diabetes preven-  
13          tion and control intervention for such popu-  
14          lations.

15          “(D) Through the Division of Diabetes  
16          Translation, carrying out culturally appropriate  
17          community-based interventions designed to ad-  
18          dress issues and problems experienced by such  
19          populations.

20          “(E) Conducting applied research within  
21          the Division of Diabetes Translation to reduce  
22          health disparities within such populations with  
23          diabetes.

24          “(F) Conducting applied research on pri-  
25          mary prevention within the Division of Diabetes

1 Translation to specifically focus on such popu-  
2 lations with pre-diabetes.

3 “(b) EDUCATION.—

4 “(1) IN GENERAL.—The Secretary, acting  
5 through the Director of the Centers for Disease  
6 Control and Prevention, shall direct the Division of  
7 Diabetes Translation to conduct and support pro-  
8 grams to educate the public on the causes and ef-  
9 fects of diabetes in minority populations.

10 “(2) CERTAIN ACTIVITIES.—Programs under  
11 paragraph (1) regarding education on diabetes in  
12 minority populations shall include carrying out pub-  
13 lic awareness campaigns directed toward such popu-  
14 lations to aggressively emphasize the importance and  
15 impact of physical activity and diet in regard to dia-  
16 betes and diabetes-related complications through the  
17 National Diabetes Education Program.

18 “(c) DIABETES; HEALTH PROMOTION, PREVENTION  
19 ACTIVITIES, AND ACCESS.—

20 “(1) IN GENERAL.—The Secretary, acting  
21 through the Director of the Centers for Disease  
22 Control and Prevention, shall carry out culturally  
23 appropriate diabetes health promotion and preven-  
24 tion programs for minority populations.

1           “(2) CERTAIN ACTIVITIES.—Activities regard-  
2           ing culturally appropriate diabetes health promotion  
3           and prevention programs for minority populations  
4           shall include the following:

5                   “(A) Expanding the Diabetes Prevention  
6                   and Control Program (currently existing in all  
7                   the States and territories) and providing funds  
8                   for education and community outreach on dia-  
9                   betes.

10                   “(B) Providing funds for an expansion of  
11                   the Diabetes Prevention Program Initiative that  
12                   focuses on physical inactivity and diet and its  
13                   relation to type 2 diabetes within such popu-  
14                   lations.

15                   “(C) Providing funds to strengthen exist-  
16                   ing surveillance systems to improve the quality,  
17                   accuracy, and timeliness of morbidity and mor-  
18                   tality diabetes data for such populations.

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(g).

22           “(e) AUTHORIZATION OF APPROPRIATIONS.—For the  
23           purpose of carrying out this section, there are authorized  
24           to be appropriated such sums as are necessary for fiscal  
25           year 2012 and each subsequent fiscal year.”.

1 (c) RESEARCH, EDUCATION, AND OTHER ACTIVI-  
2 TIES.—Part P of title III of the Public Health Service  
3 Act is amended—

4 (1) by redesignating the section 399R inserted  
5 by section 2 of Public Law 110–373 as section  
6 399S;

7 (2) by redesignating the section 399R inserted  
8 by section 3 of Public Law 110–374 as section  
9 399T; and

10 (3) by adding at the end the following new sec-  
11 tion:

12 **“SEC. 399V-6. PROGRAMS TO EDUCATE HEALTH PRO-**  
13 **VIDERS ON THE CAUSES AND EFFECTS OF DI-**  
14 **ABETES IN MINORITY POPULATIONS.**

15 “(a) IN GENERAL.—The Secretary, acting through  
16 the Director of the Health Resources and Services Admin-  
17 istration, shall conduct and support programs described  
18 in subsection (b) to educate health professionals on the  
19 causes and effects of diabetes in minority populations.

20 “(b) PROGRAMS.—Programs described in this sub-  
21 section, with respect to education on diabetes in minority  
22 populations, shall include the following:

23 “(1) Making grants for diabetes-focused edu-  
24 cation classes or training programs on cultural sen-

1       sitivity and patient care within such populations for  
2       health care providers.

3               “(2) Providing funds to community health cen-  
4       ters for programs that provide diabetes services and  
5       screenings.

6               “(3) Providing additional funds for the Health  
7       Careers Opportunity Program, Centers for Excel-  
8       lence, and the Minority Faculty Fellowship Program  
9       to partner with the Office of Minority Health under  
10      section 1707 and the National Institutes of Health  
11      to strengthen programs for career opportunities  
12      within minority populations focused on diabetes  
13      treatment and care.

14              “(4) Developing a diabetes focus within, and  
15      providing additional funds for, the National Health  
16      Service Corps Scholarship program to place individ-  
17      uals in areas that are disproportionately affected by  
18      diabetes and to provide health care services to such  
19      areas.

20              “(5) Establishing a diabetes ambassador pro-  
21      gram for recruitment efforts to increase the number  
22      of underrepresented minorities currently serving in  
23      student, faculty, or administrative positions in insti-  
24      tutions of higher learning, hospitals, and community  
25      health centers.

1           “(6) Establishing a loan repayment program  
2           that focuses on diabetes care and prevention in mi-  
3           nority populations.”.

4           (d) RESEARCH, EDUCATION, AND OTHER ACTIVI-  
5 TIES.—Part P of title III of the Public Health Service  
6 Act (42 U.S.C. 280g et seq.), as amended by subsection  
7 (c), is further amended by adding at the end the following  
8 section:

9           **“SEC. 399V-7. RESEARCH, EDUCATION, AND OTHER ACTIVI-**  
10                           **TIES REGARDING DIABETES IN MINORITY**  
11                           **POPULATIONS.**

12           “(a) RESEARCH AND OTHER ACTIVITIES.—

13                   “(1) IN GENERAL.—In addition to activities  
14                   under sections 317U and 434B, the Secretary shall  
15                   conduct and support research and other activities  
16                   with respect to diabetes within minority populations.

17                   “(2) CERTAIN ACTIVITIES.—Activities under  
18                   paragraph (1) regarding diabetes in minority popu-  
19                   lations shall include the following:

20                           “(A) Through the National Center on Mi-  
21                           nority Health and Health Disparities, the Office  
22                           of Minority Health under section 1707, the  
23                           Health Resources and Services Administration,  
24                           the Centers for Disease Control and Prevention,  
25                           and the Indian Health Service, establishing

1 partnerships within minority populations to  
2 conduct studies on cultural, familial, and social  
3 factors that may influence health promotion, di-  
4 abetes management, and prevention.

5 “(B) Through the Indian Health Service,  
6 in collaboration with other appropriate Federal  
7 agencies, coordinating the collection of data on  
8 ethnic and culturally appropriate diabetes treat-  
9 ment, care, prevention, and services by health  
10 care professionals to the American Indian popu-  
11 lation.

12 “(3) PROGRAMS RELATING TO CLINICAL RE-  
13 SEARCH.—

14 “(A) EDUCATION REGARDING CLINICAL  
15 TRIALS.—The Secretary shall carry out edu-  
16 cation and awareness programs designed to in-  
17 crease participation of minority populations in  
18 clinical trials.

19 “(B) MINORITY RESEARCHERS.—The Sec-  
20 retary shall carry out mentorship programs for  
21 minority researchers who are conducting or in-  
22 tend to conduct research on diabetes in minor-  
23 ity populations.

24 “(C) SUPPLEMENTING CLINICAL RE-  
25 SEARCH REGARDING CHILDREN.—The Sec-

1           retary shall make grants to supplement clinical  
2           research programs to assist such programs in  
3           obtaining the services of health professionals  
4           and other resources to provide specialized care  
5           for children with type 1 and type 2 diabetes.

6           “(4) ADDITIONAL PROGRAMS.—Activities under  
7           paragraph (1) regarding education on diabetes shall  
8           include providing funds for new and existing diabe-  
9           tes-focused education grants and programs for  
10          present and future students and clinicians in the  
11          medical field from minority populations, including  
12          for the following:

13                 “(A) For Federal and State loan repay-  
14                 ment programs for health profession students  
15                 within communities of color.

16                 “(B) For the Office of Minority Health  
17                 under section 1707 for training health profes-  
18                 sion students to focus on diabetes within such  
19                 populations.

20          “(b) DEFINITION.—For purposes of this section, the  
21          term ‘minority population’ means a racial and ethnic mi-  
22          nority group as defined in section 1707(g).

23          “(c) AUTHORIZATION OF APPROPRIATIONS.—For the  
24          purpose of carrying out this section, there are authorized



1 to be appropriated such sums as are necessary for fiscal  
2 year 2012 and each subsequent fiscal year.”.

3 (e) SENSE OF THE CONGRESS.—It is the sense of the  
4 Congress that States and localities are encourage to recog-  
5 nize established times of diabetes awareness, such as  
6 American Diabetes Month (November), American Diabe-  
7 tes Alert Day (annually on the 4th Tuesday of March),  
8 and World Diabetes Day (November 14th).

### 9 **Subtitle G—Lung Disease**

#### 10 **SEC. 761. EXPANSION OF THE NATIONAL ASTHMA EDU-** 11 **CATION AND PREVENTION PROGRAM.**

12 (a) IN GENERAL.—Not later than 2 years after the  
13 date of the enactment of this Act, the Secretary of Health  
14 and Human Services shall convene a working group com-  
15 prised of patient groups, nonprofit organizations, medical  
16 societies, and other relevant governmental and nongovern-  
17 mental entities, including those that participate in the Na-  
18 tional Asthma Education and Prevention Program, to de-  
19 velop a report to Congress that—

20 (1) catalogs, with respect to asthma prevention,  
21 management, and surveillance—

22 (A) the activities of the Federal Govern-  
23 ment, including identifying all Federal pro-  
24 grams that carry out asthma-related activities,  
25 as well as assessment of the progress of the

1 Federal Government and States, with respect to  
2 achieving the goals of the Healthy People 2020  
3 initiative; and

4 (B) the activities of other entities that par-  
5 ticipate in the program, including nonprofit or-  
6 ganizations, patient advocacy groups, and med-  
7 ical societies; and

8 (2) makes recommendations for the future di-  
9 rection of asthma activities, in consultation with re-  
10 searchers from the National Institutes of Health and  
11 other member bodies of the National Asthma Edu-  
12 cation and Prevention Program who are qualified to  
13 review and analyze data and evaluate interventions,  
14 including—

15 (A) description of how the Federal Govern-  
16 ment may better coordinate and improve its re-  
17 sponse to asthma including identifying any bar-  
18 riers that may exist;

19 (B) description of how the Federal Govern-  
20 ment may continue, expand, and improve its  
21 private-public partnerships with respect to asth-  
22 ma including identifying any barriers that may  
23 exist;

24 (C) identification of steps that may be  
25 taken to reduce the—

1 (i) morbidity, mortality, and overall  
2 prevalence of asthma;

3 (ii) financial burden of asthma on so-  
4 ciety;

5 (iii) burden of asthma on dispro-  
6 tionately affected areas, particularly those  
7 in medically underserved populations (as  
8 defined in section 330(b)(3) of the Public  
9 Health Service Act (42 U.S.C.  
10 254b(b)(3)); and

11 (iv) burden of asthma as a chronic  
12 disease;

13 (D) identification of programs and policies  
14 that have achieved the steps described in sub-  
15 paragraph (C), and steps that may be taken to  
16 expand such programs and policies to benefit  
17 larger populations; and

18 (E) recommendations for future research  
19 and interventions.

20 (b) REPORT TO CONGRESS.—At the end of the 5-year  
21 period following the submission of the report under sub-  
22 section (a), the National Asthma Education and Preven-  
23 tion Program shall evaluate the analyses and rec-  
24 ommendations under such report and determine whether

1 a new report to the Congress is necessary, and make ap-  
2 propriate recommendations to the Congress.

3 **SEC. 762. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**  
4 **FOR DISEASE CONTROL AND PREVENTION.**

5 Section 317I of the Public Health Service Act (42  
6 U.S.C. 247b–10) is amended to read as follows:

7 **“SEC. 317I. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**  
8 **FOR DISEASE CONTROL AND PREVENTION.**

9 “(a) PROGRAM FOR PROVIDING INFORMATION AND  
10 EDUCATION TO THE PUBLIC.—The Secretary, acting  
11 through the Director of the Centers for Disease Control  
12 and Prevention, shall collaborate with State and local  
13 health departments to conduct activities, including the  
14 provision of information and education to the public re-  
15 garding asthma including—

16 “(1) deterring the harmful consequences of un-  
17 controlled asthma; and

18 “(2) disseminating health education and infor-  
19 mation regarding prevention of asthma episodes and  
20 strategies for managing asthma.

21 “(b) DEVELOPMENT OF STATE ASTHMA PLANS.—  
22 The Secretary, acting through the Director of the Centers  
23 for Disease Control and Prevention, shall collaborate with  
24 State and local health departments to develop State plans  
25 incorporating public health responses to reduce the burden

1 of asthma, particularly regarding disproportionately af-  
2 fected populations.

3 “(c) COMPILATION OF DATA.—The Secretary, acting  
4 through the Director of the Centers for Disease Control  
5 and Prevention, shall, in cooperation with State and local  
6 public health officials—

7 “(1) conduct asthma surveillance activities to  
8 collect data on the prevalence and severity of asth-  
9 ma, the effectiveness of public health asthma inter-  
10 ventions, and the quality of asthma management, in-  
11 cluding—

12 “(A) collection of household data on the  
13 local burden of asthma;

14 “(B) surveillance of health care facilities;  
15 and

16 “(C) collection of data not containing indi-  
17 vidually identifiable information from electronic  
18 health records or other electronic communica-  
19 tions;

20 “(2) compile and annually publish data regard-  
21 ing the prevalence and incidence of childhood asth-  
22 ma, the child mortality rate, and the number of hos-  
23 pital admissions and emergency department visits by  
24 children associated with asthma nationally and in  
25 each State and at the county level by age, sex, race,

1 and ethnicity, as well as lifetime and current preva-  
2 lence; and

3 “(3) compile and annually publish data regard-  
4 ing the prevalence and incidence of adult asthma,  
5 the adult mortality rate, and the number of hospital  
6 admissions and emergency department visits by  
7 adults associated with asthma nationally and in each  
8 State and at the county level by age, sex, race, eth-  
9 nicity, industry, and occupation, as well as lifetime  
10 and current prevalence.

11 “(d) COORDINATION OF DATA COLLECTION.—The  
12 Director of the Centers for Disease Control and Preven-  
13 tion, in conjunction with State and local health depart-  
14 ments, shall coordinate data collection activities under  
15 subsection (c)(2) so as to maximize comparability of re-  
16 sults.

17 “(e) COLLABORATION.—The Centers for Disease  
18 Control and Prevention are encouraged to collaborate with  
19 national, State, and local nonprofit organizations to pro-  
20 vide information and education about asthma, and to  
21 strengthen such collaborations when possible.

22 “(f) ADDITIONAL FUNDING.—In addition to any  
23 other authorization of appropriations that is available to  
24 the Centers for Disease Control and Prevention for the  
25 purpose of carrying out this section, there are authorized

1 to be appropriated to such Centers such sums as may be  
2 necessary for each of fiscal years 2012 through 2016 for  
3 the purpose of carrying out this section.”.

4 **SEC. 763. INFLUENZA AND PNEUMONIA VACCINATION CAM-**  
5 **PAIGN.**

6 (a) IN GENERAL.—The Secretary of Health and  
7 Human Services shall—

8 (1) enhance the annual campaign by the De-  
9 partment of Health and Human Services to increase  
10 the number of people vaccinated each year for influ-  
11 enza and pneumonia; and

12 (2) include in such campaign the use of written  
13 educational materials, public service announcements,  
14 physician education, and any other means which the  
15 Secretary deems effective.

16 (b) MATERIALS AND ANNOUNCEMENTS.—In carrying  
17 out the annual campaign described in subsection (a), the  
18 Secretary of Health and Human Services shall ensure  
19 that—

20 (1) educational materials and public service an-  
21 nouncements are readily and widely available in  
22 communities experiencing disparities in the incidence  
23 and mortality rates of influenza and pneumonia; and

1           (2) the campaign uses targeted, culturally ap-  
2           propriate messages and messengers to reach under-  
3           served communities.

4           (c) AUTHORIZATION OF APPROPRIATIONS.—There  
5           are authorized to be appropriated to carry out this section  
6           such sums as may be necessary for each of fiscal years  
7           2012 through 2016.

8           **SEC. 764. CHRONIC OBSTRUCTIVE PULMONARY DISEASE**  
9                           **ACTION PLAN.**

10          (a) IN GENERAL.—The Director of the Centers for  
11          Disease Control and Prevention shall conduct, support,  
12          and expand public health strategies, prevention, diagnosis,  
13          surveillance, and public and professional awareness activi-  
14          ties regarding chronic obstructive pulmonary disease.

15          (b) NATIONAL ACTION PLAN.—

16                 (1) DEVELOPMENT.—Not later than 2 years  
17          after the date of the enactment of this Act, the Di-  
18          rector of the National Heart, Lung, and Blood Insti-  
19          tute, in consultation with the Director of the Centers  
20          for Disease Control and Prevention, shall develop a  
21          national action plan to address chronic obstructive  
22          pulmonary disease in the United States with partici-  
23          pation from patients, caregivers, health profes-  
24          sionals, patient advocacy organizations, researchers,



1 providers, public health professionals, and other  
2 stakeholders.

3 (2) CONTENTS.—At a minimum, such plan  
4 shall include recommendations for—

5 (A) public health interventions for the pur-  
6 pose of implementation of the national plan;

7 (B) biomedical, health services, and public  
8 health research on chronic obstructive pul-  
9 monary disease; and

10 (C) inclusion of chronic obstructive pul-  
11 monary disease in the health data collections of  
12 all Federal agencies.

13 (3) CONSIDERATION.—In developing such plan,  
14 the Director of the National Heart, Lung, and Blood  
15 Institute shall consider the recommendations and  
16 findings of the Institute of Medicine in the report  
17 entitled “A Nationwide Framework for Surveillance  
18 of Cardiovascular and Chronic Lung Diseases” (July  
19 22, 2011).

20 (c) CHRONIC DISEASE PREVENTION PROGRAMS.—

21 The Director of the National Heart, Lung, and Blood In-  
22 stitute shall carry out the following:

23 (1) Conduct public education and awareness ac-  
24 tivities with patient and professional organizations  
25 to stimulate earlier diagnosis and improve patient

1 outcomes from treatment of chronic obstructive pul-  
2 monary disease. To the extent known and relevant,  
3 such public education and awareness activities shall  
4 reflect differences in chronic obstructive pulmonary  
5 disease by cause (tobacco, environmental, occupa-  
6 tional, biological, and genetic) and include a focus  
7 on outreach to undiagnosed and, as appropriate, mi-  
8 nority populations.

9 (2) Supplement and expand upon the activities  
10 of the National Heart, Lung, and Blood Institute by  
11 making grants to nonprofit organizations, State and  
12 local jurisdictions, and Indian tribes for the purpose  
13 of reducing the burden of chronic obstructive pul-  
14 monary disease, especially in disproportionately im-  
15 pacted communities, through public health interven-  
16 tions and related activities.

17 (3) Coordinate with the Centers for Disease  
18 Control and Prevention, the Indian Health Service,  
19 the Health Resources and Services Administration,  
20 and the Department of Veterans Affairs to develop  
21 pilot programs to demonstrate best practices for the  
22 diagnosis and management of chronic obstructive  
23 pulmonary disease.

24 (4) Develop improved techniques and identify  
25 best practices, in coordination with the Secretary of

1 Veterans Affairs, for assisting chronic obstructive  
2 pulmonary disease patients to successfully stop  
3 smoking, including identification of subpopulations  
4 with different needs. Initiatives under this para-  
5 graph may include research to determine whether  
6 successful smoking cessation strategies are different  
7 for chronic obstructive pulmonary disease patients  
8 compared to such strategies for patients with other  
9 chronic diseases.

10 (d) ENVIRONMENTAL AND OCCUPATIONAL HEALTH  
11 PROGRAMS.—The Director of the Centers for Disease  
12 Control and Prevention shall—

13 (1) support research into the environmental and  
14 occupational causes and biological mechanisms that  
15 contribute to chronic obstructive pulmonary disease;  
16 and

17 (2) develop and disseminate public health inter-  
18 ventions that will lessen the impact of environmental  
19 and occupational causes of chronic obstructive pul-  
20 monary disease.

21 (e) DATA COLLECTION.—Not later than 180 days  
22 after the enactment of this Act, the Director of the Na-  
23 tional Heart, Lung, and Blood Institute and the Director  
24 of the Centers for Disease Control and Prevention, acting  
25 jointly, shall assess the depth and quality of information

1 on chronic obstructive pulmonary disease that is collected  
2 in surveys and population studies conducted by the Cen-  
3 ters for Disease Control and Prevention, including wheth-  
4 er there are additional opportunities for information to be  
5 collected in the National Health and Nutrition Examina-  
6 tion Survey, the National Health Interview Survey, and  
7 the Behavioral Risk Factors Surveillance System surveys.  
8 The Director of the National Heart, Lung, and Blood In-  
9 stitute shall include the results of such assessment in the  
10 national action plan under subsection (b).

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 2012 through 2016.

15 **TITLE VIII—HEALTH**  
16 **INFORMATION TECHNOLOGY**  
17 **Subtitle A—Reducing Health**  
18 **Disparities Through Health IT**

19 **SEC. 801. HRSA ASSISTANCE TO HEALTH CENTERS FOR**  
20 **PROMOTION OF HEALTH IT.**

21 The Secretary of Health and Human Services, acting  
22 through the Administrator of the Health Resources and  
23 Services Administration, shall expand and intensify the  
24 programs and activities of the Administration (directly or  
25 through grants or contracts) to provide technical assist-

1   ance and resources to health centers (as defined in section  
2   330(a) of the Public Health Service Act (42 U.S.C.  
3   254b(a)) to adopt and meaningfully use certified EHR  
4   technology (as defined in section 3000(1) of such Act (42  
5   U.S.C. 300jj(1)) for the management of chronic diseases  
6   and health conditions.

7   **SEC. 802. ASSESSMENT OF IMPACT OF HEALTH IT ON RA-**  
8                                   **CIAL AND ETHNIC MINORITY COMMUNITIES;**  
9                                   **OUTREACH AND ADOPTION OF HEALTH IT IN**  
10                                  **SUCH COMMUNITIES.**

11       Section 3001(c)(6)(C) of the Public Health Service  
12   Act (42 U.S.C. 300jj–11(c)(6)(C)) is amended—

13               (1) in the heading by inserting “, RACIAL AND  
14       ETHNIC MINORITY COMMUNITIES,” after “HEALTH  
15       DISPARITIES”;

16               (2) by inserting “, in communities with a high  
17       proportion of individuals from racial and ethnic mi-  
18       nority groups (as defined in section 1707(g)),” after  
19       “communities with health disparities”; and

20               (3) by adding at the end the following new sen-  
21       tence: “In any publication under the previous sen-  
22       tence, the National Coordinator shall include best  
23       practices for encouraging partnerships between the  
24       Federal Government and private entities to expand  
25       outreach for and the adoption of such technology in

1 communities with a high proportion of individuals  
2 from racial and ethnic minority groups (as so de-  
3 fined), while also maintaining the accessibility re-  
4 quirements of section 508 of the Rehabilitation Act  
5 to encourage patient involvement in their own health  
6 care. The National Coordinator shall—

7 “(i) not later than 6 months after the  
8 submission to the Congress of the reports  
9 required by sections 832 and 833 of the  
10 Health Equity and Accountability Act of  
11 2011, establish criteria for evaluating the  
12 impact of health information technology on  
13 communities with a high proportion of in-  
14 dividuals from racial and ethnic minority  
15 groups (as so defined) taking into account  
16 the findings in such reports; and

17 “(ii) not later than 12 months after  
18 the submission to the Congress of such re-  
19 ports, conduct and publish the results of  
20 an evaluation of such impact.”.

1 **Subtitle B—Modifications to**  
2 **Achieve Parity in Existing Pro-**  
3 **grams**

4 **SEC. 811. EXTENDING FUNDING TO STRENGTHEN THE**  
5 **HEALTH IT INFRASTRUCTURE IN RACIAL**  
6 **AND ETHNIC MINORITY COMMUNITIES.**

7 Section 3011 of the Public Health Service Act (42  
8 U.S.C. 300jj–31) is amended—

9 (1) in subsection (a), by adding at the end the  
10 following new paragraph:

11 “(8) Activities described in the previous para-  
12 graphs of this subsection with respect to commu-  
13 nities with a high proportion of individuals from ra-  
14 cial and ethnic minority groups (as defined in sec-  
15 tion 1707(g)).”; and

16 (2) by adding at the end the following new sub-  
17 section:

18 “(e) ANNUAL REPORT ON EXPENDITURES.—The  
19 National Coordinator shall report annually to the Con-  
20 gress on activities and expenditures under this section.”.

21 **SEC. 812. PRIORITIZING REGIONAL EXTENSION CENTER AS-**  
22 **SISTANCE TO RACIAL AND ETHNIC MINORITY**  
23 **GROUPS.**

24 (a) IN GENERAL.—Section 3012(c)(4)(C) of the Pub-  
25 lic Health Service Act (42 U.S.C. 300jj–32(c)(4)(C)) is

1 amended by inserting “or individuals from racial and eth-  
2 nic minority groups (as defined in section 1707(g))” after  
3 “medically underserved individuals”.

4 (b) BIENNIAL EVALUATION.—Section 3012(c)(8) of  
5 such Act (42 U.S.C. 300jj–32(c)(8)) is amended—

6 (1) by inserting: “Each evaluation panel shall  
7 include at least one consumer advocate from a racial  
8 and ethnic minority community served by the center  
9 involved and at least one representative of a minor-  
10 ity-serving institution.” after “and of Federal offi-  
11 cials.”; and

12 (2) by inserting “and shall determine the de-  
13 gree to which such center provides outreach and as-  
14 sistance to providers predominantly serving racial  
15 and ethnic minority groups (as defined in section  
16 1707(g))” after “specified in paragraph (3)”.

17 **SEC. 813. EXTENDING COMPETITIVE GRANTS FOR THE DE-**  
18 **VELOPMENT OF LOAN PROGRAMS TO FACILI-**  
19 **TATE ADOPTION OF CERTIFIED EHR TECH-**  
20 **NOLOGY BY PROVIDERS SERVING RACIAL**  
21 **AND ETHNIC MINORITY GROUPS.**

22 Section 3014(e) of the Public Health Service Act (42  
23 U.S.C. 300jj–34(e)) is amended—

24 (1) in paragraph (3), by striking at the end  
25 “or”;



1 (2) in paragraph (4), by striking the period at  
2 the end and inserting “; or”; and

3 (3) by adding at the end the following new  
4 paragraph:

5 “(5) carry out any of the activities described in  
6 a previous paragraph of this subsection with respect  
7 to communities with a high proportion of individuals  
8 from racial and ethnic minority groups (as defined  
9 in section 1707(g)).”.

## 10 **Subtitle C—Additional Research** 11 **and Studies**

### 12 **SEC. 831. DATA COLLECTION AND ASSESSMENTS CON-** 13 **DUCTED IN COORDINATION WITH MINORITY-** 14 **SERVING INSTITUTIONS.**

15 Section 3001(c)(6) of the Public Health Service Act  
16 (42 U.S.C. 300jj–11(c)(6)) is amended by adding at the  
17 end the following new subparagraph:

18 “(F) DATA COLLECTION AND ASSESS-  
19 MENTS CONDUCTED IN COORDINATION WITH  
20 MINORITY-SERVING INSTITUTIONS.—

21 “(i) IN GENERAL.—In carrying out  
22 subparagraph (C) with respect to commu-  
23 nities with a high proportion of individuals  
24 from racial and ethnic minority groups (as  
25 defined in section 1707(g)), the National

1 Coordinator shall, to the greatest extent  
2 possible, coordinate with an entity de-  
3 scribed in clause (ii).

4 “(ii) MINORITY-SERVING INSTITU-  
5 TIONS.—For purposes of clause (i), an en-  
6 tity described in this clause is a historically  
7 Black college or university, an Hispanic-  
8 serving institution, a tribal college or uni-  
9 versity, or an Asian-American-, Native  
10 American-, and Pacific Islander-serving in-  
11 stitution with an accredited public health,  
12 health policy, or health services research  
13 program.”.

14 **SEC. 832. IOM STUDY AND REPORT ON PRIVACY CONCERNS**  
15 **OF CERTAIN MINORITY POPULATIONS.**

16 (a) IN GENERAL.—The Secretary of Health and  
17 Human Services shall seek to enter into an agreement  
18 with the Institute of Medicine of the National Academies  
19 to—

20 (1) complete a study—

21 (A) on the privacy concerns, relating to the  
22 exchange of health information, of individuals  
23 described in subsection (b);

24 (B) on how such concerns may create bar-  
25 riers for such individuals to access health care

1 or participate in the exchange of health infor-  
2 mation; and

3 (C) including recommendations for over-  
4 coming such barriers for such individuals; and

5 (2) not later than 24 months after the date of  
6 the enactment of this Act, submit to Congress a re-  
7 port on the results of such study.

8 If such Institute declines to conduct the study and submit  
9 the report, the Secretary shall enter into an agreement  
10 with another appropriate public or nonprofit private entity  
11 to conduct the study and submit the report.

12 (b) INDIVIDUALS DESCRIBED.—For purposes of sub-  
13 section (a), the individuals described in this subsection are  
14 individuals from racial and ethnic minority groups (as de-  
15 fined in section 1707(g)), including such individuals  
16 who—

17 (1) are immigrants, as well as citizens living  
18 within immigrant households (“mixed-status” house-  
19 holds) in the United States;

20 (2) are lesbian, gay, bisexual, or transgender; or

21 (3) have a mental health disability or a record  
22 of a mental health disability or treatment for a men-  
23 tal health disability.

1 **SEC. 833. STUDY OF HEALTH INFORMATION TECHNOLOGY**  
2 **IN MEDICALLY UNDERSERVED COMMU-**  
3 **NITIES.**

4 (a) STUDY.—The Secretary of Health and Human  
5 Services shall seek to enter into an agreement with the  
6 Institute of Medicine of the National Academies to con-  
7 duct a study on the development and implementation of  
8 health information technology in communities with a high  
9 proportion of individuals from racial and ethnic minority  
10 groups (as defined in section 1707(g)) and submit the re-  
11 port under subsection (b). The study shall—

12 (1) identify barriers to successful implementa-  
13 tion of health information technology in these com-  
14 munities;

15 (2) examine the impact of health information  
16 technology on providing quality care and reducing  
17 the cost of care to these communities;

18 (3) examine urban and rural community health  
19 systems and determine the impact that health infor-  
20 mation technology may have on the capacity of pri-  
21 mary health providers;

22 (4) identify specific best practices for using  
23 health information technology to foster the con-  
24 sistent provision of physical accessibility and reason-  
25 able policy accommodations in health care to individ-  
26 uals with disabilities in these communities; and

1           (5) assess the feasibility and the costs of associ-  
2           ated with the use of health information technology  
3           in these communities.

4 If such Institute declines to conduct the study, the Sec-  
5 retary shall enter into an agreement with another appro-  
6 priate public or nonprofit private entity to conduct the  
7 study.

8           (b) REPORT.—The Secretary shall ensure that, not  
9 later than 24 months after the date of the enactment of  
10 this Act, the study required under subsection (a) is com-  
11 pleted and a report on the study is submitted to Congress,  
12 including any recommendations for legislation or adminis-  
13 trative action.

14           **Subtitle D—Closing Gaps in**  
15           **Funding To Adopt Certified EHRs**

16           **SEC. 841. APPLICATION OF MEDICARE HITECH PAYMENTS**  
17           **TO HOSPITALS IN PUERTO RICO.**

18           (a) IN GENERAL.—Subsection (n)(6)(B) of section  
19 1886 of the Social Security Act (42 U.S.C. 1395ww) is  
20 amended by striking “subsection (d) hospital” and insert-  
21 ing “hospital that is a subsection (d) hospital or a sub-  
22 section (d) Puerto Rico hospital”.

23           (b) OFFSETTING REDUCTION.—Subsection (n)(2) of  
24 such section is amended by adding at the end the following  
25 new subparagraph:

1           “(H) BUDGET NEUTRALITY ADJUST-  
2           MENT.—The Secretary shall reduce the applica-  
3           ble amounts that would otherwise be deter-  
4           mined under this subsection with respect to—

5                   “(i) the first fiscal year to which this  
6                   subparagraph applies by an amount that  
7                   the Secretary estimates would ensure that  
8                   estimated aggregate payments under this  
9                   subsection for such fiscal year are not in-  
10                  creased as a result of the amendments  
11                  made by subsection (a) of section 841 of  
12                  the Health Equity and Accountability Act  
13                  of 2011; or

14                   “(ii) a succeeding fiscal year by an  
15                   amount that the Secretary estimates would  
16                   ensure that estimated aggregate payments  
17                   under this subsection for such fiscal year  
18                   are not increased as a result of the amend-  
19                   ments made by subsections (a) and (c) of  
20                   such section.”.

21           (c) CONFORMING AMENDMENTS.—(1) Subsection  
22 (b)(3)(B)(ix) of such section is amended—

23                   (A) in subclause (I), by striking “(n)(6)(A)”  
24                   and inserting “(n)(6)(B)”; and

1 (B) in subclause (II), by striking “subsection  
2 (d) hospital” and inserting “an eligible hospital”.

3 (2) Paragraphs (2) and (4)(A) of section 1853(m) of  
4 the Social Security Act (42 U.S.C. 1395w–23(m)) are  
5 each amended by striking “1886(n)(6)(A)” and inserting  
6 “1886(n)(6)(B)”.

7 (d) IMPLEMENTATION.—Notwithstanding any other  
8 provision of law, the Secretary of Health and Human  
9 Services may implement the amendments made by sub-  
10 sections (a), (b) and (c) by program instruction or other-  
11 wise.

12 (e) EFFECTIVE DATE.—The amendments made by  
13 this section shall apply to payments for payment years for  
14 fiscal years beginning after the date of the enactment of  
15 this Act.

16 **SEC. 842. EXTENDING MEDICAID EHR INCENTIVE PAY-**  
17 **MENTS TO LONG-TERM CARE FACILITIES AND**  
18 **HOME HEALTH AGENCIES.**

19 Section 1903(t)(2)(B) of the Social Security Act (42  
20 U.S.C. 1396b(t)(2)(B)) is amended—

21 (1) in clause (i), by striking “, or” and insert-  
22 ing a semicolon;

23 (2) in clause (ii), by striking the period at the  
24 end and inserting a semicolon; and

1           (3) by adding at the end the following new  
2 clauses:

3                   “(iii) a long-term care facility; or

4                   “(iv) a home health agency (as defined in  
5 section 1861(o)).”.

6 **SEC. 843. EXTENDING PHYSICIAN ASSISTANT ELIGIBILITY**  
7                   **FOR MEDICAID ELECTRONIC HEALTH**  
8                   **RECORD INCENTIVE PAYMENTS.**

9           (a) **IN GENERAL.**—Section 1903(t)(3)(B)(v) of the  
10 Social Security Act (42 U.S.C. 1396b(t)(3)(B)(v)) is  
11 amended by striking “insofar as the assistant is prac-  
12 ticing” and all that follows through “so led”.

13           (b) **EFFECTIVE DATE.**—The amendment made by  
14 subsection (a) shall apply with respect to amounts ex-  
15 pended under 1903(a)(3)(F) of the Social Security Act  
16 (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters begin-  
17 ning on or after the date of the enactment of this Act.



1           **TITLE IX—ACCOUNTABILITY**  
2                           **AND EVALUATION**

3   **SEC. 901. PROHIBITION ON DISCRIMINATION IN FEDERAL**  
4                           **ASSISTED HEALTH CARE SERVICES AND RE-**  
5                           **SEARCH PROGRAMS ON THE BASIS OF SEX,**  
6                           **RACE, COLOR, NATIONAL ORIGIN, SEXUAL**  
7                           **ORIENTATION, GENDER IDENTITY, OR DIS-**  
8                           **ABILITY STATUS.**

9           No person in the United States shall, on the basis  
10 of sex, race, color, national origin, sexual orientation, gen-  
11 der identity, or disability status, be excluded from partici-  
12 pation in, be denied the benefits of, or be subjected to dis-  
13 crimination under any health care service or research pro-  
14 gram or activity receiving Federal financial assistance.

15   **SEC. 902. TREATMENT OF MEDICARE PAYMENTS UNDER**  
16                           **TITLE VI OF THE CIVIL RIGHTS ACT OF 1964.**

17           A payment to a provider of services, physician, or  
18 other supplier under part B, C, or D of title XVIII of  
19 the Social Security Act shall be deemed a grant, and not  
20 a contract of insurance or guaranty, for the purposes of  
21 title VI of the Civil Rights Act of 1964.

1 **SEC. 903. ACCOUNTABILITY AND TRANSPARENCY WITHIN**  
2 **THE DEPARTMENT OF HEALTH AND HUMAN**  
3 **SERVICES.**

4 Title XXXIV of the Public Health Service Act, as  
5 amended by titles I, II, and III of this Act, is further  
6 amended by inserting after subtitle B the following:

7 **“Subtitle C—Strengthening**  
8 **Accountability**

9 **“SEC. 3441. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.**

10 “(a) IN GENERAL.—The Secretary shall establish  
11 within the Office for Civil Rights an Office of Health Dis-  
12 parities, which shall be headed by a director to be ap-  
13 pointed by the Secretary.

14 “(b) PURPOSE.—The Office of Health Disparities  
15 shall ensure that the health programs, activities, and oper-  
16 ations of health entities which receive Federal financial as-  
17 sistance are in compliance with title VI of the Civil Rights  
18 Act, which prohibits discrimination on the basis of race,  
19 color, or national origin. The activities of the Office shall  
20 include the following:

21 “(1) The development and implementation of  
22 an action plan to address racial and ethnic health  
23 care disparities, which shall address concerns relat-  
24 ing to the Office for Civil Rights as released by the  
25 United States Commission on Civil Rights in the re-  
26 port entitled ‘Health Care Challenge: Acknowledging

1 Disparity, Confronting Discrimination, and Ensuring  
2 Equity’ (September 1999) in conjunction with  
3 the reports by the Institute of Medicine entitled ‘Un-  
4 equal Treatment: Confronting Racial and Ethnic  
5 Disparities in Health Care’, ‘Crossing the Quality  
6 Chasm: A New Health System for the 21st Cen-  
7 tury’, and ‘In the Nation’s Compelling Interest: En-  
8 suring Diversity in the Health Care Workforce’, and  
9 ‘The National Partnership for Action to End Health  
10 Disparities’, and other related reports by the Insti-  
11 tute of Medicine. This plan shall be publicly dis-  
12 closed for review and comment and the final plan  
13 shall address any comments or concerns that are re-  
14 ceived by the Office.

15 “(2) Investigative and enforcement actions  
16 against intentional discrimination and policies and  
17 practices that have a disparate impact on minorities.

18 “(3) The review of racial, ethnic, and primary  
19 language health data collected by Federal health  
20 agencies to assess health care disparities related to  
21 intentional discrimination and policies and practices  
22 that have a disparate impact on minorities.

23 “(4) Outreach and education activities relating  
24 to compliance with title VI of the Civil Rights Act.

1           “(5) The provision of technical assistance for  
2 health entities to facilitate compliance with title VI  
3 of the Civil Rights Act.

4           “(6) Coordination and oversight of activities of  
5 the civil rights compliance offices established under  
6 section 3442.

7           “(7) Ensuring compliance with the 1997 Office  
8 of Management and Budget Standards for Maintain-  
9 ing, Collecting, and Presenting Federal Data on  
10 Race, Ethnicity and the available language stand-  
11 ards.

12          “(c) FUNDING AND STAFF.—The Secretary shall en-  
13 sure the effectiveness of the Office of Health Disparities  
14 by ensuring that the Office is provided with—

15           “(1) adequate funding to enable the Office to  
16 carry out its duties under this section; and

17           “(2) staff with expertise in—

18                   “(A) epidemiology;

19                   “(B) statistics;

20                   “(C) health quality assurance;

21                   “(D) minority health and health dispari-  
22 ties;

23                   “(E) cultural and linguistic competency;

24           and

25                   “(F) civil rights.

1       “(d) REPORT.—Not later than December 31, 2012,  
2 and annually thereafter, the Secretary, in collaboration  
3 with the Director of the Office for Civil Rights and the  
4 Deputy Assistant Secretary for Minority Health, shall  
5 submit a report to the Committee on Health, Education,  
6 Labor, and Pensions of the Senate and the Committee on  
7 Energy and Commerce of the House of Representatives  
8 that includes—

9               “(1) the number of cases filed, broken down by  
10 category;

11              “(2) the number of cases investigated and  
12 closed by the office;

13              “(3) the outcomes of cases investigated;

14              “(4) the staffing levels of the office including  
15 staff credentials;

16              “(5) the number of other lingering and emerg-  
17 ing cases in which civil rights inequities can be dem-  
18 onstrated; and

19              “(6) the number of cases remaining open and  
20 an explanation for their open status.

21       “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
22 are authorized to be appropriated to carry out this section,  
23 such sums as may be necessary for each of fiscal years  
24 2012 through 2017.

1 **“SEC. 3442. ESTABLISHMENT OF HEALTH PROGRAM OF-**  
2 **FICES FOR CIVIL RIGHTS WITHIN FEDERAL**  
3 **HEALTH AND HUMAN SERVICES AGENCIES.**

4 “(a) IN GENERAL.—The Secretary shall establish  
5 civil rights compliance offices in each agency within the  
6 Department of Health and Human Services that admin-  
7 isters health programs.

8 “(b) PURPOSE OF OFFICES.—Each office established  
9 under subsection (a) shall ensure that recipients of Fed-  
10 eral financial assistance under Federal health programs  
11 administer their programs, services, and activities in a  
12 manner that—

13 “(1) does not discriminate, either intentionally  
14 or in effect, on the basis of race, national origin, lan-  
15 guage, ethnicity, sex, age, disability, sexual orienta-  
16 tion, and gender identity; and

17 “(2) promotes the reduction and elimination of  
18 disparities in health and health care based on race,  
19 national origin, language, ethnicity, sex, age, dis-  
20 ability, sexual orientation, and gender identity.

21 “(c) POWERS AND DUTIES.—The offices established  
22 in subsection (a) shall have the following powers and du-  
23 ties:

24 “(1) The establishment of compliance and pro-  
25 gram participation standards for recipients of Fed-  
26 eral financial assistance under each program admin-

1 istered by an agency within the Department of  
2 Health and Human Services including the establish-  
3 ment of disparity reduction standards to encompass  
4 disparities in health and health care related to race,  
5 national origin, language, ethnicity, sex, age, dis-  
6 ability, sexual orientation, and gender identity.

7 “(2) The development and implementation of  
8 program-specific guidelines that interpret and apply  
9 Department of Health and Human Services guid-  
10 ance under title VI of the Civil Rights Act of 1964  
11 and section 1557 of the Patient Protection and Af-  
12 fordable Care Act to each Federal health program  
13 administered by the agency.

14 “(3) The development of a disparity-reduction  
15 impact analysis methodology that shall be applied to  
16 every rule issued by the agency and published as  
17 part of the formal rulemaking process under sections  
18 555, 556, and 557 of title 5, United States Code.

19 “(4) Oversight of data collection, analysis, and  
20 publication requirements for all recipients of Federal  
21 financial assistance under each Federal health pro-  
22 gram administered by the agency, and compliance  
23 with the 1997 Office of Management and Budget  
24 Standards for Maintaining, Collecting, and Pre-

1        sending Federal Data on Race and Ethnicity and the  
2        available language standards.

3            “(5) The conduct of publicly available studies  
4        regarding discrimination within Federal health pro-  
5        grams administered by the agency as well as dis-  
6        parity reduction initiatives by recipients of Federal  
7        financial assistance under Federal health programs.

8            “(6) Annual reports to the Committee on  
9        Health, Education, Labor, and Pensions and the  
10       Committee on Finance of the Senate and the Com-  
11       mittee on Energy and Commerce and the Committee  
12       on Ways and Means of the House of Representatives  
13       on the progress in reducing disparities in health and  
14       health care through the Federal programs adminis-  
15       tered by the agency.

16        “(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS  
17       IN THE DEPARTMENT OF JUSTICE.—

18            “(1) DEPARTMENT OF HEALTH AND HUMAN  
19        SERVICES.—The Office for Civil Rights in the De-  
20        partment of Health and Human Services shall pro-  
21        vide standard-setting and compliance review inves-  
22        tigation support services to the Civil Rights Compli-  
23        ance Office for each agency.

24            “(2) DEPARTMENT OF JUSTICE.—The Office  
25        for Civil Rights in the Department of Justice shall



1 continue to maintain the power to institute formal  
2 proceedings when an agency Office for Civil Rights  
3 determines that a recipient of Federal financial as-  
4 sistance is not in compliance with the disparity re-  
5 duction standards of the agency.

6 “(e) DEFINITION.—In this section, the term ‘Federal  
7 health programs’ mean programs—

8 “(1) under the Social Security Act (42 U.S.C.  
9 301 et seq.) that pay for health care and services;  
10 and

11 “(2) under this Act that provide Federal finan-  
12 cial assistance for health care, biomedical research,  
13 health services research, and programs designed to  
14 improve the public’s health.”.

15 **SEC. 904. UNITED STATES COMMISSION ON CIVIL RIGHTS.**

16 (a) COORDINATION WITHIN DEPARTMENT OF JUS-  
17 TICE OF ACTIVITIES REGARDING HEALTH DISPARI-  
18 TIES.—Section 3 of the Civil Rights Commission Act of  
19 1983 (42 U.S.C. 1975a) is amended—

20 (1) in paragraph (1), by striking “and” at the  
21 end;

22 (2) in paragraph (2), by striking the period at  
23 the end and inserting “; and”; and

24 (3) by adding at the end the following:

1           “(3) shall, with respect to activities carried out  
2           in health care and correctional facilities toward the  
3           goal of eliminating health disparities between the  
4           general population and members of racial or ethnic  
5           minority groups, coordinate such activities of—

6                   “(A) the Office for Civil Rights within the  
7           Department of Justice;

8                   “(B) the Office of Justice Programs within  
9           the Department of Justice;

10                   “(C) the Office for Civil Rights within the  
11           Department of Health and Human Services;  
12           and

13                   “(D) the Office of Minority Health within  
14           the Department of Health and Human Services  
15           (headed by the Deputy Assistant Secretary for  
16           Minority Health).”.

17           (b) AUTHORIZATION OF APPROPRIATIONS.—Section  
18   5 of the Civil Rights Commission Act of 1983 (42 U.S.C.  
19   1975c) is amended by striking the first sentence and in-  
20   serting the following: “For the purpose of carrying out  
21   this Act, there are authorized to be appropriated  
22   \$30,000,000 for fiscal year 2012, and such sums as may  
23   be necessary for each of the fiscal years 2013 through  
24   2017.”.

1 **SEC. 905. SENSE OF CONGRESS CONCERNING FULL FUND-**  
2 **ING OF ACTIVITIES TO ELIMINATE RACIAL**  
3 **AND ETHNIC HEALTH DISPARITIES.**

4 (a) FINDINGS.—Congress makes the following find-  
5 ings:

6 (1) The health status of the American populace  
7 is declining and the United States currently ranks  
8 below most industrialized nations in health status  
9 measured by longevity, sickness, and mortality.

10 (2) Racial and ethnic minority populations tend  
11 have the poorest health status and face substantial  
12 cultural, social, and economic barriers to obtaining  
13 quality health care.

14 (3) Efforts to improve minority health have  
15 been limited by inadequate resources (funding, staff-  
16 ing, and stewardship) and accountability.

17 (b) SENSE OF CONGRESS.—It is the sense of Con-  
18 gress that—

19 (1) funding should be doubled by fiscal year  
20 2013 for the National Institute for Minority Health  
21 Disparities, the Office of Civil Rights in the Depart-  
22 ment of Health and Human Services, the National  
23 Institute of Nursing Research, and the Office of Mi-  
24 nority Health;

25 (2) adequate funding by fiscal year 2013, and  
26 subsequent funding increases, should be provided for

1 health professions training programs, the Racial and  
2 Ethnic Approaches to Community Health (REACH)  
3 at the Centers for Disease Control and Prevention,  
4 the Minority HIV/AIDS Initiative, and the Excel-  
5 lence Centers to Eliminate Ethnic/Racial Disparities  
6 (EXCEED) Program at the Agency for Healthcare  
7 Research and Quality;

8 (3) funding should be restored to the Racial  
9 and Ethnic Approaches to Community Health  
10 (REACH) program at the Centers for Disease Con-  
11 trol and Prevention, which has been a successful  
12 program at the community health level;

13 (4) current and newly created health disparity  
14 elimination incentives, programs, agencies, and de-  
15 partments under this Act (and the amendments  
16 made by this Act) should receive adequate staffing  
17 and funding by fiscal year 2013; and

18 (5) stewardship and accountability should be  
19 provided to the Congress and the President for  
20 measurable and sustainable progress toward health  
21 disparity elimination.

22 **SEC. 906. GAO AND NIH REPORTS.**

23 (a) GAO REPORT ON NIH GRANT RACIAL AND ETH-  
24 NIC DIVERSITY.—

1           (1) IN GENERAL.—The Comptroller General of  
2 the United States shall conduct a study on the racial  
3 and ethnic diversity among the following groups:

4           (A) All applicants for grants, contracts,  
5 and cooperative agreements awarded by the Na-  
6 tional Institutes of Health during the period be-  
7 ginning January 1, 1990, and ending December  
8 31, 2011.

9           (B) All recipients of such grants, con-  
10 tracts, and cooperative agreements.

11           (C) All members of the peer review panels  
12 of such applicants and recipients, respectively.

13           (2) REPORT.—Not later than six months after  
14 the date of the enactment of this Act, the Comp-  
15 troller General shall complete the study under para-  
16 graph (1) and submit to Congress a report con-  
17 taining the results of such study.

18           (b) NIH REPORT ON CERTAIN AUTHORITY OF NA-  
19 TIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH  
20 DISPARITIES.—Not later than six months after the date  
21 of the enactment of this Act, and biennially thereafter, the  
22 Director of the National Institutes of Health, in collabora-  
23 tion with the Director of the National Institute on Minor-  
24 ity Health and Health Disparities, shall submit to Con-  
25 gress a report that details and evaluates—

1           (1) the steps taken during the applicable report  
2           period by the Director of the National Institutes of  
3           Health to enforce the expanded planning, coordina-  
4           tion, review, and evaluation authority provided the  
5           National Institute on Minority Health and Health  
6           Disparities under section 464z-3(h) of the Public  
7           Health Service Act (42 U.S.C. 285(h)), as added by  
8           section 10334(c) of the Patient Protection and Af-  
9           fordable Care Act, over all minority health and  
10          health disparity research that is conducted or sup-  
11          ported by the Institutes and Centers at the National  
12          Institutes of Health; and

13           (2) the outcomes of such steps.

14          (c) GAO REPORT RELATED TO RECIPIENTS OF  
15          PPACA FUNDING.—Not later than one year after the  
16          date of the enactment of this Act and biennially thereafter  
17          until 2020, the Comptroller General of the United States  
18          shall submit to Congress a report that identifies, with re-  
19          spect to minority community-based organizations that ap-  
20          plied during the applicable report period for Federal fund-  
21          ing provided pursuant to the provisions of (and amend-  
22          ments made by) the Patient Protection and Affordable  
23          Care Act for purposes of achieving health equity and elimi-  
24          nating health disparities, the percentage of such organiza-  
25          tions that were awarded such funding.

1 (d) ANNUAL REPORT ON ACTIVITIES OF NATIONAL  
2 INSTITUTE ON MINORITY HEALTH AND HEALTH DIS-  
3 PARITIES.—The Director of the National Institute on Mi-  
4 nority Health and Health Disparities shall prepare an an-  
5 nual report on the activities carried out or to be carried  
6 out by the Institute, and shall submit each such report  
7 to the Committee on Health, Education, Labor, and Pen-  
8 sions of the Senate, the Committee on Energy and Com-  
9 merce of the House of Representatives, the Secretary of  
10 Health and Human Services, and the Director of the Na-  
11 tional Institutes of Health. With respect to the fiscal year  
12 involved, the report shall—

13 (1) describe and evaluate the progress made in  
14 health disparities research conducted or supported  
15 by institutes and centers of the National Institutes  
16 of Health;

17 (2) summarize and analyze expenditures made  
18 for activities with respect to health disparities re-  
19 search conducted or supported by the National Insti-  
20 tutes of Health;

21 (3) include a separate statement applying the  
22 requirements of paragraphs (1) and (2) specifically  
23 to minority health disparities research; and

24 (4) contain such recommendations as the Direc-  
25 tor of the Institute considers appropriate.

1 **TITLE X—ADDRESSING SOCIAL**  
2 **DETERMINANTS AND IM-**  
3 **PROVING ENVIRONMENTAL**  
4 **JUSTICE**

5 **SEC. 1001. CODIFICATION OF EXECUTIVE ORDER 12898.**

6 (a) IN GENERAL.—The President of the United  
7 States is authorized and directed to execute, administer,  
8 and enforce as a matter of Federal law the provisions of  
9 Executive Order 12898, dated February 11, 1994 (“Fed-  
10 eral Actions To Address Environmental Justice In Minor-  
11 ity Populations and Low-Income Populations”), with such  
12 modifications as are provided in this section.

13 (b) DEFINITION OF ENVIRONMENTAL JUSTICE.—For  
14 purposes of carrying out the provisions of Executive Order  
15 12898, the following definitions shall apply:

16 (1) The term “environmental justice” means  
17 the fair treatment and meaningful involvement of all  
18 people regardless of race, color, national origin, edu-  
19 cational level, or income with respect to the develop-  
20 ment, implementation, and enforcement of environ-  
21 mental laws and regulations in order to ensure  
22 that—

23 (A) minority and low-income communities  
24 have access to public information relating to



1 human health and environmental planning, reg-  
2 ulations, and enforcement; and

3 (B) no minority or low-income population  
4 is forced to shoulder a disproportionate burden  
5 of the negative human health and environ-  
6 mental impacts of pollution or other environ-  
7 mental hazard.

8 (2) The term “fair treatment” means policies  
9 and practices that ensure that no group of people,  
10 including racial, ethnic, or socioeconomic groups  
11 bear disproportionately high and adverse human  
12 health or environmental effects resulting from Fed-  
13 eral agency programs, policies, and activities.

14 (c) JUDICIAL REVIEW AND RIGHTS OF ACTION.—  
15 The provisions of section 6–609 of Executive Order 12898  
16 shall not apply for purposes of this Act.

17 **SEC. 1002. IMPLEMENTATION OF RECOMMENDATIONS BY**  
18 **ENVIRONMENTAL PROTECTION AGENCY.**

19 (a) INSPECTOR GENERAL RECOMMENDATIONS.—The  
20 Administrator of the Environmental Protection Agency  
21 shall, as promptly as practicable, carry out each of the  
22 following recommendations of the Inspector General of the  
23 agency as set forth in Report No. 2006–P–00034 entitled  
24 “EPA needs to conduct environmental justice reviews of  
25 its programs, policies and activities”:

1           (1) The recommendation that the Agency’s pro-  
2           gram and regional offices identify which programs,  
3           policies, and activities need environmental justice re-  
4           views and require these offices to establish a plan to  
5           complete the necessary reviews.

6           (2) The recommendation that the Administrator  
7           of the Agency ensure that these reviews determine  
8           whether the programs, policies, and activities may  
9           have a disproportionately high and adverse health or  
10          environmental impact on minority and low-income  
11          populations.

12          (3) The recommendation that each program  
13          and regional office develop specific environmental  
14          justice review guidance for conducting environmental  
15          justice reviews.

16          (4) The recommendation that the Administrator  
17          designate a responsible office to compile results of  
18          environmental justice reviews and recommend appro-  
19          priate actions.

20          (b) GAO RECOMMENDATIONS.—In developing rules  
21          under laws administered by the Environmental Protection  
22          Agency, the Administrator of the Agency shall, as prompt-  
23          ly as practicable, carry out each of the following rec-  
24          ommendations of the Comptroller General of the United  
25          States as set forth in GAO Report numbered GAO–05–

1 289 entitled “EPA Should Devote More Attention to En-  
2 vironmental Justice when Developing Clean Air Rules”:

3 (1) The recommendation that the Administrator  
4 ensure that workgroups involved in developing a rule  
5 devote attention to environmental justice while draft-  
6 ing and finalizing the rule.

7 (2) The recommendation that the Administrator  
8 enhance the ability of such workgroups to identify  
9 potential environmental justice issues through such  
10 steps as providing workgroup members with guid-  
11 ance and training to helping them identify potential  
12 environmental justice problems and involving envi-  
13 ronmental justice coordinators in the workgroups  
14 when appropriate.

15 (3) The recommendation that the Administrator  
16 improve assessments of potential environmental jus-  
17 tice impacts in economic reviews by identifying the  
18 data and developing the modeling techniques needed  
19 to assess such impacts.

20 (4) The recommendation that the Administrator  
21 direct appropriate Agency officers and employees to  
22 respond fully when feasible to public comments on  
23 environmental justice, including improving the Agen-  
24 cy’s explanation of the basis for its conclusions, to-  
25 gether with supporting data.

1 (c) 2004 INSPECTOR GENERAL REPORT.—The Ad-  
2 ministrator of the Environmental Protection Agency shall,  
3 as promptly as practicable, carry out each of the following  
4 recommendations of the Inspector General of the Agency  
5 as set forth in the report entitled “EPA Needs to Consist-  
6 ently Implement the Intent of the Executive Order on En-  
7 vironmental Justice” (Report No. 2004–P–00007):

8 (1) The recommendation that the Agency clear-  
9 ly define the mission of the Office of Environmental  
10 Justice (OEJ) and provide Agency staff with an un-  
11 derstanding of the roles and responsibilities of the  
12 Office.

13 (2) The recommendation that the Agency estab-  
14 lish (through issuing guidance or a policy statement  
15 from the Administrator) specific time frames for the  
16 development of definitions, goals, and measurements  
17 regarding environmental justice and provide the re-  
18 gions and program offices a standard and consistent  
19 definition for a minority and low-income community,  
20 with instructions on how the Agency will implement  
21 and operationalize environmental justice into the  
22 Agency’s daily activities.

23 (3) The recommendation that the Agency en-  
24 sure the comprehensive training program currently  
25 under development includes standard and consistent

1 definitions of the key environmental justice concepts  
2 (such as “low-income”, “minority”, and “dispropor-  
3 tionately impacted”) and instructions for implemen-  
4 tation of those concepts.

5 The Administrator shall submit an initial report to Con-  
6 gress within 6 months after the enactment of this Act re-  
7 garding the Administrator’s strategy for implementing the  
8 recommendations referred to in paragraphs (1), (2), and  
9 (3). Thereafter, the Administrator shall provide semi-  
10 annual reports to Congress regarding the Administrator’s  
11 progress in implementing such recommendations and  
12 modifying the Administrator’s emergency management  
13 procedures to incorporate environmental justice in the  
14 Agency’s Incident Command Structure (in accordance  
15 with the December 18, 2006, letter from the Deputy Ad-  
16 ministrator to the Acting Inspector General of the Agen-  
17 cy).

18 (d) FEDERAL ACTION PLAN FOR SAVING LIVES,  
19 PROTECTING PEOPLE AND THEIR FAMILIES FROM  
20 RADON.—

21 (1) IN GENERAL.—Because radon is a naturally  
22 occurring radioactive gas that is recognized as the  
23 leading cause of lung cancer among nonsmokers and  
24 is a particular environmental threat for low-income  
25 and minority individuals because of the lack of infor-

1       mation about radon levels in their own homes, the  
2       Administrator of the Environmental Protection  
3       Agency shall within 6 months after the date of the  
4       enactment of this Act, implement the action plan en-  
5       titled “Protecting People and Families from Radon:  
6       A Federal Action Plan for Saving Lives” (June 20,  
7       2011), working with the Secretary of Health and  
8       Human Services acting through the Director of the  
9       Centers for Disease Control and Prevention, and  
10      with the other Federal agencies mentioned in and as  
11      set forth in the action plan.

12           (2) SPECIFIC STEPS.—In carrying out para-  
13      graph (1), the Administrator shall take steps to  
14      achieve each of the following:

15           (A) The recommendation that the  
16      workgroup comprised of the Federal agencies  
17      participating in the development of the action  
18      plan referred to in paragraph (1) implement  
19      specific steps within the current authority and  
20      activities of each Federal agency to reduce ex-  
21      posure to radon.

22           (B) The recommendation that such  
23      workgroup meet on the 1-year anniversary of  
24      the plan to assess and recognize achievements  
25      of the plan.

1           (3) REPORT.—The Administrator shall report  
2 to the Congress on the 1-year assessment of the  
3 plan’s implementation, including the challenges re-  
4 maining and the progress in reducing radon expo-  
5 sure particularly to low-income and minority fami-  
6 lies.

7 **SEC. 1003. GRANT PROGRAM.**

8           (a) DEFINITIONS.—In this section:

9           (1) DIRECTOR.—The term “Director” means  
10 the Director of the Centers for Disease Control and  
11 Prevention, acting in collaboration with the Adminis-  
12 trator of the Environmental Protection Agency and  
13 the Director of the National Institute of Environ-  
14 mental Health Sciences.

15           (2) ELIGIBLE ENTITY.—The term “eligible enti-  
16 ty” means a State or local community that—

17                   (A) bears a disproportionate burden of ex-  
18 posure to environmental health hazards;

19                   (B) has established a coalition—

20                           (i) with not less than 1 community-  
21 based organization; and

22                           (ii) with not less than 1—

23                                   (I) public health entity;

24                                   (II) health care provider organi-  
25 zation; or

1 (III) academic institution, includ-  
2 ing any minority-serving institution  
3 (including an Hispanic-serving institu-  
4 tion, a historically Black college or  
5 university, and a tribal college or uni-  
6 versity);

7 (C) ensures planned activities and funding  
8 streams are coordinated to improve community  
9 health; and

10 (D) submits an application in accordance  
11 with subsection (c).

12 (b) ESTABLISHMENT.—The Director shall establish a  
13 grant program under which eligible entities shall receive  
14 grants to conduct environmental health improvement ac-  
15 tivities.

16 (c) APPLICATION.—To receive a grant under this sec-  
17 tion, an eligible entity shall submit an application to the  
18 Director at such time, in such manner, and accompanied  
19 by such information as the Director may require.

20 (d) COOPERATIVE AGREEMENTS.—An eligible entity  
21 may use a grant under this section—

22 (1) to promote environmental health; and

23 (2) to address environmental health disparities.

24 (e) AMOUNT OF COOPERATIVE AGREEMENT.—



1           (1) IN GENERAL.—The Director shall award  
2 grants to eligible entities at the 2 different funding  
3 levels described in this subsection.

4           (2) LEVEL 1 COOPERATIVE AGREEMENTS.—

5           (A) IN GENERAL.—An eligible entity  
6 awarded a grant under this paragraph shall use  
7 the funds to identify environmental health prob-  
8 lems and solutions by—

9           (i) establishing a planning and  
10 prioritizing council in accordance with sub-  
11 paragraph (B); and

12           (ii) conducting an environmental  
13 health assessment in accordance with sub-  
14 paragraph (C).

15           (B) PLANNING AND PRIORITIZING COUN-  
16 CIL.—

17           (i) IN GENERAL.—A prioritizing and  
18 planning council established under sub-  
19 paragraph (A)(i) (referred to in this para-  
20 graph as a “PPC”) shall assist the envi-  
21 ronmental health assessment process and  
22 environmental health promotion activities  
23 of the eligible entity.

24           (ii) MEMBERSHIP.—Membership of a  
25 PPC shall consist of representatives from

1 various organizations within public health,  
2 planning, development, and environmental  
3 services and shall include stakeholders  
4 from vulnerable groups such as children,  
5 the elderly, disabled, and minority ethnic  
6 groups that are often not actively involved  
7 in democratic or decisionmaking processes.

8 (iii) DUTIES.—A PPC shall—

9 (I) identify key stakeholders and  
10 engage and coordinate potential part-  
11 ners in the planning process;

12 (II) establish a formal advisory  
13 group to plan for the establishment of  
14 services;

15 (III) conduct an in-depth review  
16 of the nature and extent of the need  
17 for an environmental health assess-  
18 ment, including a local epidemiological  
19 profile, an evaluation of the service  
20 provider capacity of the community,  
21 and a profile of any target popu-  
22 lations; and

23 (IV) define the components of  
24 care and form essential programmatic

1 linkages with related providers in the  
2 community.

3 (C) ENVIRONMENTAL HEALTH ASSESS-  
4 MENT.—

5 (i) IN GENERAL.—A PPC shall carry  
6 out an environmental health assessment to  
7 identify environmental health concerns.

8 (ii) ASSESSMENT PROCESS.—The  
9 PPC shall—

10 (I) define the goals of the assess-  
11 ment;

12 (II) generate the environmental  
13 health issue list;

14 (III) analyze issues with a sys-  
15 tems framework;

16 (IV) develop appropriate commu-  
17 nity environmental health indicators;

18 (V) rank the environmental  
19 health issues;

20 (VI) set priorities for action;

21 (VII) develop an action plan;

22 (VIII) implement the plan; and

23 (IX) evaluate progress and plan-  
24 ning for the future.

1 (D) EVALUATION.—Each eligible entity  
2 that receives a grant under this paragraph shall  
3 evaluate, report, and disseminate program find-  
4 ings and outcomes.

5 (E) TECHNICAL ASSISTANCE.—The Direc-  
6 tor may provide such technical and other non-  
7 financial assistance to eligible entities as the  
8 Director determines to be necessary.

9 (3) LEVEL 2 COOPERATIVE AGREEMENTS.—

10 (A) ELIGIBILITY.—

11 (i) IN GENERAL.—The Director shall  
12 award grants under this paragraph to eli-  
13 gible entities that have already—

14 (I) established broad-based col-  
15 laborative partnerships; and

16 (II) completed environmental as-  
17 sessments.

18 (ii) NO LEVEL 1 REQUIREMENT.—To  
19 be eligible to receive a grant under this  
20 paragraph, an eligible entity is not re-  
21 quired to have successfully completed a  
22 Level 1 Cooperative Agreement (as de-  
23 scribed in paragraph (2)).

24 (B) USE OF GRANT FUNDS.—An eligible  
25 entity awarded a grant under this paragraph

1 shall use the funds to further activities to carry  
2 out environmental health improvement activi-  
3 ties, including—

4 (i) addressing community environ-  
5 mental health priorities in accordance with  
6 paragraph (2)(C)(ii), including—

7 (I) air quality;

8 (II) water quality;

9 (III) solid waste;

10 (IV) land use;

11 (V) housing;

12 (VI) food safety;

13 (VII) crime;

14 (VIII) injuries; and

15 (IX) health care services;

16 (ii) building partnerships between  
17 planning, public health, and other sectors,  
18 to address how the built environment im-  
19 pacts food availability and access and  
20 physical activity to promote healthy behav-  
21 iors and lifestyles and reduce overweight  
22 and obesity, asthma, respiratory condi-  
23 tions, dental, oral and mental health condi-  
24 tions, poverty, and related co-morbidities;

1 (iii) establishing programs to ad-  
2 dress—

3 (I) how environmental and social  
4 conditions of work and living choices  
5 influence physical activity and dietary  
6 intake; or

7 (II) how those conditions influ-  
8 ence the concerns and needs of people  
9 who have impaired mobility and use  
10 assistance devices, including wheel-  
11 chairs and lower limb prostheses; and

12 (iv) convening intervention programs  
13 that examine the role of the social environ-  
14 ment in connection with the physical and  
15 chemical environment in—

16 (I) determining access to nutri-  
17 tional food; and

18 (II) improving physical activity to  
19 reduce morbidity and increase quality  
20 of life.

21 (f) AUTHORIZATION OF APPROPRIATIONS.—There  
22 are authorized to be appropriated to carry out this sec-  
23 tion—

24 (1) \$25,000,000 for fiscal year 2012; and

1           (2) such sums as may be necessary for fiscal  
2           years 2013 through 2016.

3 **SEC. 1004. ADDITIONAL RESEARCH ON THE RELATIONSHIP**  
4                   **BETWEEN THE BUILT ENVIRONMENT AND**  
5                   **THE HEALTH OF COMMUNITY RESIDENTS.**

6           (a) DEFINITION OF ELIGIBLE INSTITUTION.—In this  
7 section, the term “eligible institution” means a public or  
8 private nonprofit institution that submits to the Secretary  
9 of Health and Human Services (in this section referred  
10 to as the “Secretary”) and the Administrator of the Envi-  
11 ronmental Protection Agency (in this section referred to  
12 as the “Administrator”) an application for a grant under  
13 the grant program authorized under subsection (b)(2) at  
14 such time, in such manner, and containing such agree-  
15 ments, assurances, and information as the Secretary and  
16 Administrator may require.

17           (b) RESEARCH GRANT PROGRAM.—

18           (1) DEFINITION OF HEALTH.—In this section,  
19           the term “health” includes—

20                   (A) levels of physical activity;

21                   (B) consumption of nutritional foods;

22                   (C) rates of crime;

23                   (D) air, water, and soil quality;

24                   (E) risk of injury;

1 (F) accessibility to health care services;  
2 and

3 (G) other indicators as determined appro-  
4 priate by the Secretary.

5 (2) GRANTS.—The Secretary, in collaboration  
6 with the Administrator, shall provide grants to eligi-  
7 ble institutions to conduct and coordinate research  
8 on the built environment and its influence on indi-  
9 vidual and population-based health.

10 (3) RESEARCH.—The Secretary shall support  
11 research that—

12 (A) investigates and defines the causal  
13 links between all aspects of the built environ-  
14 ment and the health of residents;

15 (B) examines—

16 (i) the extent of the impact of the  
17 built environment (including the various  
18 characteristics of the built environment) on  
19 the health of residents;

20 (ii) the variance in the health of resi-  
21 dents by—

22 (I) location (such as inner cities,  
23 inner suburbs, and outer suburbs);  
24 and



1 (II) population subgroup (such as  
2 children, the elderly, the disadvan-  
3 tagged); or

4 (iii) the importance of the built envi-  
5 ronment to the total health of residents,  
6 which is the primary variable of interest  
7 from a public health perspective;

8 (C) is used to develop—

9 (i) measures to address health and the  
10 connection of health to the built environ-  
11 ment; and

12 (ii) efforts to link the measures to  
13 travel and health databases; and

14 (D) distinguishes carefully between per-  
15 sonal attitudes and choices and external influ-  
16 ences on observed behavior to determine how  
17 much an observed association between the built  
18 environment and the health of residents, versus  
19 the lifestyle preferences of the people that  
20 choose to live in the neighborhood, reflects the  
21 physical characteristics of the neighborhood;  
22 and

23 (E)(i) identifies or develops effective inter-  
24 vention strategies to promote better health  
25 among residents with a focus on behavioral

1 interventions and enhancements of the built en-  
2 vironment that promote increased use by resi-  
3 dents; and

4 (ii) in developing the intervention strate-  
5 gies under clause (i), ensures that the interven-  
6 tion strategies will reach out to high-risk popu-  
7 lations, including racial and ethnic minorities  
8 and low-income urban and rural communities.

9 (4) PRIORITY.—In providing assistance under  
10 the grant program authorized under paragraph (2),  
11 the Secretary and the Administrator shall give pri-  
12 ority to research that incorporates—

13 (A) minority-serving institutions as grant-  
14 ees;

15 (B) interdisciplinary approaches; or

16 (C) the expertise of the public health,  
17 physical activity, urban planning, and transpor-  
18 tation research communities in the United  
19 States and abroad.

20 **SEC. 1005. ENVIRONMENT AND PUBLIC HEALTH RESTORA-**  
21 **TION.**

22 (a) FINDINGS.—

23 (1) GENERAL FINDINGS.—The Congress finds  
24 as follows:

1           (A) As human beings, we share our envi-  
2           ronment with a wide variety of habitats and  
3           ecosystems that nurture and sustain a diversity  
4           of species.

5           (B) The abundance of natural resources in  
6           our environment forms the basis for our econ-  
7           omy and has greatly contributed to human de-  
8           velopment throughout history.

9           (C) The accelerated pace of human devel-  
10          opment over the last several hundred years has  
11          significantly impacted our natural environment  
12          and its resources, the health and diversity of  
13          plant and animal wildlife, the availability of  
14          critical habitats, the quality of our air and our  
15          water, and our global climate.

16          (D) The intervention of the Federal Gov-  
17          ernment is necessary to minimize and mitigate  
18          human impact on the environment for the ben-  
19          efit of public health, to maintain air quality and  
20          water quality, to sustain the diversity of plants  
21          and animals, to combat global climate change,  
22          and to protect the environment.

23          (E) Laws and regulations in the United  
24          States have been created and promulgated to  
25          minimize and mitigate human impact on the en-

1 vironment for the benefit of public health, to  
2 maintain air quality and water quality, to sus-  
3 tain wildlife, and to protect the environment.

4 (F) Such laws include the Antiquities Act  
5 of 1906 (16 U.S.C. 431 et seq.) initiated by  
6 President Theodore Roosevelt to create the na-  
7 tional park system, the National Environmental  
8 Policy Act of 1969 (42 U.S.C. 4321 et seq.),  
9 the Clean Air Act (42 U.S.C. 7401 et seq.), the  
10 Federal Water Pollution Control Act (33 U.S.C.  
11 1251 et seq.), the Comprehensive Environ-  
12 mental Response, Compensation, and Liability  
13 Act of 1980 (Public Law 96–510), the Endan-  
14 gered Species Act of 1973 (Public Law 93–  
15 205), and the National Forest Management Act  
16 of 1976 (Public Law 94–588).

17 (G) Attempts to repeal or weaken key envi-  
18 ronmental safeguards pose dangers to the pub-  
19 lic health, air quality, water quality, wildlife,  
20 and the environment.

21 (2) FINDINGS ON CHANGES AND PROPOSED  
22 CHANGES IN LAW.—The Congress finds that, since  
23 2001, the following changes and proposed changes  
24 to existing law or regulations have negatively im-

1       pacted or will negatively impact the environment and  
2       public health:

3               (A) CLEAN WATER.—

4               (i) On May 9, 2002, the Environ-  
5               mental Protection Agency (EPA) and the  
6               Army Corps of Engineers put forth a final  
7               rule that reconciled regulations imple-  
8               menting section 404 of the Federal Water  
9               Pollution Control Act by redefining the  
10              term “fill material” and amending the def-  
11              inition of the term “discharge of fill mate-  
12              rial”, reversing a 25-year-old regulation.  
13              The new rule fails to restrict the dumping  
14              of hardrock mining waste, construction de-  
15              bris, and other industrial wastes into riv-  
16              ers, streams, lakes, and wetlands. The rule  
17              further allows destructive mountaintop re-  
18              moval coal mining companies to dump  
19              waste into streams and lakes, polluting the  
20              surrounding natural habitat and poisoning  
21              plants and animals that depend on those  
22              water sources.

23              (ii) On February 12, 2003, the Envi-  
24              ronmental Protection Agency published the  
25              rule “National Pollutant Discharge Elimini-

1 nation System Permit Regulation and Ef-  
2 fluent Limitation Guidelines and Stand-  
3 ards for Concentrated Animal Feeding Op-  
4 erations”, new livestock waste regulations  
5 that aimed to control factory farm pollu-  
6 tion but which would severely undermine  
7 existing protections under the Federal  
8 Water Pollution Control Act. This regula-  
9 tion allows large-scale animal factories to  
10 foul the Nation’s waters with animal  
11 waste, allows livestock owners to draft  
12 their own pollution-management plans and  
13 avoid ground water monitoring, legalizes  
14 the discharge of contaminated runoff water  
15 rich in nitrogen, phosphorus, bacteria, and  
16 metals, and ensures that large factory  
17 farms are not held liable for the environ-  
18 mental damage they cause. In a 2005 Fed-  
19 eral court decision (“Waterkeeper Alliance,  
20 et al. v. Environmental Protection Agency”,  
21 399 F.3d 486 (2nd Cir. 2005)), major  
22 parts of the rule were upheld, others va-  
23 cated, and still others remanded back to  
24 the EPA. On November 20, 2008, the En-  
25 vironmental Protection Agency published a

1 revised final rule which undermines envi-  
2 ronmental protection provisions by remov-  
3 ing mandatory permitting requirements  
4 and allowing large animal farms to self-  
5 certify the absence of pollutant discharge  
6 activity.

7 (iii) On March 19, 2003, the Environ-  
8 mental Protection Agency published a new  
9 rule regarding the Total Maximum Daily  
10 Load program of the Federal Water Pollu-  
11 tion Control Act that regulates the max-  
12 imum amount of a particular pollutant  
13 that can be present in a body of water and  
14 still meet water quality standards. The new  
15 rule withdrew the existing regulation put  
16 forth on July 13, 2000, and halted mo-  
17 mentum in cleaning up polluted waterways  
18 throughout the Nation. By abandoning the  
19 existing rule, the Environmental Protection  
20 Agency is undermining the effectiveness of  
21 clean-up plans and is allowing States to  
22 avoid cleaning polluted waters entirely by  
23 dropping them from their clean-up lists.  
24 Waterways play a crucial role in the lives  
25 of the people of the United States and are

1 critical to the livelihood of fish and wildlife.  
2 The result of dropping the July 2000 rule  
3 is that the restoration of polluted rivers,  
4 shorelines, and lakes will be delayed, harm-  
5 ing more fish and wildlife and worsening  
6 the quality of drinking water.

7 (iv) On December 2, 2008, the Envi-  
8 ronmental Protection Agency and the  
9 Army Corps of Engineers jointly issued a  
10 guidance document in the form of a legal  
11 memorandum, titled “Clean Water Act Ju-  
12 risdiction Following the U.S. Supreme  
13 Court’s Decision in *Rapanos v. United*  
14 *States & Carabell v. United States*”. This  
15 new guidance dictates enforcement actions  
16 under the Federal Water Pollution Control  
17 Act and calls for a complicated “case-by-  
18 case” analysis to determine jurisdiction for  
19 waterways that do not flow all year. Such  
20 actions endanger small streams and wet-  
21 lands that serve as important habitats for  
22 aquatic life, which play a fundamental role  
23 in safeguarding sources of clean drinking  
24 water and mitigate the risks and effects of  
25 floods and droughts. Further, the defini-



1           tion provided therein for “waters of the  
2           United States” is applicable to the Federal  
3           Water Pollution Control Act as a whole,  
4           potentially affecting programs that control  
5           industrial pollution and sewage levels, pre-  
6           vent oil spills, and set water quality stand-  
7           ards for all waters in the United States  
8           protected under the Federal Water Pollu-  
9           tion Control Act.

10           (B) FORESTS AND LAND MANAGEMENT.—

11           (i) On December 3, 2003, the Presi-  
12           dent signed into law the Healthy Forests  
13           Restoration Act of 2003 (Public Law 108-  
14           148; 16 U.S.C. 6501 et seq.). Although the  
15           law attempts to reduce the risk of cata-  
16           strophic forest fires, it provides a boon to  
17           timber companies by accelerating the ag-  
18           gressive thinning of backcountry forests  
19           that are far from at-risk communities. The  
20           law allows for increased logging of large,  
21           fire-resistant trees that are not in close  
22           proximity of homes and communities; it  
23           undermines critical protections for endan-  
24           gered species by exempting Federal land  
25           management agencies from consulting with

1 the United States Fish and Wildlife Serv-  
2 ice before approving any action that could  
3 harm endangered plants or wildlife; and it  
4 limits public participation by reducing the  
5 number of environmental project reviews.

6 (ii) On April 21, 2008, the Depart-  
7 ment of Agriculture issued a Final Plan-  
8 ning Rule and Record of Decision for Na-  
9 tional Forest System Land Management  
10 Planning. Similar to rules enacted by the  
11 Administration on January 5, 2005, later  
12 remanded back to the agency in Federal  
13 district court for violating the National  
14 Environmental Policy Act of 1969, the En-  
15 dangered Species Act of 1973, and the Ad-  
16 ministrative Procedure Act (“Citizens for  
17 Better Forestry v. United States Depart-  
18 ment of Agriculture”, 481 F. Supp. 2d  
19 1059 (N.D. Cal. 2007)), this revised rule  
20 eliminates strict forest planning standards  
21 established in 1982, and opens millions of  
22 acres of public lands to damaging and  
23 invasive logging, mining, and drilling oper-  
24 ations. These regulations would reverse  
25 more than 20 years of protection for wild-

1 life and national forests by removing the  
2 overall goal of ensuring ecological sustain-  
3 ability in managing the national forest sys-  
4 tem, weakening the National Forest Man-  
5 agement Act of 1976, and effectively end-  
6 ing the review of forest management plans  
7 under the National Environmental Policy  
8 Act of 1969.

9 (iii) On September 20, 2006, the Dis-  
10 trict Court for the Northern District of  
11 California vacated the Protection of Inven-  
12 toried Roadless Areas rule, enacted on May  
13 13, 2005, which gave State Governors 18  
14 months to petition the Federal Government  
15 to either restore the previous rule for their  
16 States, or submit a new management and  
17 development plan for national forest areas  
18 inventoried under the rule. Despite the  
19 enjoinder of the Administration's 2005  
20 rule, and the subsequent restoration of the  
21 original Roadless Area Conservation Rule,  
22 the U.S. Forest Service has continued to  
23 allow States to petition for a special rule  
24 under the authority of the Administrative  
25 Procedure Act, publishing a final special

1 rule for Idaho on October 16, 2008. As a  
2 result, 58.5 million acres of wild national  
3 forests are still vulnerable to logging, road  
4 building, and other developments that may  
5 fragment natural habitats and negatively  
6 impact fish and wildlife.

7 (iv) On November 17, 2008, the De-  
8 partment of the Interior's Bureau of Land  
9 Management (BLM) signed the Record of  
10 Decision (ROD) amending 12 resource  
11 management plans in Colorado, Utah, and  
12 Wyoming, opening 2,000,000 acres of pub-  
13 lic lands to commercial tar sands and oil  
14 shale exploration and development. On No-  
15 vember 18, 2008, the BLM published a  
16 final rule for Oil Shale Management set-  
17 ting the policies and procedures for a com-  
18 mercial leasing program for the manage-  
19 ment of federally owned oil shale in those  
20 three States. Previously barred by a con-  
21 gressional moratorium on the commercial  
22 leasing regulations for oil shale until Sep-  
23 tember 30, 2008, the development of oil  
24 shale on public lands poses a serious threat  
25 to land conservation, endangered and

1           threatened species, and critical habitat.  
2           Domestic shale oil production allowed by  
3           these regulations is highly water and en-  
4           ergy intensive, the impacts of which will in-  
5           tensify existing water scarcity in the arid  
6           Western Region and potentially degrade  
7           air and water quality for surrounding pop-  
8           ulations.

9           (C) SCIENTIFIC REVIEW.—On December  
10          16, 2008, the United States Fish and Wildlife  
11          Service of the Department of the Interior and  
12          the National Oceanic and Atmospheric Admin-  
13          istration of the Department of Commerce joint-  
14          ly issued a new rule amending regulations gov-  
15          erning interagency cooperation under section 7  
16          of the Endangered Species Act of 1973 (ESA).  
17          This rule undermines the intention of the ESA  
18          to protect species and the ecosystems upon  
19          which they depend by allowing Federal agencies  
20          to carry out, permit, or fund an action without  
21          proper environmental review and expert third-  
22          party consultation from Federal wildlife ex-  
23          perts. Under this new rule, Federal agencies  
24          can unilaterally circumvent the formal review  
25          process, eliminating longstanding and scientif-

1           ically grounded safeguards that serve to protect  
2           the biodiversity of our Nation’s ecosystems and  
3           avert harm to thousands of endangered and  
4           threatened species.

5           (b) STATEMENT OF POLICY.—It is the policy of the  
6 United States Government to work in conjunction with  
7 States, territories, tribal governments, international orga-  
8 nizations, and foreign governments in order to act as a  
9 steward of the environment for the benefit of public  
10 health, to maintain air quality and water quality, to sus-  
11 tain the diversity of plant and animal species, to combat  
12 global climate change, and to protect the environment for  
13 future generations to enjoy.

14           (c) STUDY AND REPORT ON PUBLIC HEALTH OR EN-  
15 VIRONMENTAL IMPACT OF REVISED RULES, REGULA-  
16 TIONS, LAWS, OR PROPOSED LAWS.—

17           (1) STUDY.—Not later than 30 days after the  
18 date of enactment of this Act, the President shall  
19 enter into an arrangement under which the National  
20 Academy of Sciences will conduct a study to deter-  
21 mine the impact on public health, air quality, water  
22 quality, wildlife, and the environment of the fol-  
23 lowing regulations, laws, and proposed laws:

24           (A) CLEAN WATER.—

1 (i) Final revisions to the Federal  
2 Water Pollution Control Act regulatory  
3 definitions of “fill material” and “dis-  
4 charge of fill material”, finalized and pub-  
5 lished in the Federal Register on May 9,  
6 2002 (67 FR 31129), amending part 232  
7 of title 40, Code of Federal Regulations.

8 (ii) Revised National Pollutant Dis-  
9 charge Elimination System Permit Regula-  
10 tion and Effluent Limitation Guidelines  
11 and Standards for Concentrated Animal  
12 Feeding Operations in response to the  
13 “Waterkeeper Alliance, et al. v.  
14 Environmental Protection Agency” decision,  
15 finalized and published in the Federal Reg-  
16 ister on November 20, 2008 (73 FR 225),  
17 amending parts 9, 122, and 412 of title  
18 40, Code of Federal Regulations.

19 (iii) A March 19, 2003, rule published  
20 in the Federal Register (68 FR 13608)  
21 withdrawing a July 13, 2000, rule revising  
22 the Total Maximum Daily Load program  
23 of the Federal Water Pollution Control Act  
24 (65 FR 43586), amending parts 9, 122,

1 123, 124, and 130 of title 40, Code of  
2 Federal Regulations.

3 (iv) Official Guidance Document,  
4 “Clean Water Act Jurisdiction Following  
5 the United States Supreme Court’s Deci-  
6 sion in *Rapanos v. United States &*  
7 *Carabell v. United States*”, issued on De-  
8 cember 2, 2008, relating to jurisdiction  
9 under section 404 of the Federal Water  
10 Pollution Control Act.

11 (B) FORESTS AND LAND MANAGEMENT.—

12 (i) Healthy Forests Restoration Act of  
13 2003, signed into law on December 3,  
14 2003 (Public Law 108–148; 16 U.S.C.  
15 6501 et seq.).

16 (ii) National Forest System Land  
17 Management Planning Rule, finalized and  
18 published in the Federal Register on April  
19 21, 2008 (73 FR 21468), replacing the  
20 2005 final rule (70 FR 1022, Jan. 5,  
21 2005), as amended March 3, 2006 (71 FR  
22 10837) and the 2000 final rule adopted on  
23 November 9, 2000 (65 FR 67514) as  
24 amended on September 29, 2004 (69 FR



1 58055), amending title 36, Code of Fed-  
2 eral Regulations, part 219.

3 (iii) The application of the Adminis-  
4 trative Procedure Act (5 U.S.C. 551 to  
5 559, 701 to 706, et seq.), such that States  
6 may petition for a special rule for the  
7 roadless areas in all or part of said State.

8 (iv) Record of Decision, “Oil Shale  
9 and Tar Sands Resources Resource Man-  
10 agement Plan Amendments”, issued on  
11 November 17, 2008, along with the Final  
12 Rule, Oil Shale Management-General, pub-  
13 lished in the Federal Register on Novem-  
14 ber 18, 2008 (73 FR 223), amending title  
15 43, Code of Federal Regulations, parts  
16 3900, 3910, 3920, and 3930.

17 (C) SCIENTIFIC REVIEW.—Final Rule,  
18 Interagency Cooperation Under the Endangered  
19 Species Act, published in the Federal Register  
20 on December 16, 2008, amending title 50, Code  
21 of Federal Regulations, part 402.

22 (2) METHOD.—In conducting the study under  
23 paragraph (1), the National Academy of Sciences  
24 may utilize and compare existing scientific studies

1 regarding the regulations, laws, and proposed laws  
2 listed in paragraph (1).

3 (3) REPORT.—Under the arrangement entered  
4 into under paragraph (1), not later than 270 days  
5 after the date on which such arrangement is entered  
6 into, the National Academy of Sciences shall make  
7 publicly available and shall submit to the Congress  
8 and to the head of each department and agency of  
9 the Federal Government that issued, implements, or  
10 would implement a regulation, law, or proposed law  
11 listed in paragraph (1), a report containing—

12 (A) a description of the impact of all such  
13 regulations, laws, and proposed laws on public  
14 health, air quality, water quality, wildlife, and  
15 the environment, compared to the impact of  
16 preexisting regulations, or laws in effect, includ-  
17 ing—

18 (i) any negative impacts to air quality  
19 or water quality;

20 (ii) any negative impacts to wildlife;

21 (iii) any delays in hazardous waste  
22 cleanup that are projected to be hazardous  
23 to public health; and

24 (iv) any other negative impact on pub-  
25 lic health or the environment; and

1           (B) any recommendations that the Na-  
2           tional Academy of Sciences considers appro-  
3           priate to maintain, restore, or improve in whole  
4           or in part protections for public health, air  
5           quality, water quality, wildlife, and the environ-  
6           ment for each of the regulations, laws, and pro-  
7           posed laws listed in paragraph (1), which may  
8           include recommendations for the adoption of  
9           any regulation or law in place or proposed prior  
10          to January 1, 2001.

11          (d) DEPARTMENT AND AGENCY REVISION OF EXIST-  
12          ING RULES, REGULATIONS, OR LAWS.—Not later than  
13          180 days after the date on which the report is submitted  
14          pursuant to subsection (c)(3), the head of each depart-  
15          ment and agency that has issued or implemented a regula-  
16          tion or law listed in subsection (c)(1) shall submit to the  
17          Congress a plan describing the steps such department or  
18          such agency will take, or has taken, to restore or improve  
19          protections for public health and the environment in whole  
20          or in part that were in existence prior to the issuance of  
21          such regulation or law.

22          **SEC. 1006. HEALTHY FOOD FINANCING INITIATIVE.**

23          (a) IN GENERAL.—Subtitle D of the Department of  
24          Agriculture Reorganization Act of 1994 (7 U.S.C. 6951)  
25          is amended by adding at the end the following:

1 **“SEC. 242. HEALTHY FOOD FINANCING INITIATIVE.**

2       “(a) PURPOSE.—The purpose of this section is to es-  
3 tablish a program to improve access to healthy foods in  
4 underserved areas, to create and preserve quality jobs, and  
5 to revitalize low-income communities by providing loans  
6 and grants to eligible fresh, healthy food retailers to over-  
7 come the higher costs and initial barriers to entry in un-  
8 derserved, urban, suburban, and rural areas.

9       “(b) DEFINITIONS.—In this section:

10           “(1) COMMUNITY DEVELOPMENT FINANCIAL IN-  
11 STITUTION.—The term ‘community development fi-  
12 nancial institution’ has the meaning given the term  
13 in section 103 of the Community Development  
14 Banking and Financial Institutions Act of 1994 (12  
15 U.S.C. 4702).

16           “(2) FOOD ACCESS ORGANIZATION.—The term  
17 ‘food access organization’ means a nonprofit organi-  
18 zation with expertise in improving access to healthy  
19 food in underserved communities.

20           “(3) INITIATIVE.—The term ‘Initiative’ means  
21 the Healthy Food Financing Initiative established in  
22 the Department by subsection (c)(1).

23           “(4) LOCAL FUNDS.—The term ‘local funds’  
24 means the allocation of national funds and any other  
25 forms of financial assistance (including grants,  
26 loans, and equity investments) that are raised by

1 partnerships to carry out the purposes of this sec-  
2 tion.

3 “(5) NATIONAL FUNDS.—The term ‘national  
4 funds’ means any Federal appropriation made to  
5 carry out this section and any other forms of finan-  
6 cial assistance (including grants, loans, and equity  
7 investments) that are raised by the national fund  
8 manager to carry out the purposes of this section.

9 “(6) NATIONAL FUND MANAGER.—The term  
10 ‘national fund manager’ means a community devel-  
11 opment financial institution in existence as of the  
12 date of enactment of this section and certified by the  
13 Community Development Financial Institutions  
14 Fund of the Department of the Treasury that is des-  
15 ignated by the Secretary to manage the Initiative for  
16 purposes of—

17 “(A) raising private capital;

18 “(B) providing financial and technical as-  
19 sistance to partnerships; and

20 “(C) funding eligible projects directly at  
21 the request of partnerships to attract fresh,  
22 healthy food retailers to underserved urban,  
23 suburban, and rural areas, in accordance with  
24 this section.

25 “(7) PARTNERSHIP.—

1           “(A) IN GENERAL.—The term ‘partner-  
2           ship’ means a regional, State, or local public  
3           and private partnership that is organized to im-  
4           prove access to fresh, healthy foods by pro-  
5           viding financial and technical assistance to eli-  
6           gible projects.

7           “(B) INCLUSIONS.—The term ‘partnership’  
8           includes—

9                   “(i) an unit of State, local, or tribal  
10                  government or a quasi-public State or local  
11                  government agency;

12                  “(ii) a food access or community  
13                  health organization committed to improv-  
14                  ing access to healthy foods;

15                  “(iii) a community development finan-  
16                  cial institution or other organization that  
17                  is capable of administering a loan and  
18                  grant program in accordance with this sec-  
19                  tion; and

20                  “(iv) other organizations interested in  
21                  improving access to healthy foods in under-  
22                  served areas.

23           “(c) ESTABLISHMENT.—

24                   “(1) IN GENERAL.—There is established in the  
25           Department a Healthy Food Financing Initiative.

1           “(2) MANAGEMENT.—Not later than 1 year  
2 after the date of enactment of this section, the Sec-  
3 retary shall select and enter into a grant agreement  
4 with a national fund manager who shall be respon-  
5 sible for the management of the Initiative nationally.

6           “(3) ELIGIBLE PROJECTS.—

7           “(A) IN GENERAL.—Subject to the re-  
8 quirements of this paragraph, the national fund  
9 manager shall establish the eligibility criteria  
10 for projects to be assisted by the Initiative.

11           “(B) REQUIREMENTS.—To be eligible to  
12 receive assistance through the Initiative, a  
13 project shall—

14           “(i) include a supermarket, grocery  
15 store, farmers market, or other fresh,  
16 healthy food retailer;

17           “(ii) consist of a for-profit business  
18 enterprise, a member- or worker-owned co-  
19 operative, or a nonprofit organization;

20           “(iii) meet the eligibility criteria es-  
21 tablished under this section;

22           “(iv) continue to be a viable business  
23 enterprise with a financial viability plan;

1           “(v) require an investment of public  
2 funding to move forward and be competi-  
3 tive;

4           “(vi) operate on a self-service basis;

5           “(vii) in accordance with subpara-  
6 graph (C), expand or preserve the avail-  
7 ability of healthy, fresh, high quality un-  
8 prepared and unprocessed foods, particu-  
9 larly fresh fruits and vegetables, in under-  
10 served areas; and

11           “(viii) agree to accept benefits under  
12 the supplemental nutrition assistance pro-  
13 gram established under the Food and Nu-  
14 trition Act of 2008 (7 U.S.C. 2011 et  
15 seq.).

16           “(C) REQUIREMENTS.—

17           “(i) DEFINITIONS.—In this subpara-  
18 graph:

19           “(I) PERISHABLE FOOD.—

20           “(aa) IN GENERAL.—The  
21 term ‘perishable food’ means food  
22 that is fresh, refrigerated, or fro-  
23 zen.

24           “(bb) EXCLUSION.—The  
25 term ‘perishable food’ does not



1 include packaged or canned  
2 goods.

3 “(II) STAPLE FOOD.—

4 “(aa) IN GENERAL.—The  
5 term ‘staple food’ means food  
6 that is a basic dietary item, in-  
7 cluding bread, flour, fruits, vege-  
8 tables, and meat.

9 “(bb) EXCLUSIONS.—The  
10 term ‘staple food’ does not in-  
11 clude snack or accessory food  
12 (such as chips, soda, coffee, con-  
13 diments, and spices) or ready-to-  
14 eat, prepared food.

15 “(III) VARIETY.—The term ‘vari-  
16 ety’ means an assortment of different  
17 types of food items.

18 “(ii) IN GENERAL.—For purposes of  
19 subparagraph (B)(vii), to expand or pre-  
20 serve the availability of fresh fruits and  
21 vegetables in underserved areas shall  
22 mean, with respect to a project, that the  
23 project maintains a store that—

24 “(I) carries a full line of fresh  
25 produce, as defined by the national

1 fund manager to reflect differences in  
2 project size and overall store size;

3 “(II) sells food for home prepara-  
4 tion and consumption; and

5 “(III) at a minimum—

6 “(aa) offers for sale at least  
7 3 different varieties of food in  
8 each of the 4 staple food groups  
9 (bread and grains, dairy, fruits  
10 and vegetables, and meat, poul-  
11 try, and fish), with perishable  
12 food in at least 2 categories, on  
13 a daily basis; or

14 “(bb) has a store at which  
15 at least 50 percent of the total  
16 sales of the store (including food  
17 and nonfood items or services)  
18 are from the sale of eligible sta-  
19 ple food.

20 “(D) INCOME CRITERIA.—Each eligible  
21 project shall be located in—

22 “(i) a low- or moderate-income census  
23 tract, as determined by the Bureau of the  
24 Census of the Department of Commerce;

1           “(ii) a population census tract that is  
2           treated as a low-income community under  
3           section 45D(e) of the Internal Revenue  
4           Code of 1986; or

5           “(iii) an area that significantly serves  
6           an adjacent area that meets the criteria  
7           described in clause (i) or (ii), as approved  
8           by the national fund manager.

9           “(E) UNDERSERVED CRITERIA.—

10           “(i) IN GENERAL.—Each eligible  
11           project shall be located in an underserved  
12           area, as determined by the partnerships  
13           according to criteria established by the na-  
14           tional fund manager.

15           “(ii) FACTORS.—In determining  
16           whether an area is an underserved area,  
17           the following factors shall be taken into  
18           consideration:

19                   “(I) Population density.

20                   “(II) Below average supermarket  
21                   density or sales.

22                   “(III) Car ownership.

23                   “(IV) Geographical or physical  
24                   barriers, such as highways, moun-  
25                   tains, major parks, or bodies of water.

1                   “(iii) LOCATIONS.—On an annual  
2                   basis, the national fund manager shall col-  
3                   lect data and publish maps that show the  
4                   location of underserved areas.

5                   “(4) PRIORITY PROJECTS.—

6                   “(A) IN GENERAL.—Priority shall be given  
7                   to projects that—

8                   “(i) are located in severely distressed  
9                   low-income communities, as defined by the  
10                  Community Development Financial Insti-  
11                  tutions Fund of the Department of the  
12                  Treasury; and

13                  “(ii) include 1 or more of the fol-  
14                  lowing characteristics:

15                         “(I) The project will create or re-  
16                         tain quality jobs in the community, as  
17                         determined in accordance with sub-  
18                         paragraph (B).

19                         “(II) The project has community  
20                         support in terms of store quality, af-  
21                         fordability, site location, and coordina-  
22                         tion with local community plans or  
23                         other programs promoting community  
24                         and economic development.

1           “(III) The project supports re-  
2           gional food systems and locally grown  
3           foods, to the extent available.

4           “(IV) In major metropolitan  
5           areas, the project is associated with a  
6           transit-oriented development project.

7           “(V) In areas with public transit,  
8           the project is accessible by public  
9           transit.

10          “(VI) The project involves the  
11          reuse of a building that is listed in or  
12          eligible for the National Register of  
13          Historic Places.

14          “(VII) The project involves a  
15          brownfield or grayfield (as those  
16          terms are used in the Comprehensive  
17          Environmental Response, Compensa-  
18          tion, and Liability Act of 1980 (42  
19          U.S.C. 9601 et seq.)).

20          “(VIII) The estimated energy  
21          consumption of the project, calculated  
22          using building energy software ap-  
23          proved by the Department of Energy,  
24          will qualify the project for designation  
25          under the Energy Star program estab-

1                   lished by section 324A of the Energy  
2                   Policy and Conservation Act (42  
3                   U.S.C. 6294a).

4                   “(IX) The project involves  
5                   women- and minority-owned busi-  
6                   nesses.

7                   “(B) QUALITY JOBS.—For purposes of  
8                   subparagraph (A)(ii)(I), a quality job is a job  
9                   that—

10                   “(i) provides wages that are com-  
11                   parable to or better than similar positions  
12                   in existing businesses of similar size in  
13                   similar local economies;

14                   “(ii) offers benefits that are com-  
15                   parable to or better than what is offered  
16                   for similar positions in existing local busi-  
17                   nesses of similar size in similar local econo-  
18                   mies; and

19                   “(iii) is targeted for residents of  
20                   neighborhoods with a high proportion of  
21                   persons of low income (as that term is de-  
22                   fined in section 102(a) of the Housing and  
23                   Community Development Act of 1974 (42  
24                   U.S.C. 5302(a))) through local targeted  
25                   hiring programs.

1 “(d) DUTIES OF THE SECRETARY.—

2 “(1) IN GENERAL.—The Secretary shall—

3 “(A) designate a national fund manager to  
4 manage national funds;

5 “(B) oversee the Initiative nationally;

6 “(C) work closely with the designated na-  
7 tional fund manager—

8 “(i) to ensure that funds are used ap-  
9 propriately and in the most effective man-  
10 ner practicable; and

11 “(ii) to develop the program strategy  
12 into a detailed work plan, program, and  
13 operating budget;

14 “(D) review and approve the operating  
15 budget for the national fund manager to ensure  
16 that the administrative costs are—

17 “(i) reasonable (not more than 5 per-  
18 cent of the total budget);

19 “(ii) connected to the costs of oper-  
20 ations; and

21 “(iii) reflect efficient operations by the  
22 national fund manager; and

23 “(E) make available to the public an an-  
24 nual report, using data obtained from the De-  
25 partment of Agriculture, the Department of

1 Health and Human Services, and the Commu-  
2 nity Development Financial Institutions, that  
3 describes the impacts of the Initiative, including  
4 tracking health and economic development indi-  
5 cators at the local, State, and national levels to  
6 determine the impacts of individual projects  
7 and the collective impact in local areas and  
8 statewide of funded projects and the Initiative  
9 overall.

10 “(2) NATIONAL FUND MANAGER.—The Sec-  
11 retary shall—

12 “(A) select the national fund manager  
13 through a competitive process from among com-  
14 munity development financial institutions that  
15 have a proven and recent track record of suc-  
16 cess and effectiveness in—

17 “(i) attracting private capital;

18 “(ii) developing and managing pro-  
19 grams that provide grants and loans to  
20 support supermarkets and other fresh,  
21 healthy food retail business enterprises in  
22 low- and moderate-income communities, in-  
23 cluding the development of grocery stores,  
24 farmers markets, and other fresh, healthy  
25 food retail models;



1           “(iii) making and servicing loans that  
2           are similar to loans proposed in the Initia-  
3           tive or having a record of otherwise suc-  
4           cessfully investing in fresh, healthy food  
5           retail development projects;

6           “(iv) effectively managing multiple  
7           contracts and subcontractors;

8           “(v) effectively managing large capital  
9           pools, of at least \$100,000,000; and

10          “(vi) providing or contracting for the  
11          provision of technical assistance; and

12          “(B) administer the Initiative by approving  
13          the disbursement of funds to the national fund  
14          manager in a manner that facilitates the imple-  
15          mentation of the overall Initiative.

16          “(3) COORDINATION.—

17               “(A) IN GENERAL.—Not later than 45  
18               days after the date of receipt of an award, the  
19               national fund manager shall develop, with guid-  
20               ance from and in consultation with the Sec-  
21               retary, and submit to the Secretary, a detailed  
22               work plan.

23               “(B) APPROVAL REQUIRED.—The Sec-  
24               retary shall review and approve the work plan,  
25               program budget, and administrative costs under

1 subsection (e)(4)(C) prior to entering into an  
2 agreement with the national fund manager to  
3 administer the Initiative.

4 “(4) PERFORMANCE TARGETS.—

5 “(A) IN GENERAL.—The Secretary shall  
6 conduct financial audits of, and establish per-  
7 formance targets for, the national fund man-  
8 ager, which shall include, at a minimum, the re-  
9 quirements described in this paragraph.

10 “(B) GEOGRAPHIC SPREAD.—Partnerships  
11 funded by the Initiative shall be geographically  
12 diverse and representative of the underserved  
13 areas across the United States.

14 “(C) FOCUS ON LOW-INCOME COMMU-  
15 NITIES.—A substantial portion of the projects  
16 funded by partnerships shall serve very low-  
17 and low-income communities, as defined by the  
18 Bureau of the Census of the Department of  
19 Commerce.

20 “(D) FINANCIAL EFFECTIVENESS OF THE  
21 NATIONAL FUND MANAGER.—The national fund  
22 manager and any local financial institution in-  
23 volved in a partnership shall demonstrate on-  
24 going capacity and timeliness in raising private

1 capital and disbursing funds as required under  
2 the Initiative.

3 “(E) TECHNICAL ASSISTANCE EFFECTIVE-  
4 NESS OF THE NATIONAL FUND MANAGER.—The  
5 provision of technical assistance by the national  
6 fund manager shall be evaluated based on—

7 “(i) the responsiveness of the national  
8 fund manager to requests for assistance;  
9 and

10 “(ii) the ability of the national fund  
11 manager to craft programs that develop  
12 needed new capacities in partnerships.

13 “(F) IMPACT.—Performance targets shall  
14 address the allocation of funds by the national  
15 fund manager to partnerships and the tracking  
16 and reporting of the impacts of the funds in im-  
17 proving access to fresh, healthy foods and in  
18 achieving other related impacts.

19 “(e) DUTIES OF THE NATIONAL FUND MANAGER.—

20 “(1) ALLOCATION OF FUNDS.—

21 “(A) IN GENERAL.—The national fund  
22 manager shall—

23 “(i) allocate at least 70 percent of any  
24 Federal appropriation made to carry out  
25 this section to partnerships that are se-

1 lected based on the criteria described in  
2 paragraph (3); and

3 “(ii) retain not more than 30 percent  
4 of any Federal appropriation made to  
5 carry out this section to undertake financ-  
6 ing activities described in subparagraph  
7 (C), including a reasonable amount for ad-  
8 ministrative costs (not to exceed 5 percent)  
9 approved by the Secretary in accordance  
10 with paragraph (4)(C).

11 “(B) USE OF THE NATIONAL FUNDS BY  
12 PARTNERSHIP PROGRAMS.—

13 “(i) IN GENERAL.—As a condition on  
14 the receipt of funds, each partnership shall  
15 use—

16 “(I) the national funds received  
17 from the national fund manager under  
18 subparagraph (A)(i) to create 1 or  
19 more revolving loan programs or other  
20 revolving pools of capital or other  
21 products to facilitate financing of local  
22 projects as determined by the agree-  
23 ment between the partnership and the  
24 national fund manager; and

1           “(II) any remaining funds for  
2 grants, or, as approved, for innovative  
3 financing mechanisms.

4           “(ii) LIMITATIONS.—

5           “(I) IN GENERAL.—Use of funds  
6 for administrative costs and other  
7 purposes shall be—

8           “(aa) limited in accordance  
9 with the terms of the agreement  
10 negotiated between the national  
11 fund manager and partnerships;

12           “(bb) based on whether ad-  
13 ministrative costs are reasonable,  
14 connected to the costs of oper-  
15 ation, and reflect efficient oper-  
16 ations by the partnership; and

17           “(cc) determined using cri-  
18 teria including geographic cov-  
19 erage, program duration, and  
20 total funding amount.

21           “(II) GOAL.—The goal of this  
22 clause to limit administrative costs to  
23 the maximum extent practicable, but  
24 in no case may the amount used for

1 administrative costs exceed 10 percent  
2 of the Federal funds allocated.

3 “(C) USE OF THE NATIONAL FUNDS BY  
4 THE NATIONAL FUND MANAGER.—The national  
5 fund manager shall use national funds de-  
6 scribed in subparagraph (A)(ii) to undertake fi-  
7 nancing and other activities to enhance and  
8 maximize the effectiveness of the Initiative, as  
9 determined by the agreement with the Sec-  
10 retary, including—

11 “(i) attracting other forms of financial  
12 assistance to match or leverage the na-  
13 tional funds;

14 “(ii) awarding national funds to part-  
15 nerships in accordance with paragraph (3);

16 “(iii) creating and managing pools of  
17 grant or loan capital that blend or leverage  
18 national funds with other forms of finan-  
19 cial assistance, including capital in the  
20 form of tax credits under section 45D of  
21 the Internal Revenue Code of 1986, for the  
22 benefit of partnerships;

23 “(iv) creating and managing pools of  
24 grant or loan capital that blend or leverage  
25 the national funds with other forms of fi-

1           nancial assistance, including capital in the  
2           form of tax credits under section 45D of  
3           the Internal Revenue Code of 1986, to fi-  
4           nance eligible local projects identified by  
5           partnerships or the national fund manager  
6           that have special or unique characteristics;

7           “ (v) providing loans or grants directly  
8           to eligible local projects as matching funds  
9           if requested by a partnership;

10          “ (vi) providing credit enhancement or  
11          other financial products and instruments  
12          for the benefit of partnerships or eligible  
13          local projects;

14          “ (vii) providing technical assistance;  
15          and

16          “ (viii) funding reasonable administra-  
17          tive costs approved by the Secretary in ac-  
18          cordance with paragraph (4)(C).

19          “(2) RESPONSIBILITIES OF THE NATIONAL  
20          FUND MANAGER.—The designated national fund  
21          manager shall—

22                 “(A) raise other forms of financial assist-  
23                 ance to match or leverage the national funds;

1           “(B) use administrative funds to develop  
2 appropriate training programs and offer tech-  
3 nical assistance services to—

4                   “(i) partnerships;

5                   “(ii) State, local, and tribal govern-  
6 ments;

7                   “(iii) the food retail industry; and

8                   “(iv) food access and health advocacy  
9 organizations to augment local capacities;

10           “(C) develop financial products such as  
11 loans, grants, and credit enhancement tools  
12 that can be used by partnerships to incentivize  
13 and support the development and retention of  
14 supermarkets and other fresh, healthy food re-  
15 tail in underserved areas;

16           “(D) award Initiative funds to eligible  
17 partnerships through an annual competitive  
18 process in accordance with paragraph (3);

19           “(E) contract with a national food access  
20 organization to assist in the review of applica-  
21 tions from partnerships and to provide technical  
22 assistance to local food access organizations in  
23 the proposed partnerships;



1           “(F) award and disburse funds to partner-  
2           ships or eligible local projects in a timely man-  
3           ner;

4           “(G) create and meet performance bench-  
5           marks and reporting guidelines, as approved by  
6           the Secretary, including for—

7                   “(i) the amount of capital raised and  
8                   leveraged from financial institutions, part-  
9                   nerships, and other resources;

10                   “(ii) the geographic diversity of part-  
11                   nerships; and

12                   “(iii) the proportion of projects fund-  
13                   ed by the partnership that are in severely  
14                   distressed low-income communities;

15           “(H) develop program guidelines and oper-  
16           ating procedures for the Initiative, including—

17                   “(i) maximum grant and loan  
18                   amounts for projects;

19                   “(ii) eligible uses of funds;

20                   “(iii) prudent underwriting criteria;

21                   “(iv) performance targets;

22                   “(v) reporting guidelines;

23                   “(vi) limits on administrative costs;

24           and

25                   “(vii) implementation milestones;

1           “(I) monitor the performance of partner-  
2           ships; and

3           “(J) collect data, compile information, and  
4           conduct such research studies as the national  
5           fund manager determines to be relevant to the  
6           successful implementation of the Initiative, in-  
7           cluding—

8                   “(i) to assess national and local mar-  
9                   ket conditions;

10                   “(ii) to determine barriers to market  
11                   entry; and

12                   “(iii) to identify opportunities for the  
13                   development or retention of supermarkets  
14                   and other fresh, healthy food retail enter-  
15                   prises in underserved communities.

16           “(3) CRITERIA FOR AWARDING NATIONAL  
17           FUNDS TO PARTNERSHIPS.—

18                   “(A) IN GENERAL.—The national fund  
19                   manager shall award national funds to partner-  
20                   ships through a competitive process on an an-  
21                   nual basis.

22                   “(B) FIRST ROUND PRIORITY.—In the  
23                   first round of funding, the national fund man-  
24                   ager shall give priority to existing partnerships  
25                   that have demonstrable capacity to implement

1 fresh food financing programs in underserved  
2 areas quickly.

3 “(C) ADDITIONAL ROUNDS.—Additional  
4 rounds shall be designed to promote geographic  
5 diversity.

6 “(D) CRITERIA.—In awarding national  
7 funds to partnerships, the national fund man-  
8 ager shall consider—

9 “(i) the amount of funds and other  
10 resources pledged by a partnership to  
11 match or leverage national funds;

12 “(ii) the degree of State, local, or trib-  
13 al government support of the partnership  
14 as evidenced by matching grant and loan  
15 funds or other types of support, such as al-  
16 location of tax-exempt bonds, loan guaran-  
17 tees, and coordination of resources from  
18 other State or local economic development  
19 programs;

20 “(iii) the capacity of the partnership  
21 to successfully develop and manage loan  
22 and grant programs;

23 “(iv) the lack of supermarkets and  
24 other fresh, healthy food retail enterprises

1 in low- and moderate-income areas that  
2 would be served by the partnership;

3 “(v) the experience of the food access  
4 or community health organization of the  
5 partnership in outreach about access to  
6 healthy foods and local healthy food access  
7 issues;

8 “(vi) the degree of community engage-  
9 ment and support in the development and  
10 retention of supermarkets and other fresh,  
11 healthy food retail enterprises; and

12 “(vii) the contribution of the program  
13 of the partnership to the overall geographic  
14 diversity of the Initiative.

15 “(4) ADMINISTRATIVE COSTS.—

16 “(A) IN GENERAL.—Not later than 45  
17 days after the date of receipt of an award, the  
18 national fund manager shall submit to the Sec-  
19 retary for approval a 3-year program and oper-  
20 ating budget and detailed work plan that shall  
21 include—

22 “(i) costs for research and evaluation,  
23 technical assistance, and training; and

24 “(ii) program and operating costs.

1           “(B) EARNED REVENUES.—Earned reve-  
2           nues from loan fees and interest may be ex-  
3           pended on program and operating costs in ac-  
4           cordance with the budget approved by the Sec-  
5           retary.

6           “(C) BASIS OF REVIEW.—The Secretary  
7           shall base the review under subparagraph (A)  
8           on—

9                   “(i) the likelihood of the plan and ex-  
10                  penditures to further the purposes of this  
11                  section; and

12                   “(ii) whether the administrative costs  
13                  are reasonable, connected to the costs of  
14                  operation, and reflect efficient operations  
15                  by the national fund manager.

16          “(f) PARTNERSHIPS.—

17                  “(1) IN GENERAL.—Each partnership that re-  
18                  ceives assistance through the Initiative shall provide  
19                  financial and technical assistance to eligible fresh,  
20                  healthy food retail projects in underserved areas  
21                  within the defined communities of the partnership.

22                  “(2) ADMINISTRATION.—Each partnership shall  
23                  designate a community development financial insti-  
24                  tution or other organization that is capable of ad-  
25                  ministering a loan and grant program—

1           “(A) to execute grant agreements with the  
2 national fund manager; and

3           “(B) to serve as the manager of local  
4 funds.

5           “(3) RESPONSIBILITIES OF PARTNERSHIPS.—A  
6 partnership shall—

7           “(A) raise other forms of financial assist-  
8 ance to match the national funds received by  
9 the partnership;

10           “(B) provide marketing and outreach to  
11 communities, the supermarket industry, other  
12 fresh, healthy food retailers, State and local  
13 government officials, and civic and public inter-  
14 est organizations—

15           “(i) to solicit applications from under-  
16 served areas from across the State or local-  
17 ity to be served by the partnership; and

18           “(ii) to inform the communities and  
19 other persons about the availability of  
20 grants, loans, training, and technical as-  
21 sistance;

22           “(C) review and underwrite projects to de-  
23 termine whether—

1           “(i) a proposed project meets the cri-  
2           teria for eligible projects under subsection  
3           (c)(3); and

4           “(ii) a proposed project meets the cri-  
5           teria for priority projects under subsection  
6           (c)(4);

7           “(D) provide technical assistance services  
8           to eligible fresh, healthy food retail operators  
9           and developers;

10          “(E) track and report outcomes, includ-  
11          ing—

12               “(i) the number of jobs created or re-  
13               tained;

14               “(ii) the quantity of fresh, healthy  
15               food retail space created or retained; and

16               “(iii) such other health and economic  
17               indicators as are required by the national  
18               fund manager;

19          “(F) monitor and audit funded projects to  
20          ensure compliance with the Initiative, the na-  
21          tional fund manager, and partnership program  
22          requirements for a period of at least 3 years;

23          “(G) submit an annual report to the na-  
24          tional fund manager that describes—

25               “(i) the activities of the partnership;

1                   “(ii) the expenditure of local funds;  
2                   and

3                   “(iii) success in meeting performance  
4                   targets and satisfying such other terms  
5                   and conditions as are specified in the  
6                   agreement between the partnership and the  
7                   national fund manager; and

8                   “(H) coordinate with the national fund  
9                   manager for the smooth operation of the Initia-  
10                  tive.

11                  “(4) ADMINISTRATIVE COSTS.—

12                   “(A) IN GENERAL.—As a condition on the  
13                   receipt of assistance under this section, each  
14                   partnership shall submit to the national fund  
15                   manager for approval a 3-year budget and plan  
16                   for all program and operating costs, includ-  
17                   ing—

18                   “(i) costs for research and evaluation,  
19                   technical assistance, and training; and

20                   “(ii) administrative and operating  
21                   costs.

22                   “(B) EARNED REVENUES.—Earned reve-  
23                   nues from loan fees and interest may be ex-  
24                   pended on program and operating costs in ac-



1 cordance with the budget approved by the na-  
2 tional fund manager.

3 “(C) BASIS OF REVIEW.—The national  
4 fund manager shall base the review under sub-  
5 paragraph (A) on the likelihood of the budget  
6 and plan to further the purposes of this section.

7 “(g) EVALUATION AND MONITORING.—

8 “(1) IN GENERAL.—Program evaluation and fi-  
9 nancial audits shall occur at all levels of the Initia-  
10 tive to ensure that—

11 “(A) national and local funds are used  
12 properly; and

13 “(B) the objectives of the Initiative are  
14 met.

15 “(2) PROGRAM EVALUATION AND FINANCIAL  
16 AUDITS.—

17 “(A) IN GENERAL.—The Secretary shall—

18 “(i) conduct periodic program evalua-  
19 tions and financial audits of the national  
20 fund manager, partnerships, and projects  
21 funded by the Initiative; and

22 “(ii) share with the national fund  
23 manager the results of the evaluations and  
24 audits.

1           “(B) FUNDED PROJECTS.—The Secretary  
2 or the national fund manager shall evaluate  
3 partnerships to assess the health and economic  
4 impacts of projects funded by the Initiative.

5           “(C) OTHER IMPACTS.—

6           “(i) SECRETARY OF HEALTH AND  
7 HUMAN SERVICES.—The Secretary of  
8 Health and Human Services shall conduct  
9 research studies and evaluate the health  
10 impacts of the Initiative.

11           “(ii) COMMUNITY DEVELOPMENT FI-  
12 NANCIAL INSTITUTIONS.—Representatives  
13 of the Community Development Financial  
14 Institutions shall conduct research studies  
15 and evaluate the economic impacts of the  
16 Initiative.

17           “(D) PARTNERSHIPS.—

18           “(i) IN GENERAL.—Each partnership  
19 shall—

20           “(I) conduct periodic administra-  
21 tive and financial audits of projects  
22 funded by the Initiative; and

23           “(II) share with the national  
24 fund manager the results of the au-  
25 dits.

1                   “(ii) FAILURE OF PARTNERSHIP.—In  
2                   a case in which a partnership fails, the na-  
3                   tional fund manager shall take over the  
4                   portfolio of the failed partnership.

5           “(h) ADMINISTRATIVE PROVISIONS.—Not later than  
6 180 days after the date of enactment of this section, the  
7 Secretary shall promulgate such regulations as may be  
8 necessary to carry out this section, including regulations—

9                   “(1) for the conduct of a performance evalua-  
10                  tion at the end of the initial 5-year period;

11                  “(2) to terminate the contract for cause; and

12                  “(3) to extend the contract for an additional 5-  
13                  year period.

14           “(i) AUTHORIZATION OF APPROPRIATIONS.—There is  
15 authorized to be appropriated to the Secretary to carry  
16 out this section \$500,000,000, to remain available until  
17 expended.”.

18           (b) CONFORMING AMENDMENT.—Section 296(b) of  
19 the Department of Agriculture Reorganization Act of  
20 1994 (7 U.S.C. 7014(b)) is amended—

21                  (1) in paragraph (6)(C), by striking “or” at the  
22                  end;

23                  (2) in paragraph (7), by striking the period at  
24                  the end and inserting “; or”; and

25                  (3) by adding at the end the following:

1           “(8) the authority of the Secretary to establish  
2           in the Department the Healthy Food Financing Ini-  
3           tiative in accordance with section 242.”.

4 **SEC. 1007. GAO REPORT ON HEALTH EFFECTS OF DEEP-**  
5 **WATER HORIZON OIL RIG EXPLOSION IN THE**  
6 **GULF COAST.**

7           (a) STUDY.—The Comptroller General of the United  
8 States shall conduct a study on the type and scope of  
9 health care services administered through the Department  
10 of Health and Human Services addressing the provision  
11 of health care to racial and ethnic minorities (whether  
12 residents, clean-up workers, or volunteers) affected by the  
13 explosion of the mobile offshore drilling unit Deepwater  
14 Horizon that occurred on April 20, 2010.

15           (b) SPECIFIC COMPONENTS; REPORTING.—In car-  
16 rying out subsection (a), the Comptroller General shall—

17               (1) assess the type, size, and scope of programs  
18 administered by the Department of Health and  
19 Human Services that focus on provision of health  
20 care to communities in the Gulf Coast;

21               (2) identify the merits and disadvantages asso-  
22 ciated with each the programs;

23               (3) perform an analysis of the costs and bene-  
24 fits of the programs;

1           (4) determine whether there is any duplication  
2 of programs; and

3           (5) not later than 180 days after the date of  
4 the enactment of this Act, report findings and rec-  
5 ommendations for improving access to health care  
6 for racial and ethnic minorities to the Congress.

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