

114TH CONGRESS
2D SESSION

H. R. 5475

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

IN THE HOUSE OF REPRESENTATIVES

JUNE 14, 2016

Ms. KELLY of Illinois (for herself, Ms. MICHELLE LUJAN GRISHAM of New Mexico, Ms. LINDA T. SÁNCHEZ of California, Ms. LEE, Ms. JUDY CHU of California, Mr. PAYNE, and Mr. BUTTERFIELD) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Agriculture, Education and the Workforce, the Budget, the Judiciary, Veterans' Affairs, Armed Services, and Natural Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

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

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Health Equity and
5 Accountability Act of 2016”.

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

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

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1 **SEC. 3. FINDINGS.**

2 The Congress finds as follows:

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

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

20 (3) By 2020, the Nation will face a shortage of
21 health care providers and allied health workers and

1 this shortage disproportionately affects health pro-
2 fessional shortage areas where many racial and eth-
3 nic minority populations reside.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 “(a) **REQUIREMENTS.**—

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

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

8 “(i) using, at a minimum, the stand-
9 ards for data collection on race, ethnicity,
10 sex, primary language, sexual orientation,
11 disability status, gender identity, and so-
12 cioeconomic status developed under section
13 3101;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 “(c) NATIONAL PLAN OF THE DATA COUNCIL.—The
21 Secretary shall develop and implement a national plan to
22 ensure the collection of data in a culturally appropriate
23 and competent manner, to improve the collection, analysis,
24 and reporting of racial, ethnic, sex, primary language, sex-
25 ual orientation, disability status, gender identity, and so-

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

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

17 “(2) expand awareness among Federal agencies,
18 States, territories, Indian tribes, health providers,
19 health plans, health insurance issuers, and the gen-
20 eral public that data collection, analysis, and report-
21 ing by race, ethnicity, primary language, sexual ori-
22 entation, disability status, gender identity, and socio-
23 economic status is legal and necessary to assure eq-
24 uity and nondiscrimination in the quality of health
25 care services;

1 “(3) ensure that future patient record systems
2 have data code sets for racial, ethnic, primary lan-
3 guage, sexual orientation, disability status, gender
4 identity, and socioeconomic status identifiers and
5 that such identifiers can be retrieved from clinical
6 records, including records transmitted electronically;

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

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

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

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

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

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

8 “(2) TYPES OF ASSISTANCE.—Assistance pro-
9 vided under this subsection may include assistance
10 to—

11 “(A) enhance or upgrade computer tech-
12 nology that will facilitate racial, ethnic, primary
13 language, sexual orientation, disability status,
14 gender identity, and socioeconomic status data
15 collection and analysis;

16 “(B) improve methods for health data col-
17 lection and analysis, including additional popu-
18 lation groups if such groups can be aggregated
19 into the race and ethnicity categories outlined
20 by the standards developed under section 3101;

21 “(C) develop mechanisms for submitting
22 collected data subject to existing privacy and
23 confidentiality regulations; and

24 “(D) develop educational programs to in-
25 form health insurance issuers, health plans,

1 health providers, health-related agencies, and
2 the general public that data collection and re-
3 porting by race, ethnicity, primary language,
4 sexual orientation, disability status, gender
5 identity, and socioeconomic status are legal and
6 essential for eliminating health and health care
7 disparities.

8 “(f) ANALYSIS OF HEALTH DISPARITY DATA.—The
9 Secretary, acting through the Director of the Agency for
10 Healthcare Research and Quality and in coordination with
11 the Administrator of the Centers for Medicare & Medicaid
12 Services, shall provide technical assistance to agencies of
13 the Department of Health and Human Services in meeting
14 Federal standards for health disparity data collection and
15 for analysis of racial and ethnic disparities in health and
16 health care in public programs by—

17 “(1) identifying appropriate quality assurance
18 mechanisms to monitor for health disparities;

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

21 “(3) developing new quality measures relating
22 to racial and ethnic disparities and their overlap
23 with other disparity factors in health and health
24 care;

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

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

5 “(g) PRIMARY LANGUAGE.—References in this sec-
6 tion—

7 “(1) to primary language data, include spoken
8 and written primary language data; and

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

14 “(h) DEFINITION.—In this section, the term ‘health-
15 related program’ mean a program—

16 “(1) under the Social Security Act (42 U.S.C.
17 301 et seq.) that pays for health care and services;
18 and

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

23 “(i) 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 2017 through 2022.

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

4 “(a) ESTABLISHMENT OF EPIDEMIOLOGY CEN-
5 TERS.—The Secretary shall establish an epidemiology cen-
6 ter in each service area to carry out the functions de-
7 scribed in subsection (b). Any new center established after
8 the date of the enactment of the Health Equity and Ac-
9 countability Act of 2016 may be operated under a grant
10 authorized by subsection (d), but funding under such a
11 grant shall not be divisible.

12 “(b) FUNCTIONS OF CENTERS.—In consultation with
13 and upon the request of Indian tribes, tribal organizations,
14 and urban Indian organizations, each service area epide-
15 miology center established under this subsection shall,
16 with respect to such service area—

17 “(1) collect data relating to, and monitor
18 progress made toward meeting, each of the health
19 status objectives of the service, the Indian tribes,
20 tribal organizations, and urban Indian organizations
21 in the service area;

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

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

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

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

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

15 “(7) provide disease surveillance and assist In-
16 dian tribes, tribal organizations, and urban Indian
17 organizations to promote public health.

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

22 “(d) GRANTS FOR STUDIES.—

23 “(1) IN GENERAL.—The Secretary may make
24 grants to Indian tribes, tribal organizations, urban
25 Indian organizations, and eligible intertribal con-

1 sortia to conduct epidemiological studies of Indian
2 communities.

3 “(2) ELIGIBLE INTERTRIBAL CONSORTIA.—An
4 intertribal consortium is eligible to receive a grant
5 under this subsection if—

6 “(A) the intertribal consortium is incor-
7 porated for the primary purpose of improving
8 Indian health; and

9 “(B) the intertribal consortium is rep-
10 resentative of the Indian tribes or urban Indian
11 communities in which the intertribal consortium
12 is located.

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

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

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

23 “(B) consult and cooperate with providers
24 of related health and social services in order to
25 avoid duplication of existing services; and

1 “(C) demonstrate cooperation from Indian
2 tribes or urban Indian organizations in the area
3 to be served.

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

6 “(A) to carry out the functions described
7 in subsection (b);

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

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

17 “(e) ACCESS TO INFORMATION.—An epidemiology
18 center operated by a grantee pursuant to a grant awarded
19 under subsection (d) shall be treated as a public health
20 authority for purposes of the Health Insurance Portability
21 and Accountability Act of 1996 (Public Law 104–191; 110
22 Stat. 2033), as such entities are defined in part 164.501
23 of title 45, Code of Federal Regulations (or a successor
24 regulation). The Secretary shall grant such grantees ac-
25 cess to and use of data, data sets, monitoring systems,

1 delivery systems, and other protected health information
2 in the possession of the Secretary.”.

3 **SEC. 102. ELIMINATION OF PREREQUISITE OF DIRECT AP-**
4 **PROPRIATIONS FOR DATA COLLECTION AND**
5 **ANALYSIS.**

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

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

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

11 **SEC. 103. COLLECTION OF RACE AND ETHNICITY DATA BY**
12 **THE SOCIAL SECURITY ADMINISTRATION.**

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

16 “COLLECTION OF RACE AND ETHNICITY DATA BY THE
17 SOCIAL SECURITY ADMINISTRATION

18 “SEC. 1150C. (a) REQUIREMENT.—The Commis-
19 sioner of Social Security, in consultation with the Admin-
20 istrator of the Centers for Medicare & Medicaid Services,
21 shall—

22 “(1) require the collection of data on the race,
23 ethnicity, primary language, and disability status of
24 all applicants for Social Security account numbers or
25 benefits under title II or part A of title XVIII and
26 all individuals with respect to whom the Commis-

1 sioner maintains records of wages and self-employ-
2 ment income in accordance with reports received by
3 the Commissioner or the Secretary of the Treas-
4 ury—

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

9 “(B) where practicable, collecting data for
10 additional population groups if such groups can
11 be aggregated into the race and ethnicity cat-
12 egories outlined by the standards developed
13 under section 3101 of the Public Health Service
14 Act; and

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

21 “(2) with respect to the collection of the data
22 described in paragraph (1) for applicants who are
23 under 18 years of age or otherwise legally incapaci-
24 tated, 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 2017 through 2022.”.

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 “2022”;

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

13 (3) in paragraph (3), by striking “2002” and
14 inserting “2022”.

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 2017 through 2022.”.

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 PRIMARY LANGUAGE DATA**
4 **COLLECTED 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 primary language data during the pre-
10 ceding calendar year shall submit such data to the Sec-
11 retary of Health and Human Services.

12 (b) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—
13 Not later than April 30, 2017, 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 primary language data submitted under subsection
20 (a) for 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. 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. 112. 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 505E the following:

20 **“SEC. 505F. 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 “(dd) 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 505F.”.

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 505F”.

18 **SEC. 113. IMPROVING HEALTH DATA REGARDING NATIVE**

19 **HAWAIIANS AND OTHER PACIFIC ISLANDERS.**

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

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

24 **LANDER HEALTH DATA.**

25 “(a) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

12 “(b) NATIONAL STRATEGY.—

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

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

3 “(2) CONSULTATION.—In developing and imple-
4 menting a national strategy, as described in para-
5 graph (1), not later than 180 days after the date of
6 enactment of the Health Equity and Accountability
7 Act of 2016, the Secretary—

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

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

15 “(c) PRELIMINARY HEALTH SURVEY.—

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

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

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

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

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

16 “(4) TIMEFRAME.—The survey required under
17 this subsection shall be completed not later than 18
18 months after the date of enactment of the Health
19 Equity and Accountability Act of 2016.

20 “(d) PROGRESS REPORT.—Not later than 2 years
21 after the date of enactment of the Health Equity and Ac-
22 countability Act of 2016, the Secretary shall submit to
23 Congress a progress report, which shall include the na-
24 tional strategy described in subsection (b)(1).

25 “(e) STUDY AND REPORT BY THE IOM.—

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

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

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

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

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

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

1 later than 2 years after the date of the enactment
2 of the Health Equity and Accountability Act of
3 2016, a report containing a description of the results
4 of the study conducted under paragraph (1), includ-
5 ing the conclusions and recommendations of the In-
6 stitute of Medicine for each of the items described
7 in subparagraphs (A) through (D) of such para-
8 graph.

9 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
10 carry out this section, there are authorized to be appro-
11 priated such sums as may be necessary for fiscal years
12 2017 through 2022.”.

13 **SEC. 114. CLARIFICATION OF SIMPLIFIED ADMINISTRATIVE**
14 **REPORTING REQUIREMENT.**

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

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

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

4 **SEC. 201. DEFINITIONS.**

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

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

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

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

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

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

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

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

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

24 (7) All members of the health care and health-
25 care-related-services community should continue to

1 educate their staff and constituents about limited-
 2 English-proficient and disability communication
 3 issues and help them identify resources to improve
 4 access to quality care for limited-English-proficient
 5 individuals and individuals with communication dis-
 6 abilities such as hearing, vision, or print impair-
 7 ments.

8 (8) Access to English as a second language and
 9 sign language instructions is an important mecha-
 10 nism for ensuring effective communication and elimi-
 11 nating the language barriers that impede access to
 12 health care.

13 (9) Competent language services in health care
 14 settings should be available as a matter of course.

15 (b) AMENDMENT.—The Public Health Service Act
 16 (42 U.S.C. 201 et seq.) is amended by adding at the end
 17 the following:

18 **“TITLE XXXIV—CULTURALLY**
 19 **AND LINGUISTICALLY APPRO-**
 20 **PRIATE HEALTH CARE**

21 **“SEC. 3400. DEFINITIONS.**

22 “In this title:

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

1 “(2) COMMUNITY HEALTH WORKER.—The term
2 ‘community health worker’ includes a community
3 health advocate, a lay health educator, a community
4 health representative, a peer health promoter, a
5 community health outreach worker, and in Spanish,
6 promotores de salud.

7 “(3) COMPETENT INTERPRETER SERVICES.—
8 The term ‘competent interpreter services’ means a
9 translanguage rendition of a spoken or signed mes-
10 sage in which the interpreter—

11 “(A) comprehends the source language and
12 can communicate comprehensively in the target
13 language to convey the meaning intended in the
14 source language; and

15 “(B) knows health and health-related ter-
16 minology and provides accurate interpretations
17 by choosing equivalent expressions that convey
18 the best matching and meaning to the source
19 language and capture, to the greatest possible
20 extent, all nuances intended in the source mes-
21 sage.

22 “(4) COMPETENT TRANSLATION SERVICES.—
23 The term ‘competent translation services’ means a
24 translanguage rendition of a written document in
25 which the translator—

1 “(A) comprehends the source language and
2 can write or sign comprehensively in the target
3 language to convey the meaning intended in the
4 source language; and

5 “(B) knows health and health-related ter-
6 minology and provides accurate translations by
7 choosing equivalent expressions that convey the
8 best matching and meaning to the source lan-
9 guage and capture, to the greatest possible ex-
10 tent, all nuances intended in the source docu-
11 ment.

12 “(5) CULTURAL COMPETENCE.—The term ‘cul-
13 tural competence’ means a set of congruent behav-
14 iors, attitudes, and policies that come together in a
15 system, agency, or among professionals that enables
16 effective work in cross-cultural situations. In the
17 preceding sentence—

18 “(A) the term ‘cultural’ refers to inte-
19 grated patterns of human behavior that include
20 the language, thoughts, communications, ac-
21 tions, customs, beliefs, values, and institutions
22 of racial, ethnic, religious, or social groups, in-
23 cluding lesbian, gay, bisexual, transgender,
24 queer, and questioning individuals, and individ-
25 uals with physical and mental disabilities; and

1 “(B) the term ‘competence’ implies having
2 the capacity to function effectively as an indi-
3 vidual and an organization within the context of
4 the cultural beliefs, behaviors, and needs pre-
5 sented by consumers and their communities.

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

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

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

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

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

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

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

21 “(12) INTEGRATED HEALTH CARE DELIVERY
22 SYSTEM.—The term ‘integrated health care delivery
23 system’ means an interdisciplinary system that
24 brings together providers from the primary health,
25 mental health, substance use and related disciplines

1 to improve the health outcomes of an individual.
2 Providers may include but are not limited to hos-
3 pitals, health, mental health or substance use clinics
4 and providers, home health agencies, ambulatory
5 surgery centers, skilled nursing facilities, rehabilita-
6 tion centers, and employed, independent, or con-
7 tracted physicians.

8 “(13) INTERPRETING/INTERPRETATION.—The
9 terms ‘interpreting’ and ‘interpretation’ mean the
10 transmission of a spoken, written, or signed message
11 from one language or format into another, faithfully,
12 accurately, and objectively.

13 “(14) LANGUAGE ACCESS.—The term ‘language
14 access’ means the provision of language services to
15 an LEP individual or individual with communication
16 disabilities designed to enhance that individual’s ac-
17 cess to, understanding of, or benefit from health
18 care or health-care-related services.

19 “(15) LANGUAGE OR LANGUAGE ACCESS SERV-
20 ICES.—The term ‘language or language access serv-
21 ices’ means provision of health care services directly
22 in a non-English language, interpretation, trans-
23 lation, signage, video recording, and English or non-
24 English alternative formats.

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

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

7 “(18) MINORITY.—

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

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

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

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

24 “(21) ONSITE INTERPRETATION.—The term
25 ‘onsite interpretation’ means a method of inter-

1 preting or interpretation for which the interpreter is
2 in the physical presence of the provider of health
3 care or health-care-related services and the recipient
4 of such services who is limited in English proficiency
5 or has a communication impairment such as hear-
6 ing, vision, or learning.

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

9 “(23) SIGHT TRANSLATION.—The term ‘sight
10 translation’ means the transmission of a written
11 message in one language into a spoken or signed
12 message in another language, or an alternative for-
13 mat in English or another language.

14 “(24) STATE.—The term ‘State’ means each of
15 the several States, the District of Columbia, the
16 Commonwealth of Puerto Rico, the Indian tribes,
17 the United States Virgin Islands, Guam, American
18 Samoa, and the Commonwealth of the Northern
19 Mariana Islands.

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

1 English-proficient recipient of such services but is
2 connected via telephone.

3 “(26) TRANSLATION.—The term ‘translation’
4 means the transmission of a written message in one
5 language into a written or signed message in an-
6 other language, and includes translation into an-
7 other language or alternative format, such as large
8 print font, Braille, audio recording, or CD.

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

17 “(28) VITAL DOCUMENT.—The term ‘vital doc-
18 ument’ includes but is not limited to applications for
19 government programs that provide health care serv-
20 ices, medical or financial consent forms, financial as-
21 sistance documents, letters containing important in-
22 formation regarding patient instructions (such as
23 prescriptions, referrals to other providers, and dis-
24 charge plans) and participation in a program (such
25 as a Medicaid managed care program), notices per-

1 taining to the reduction, denial, or termination of
2 services or benefits, notices of the right to appeal
3 such actions, and notices advising limited-English-
4 proficient individuals and individuals with commu-
5 nication disabilities of the availability of free lan-
6 guage services, alternative formats, and other out-
7 reach materials.

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

10 “(a) PURPOSE.—As provided in Executive Order
11 13166, it is the purpose of this section—

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

16 “(2) to require each Federal agency to examine
17 the services it provides and develop and implement
18 a system by which limited-English-proficient individ-
19 uals can obtain cultural competence and meaningful
20 access to those services consistent with, and without
21 substantially burdening, the fundamental mission of
22 the agency;

23 “(3) to require each Federal agency to ensure
24 that recipients of Federal financial assistance pro-
25 vide cultural competence and meaningful access to

1 their limited-English-proficient applicants and bene-
2 ficiaries;

3 “(4) to ensure that recipients of Federal finan-
4 cial assistance take reasonable steps, consistent with
5 the guidelines set forth in the Limited English Pro-
6 ficient Guidance of the Department of Justice (as
7 issued on June 12, 2002), to ensure cultural com-
8 petence and meaningful access to their programs
9 and activities by limited-English-proficient individ-
10 uals; and

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

15 “(b) **FEDERALLY CONDUCTED PROGRAMS AND AC-**
16 **TIVITIES.—**

17 “(1) **IN GENERAL.—**Not later than 120 days
18 after the date of enactment of this title, each Fed-
19 eral agency that carries out health-care-related ac-
20 tivities shall prepare a plan to improve access cul-
21 tural competence to the federally conducted, health-
22 care-related programs and activities of the agency by
23 limited-English-proficient individuals. Not later than
24 one year after the date of enactment of this title,

1 each such Federal agency shall ensure that such
2 plan is fully implemented.

3 “(2) PLAN REQUIREMENT.—Each plan under
4 paragraph (1) shall include—

5 “(A) the steps the agency will take to en-
6 sure that limited-English-proficient individuals
7 have access to the agency’s federally conducted
8 health care and health-care-related programs
9 and activities;

10 “(B) the policies and procedures for identi-
11 fying, assessing, and meeting the language
12 needs and cultural competence needs of its lim-
13 ited-English-proficient beneficiaries served by
14 federally conducted programs and activities;

15 “(C) the steps the agency will take for its
16 federally conducted programs and activities to
17 improve cultural competence to provide a range
18 of language assistance options, notice to lim-
19 ited-English-proficient individuals of the right
20 to competent language services, periodic train-
21 ing of staff, monitoring and quality assessment
22 of the language services and, in appropriate cir-
23 cumstances, the translation of written mate-
24 rials;

1 “(D) the steps the agency will take to en-
2 sure that applications, forms, and other rel-
3 evant documents for its federally conducted pro-
4 grams and activities are competently translated
5 into the primary language of a limited-English-
6 proficient client where such materials are need-
7 ed to improve access to federally conducted and
8 federally assisted programs and activities for
9 such a limited-English-proficient individual;

10 “(E) the resources the agency will provide
11 to improve cultural competence to assist recipi-
12 ents of Federal funds to improve access to
13 health care or health-care-related programs and
14 activities for limited-English-proficient individ-
15 uals;

16 “(F) the resources the agency will provide
17 to ensure that competent language assistance is
18 provided to limited-English-proficient patients
19 by interpreters or trained bilingual staff; and

20 “(G) the resources the agency will provide
21 to ensure that family, particularly minor chil-
22 dren, and friends are not used to provide inter-
23 pretation services, except—

24 “(i) in the case of a medical emer-
25 gency where delay directly associated with

1 obtaining a competent interpreter would
2 jeopardize the health of the patient; or

3 “(ii) on request of the patient, who
4 has been informed in his or her preferred
5 language of the availability of free inter-
6 pretation services, if the health care serv-
7 ices provider has determined that the fam-
8 ily or friend can provide competent inter-
9 preter services as defined in section 3400.

10 “(3) SUBMISSION OF PLAN TO DOJ.—Each
11 agency that is required to prepare a plan under
12 paragraph (1) shall send a copy of such plan to the
13 Department of Justice, which shall serve as the cen-
14 tral repository of such plans.

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

21 “(c) FEDERALLY ASSISTED PROGRAMS AND ACTIVI-
22 TIES.—

23 “(1) IN GENERAL.—Not later than 120 days
24 after the date of enactment of this title, each Fed-
25 eral agency providing health-care-related Federal fi-

1 nancial assistance shall ensure that the guidance for
2 recipients of Federal financial assistance developed
3 by the agency to ensure compliance with title VI of
4 the Civil Rights Act of 1964 (42 U.S.C. 2000d et
5 seq.) is specifically tailored to the recipients of such
6 assistance. Each agency shall send a copy of such
7 guidance to the Department of Justice which shall
8 serve as the central repository of the agency’s plans.
9 After approval by the Department of Justice, each
10 agency shall publish its guidance document in the
11 Federal Register for public comment.

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

18 “(3) EXISTING GUIDANCES.—A Federal agency
19 that has developed a guidance for purposes of title
20 VI of the Civil Rights Act of 1964 shall examine
21 such existing guidance, as well as the programs and
22 activities to which such guidance applies, to deter-
23 mine if modification of such guidance is necessary to
24 comply with this subsection.

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

4 “(d) CONSULTATIONS.—

5 “(1) IN GENERAL.—In carrying out this sec-
6 tion, each Federal agency that carries out health
7 care and health-care-related activities shall ensure
8 that stakeholders, such as limited-English-proficient
9 individuals and their representative organizations,
10 recipients of Federal assistance, and other appro-
11 priate individuals or entities, have an adequate op-
12 portunity to provide input with respect to the actions
13 of the agency.

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

16 “(A) particular needs of the limited-
17 English-proficient individuals served by the
18 agency;

19 “(B) particular needs of the limited-
20 English-proficient individuals served by the
21 agency’s recipients of Federal financial assist-
22 ance; and

23 “(C) burdens of compliance with the agen-
24 cy guidance and this section for the agency and
25 its recipients.

1 **“SEC. 3402. NATIONAL STANDARDS FOR CULTURALLY AND**
2 **LINGUISTICALLY APPROPRIATE SERVICES IN**
3 **HEALTH CARE.**

4 “(a) **APPLICABILITY.**—This section applies to any
5 health program or activity, any part of which is receiving
6 Federal financial assistance, including credits, subsidies,
7 or contracts of insurance, or any program or activity that
8 is administered by an executive agency or any entity estab-
9 lished under title I of the Patient Protection and Afford-
10 able Care Act (or amendments made thereby), as such
11 programs, activities, agencies, and entities are described
12 in section 1557(a) of the Patient Protection and Afford-
13 able Care Act.

14 “(b) **STANDARDS.**—The programs, activities, agen-
15 cies, and entities described in subsection (a) shall—

16 “(1) implement strategies to recruit, retain, and
17 promote individuals at all levels to maintain a di-
18 verse staff and leadership that can provide culturally
19 and linguistically appropriate health care to patient
20 populations of the service area of the programs, ac-
21 tivities, agencies, and entities;

22 “(2) educate and train governance, leadership,
23 and workforce at all levels and across all disciplines
24 of the programs, activities, agencies, and entities in
25 culturally and linguistically appropriate policies and
26 practices on an ongoing basis;

1 “(3) offer and provide language assistance, in-
2 cluding trained bilingual staff and interpreter serv-
3 ices, to individuals who have limited-English pro-
4 ficiency or other communication needs, at no cost to
5 them at all points of contact, and during all hours
6 of operation, to facilitate timely access to all health
7 care and services;

8 “(4) notify patients, in a culturally appropriate
9 manner, of their right to receive language assistance
10 services in their primary language, verbally and in
11 writing;

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

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

18 “(B) except on request of the patient, who
19 has been informed in his or her preferred lan-
20 guage of the availability of free interpretation
21 services if the health care services provider has
22 determined that the family or friend can pro-
23 vide competent interpreter services as defined in
24 section 3400;

1 “(6) for each eligible LEP language group that
2 constitutes 5 percent or 500 individuals, whichever
3 is less, of the population of persons eligible to be
4 served or likely to be affected or encountered in the
5 service area of the organization, make available—

6 “(A) easily understood patient-related ma-
7 terials, including print and multimedia mate-
8 rials;

9 “(B) information or notices about termi-
10 nation of benefits; and

11 “(C) signage;

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 and in-
16 fuse them throughout the organization’s planning
17 and operations;

18 “(8) conduct initial and ongoing organizational
19 assessments of culturally and linguistically appro-
20 priate services-related activities and integrate valid
21 linguistic, competence-related National Standards
22 for Culturally and Linguistically Appropriate Serv-
23 ices (CLAS) measures into the internal audits, per-
24 formance improvement programs, patient satisfac-
25 tion assessments, continuous quality improvement

1 activities, and outcomes-based evaluations of the or-
2 ganization and develop ways to standardize the as-
3 sessments;

4 “(9) ensure that, consistent with the privacy
5 protections provided for under the regulations pro-
6 mulgated under section 264(c) of the Health Insur-
7 ance Portability and Accountability Act of 1996,
8 data on an individual required to be collected pursu-
9 ant to section 3101, including the individual’s alter-
10 native format preferences and policy modification
11 needs, are—

12 “(A) collected in health records;

13 “(B) integrated into the organization’s
14 management information systems; and

15 “(C) periodically updated;

16 “(10) maintain a current demographic, cultural,
17 and epidemiological profile of the community, con-
18 duct regular assessments of community health assets
19 and needs, and use the results to accurately plan for
20 and implement services that respond to the cultural
21 and linguistic characteristics of the service area of
22 the organization;

23 “(11) develop participatory, collaborative part-
24 nerships with communities and utilize a variety of
25 formal and informal mechanisms to facilitate com-

1 community and patient involvement in designing, imple-
2 menting, and evaluating policies and practices to en-
3 sure culturally and linguistically appropriate service-
4 related activities;

5 “(12) ensure that conflict and grievance resolu-
6 tion processes are culturally and linguistically sen-
7 sitive and capable of identifying, preventing, and re-
8 solving cross-cultural conflicts or complaints by pa-
9 tients;

10 “(13) regularly make available to the public in-
11 formation about their progress and successful inno-
12 vations in implementing the standards under this
13 section and provide public notice in their commu-
14 nities about the availability of this information; and

15 “(14) if requested, regularly make available to
16 the head of each Federal entity from which Federal
17 funds are received, information about their progress
18 and successful innovations in implementing the
19 standards under this section as required by the head
20 of such entity.

21 **“SEC. 3403. ROBERT T. MATSUI CENTER FOR CULTURAL**
22 **AND LINGUISTIC COMPETENCE IN HEALTH**
23 **CARE.**

24 “(a) ESTABLISHMENT.—The Secretary, acting
25 through the Director of the Agency for Healthcare Re-

1 search and Quality, shall establish and support a center
2 to be known as the ‘Robert T. Matsui Center for Cultural
3 and Linguistic Competence in Health Care’ (referred to
4 in this section as the ‘Center’) to carry out the following
5 activities:

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

10 “(2) TRANSLATION OF WRITTEN MATERIAL.—

11 “(A) The Center shall provide, directly or
12 through contract, vital documents from com-
13 petent translation services for providers of
14 health care and health-care-related services at
15 no cost to such providers. Materials may be
16 submitted for translation into non-English lan-
17 guages. Translation services shall be provided
18 in a timely and reasonable manner. The quality
19 of such translation services shall be monitored
20 and reported publicly.

21 “(B) For each form developed or revised
22 by the Secretary that will be used by LEP indi-
23 viduals in health care or health-care-related set-
24 tings, the Center shall translate the form, at a
25 minimum, into the top 15 non-English lan-

1 guages in the United States according to the
2 most recent data from the American Commu-
3 nity Survey or its replacement. The translation
4 must be completed within 45 days of the Sec-
5 retary receiving final approval of the form from
6 the Office of Management and Budget.

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

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

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

17 “(C) to learn how to access language serv-
18 ices.

19 “(4) HEALTH INFORMATION CLEARING-
20 HOUSE.—

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

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

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

18 “(i) Administrative and legal docu-
19 ments, including—

20 “(I) intake forms;

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

24 “(III) forms informing patient of
25 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.—In 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) AVAILABILITY OF LANGUAGE ACCESS.—The Di-
8 rector shall collaborate with the Deputy Assistant Sec-
9 retary for Minority Health, the Administrator of the Cen-
10 ters for Medicare & Medicaid Services, and the Adminis-
11 trator of the Health Resources and Services Administra-
12 tion to notify health care providers and health care organi-
13 zations about the availability of language access services
14 by the Center.

15 “(d) EDUCATION.—The Secretary, directly or
16 through contract, shall undertake a national education
17 campaign to inform providers, LEP individuals, health
18 professionals, graduate schools, and community health
19 centers about—

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

22 “(2) the value of using trained interpreters and
23 the risks associated with using family members,
24 friends, minors, and untrained bilingual staff;

1 “(3) funding sources for developing and imple-
2 menting language services; and

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

5 “(e) AUTHORIZATION OF APPROPRIATIONS.—In ad-
6 dition to the amounts authorized under subsection
7 (e)(8)(F), there are authorized to be appropriated to carry
8 out this section such sums as may be necessary for each
9 of fiscal years 2017 through 2021.

10 **“SEC. 3404. INNOVATIONS IN CULTURAL AND LINGUISTIC**
11 **COMPETENCE GRANTS.**

12 “(a) IN GENERAL.—The Secretary, acting through
13 the Director of the Agency for Healthcare Research and
14 Quality, shall award grants to eligible entities to enable
15 such entities to design, implement, and evaluate innova-
16 tive, cost-effective programs to improve cultural com-
17 petence and language access in health care for individuals
18 with limited-English proficiency. The Director of the
19 Agency for Healthcare Research and Quality shall coordi-
20 nate with, and ensure the participation of, other agencies
21 including the Health Resources and Services Administra-
22 tion, the Center on Minority Health and Health Dispari-
23 ties at the National Institutes of Health, and the Office
24 of Minority Health, regarding the design and evaluation
25 of the grants program.

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

3 “(1) be—

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

6 “(B) an organization described in section
7 501(c)(3) of the Internal Revenue Code of 1986
8 and exempt from tax under section 501(a) of
9 such Code;

10 “(C) a community health, mental health,
11 or substance use center or clinic;

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

13 “(E) an integrated health care delivery
14 system;

15 “(F) a public hospital;

16 “(G) a health care group, university, or
17 college; or

18 “(H) other entity designated by the Sec-
19 retary; and

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

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

1 “(1) develop, implement, and evaluate models of
2 providing competent interpretation services through
3 onsite interpretation, telephonic interpretation, or
4 video interpretation;

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

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

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

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

21 “(6) develop and implement grievance resolu-
22 tion processes that are culturally and linguistically
23 sensitive and capable of identifying, preventing, and
24 resolving complaints by LEP individuals;

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

5 “(8) develop formal training programs, includ-
6 ing continued professional development and edu-
7 cation programs as well as supervision, for individ-
8 uals interested in becoming dedicated health care in-
9 terpreters and culturally competent providers;

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

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

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

18 “(12) develop, implement, and evaluate models
19 of improving cultural competence, including cultural
20 competence programs for community health workers;
21 and

22 “(13) ensure that, consistent with the privacy
23 protections provided for under the regulations pro-
24 mulgated under section 264(c) of the Health Insur-
25 ance Portability and Accountability Act of 1996 (42

1 U.S.C. 1320d–2 note) and any applicable State pri-
2 vacy laws, data on the individual patient or recipi-
3 ent’s race, ethnicity, and primary language are col-
4 lected (and periodically updated) in health records
5 and integrated into the organization’s information
6 management systems or any similar system used to
7 store and retrieve data.

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

13 “(e) EVALUATION.—

14 “(1) BY GRANTEES.—An entity that receives a
15 grant under this section shall submit to the Sec-
16 retary an evaluation that describes, in the manner
17 and to the extent required by the Secretary, the ac-
18 tivities carried out with funds received under the
19 grant, and how such activities improved access to
20 health and health-care-related services and the qual-
21 ity of health care for individuals with limited-English
22 proficiency. Such evaluation shall be collected and
23 disseminated through the Robert T. Matsui Center
24 for Cultural and Linguistic Competence in Health
25 Care established under section 3403. The Director

1 of the Agency for Healthcare Research and Quality
2 shall notify grantees of the availability of technical
3 assistance for the evaluation and provide such assist-
4 ance upon request.

5 “(2) BY SECRETARY.—The Director of the
6 Agency for Healthcare Research and Quality shall
7 evaluate or arrange with other individuals or organi-
8 zations to evaluate projects funded under this sec-
9 tion.

10 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
11 is authorized to be appropriated to carry out this section,
12 \$5,000,000 for each of fiscal years 2017 through 2021.

13 **“SEC. 3405. RESEARCH ON CULTURAL AND LANGUAGE COM-
14 PETENCE.**

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

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

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

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

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

7 “(3) To identify optimal approaches for deliv-
8 ering language access.

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

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

17 “(B) the development and implementation
18 of data collection and reporting systems; and

19 “(C) effective privacy safeguards for col-
20 lected data.

21 “(5) To develop a minimum data collection set
22 for primary language.

23 “(6) To evaluate the most effective ways in
24 which the Department can create or coordinate, and
25 then subsidize or otherwise fund telephonic interpre-

1 tation providers for health care providers, taking
2 into consideration, among other factors, the flexi-
3 bility necessary for such a system to accommodate
4 variations in—

5 “(A) provider type;

6 “(B) languages needed and their frequency
7 of use;

8 “(C) type of encounter;

9 “(D) time of encounter, including regular
10 business hours and after hours; and

11 “(E) location of encounter.

12 “(d) 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 2017 through 2021.”.

16 **SEC. 203. PILOT PROGRAM FOR IMPROVEMENT AND DE-**
17 **VELOPMENT OF STATE MEDICAL INTER-**
18 **PRETING SERVICES.**

19 (a) GRANTS AUTHORIZED.—The Secretary shall
20 award one grant in accordance with this section to each
21 of three States to assist each such State in designing, im-
22 plementing, and evaluating a statewide program to provide
23 onsite interpreter services under Medicaid.

1 (b) GRANT PERIOD.—A grant awarded under this
2 section is authorized for a period of three fiscal years be-
3 ginning on October 1, 2016.

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

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

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

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

13 (4) that has a population of qualified LEP en-
14 rollees that is linguistically diverse, requiring inter-
15 preter services in at least 200 non-English lan-
16 guages.

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

19 (1) ensure that all health care providers in the
20 State participating in the State plan under Medicaid
21 have access to onsite interpreter services, for the
22 purpose of enabling effective communication between
23 such providers and qualified LEP enrollees during
24 the furnishing of items and services and administra-
25 tive interactions;

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

2 (A) a statewide health care information
3 technology system that is designed to achieve
4 efficiencies and economies of scale with respect
5 to onsite interpreter services provided to health
6 care providers in the State participating in the
7 State plan under Medicaid; and

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

10 (i) procuring and scheduling inter-
11 preter services for qualified LEP enrollees;

12 (ii) procuring and scheduling inter-
13 preter services for LEP individuals seeking
14 to enroll in the State plan under Medicaid;

15 (iii) ensuring that interpreters receive
16 payment for interpreter services rendered
17 under the system; and

18 (iv) consulting regularly with organi-
19 zations representing consumers, inter-
20 preters, and health care providers; and

21 (3) develop mechanisms to establish, improve,
22 and strengthen the competency of the medical inter-
23 pretation workforce that serves qualified LEP enroll-
24 ees in the State, including a national certification
25 process that is valid, credible, and vendor-neutral.

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

5 (1) A description of the language access needs
6 of individuals in the State enrolled in the State plan
7 under Medicaid.

8 (2) A description of the extent to which the
9 program will—

10 (A) use the grant funds for the purposes
11 described in subsection (d);

12 (B) meet the health care needs of rural
13 populations of the State; and

14 (C) collect information that accurately
15 tracks the language services requested by con-
16 sumers as compared to the language services
17 provided by health care providers in the State
18 participating in the State plan under Medicaid.

19 (3) A description of how the program will be
20 evaluated, including a proposal for collaboration with
21 organizations representing interpreters, consumers,
22 and LEP individuals.

23 (f) DEFINITIONS.—In this section:

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

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

2 (B) who is enrolled in a State plan under
3 Medicaid.

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

8 (3) UNITED STATES.—The term “United
9 States” has the meaning given the term in section
10 1101(a)(2) of the Social Security Act (42 U.S.C.
11 1301(a)(2)), for purposes of title XIX of such Act.

12 (g) FUNDING.—

13 (1) AUTHORIZATION OF APPROPRIATIONS.—
14 There is authorized to be appropriated \$5,000,000
15 to carry out this section.

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

19 (3) INCREASED FEDERAL FINANCIAL PARTICI-
20 PATION.—Section 1903(a)(2)(E) of the Social Secu-
21 rity Act (42 U.S.C. 1396b(a)(2)(E)), as amended by
22 section 205(d)(1) of this Act, is further amended by
23 inserting “(or, in the case of a State receiving a
24 grant under section 203 of the Health Equity and
25 Accountability Act of 2016, 100 percent for each

1 quarter occurring during the grant period)” after
2 “90 percent”.

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

6 **SEC. 204. TRAINING TOMORROW'S DOCTORS FOR CUL-**
7 **TURALLY AND LINGUISTICALLY APPRO-**
8 **PRIATE CARE: GRADUATE MEDICAL EDU-**
9 **CATION.**

10 (a) DIRECT GRADUATE MEDICAL EDUCATION.—Sec-
11 tion 1886(h)(4) of the Social Security Act (42 U.S.C.
12 1395ww(h)(4)) is amended by adding at the end the fol-
13 lowing new subparagraph:

14 “(L) TREATMENT OF CULTURALLY COM-
15 PETENCY TRAINING.—In determining a hos-
16 pital’s number of full-time equivalent residents
17 for purposes of this subsection, all the time that
18 is spent by an intern or resident in an approved
19 medical residency training program for edu-
20 cation and training in cultural competency and
21 linguistically appropriate service delivery shall
22 be counted toward the determination of full-
23 time equivalency.”.

1 (b) INDIRECT MEDICAL EDUCATION.—Section
2 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
3 1395ww(d)(5)(B)) is amended—

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

7 (2) by adding at the end the following new
8 clause:

9 “(xii) The provisions of subparagraph (L) of
10 subsection (h)(4) shall apply under this subpara-
11 graph in the same manner as they apply under such
12 subsection.”.

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

17 **SEC. 205. FEDERAL REIMBURSEMENT FOR CULTURALLY**
18 **AND LINGUISTICALLY APPROPRIATE SERV-**
19 **ICES UNDER THE MEDICARE, MEDICAID, AND**
20 **STATE CHILDREN’S HEALTH INSURANCE**
21 **PROGRAMS.**

22 (a) LANGUAGE ACCESS GRANTS FOR MEDICARE
23 PROVIDERS.—

24 (1) ESTABLISHMENT.—

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

14 (B) APPLICATION OF INNOVATION
15 RULES.—The demonstration project under sub-
16 paragraph (A) shall be conducted in a manner
17 that is consistent with the applicable provisions
18 of subsections (b), (c), and (d) of section 1115A
19 of the Social Security Act (42 U.S.C. 1315a).

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

23 (D) GRANT PERIOD.—Except as provided
24 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 English learners, is disproportionately under-
23 served.

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 organi-
2 zations, State agencies, and local agencies,
3 that has experience in providing language serv-
4 ices.

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

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

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

16 (i) interpreter and translation services
17 that—

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

20 (aa) if the grantee operates
21 in a State that has statewide
22 health care interpreter standards,
23 meet the State standards cur-
24 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) onsite 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, with re-
22 spect to interpreter and translation services and
23 a grantee—

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

1 (I) such beneficiary has been in-
2 formed, in the beneficiary's primary
3 language, of the availability of free in-
4 terpreter and translation services and
5 the beneficiary instead requests that a
6 family member, friend, or other per-
7 son provide such services; and

8 (II) the grantee documents such
9 request in the beneficiary's medical
10 record; or

11 (ii) in the case of a medical emergency
12 where the delay directly associated with ob-
13 taining a competent interpreter or trans-
14 lation services would jeopardize the health
15 of the patient.

16 Clause (ii) shall not be construed to exempt
17 emergency rooms or similar entities that regu-
18 larly provide health care services in medical
19 emergencies to patients who are English learn-
20 ers from any applicable legal or regulatory re-
21 quirements related to providing competent in-
22 terpreter and translation services without undue
23 delay.

24 (D) MEDICARE ADVANTAGE ORGANIZA-
25 TIONS AND PDP SPONSORS.—If a grantee is a

1 Medicare Advantage organization offering a
2 Medicare Advantage plan under part C of title
3 XVIII of the Social Security Act or a PDP
4 sponsor offering a prescription drug plan under
5 part D of such title, such entity must provide
6 at least 50 percent of the grant funds that the
7 entity receives under this subsection directly to
8 the entity's network providers (including all
9 health providers and pharmacists) for the pur-
10 pose of providing support for such providers to
11 provide competent language services to Medi-
12 care beneficiaries who are English learners.

13 (E) ADMINISTRATIVE AND REPORTING
14 COSTS.—A grantee may use up to 10 percent of
15 the grant funds to pay for administrative costs
16 associated with the provision of competent lan-
17 guage services and for reporting required under
18 paragraph (9).

19 (6) DETERMINATION OF AMOUNT OF GRANT
20 PAYMENTS.—

21 (A) IN GENERAL.—Payments to grantees
22 under this subsection shall be calculated based
23 on the estimated numbers of Medicare bene-
24 ficiaries who are English learners in a grantee's
25 service area utilizing—

1 (i) data on the numbers of English
2 learners who speak English less than “very
3 well” from the most recently available data
4 from the Bureau of the Census or other
5 State-based study the Secretary determines
6 likely to yield accurate data regarding the
7 number of such individuals in such service
8 area; or

9 (ii) data provided by the grantee, if
10 the grantee routinely collects data on the
11 primary language of the Medicare bene-
12 ficiaries that the grantee serves and the
13 Secretary determines that the data is accu-
14 rate and shows a greater number of
15 English learners than would be estimated
16 using the data under clause (i).

17 (B) DISCRETION OF SECRETARY.—Subject
18 to subparagraph (C), the amount of payment
19 made to a grantee under this subsection may be
20 modified annually at the discretion of the Sec-
21 retary, based on changes in the data under sub-
22 paragraph (A) with respect to the service area
23 of a grantee for the year.

24 (C) LIMITATION ON AMOUNT.—The
25 amount of a grant made under this subsection

1 to a grantee may not exceed \$500,000 for the
2 period under paragraph (1)(D).

3 (7) ASSURANCES.—Grantees under this sub-
4 section shall, as a condition of receiving a grant
5 under this subsection—

6 (A) ensure that clinical and support staff
7 receive appropriate ongoing education and
8 training in linguistically appropriate service de-
9 livery;

10 (B) ensure the linguistic competence of bi-
11 lingual providers;

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

17 (D) notify Medicare beneficiaries of their
18 right to receive language services in their pri-
19 mary language;

20 (E) post signage in the primary languages
21 commonly used by the patient population in the
22 service area of the organization; and

23 (F) ensure that—

24 (i) primary language data are col-
25 lected for recipients of language services

1 and such data are consistent with stand-
2 ards developed under title XXXIV of the
3 Public Health Service Act, as added by
4 section 202 of this Act, to the extent such
5 standards are available upon the initiation
6 of the demonstration program; and

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

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

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

1 (A) The number of Medicare beneficiaries
2 to whom competent language services are pro-
3 vided.

4 (B) The primary languages of those Medi-
5 care beneficiaries.

6 (C) The types of language services pro-
7 vided to such beneficiaries.

8 (D) Whether such language services were
9 provided by employees of the grantee or
10 through a contract with external contractors or
11 agencies.

12 (E) The types of interpretation services
13 provided to such beneficiaries, and the approxi-
14 mate length of time such service is provided to
15 such beneficiaries.

16 (F) The costs of providing competent lan-
17 guage services.

18 (G) An account of the training or accredi-
19 tation of bilingual staff, interpreters, and trans-
20 lators providing services funded by the grant
21 under this subsection.

22 (10) EVALUATION AND REPORT TO CON-
23 GRESS.—Not later than 1 year after the completion
24 of a 3-year grant under this subsection, the Sec-
25 retary shall conduct an evaluation of the demonstra-

1 tion program under this subsection and shall submit
2 to the Congress a report that includes the following:

3 (A) An analysis of the patient outcomes
4 and the costs of furnishing care to the Medicare
5 beneficiaries who are English learners partici-
6 pating in the project as compared to such out-
7 comes and costs for such Medicare beneficiaries
8 not participating, based on the data provided
9 under paragraph (9) and any other information
10 available to the Secretary.

11 (B) The effect of delivering language serv-
12 ices on—

13 (i) Medicare beneficiary access to care
14 and utilization of services;

15 (ii) the efficiency and cost effective-
16 ness of health care delivery;

17 (iii) patient satisfaction;

18 (iv) health outcomes; and

19 (v) the provision of culturally appro-
20 priate services provided to such bene-
21 ficiaries.

22 (C) The extent to which bilingual staff, in-
23 terpreters, and translators providing services
24 under such demonstration were trained or ac-
25 credited and the nature of accreditation or

1 training needed by type of provider, service, or
2 other category as determined by the Secretary
3 to ensure the provision of high-quality interpre-
4 tation, translation, or other language services to
5 Medicare beneficiaries if such services are ex-
6 panded pursuant to subsection (c) of section
7 1907 of this Act.

8 (D) Recommendations, if any, regarding
9 the extension of such project to the entire Medi-
10 care program, subject to the provisions of sec-
11 tion 1115A(c) of the Social Security Act (42
12 U.S.C. 1315a(c)).

13 (11) APPROPRIATIONS.—There is appropriated
14 to carry out this subsection, in equal parts from the
15 Federal Hospital Insurance Trust Fund under sec-
16 tion 1817 of the Social Security Act (42 U.S.C.
17 1395i) and the Federal Supplementary Medical In-
18 surance Trust Fund under section 1841 of such Act
19 (42 U.S.C. 1395t), \$16,000,000 for each fiscal year
20 of the demonstration program.

21 (12) ENGLISH LEARNER DEFINED.—In this
22 subsection, the term “English learner” has the
23 meaning given such term in section 8101(20) of the
24 Elementary and Secondary Education Act of 1965,

1 except that subparagraphs (A), (B), and (D) of such
2 section shall not apply.

3 (b) LANGUAGE SERVICES UNDER THE MEDICARE
4 PROGRAM.—

5 (1) INCLUSION AS RURAL HEALTH CLINIC
6 SERVICES.—Section 1861 of the Social Security Act
7 (42 U.S.C. 1395x) is amended—

8 (A) in subsection (aa)(1)—

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

11 (ii) by adding “and” at the end of
12 subparagraph (C); and

13 (iii) by inserting after subparagraph
14 (C) the following new subparagraph:

15 “(D) language services as defined in subsection
16 (iii)(1),”; and

17 (B) by adding at the end the following new
18 subsection:

19 “Language Services and Related Terms

20 “(iii)

21 “(1) The term ‘language services’ has the same
22 meaning given the term ‘language or language ac-
23 cess services’ in section 3400 of the Public Health
24 Service Act.

1 “(2) The term ‘interpreter services’ has the meaning
2 given the term ‘competent interpreter services’ in section
3 3400(3) of the Public Health Service Act.

4 “(3) The term ‘interpreter’—

5 “(A) means an individual—

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

9 “(ii) who knows health and health-related
10 terminology in both languages; and

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

13 “(4) The term ‘translation’ means the transmission
14 of a written message in one language into a written mes-
15 sage in another language that retains the intended mean-
16 ing of the original message.

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

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

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

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

5 (C) by adding at the end the following new
6 subparagraph:

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

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

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

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

17 (C) by inserting after paragraph (9) the
18 following new paragraph:

19 “(10) in the case of language services described
20 in section 1861(iii)(1), 100 percent of the reasonable
21 charges for such services, as determined in consulta-
22 tion with the Medicare Payment Advisory Commis-
23 sion; and”.

24 (4) WAIVER OF BUDGET NEUTRALITY.—For
25 the 3-year period beginning on the date of enact-

1 ment of this section, the budget neutrality provision
2 of section 1848(c)(2)(B)(ii) of the Social Security
3 Act (42 U.S.C. 1395w-4(c)(2)(B)(ii)) shall not
4 apply with respect to language services (as such
5 term is defined in section 1861(iii)(1) of such Act).

6 (c) MEDICARE PARTS C AND D.—

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

14 (2) MEDICARE ADVANTAGE PLANS AND PRE-
15 SCRIPTON DRUG PLANS REPORTING REQUIRE-
16 MENT.—Section 1857(e) of the Social Security Act
17 (42 U.S.C. 1395w-27(e)) is amended by adding at
18 the end the following new paragraph:

19 “(5) REPORTING REQUIREMENTS RELATING TO
20 EFFECTIVE LANGUAGE SERVICES.—A contract under
21 this part shall require a Medicare Advantage organi-
22 zation (and, through application of section 1860D-
23 12(b)(3)(D), a contract under section 1860D-12
24 shall require a PDP sponsor) to annually submit
25 (for each year of the contract) a report that contains

1 information on the plan’s internal policies and proce-
2 dures related to recruitment and retention efforts di-
3 rected to workforce diversity and linguistically and
4 culturally appropriate provision of services in each of
5 the following contexts:

6 “(A) The collection of data in a manner
7 that meets the requirements of title I of the
8 Health Equity and Accountability Act of 2016,
9 regarding the enrollee population.

10 “(B) Education of staff and contractors
11 who have routine contact with enrollees regard-
12 ing the various needs of the diverse enrollee
13 population.

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

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

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

1 (d) IMPROVING LANGUAGE SERVICES IN MEDICAID
2 AND CHIP.—

3 (1) PAYMENTS TO STATES.—Section
4 1903(a)(2)(E) of the Social Security Act (42 U.S.C.
5 1396b(a)(2)(E)) is amended by—

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

7 (B) striking “translation or interpretation
8 services” and inserting “language services”;
9 and

10 (C) striking “children of families” and in-
11 serting “individuals”.

12 (2) STATE PLAN REQUIREMENTS.—Section
13 1902(a)(10)(A) of the Social Security Act (42
14 U.S.C. 1396a(a)(10)(A)) is amended by striking
15 “and (28)” and inserting “(28), and (29)”.

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

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

21 (B) by redesignating paragraph (29) as
22 paragraph (30); and

23 (C) by inserting after paragraph (28) the
24 following new paragraph:

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

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

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

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

12 (C) by adding at the end the following new
13 subparagraph:

14 “(F) language services described in section
15 1905(a)(29); and”.

16 (5) CHIP COVERAGE REQUIREMENTS.—Section
17 2103 of the Social Security Act (42 U.S.C. 1397cc)
18 is amended—

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

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

24 “(9) LANGUAGE SERVICES.—The child health
25 assistance provided to a targeted low-income child

1 shall include coverage of language services, as such
2 term is defined in section 1861(iii)(1), provided in a
3 timely manner to English learners (as defined in
4 section 1861(iii)(5)) who need such services.”; and

5 (C) in subsection (e)(2)—

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

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

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

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

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

23 (B) in the case of such individuals who are
24 minors or incapacitated, the primary language
25 of the individual’s parent or guardian.

1 (8) CHIP PAYMENTS TO STATES.—Section
2 2105 of the Social Security Act (42 U.S.C.
3 1397ee(c)) is amended—

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

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

11 (e) FUNDING LANGUAGE SERVICES FURNISHED BY
12 PROVIDERS OF HEALTH CARE AND HEALTH-CARE-RE-
13 LATED SERVICES THAT SERVE HIGH RATES OF UNIN-
14 SURED LEP INDIVIDUALS.—

15 (1) PAYMENT OF COSTS.—

16 (A) IN GENERAL.—Subject to subpara-
17 graph (B), the Secretary of Health and Human
18 Services shall make payments (on a quarterly
19 basis) directly to eligible entities to support the
20 provision of language services to English learn-
21 ers in an amount equal to an eligible entity’s el-
22 igible costs for such services for the quarter.

23 (B) FUNDING.—Out of any funds in the
24 Treasury not otherwise appropriated, there are
25 appropriated to the Secretary of Health and

1 Human Services such sums as may be nec-
2 essary for each of fiscal years 2017 through
3 2021.

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

11 (2) METHODOLOGY FOR PAYMENT OF
12 CLAIMS.—

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

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

20 (C) NO INDIVIDUAL CLAIMS.—The Sec-
21 retary may not require eligible entities to sub-
22 mit individual claims for language services for
23 individual patients as a requirement for pay-
24 ment under this subsection.

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

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

13 (5) REPORTING REQUIREMENTS.—

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

23 (B) REPORT TO CONGRESS.—Not later
24 than 2 years after the date of enactment of this
25 Act, and every 2 years thereafter, the Secretary

1 shall submit a report to Congress concerning
2 the implementation of this subsection.

3 (6) DEFINITIONS.—In this subsection:

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

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

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

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

20 (i) is a Medicaid provider that is—

21 (I) a physician;

22 (II) a hospital with a low-income
23 utilization rate (as defined in section
24 1923(b)(3) of the Social Security Act

1 (42 U.S.C. 1396r-4(b)(3)) of greater
2 than 25 percent; or

3 (III) a federally qualified health
4 center (as defined in section
5 1905(l)(2)(B) of the Social Security
6 Act (42 U.S.C. 1396d(l)(2)(B)));

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

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

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

23 (D) LANGUAGE SERVICES.—The term
24 “language services” has the meaning given such

1 term in section 1861(iii)(1) of the Social Secu-
2 rity Act.

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

9 (g) EFFECTIVE DATE.—

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

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

1 after the close of the first regular session of the
2 State legislature that begins after the date of the en-
3 actment of this Act. For purposes of the previous
4 sentence, in the case of a State that has a 2-year
5 legislative session, each year of such session shall be
6 deemed to be a separate regular session of the State
7 legislature.

8 **SEC. 206. INCREASING UNDERSTANDING OF AND IMPROV-**
9 **ING HEALTH LITERACY.**

10 (a) IN GENERAL.—The Secretary, acting through the
11 Director of the Agency for Healthcare Research and Qual-
12 ity and the Administrator of the Health Resources and
13 Services Administration, in consultation with the Director
14 of the National Institute on Minority Health and Health
15 Disparities and the Office of Minority Health, shall award
16 grants to eligible entities to improve health care for pa-
17 tient populations that have low functional health literacy.

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

20 (1) be a hospital, health center or clinic, health
21 plan, or other health entity (including a nonprofit
22 minority health organization or association); and

23 (2) prepare and submit to the Secretary an ap-
24 plication at such time, in such manner, and con-

1 taining such information as the Secretary may re-
2 quire.

3 (c) USE OF FUNDS.—

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

8 (A) to define and increase the under-
9 standing of health literacy;

10 (B) to investigate the correlation between
11 low health literacy and health and health care;

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

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

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

22 (A) the development of new disease man-
23 agement programs for patients with low health
24 literacy;

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

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

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

9 (E) the conduct of educational campaigns
10 for patients and providers about low health lit-
11 eracy; and

12 (F) other activities determined appropriate
13 by the Administrator of the Health Resources
14 and Services Administration.

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

19 (e) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated to carry out this section,
21 such sums as may be necessary for each of fiscal years
22 2017 through 2021.

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

24 (a) IN GENERAL.—Any health program or activity,
25 any part of which is receiving Federal financial assistance,

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

10 (1) ensure that appropriate clinical and support
11 staff receive ongoing education and training in lin-
12 guistically appropriate service delivery;

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

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

19 (4) utilize only competent interpreter or trans-
20 lation services, as defined in section 3400 of the
21 Public Health Service Act.

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

24 (1) When a patient (who has been informed in
25 his or her primary language of the availability of

1 free interpreter and translation services) requests
2 the use of family, friends, or other persons untrained
3 in interpretation or translation if the following con-
4 ditions are met:

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

7 (B) The recipient informs the patient that
8 he or she has the option of having the recipient
9 provide an interpreter for him or her without
10 charge, or of using his or her own interpreter.

11 (C) The recipient informs the patient that
12 the recipient may not require an LEP person to
13 use a family member or friend as an inter-
14 preter.

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

23 (E) If the recipient has reason to believe
24 that there is a conflict of interest between the

1 interpreter and patient, the recipient may not
2 use the patient's interpreter.

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

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

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

20 **SEC. 208. REPORT ON FEDERAL EFFORTS TO PROVIDE CUL-**
21 **TURALLY AND LINGUISTICALLY APPRO-**
22 **PRIATE HEALTH CARE SERVICES.**

23 (a) **REPORT.**—Not later than 1 year after the date
24 of enactment of this Act and annually thereafter, the Sec-
25 retary of Health and Human Services shall enter into a

1 contract with the Institute of Medicine for the preparation
2 and publication of a report that describes Federal efforts
3 to ensure that all individuals with limited-English pro-
4 ficiency have meaningful access culturally competent to
5 health care and health-care-related services. Such report
6 shall include—

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

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

13 (3) recommendations on the development and
14 implementation of policies and practices by providers
15 of health care and health-care-related services for
16 limited-English-proficient individuals;

17 (4) a description of the effect of providing lan-
18 guage services on quality of health care and access
19 to care; and

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

22 (b) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to carry out this section
24 such sums as may be necessary for each of fiscal years
25 2017 through 2021.

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

2 (a) GRANTS AUTHORIZED.—The Secretary of Edu-
3 cation is authorized to provide grants to eligible entities
4 for the provision of English as a second language (in this
5 section referred to “ESL”) instruction and shall deter-
6 mine, after consultation with appropriate stakeholders, the
7 mechanism for administering and distributing such
8 grants.

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

13 (c) APPLICATION.—An eligible entity may apply for
14 a grant under this section by submitting such information
15 as the Secretary may require and in such form and man-
16 ner as the Secretary may require.

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

19 (1) develop and implement a plan for assuring
20 the availability of ESL instruction that effectively
21 integrates information about the nature of the
22 United States health care system, how to access
23 care, and any special language skills that may be re-
24 quired for them to access and regularly negotiate the
25 system effectively;

1 (2) develop a plan, including, where appro-
2 priate, public-private partnerships, for making ESL
3 instruction progressively available to all individuals
4 seeking instruction; and

5 (3) maintain current ESL instruction efforts by
6 using the additional funds to supplement rather
7 than supplant any funds expended for ESL instruc-
8 tion in the State as of January 1, 2017.

9 (e) ADDITIONAL DUTIES OF THE SECRETARY.—The
10 Secretary of Education shall—

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

14 (2) collect data from State and local govern-
15 ments to identify the unmet needs of English lan-
16 guage learners for appropriate ESL instruction, in-
17 cluding—

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

20 (B) the extent of waiting lists including
21 how many programs maintain waiting lists and,
22 for programs that do not have waiting lists, the
23 reasons why not;

24 (C) the availability of programs to geo-
25 graphically isolated communities;

1 (D) the impact of course enrollment poli-
2 cies, including open enrollment, on the avail-
3 ability of ESL instruction;

4 (E) the number individuals in the State
5 and each participating locality;

6 (F) the effectiveness of the instruction in
7 meeting the needs of individuals receiving in-
8 struction and those needing instruction;

9 (G) as assessment of the need for pro-
10 grams that integrate job training and ESL in-
11 struction, to assist individuals to obtain better
12 jobs; and

13 (H) the availability of ESL slots by State
14 and locality;

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

18 (4) within 1 year of the date of enactment of
19 this Act, issue a report to Congress that assesses the
20 information collected in paragraphs (1), (2), and (3)
21 and makes recommendations on steps that should be
22 taken to progressively realize the goal of making
23 ESL instruction available to all English language
24 learners seeking instruction.

1 (f) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to the Secretary of Edu-
3 cation for each of fiscal years 2017 through 2020
4 \$250,000,000 to carry out this section.

5 **SEC. 210. IMPLEMENTATION.**

6 (a) GENERAL PROVISIONS.—

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

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

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

23 **SEC. 211. LANGUAGE ACCESS SERVICES.**

24 (a) ESSENTIAL BENEFITS.—Section 1302(b)(1) of
25 the Patient Protection and Affordable Care Act (42

1 U.S.C. 18022(b)(1)) is amended by adding at the end the
2 following:

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

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

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

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

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

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

1 (3) by adding at the end the following new sub-
2 paragraph:

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

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

18 (1) to provide oral interpretation services with-
19 out any threshold requirements;

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

1 (3) with respect to written translations of no-
2 tices, to apply a threshold that 5 percent of the pop-
3 ulation or at least 500 individuals per service area
4 are literate only in the same non-English language
5 in lieu of 10 percent or more residing in a county.

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

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

16 (2) require navigators, certified application
17 counselors, and other enrollment assisters to collect
18 and report requests for language assistance; and

19 (3) require the Federal and State call centers
20 established pursuant to section 1311(d)(4)(b) of the
21 Patient Protection and Affordable Care Act (42
22 U.S.C. 18031(d)(4)(b)) to submit an annual report
23 documenting the number of language assistance re-
24 quests, the types of languages requested, the range
25 and average wait time for a consumer to speak with

1 an interpreter, and any steps the call center and lan-
2 guage line have taken to actively address some of
3 the consumer complaints.

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

7 **TITLE III—HEALTH WORKFORCE**
8 **DIVERSITY**

9 **SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
10 **ACT.**

11 Title XXXIV of the Public Health Service Act, as
12 added by section 202, is amended by adding at the end
13 the following:

14 **“Subtitle A—Diversifying the**
15 **Health Care Workplace**

16 **“SEC. 3411. NATIONAL WORKING GROUP ON WORKFORCE**
17 **DIVERSITY.**

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

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

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

3 “(A) The Health Resources and Services
4 Administration.

5 “(B) The Department of Health and
6 Human Services Data Council.

7 “(C) The Office of Minority Health of the
8 Department of Health and Human Services.

9 “(D) The Substance Abuse and Mental
10 Health Services Administration.

11 “(E) The Bureau of Labor Statistics of
12 the Department of Labor.

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

16 “(G) The National Institute on Minority
17 Health and Health Disparities.

18 “(H) The Agency for Healthcare Research
19 and Quality.

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

22 “(J) The Indian Health Service.

23 “(K) The Department of Education.

24 “(L) Minority-serving academic institu-
25 tions.

1 “(M) Consumer organizations.

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

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

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

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

12 “(R) Local and State health departments.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 “(9) Helping with monitoring and implementa-
5 tion of standards for diversity, equity, and inclusion.

6 “(10) Other activities determined appropriate
7 by 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 2017 through 2022.

20 **“SEC. 3412. TECHNICAL CLEARINGHOUSE FOR HEALTH**
21 **WORKFORCE DIVERSITY.**

22 “(a) IN GENERAL.—The Secretary, acting through
23 the Deputy Assistant Secretary for Minority Health, and
24 in collaboration with the Bureau of Health Workforce
25 within the Health Resources and Services Administration,

1 the National Institute on Minority Health and Health Dis-
2 parities, shall establish a technical clearinghouse on health
3 workforce diversity within the Office of Minority Health
4 and coordinate 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, including integrated models of care.

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

18 “(5) Retainment policies that promote comple-
19 tion of health profession degrees for underserved
20 populations.

21 “(6) Lists of scholarship, loan repayment, and
22 loan cancellation grants as well as fellowship infor-
23 mation for underserved populations for health pro-
24 fessions schools.

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

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

8 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
9 is authorized to be appropriated to carry out this section
10 such sums as may be necessary for each of fiscal years
11 2017 through 2022.

12 **“SEC. 3413. SUPPORT FOR INSTITUTIONS COMMITTED TO**
13 **WORKFORCE DIVERSITY, EQUITY, AND IN-**
14 **CLUSION.**

15 “(a) IN GENERAL.—The Secretary, acting through
16 the Administrator of the Health Resources and Services
17 Administration and the Centers for Disease Control and
18 Prevention, shall award grants to eligible entities that
19 demonstrate a commitment to health workforce diversity.

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

22 “(1) be an educational institution or entity that
23 historically produces or trains meaningful numbers
24 of underrepresented minority health professionals,
25 including—

1 “(A) historically Black colleges and univer-
2 sities;

3 “(B) Hispanic-serving health professions
4 schools;

5 “(C) Hispanic-serving institutions;

6 “(D) tribal colleges and universities;

7 “(E) Asian-American, Native American,
8 and Pacific Islander-serving institutions;

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

14 “(G) health professional associations,
15 which may include underrepresented minority
16 health professional associations; and

17 “(H) institutions, including national and
18 regional community-based organizations with
19 demonstrated commitment to a diversified
20 workforce—

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

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

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

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

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

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

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

23 “(3) postbaccalaureate programs;

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

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

6 “(6) mentoring programs;

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

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

12 “(9) leadership training.

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

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

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 2017 through 2022.

3 **“SEC. 3414. CAREER DEVELOPMENT FOR SCIENTISTS AND**
4 **RESEARCHERS.**

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

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

24 “(c) DATA COLLECTION.—The head of each entity
25 within the Department of Health and Human Services

1 shall collect data on the number (expressed as an absolute
2 number and a percentage) of underrepresented minority
3 and nonminority applicants who receive and are denied
4 agency funding at every stage of review. Such data shall
5 be reported annually to the Secretary and the appropriate
6 committees of Congress.

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

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

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

1 such sums as may be necessary for each of fiscal years
2 2017 through 2022.

3 **“SEC. 3415. CAREER SUPPORT FOR NONRESEARCH HEALTH**
4 **PROFESSIONALS.**

5 “(a) IN GENERAL.—The Secretary, acting through
6 the Director of the Centers for Disease Control and Pre-
7 vention, the Administrator of the Substance Abuse and
8 Mental Health Services Administration, the Administrator
9 of the Health Resources and Services Administration, and
10 the Administrator of the Centers for Medicare & Medicaid
11 Services, shall establish a program to award grants to eli-
12 gible individuals for career support in nonresearch-related
13 health and wellness professions.

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

16 “(1) be a student in a health professions school,
17 a graduate of such a school who is working in a
18 health profession, an individual working in a health
19 or wellness profession (including mental and behav-
20 ioral health), or a faculty member of such a school;
21 and

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

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

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

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

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

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

18 “(d) DEFINITION.—In this section, the term ‘career
19 in nonresearch-related health and wellness professions’
20 means employment or intended employment in the field
21 of public health, health policy, health management, health
22 administration, medicine, nursing, pharmacy, psychology,
23 social work, psychiatry, other mental and behavioral
24 health, allied health, community health, social work, or

1 other fields determined appropriate by the Secretary,
2 other than in a position that involves research.

3 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
4 is authorized to be appropriated to carry out this section
5 such sums as may be necessary for each of fiscal years
6 2017 through 2022.

7 **“SEC. 3416. RESEARCH ON THE EFFECT OF WORKFORCE DI-**
8 **VERSITY ON QUALITY.**

9 “(a) IN GENERAL.—The Director of the Agency for
10 Healthcare Research and Quality, in collaboration with
11 the Deputy Assistant Secretary for Minority Health and
12 the Director of the National Institute on Minority Health
13 and Health Disparities, shall award grants to eligible enti-
14 ties to expand research on the link between health work-
15 force diversity and quality health care.

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

18 “(1) be a clinical, public health, or health serv-
19 ices research entity or other entity determined ap-
20 propriate by the Director; 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 awarded under subsection (a) shall be used to sup-

1 port research that investigates the effect of health work-
2 force diversity on—

3 “(1) language access;

4 “(2) cultural competence;

5 “(3) patient satisfaction;

6 “(4) timeliness of care;

7 “(5) safety of care;

8 “(6) effectiveness of care;

9 “(7) efficiency of care;

10 “(8) patient outcomes;

11 “(9) community engagement;

12 “(10) resource allocation;

13 “(11) organizational structure;

14 “(12) compliance of care; or

15 “(13) other topics determined appropriate by
16 the Director.

17 “(d) PRIORITY.—In awarding grants under sub-
18 section (a), the Director shall give individualized consider-
19 ation to all relevant aspects of the applicant’s background.
20 Consideration of prior research experience involving the
21 health of underserved communities shall be such a factor.

22 “(e) 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 2017 through 2022.

1 **“SEC. 3417. HEALTH DISPARITIES EDUCATION PROGRAM.**

2 “(a) ESTABLISHMENT.—The Secretary, acting
3 through the National Institute on Minority Health and
4 Health Disparities and in collaboration with the Office of
5 Minority Health, the Office for Civil Rights, the Centers
6 for Disease Control and Prevention, the Centers for Medi-
7 care & Medicaid Services, the Health Resources and Serv-
8 ices Administration, and other appropriate public and pri-
9 vate entities, shall establish and coordinate a health and
10 health care disparities education program to support, de-
11 velop, and implement educational initiatives and outreach
12 strategies that inform health care professionals and the
13 public about the existence of and methods to reduce racial
14 and ethnic disparities in health and health care.

15 “(b) ACTIVITIES.—The Secretary, through the edu-
16 cation program established under subsection (a), shall,
17 through the use of public awareness and outreach cam-
18 paigns targeting the general public and the medical com-
19 munity at large—

20 “(1) disseminate scientific evidence for the ex-
21 istence and extent of racial and ethnic disparities in
22 health care, including disparities that are not other-
23 wise attributable to known factors such as access to
24 care, patient preferences, or appropriateness of
25 intervention, as described in the 2002 Institute of
26 Medicine Report entitled ‘Unequal Treatment: Con-

1 fronting Racial and Ethnic Disparities in Health
2 Care’, as well as the impact of disparities related to
3 age, disability status, socioeconomic status, sex, gen-
4 der identity, and sexual orientation on racial and
5 ethnic minorities;

6 “(2) disseminate new research findings to
7 health care providers and patients to assist them in
8 understanding, reducing, and eliminating health and
9 health care disparities;

10 “(3) disseminate information about the impact
11 of linguistic and cultural barriers on health care
12 quality and the obligation of health providers who
13 receive Federal financial assistance to ensure that
14 people with limited-English proficiency have access
15 to language access services;

16 “(4) disseminate information about the impor-
17 tance and legality of racial, ethnic, disability status,
18 socioeconomic status, sex, gender identity, and sex-
19 ual orientation, and primary language data collec-
20 tion, analysis, and reporting;

21 “(5) design and implement specific educational
22 initiatives to health care providers relating to health
23 and health care disparities;

24 “(6) assess the impact of the programs estab-
25 lished under this section in raising awareness of

1 health and health care disparities and providing in-
2 formation on available resources; and

3 “(7) design and implement specific educational
4 initiatives to educate the health care workforce relat-
5 ing to unconscious bias.

6 “(c) 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 2017 through 2022.”.

10 **SEC. 302. HISPANIC-SERVING HEALTH PROFESSIONS**
11 **SCHOOLS.**

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

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

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

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

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

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

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

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

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

18 “(6) is a Regional Hispanic Center of Excel-
19 lence.”.

20 **SEC. 303. LOAN REPAYMENT PROGRAM OF CENTERS FOR**
21 **DISEASE CONTROL AND PREVENTION.**

22 Section 317F(c) of the Public Health Service Act (42
23 U.S.C. 247b-7(c)) is amended—

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

1 (2) by inserting before the period at the end the
2 following: “, \$750,000 for fiscal year 2017, and such
3 sums as may be necessary for each of the fiscal
4 years 2018 through 2022”.

5 **SEC. 304. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
6 **GREE PROGRAMS AT SCHOOLS OF PUBLIC**
7 **HEALTH AND SCHOOLS OF ALLIED HEALTH.**

8 Part B of title VII of the Public Health Service Act
9 (42 U.S.C. 293 et seq.), as amended by section 302, is
10 further amended by adding at the end the following:

11 **“SEC. 743. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
12 **GREE PROGRAMS.**

13 “(a) COOPERATIVE AGREEMENTS.—The Secretary,
14 acting through the Administrator of the Health Resources
15 and Services Administration, in consultation with the Di-
16 rector of the Centers for Disease Control and Prevention,
17 the Director of the Agency for Healthcare Research and
18 Quality, and the Deputy Assistant Secretary for Minority
19 Health, shall award cooperative agreements to schools of
20 public health and schools of allied health to design and
21 implement online degree programs.

22 “(b) PRIORITY.—In awarding cooperative agreements
23 under this section, the Secretary shall give priority to any
24 school of public health or school of allied health that has

1 an established track record of serving medically under-
2 served communities.

3 “(c) REQUIREMENTS.—Recipients of cooperative
4 agreements under this section shall design and implement
5 an online degree program that meets the following restric-
6 tions:

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

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

13 “(3) Achieving a high completion rate of en-
14 rolled underrepresented minority or disadvantaged
15 students.

16 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated to carry out this section
18 such sums as may be necessary for each of fiscal years
19 2017 through 2022.”.

20 **SEC. 305. SENSE OF CONGRESS ON THE MISSION OF THE**
21 **NATIONAL HEALTH CARE WORKFORCE COM-**
22 **MISSION.**

23 It is the sense of Congress that the National Health
24 Care Workforce Commission established by section 5101
25 of the Patient Protection and Affordable Care Act (42

1 U.S.C. 294q) should, in carrying out its assigned duties
2 under that section, give attention to the needs of racial
3 and ethnic minorities, individuals with lower socio-
4 economic status, individuals with mental, developmental,
5 and physical disabilities, lesbian, gay, bisexual,
6 transgender, queer, and questioning populations, and indi-
7 viduals who are members of multiple minority or special
8 population groups.

9 **SEC. 306. SCHOLARSHIP AND FELLOWSHIP PROGRAMS.**

10 Subtitle A of title XXXIV of the Public Health Serv-
11 ice Act, as added by section 301, is further amended by
12 inserting after section 3417 the following:

13 **“SEC. 3418. DAVID SATCHER PUBLIC HEALTH AND HEALTH**
14 **SERVICES CORPS.**

15 “(a) IN GENERAL.—The Administrator of the Health
16 Resources and Services Administration and the Director
17 of the Centers for Disease Control and Prevention, in col-
18 laboration with the Deputy Assistant Secretary for Minor-
19 ity Health, shall award grants to eligible entities to in-
20 crease awareness among postprimary and postsecondary
21 students of career opportunities in the health professions.

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

24 “(1) be a clinical, public health, or health serv-
25 ices organization, community-based or nonprofit en-

1 tity, or other entity determined appropriate by the
2 Director of the Centers for Disease Control and Pre-
3 vention;

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

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

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

12 “(c) USE OF FUNDS.—Grant awards under sub-
13 section (a) shall be used to support internships that will
14 increase awareness among students of non-research-based,
15 career opportunities in the following health professions:

16 “(1) Medicine.

17 “(2) Nursing.

18 “(3) Public Health.

19 “(4) Pharmacy.

20 “(5) Health administration and management.

21 “(6) Health policy.

22 “(7) Psychology.

23 “(8) Dentistry.

24 “(9) International health.

25 “(10) Social work.

1 “(11) Allied health.

2 “(12) Psychiatry.

3 “(13) Hospice care.

4 “(14) Other professions deemed appropriate by
5 the Director of the Centers for Disease Control and
6 Prevention.

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

11 “(1) serve a high proportion of individuals from
12 disadvantaged backgrounds;

13 “(2) have experience in health disparity elimi-
14 nation programs;

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

17 “(4) provide counseling or other services de-
18 signed to assist disadvantaged individuals in success-
19 fully completing their education at the postsecondary
20 level.

21 “(e) STIPENDS.—The Secretary may approve sti-
22 pends under this section for individuals for any period of
23 education in student-enhancement programs (other than
24 regular courses) at health professions schools, programs,
25 or entities, except that such a stipend may not be provided

1 to an individual for more than 6 months, and such a sti-
2 pend may not exceed \$20 per day (notwithstanding any
3 other provision of law regarding the amount of stipends).

4 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
5 is authorized to be appropriated to carry out this section
6 such sums as may be necessary for each of fiscal years
7 2017 through 2022.

8 **“SEC. 3419. LOUIS STOKES PUBLIC HEALTH SCHOLARS**
9 **PROGRAM.**

10 “(a) IN GENERAL.—The Director of the Centers for
11 Disease Control and Prevention, in collaboration with the
12 Deputy Assistant Secretary for Minority Health, shall
13 award scholarships to postsecondary students who seek a
14 career in public health.

15 “(b) ELIGIBILITY.—To be eligible to receive a schol-
16 arship under subsection (a), an individual shall—

17 “(1) have interest, knowledge, or skill in public
18 health research or public health practice, or other
19 health professions as determined appropriate by the
20 Director of the Centers for Disease Control and Pre-
21 vention;

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

24 “(3) demonstrate promise for becoming a leader
25 in public health;

1 “(4) secure admission to a 4-year institution of
2 higher education;

3 “(5) comply with subsection (e); and

4 “(6) 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 an
8 award under subsection (a) shall be used to support oppor-
9 tunities for students to become public health professionals.

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

13 “(1) are from disadvantaged backgrounds;

14 “(2) have secured admissions to a minority-
15 serving institution; and

16 “(3) have identified a health professional as a
17 mentor at their school or institution and an aca-
18 demic advisor to assist in the completion of their
19 baccalaureate degree.

20 “(e) SCHOLARSHIPS.—The Secretary may approve
21 payment of scholarships under this section for such indi-
22 viduals for any period of education in student under-
23 graduate tenure, except that such a scholarship may not
24 be provided to an individual for more than 4 years, and
25 such scholarships may not exceed \$10,000 per academic

1 year (notwithstanding any other provision of law regard-
2 ing the amount of scholarship).

3 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
4 is authorized to be appropriated to carry out this section
5 such sums as may be necessary for each of fiscal years
6 2017 through 2022.

7 **“SEC. 3420. PATSY MINK HEALTH AND GENDER RESEARCH**
8 **FELLOWSHIP PROGRAM.**

9 “(a) IN GENERAL.—The Director of the Centers for
10 Disease Control and Prevention, in collaboration with the
11 Deputy Assistant Secretary for Minority Health, the Ad-
12 ministrator of the Substance Abuse and Mental Health
13 Services Administration, and the Director of the Indian
14 Health Services, shall award research fellowships to post-
15 baccalaureate students to conduct research that will exam-
16 ine gender and health disparities and to pursue a career
17 in the health professions.

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

20 “(1) have experience in health research or pub-
21 lic health practice;

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

24 “(3) have expressed an interest in the health
25 professions;

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

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

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

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

10 “(c) USE OF FUNDS.—Amounts received under an
11 award under subsection (a) shall be used to support oppor-
12 tunities for students to become researchers and advance
13 the research base on the intersection between gender and
14 health.

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

19 “(1) are from disadvantaged backgrounds; and

20 “(2) have identified a mentor and academic ad-
21 visor who will assist in the completion of their grad-
22 uate or professional degree and have secured a re-
23 search assistant position with a researcher working
24 in the area of gender and health.

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

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

5 “(4) be a college senior or recent graduate of
6 a four-year higher education institution;

7 “(5) comply with subsection (e); and

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

11 “(c) USE OF FUNDS.—Amounts received under an
12 award under subsection (a) shall be used to support oppor-
13 tunities for students to become health professionals and
14 to advance their knowledge about international issues re-
15 lating to health care access and quality.

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

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

20 “(2) have identified a mentor at a health pro-
21 fessions school or institution, an academic advisor to
22 assist in the completion of their graduate or profes-
23 sional degree, and an advisor from an international
24 health non-governmental organization, private volun-
25 teer organization, or other international institution

1 or program that focuses on increasing health care
2 access and quality for residents in developing coun-
3 tries.

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

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 2017 through 2022.

16 **“SEC. 3420B. EDWARD R. ROYBAL HEALTH SCHOLAR PRO-**
17 **GRAM.**

18 “(a) IN GENERAL.—The Director of the Agency for
19 Healthcare Research and Quality, the Director of the Cen-
20 ters for Medicare and Medicaid Services, and the Adminis-
21 trator for Health Resources and Services Administration,
22 in collaboration with the Deputy Assistant Secretary for
23 Minority Health, shall award grants to eligible entities to
24 expose entering graduate students to the health profes-
25 sions.

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

3 “(1) be a clinical, public health, or health serv-
4 ices organization, community-based, academic, or
5 nonprofit entity, or other entity determined appro-
6 priate by the Director of the Agency for Healthcare
7 Research and Quality;

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

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

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

15 “(c) USE OF FUNDS.—Amounts received under a
16 grant awarded under subsection (a) shall be used to sup-
17 port opportunities that expose students to non-research-
18 based health professions, including—

19 “(1) public health policy;

20 “(2) health care and pharmaceutical policy;

21 “(3) health care administration and manage-
22 ment;

23 “(4) health economics; and

24 “(5) other professions determined appropriate
25 by the Director of the Agency for Healthcare Re-

1 search and Quality, the Director of the Centers for
2 Medicare and Medicaid Services, and the Adminis-
3 trator for Health Resources and Services Adminis-
4 tration.

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

9 “(1) have experience with health disparity elimi-
10 nation programs;

11 “(2) facilitate training in the fields described in
12 subsection (c); and

13 “(3) provide counseling or other services de-
14 signed to assist such individuals in successfully com-
15 pleting their education at the postsecondary level.

16 “(e) STIPENDS.—The Secretary may approve the
17 payment of stipends for individuals under this section for
18 any period of education in student-enhancement programs
19 (other than regular courses) at health professions schools
20 or entities, except that such a stipend may not be provided
21 to an individual for more than 2 months, and such a sti-
22 pend may not exceed \$100 per day (notwithstanding any
23 other provision of law regarding the amount of stipends).

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

1 such sums as may be necessary for each of fiscal years
2 2017 through 2022.”.

3 **SEC. 307. MCNAIR POSTBACCALAUREATE ACHIEVEMENT**
4 **PROGRAM.**

5 Section 402E of the Higher Education Act of 1965
6 (20 U.S.C. 1070a–15) is amended by striking subsection
7 (g) and inserting the following:

8 “(g) **COLLABORATION IN HEALTH PROFESSION DI-**
9 **VERSITY TRAINING PROGRAMS.**—The Secretary shall co-
10 ordinate with the Secretary of Health and Human Serv-
11 ices to ensure that there is collaboration between the goals
12 of the program under this section and programs of the
13 Health Resources and Services Administration that pro-
14 mote health workforce diversity. The Secretary of Edu-
15 cation shall take such measures as may be necessary to
16 encourage students participating in projects assisted
17 under this section to consider health profession careers.

18 “(h) **FUNDING.**—From amounts appropriated pursu-
19 ant to the authority of section 402A(g), the Secretary
20 shall, to the extent practicable, allocate funds for projects
21 authorized by this section in an amount which is not less
22 than \$31,000,000 for each of the fiscal years 2017
23 through 2023.”.

1 **SEC. 308. RULES FOR DETERMINATION OF FULL-TIME**
2 **EQUIVALENT RESIDENTS FOR COST-REPORT-**
3 **ING PERIODS.**

4 (a) DGME DETERMINATIONS.—Section 1886(h)(4)
5 of the Social Security Act (42 U.S.C. 1395ww(h)(4)), as
6 amended by section 204(a), is amended—

7 (1) in subparagraph (E), by striking “Subject
8 to subparagraphs (J) and (K), such rules” and in-
9 serting “Subject to subparagraphs (J), (K), and
10 (M), such rules”;

11 (2) in subparagraph (J), by striking “Such
12 rules” and inserting “Subject to subparagraph (M),
13 such rules”;

14 (3) in subparagraph (K), by striking “In deter-
15 mining” and inserting “Subject to subparagraph
16 (M), in determining”; and

17 (4) by adding at the end the following new sub-
18 paragraph:

19 “(M) TREATMENT OF CERTAIN RESIDENTS
20 AND INTERNS.—For purposes of cost-reporting
21 periods beginning on or after October 1, 2016,
22 in determining the hospital’s number of full-
23 time equivalent residents for purposes of this
24 paragraph, all the time spent by an intern or
25 resident in an approved medical residency train-
26 ing program shall be counted toward the deter-

1 mination of full-time equivalency if the hos-
2 pital—

3 “(i) is recognized as a subsection (d)
4 hospital;

5 “(ii) is recognized as a subsection (d)
6 Puerto Rico hospital;

7 “(iii) is reimbursed under a reim-
8 bursement system authorized under section
9 1814(b)(3); or

10 “(iv) is a provider-based hospital out-
11 patient department.”.

12 (b) IME DETERMINATIONS.—Section
13 1886(d)(5)(B)(x) of the Social Security Act (42 U.S.C.
14 1395ww(d)(5)(B)(x)) is amended—

15 (1) in subclause (II), by striking “In deter-
16 mining” and inserting “Subject to subclause (IV), in
17 determining”;

18 (2) in subclause (III), by striking “In deter-
19 mining” and inserting “Subject to subclause (IV), in
20 determining”; and

21 (3) by inserting after subclause (III) the fol-
22 lowing new subclause:

23 “(IV) The provisions of subparagraph (L)
24 of subsection (h)(4) shall apply under this sub-

1 paragraph in the same manner as they apply
2 under such subsection.”.

3 **SEC. 309. DEVELOPING AND IMPLEMENTING STRATEGIES**
4 **FOR LOCAL HEALTH EQUITY.**

5 (a) GRANTS.—The Secretaries of Health and Human
6 Services, Education, and Labor, acting jointly, shall make
7 grants to academic institutions for the purposes of—

8 (1) in accordance with subsection (b), devel-
9 oping capacity—

10 (A) to build an evidence base for successful
11 strategies for increasing local health equity; and

12 (B) to serve as national models of driving
13 local health equity;

14 (2) in accordance with subsection (c), devel-
15 oping a strategic partnership with the community in
16 which the academic institution is located; and

17 (3) collecting data on, and periodically evalu-
18 ating, the effectiveness of the institution’s programs
19 funded through this section to enable the institution
20 to adapt accordingly for maximum efficiency and
21 success.

22 (b) DEVELOPING CAPACITY FOR INCREASING LOCAL
23 HEALTH EQUITY.—As a condition on receipt of a grant
24 under subsection (a), an academic institution shall agree
25 to use the grant to build an evidence base for successful

1 strategies for increasing local health equity, and to serve
2 as a national model of driving local health equity, by sup-
3 porting—

4 (1) resources to strengthen institutional metrics
5 and capacity to execute institutionwide health work-
6 force goals that can serve as models for increasing
7 health equity in communities across the country;

8 (2) collaborations among a cohort of institu-
9 tions in implementing systemic change, partnership
10 development, and programmatic efforts supportive of
11 health equity goals across disciplines and popu-
12 lations; and

13 (3) enhanced or newly developed data systems
14 and research infrastructure capable of informing
15 current and future workforce efforts and building a
16 foundation for a broader research agenda targeting
17 urban health disparities.

18 (c) STRATEGIC PARTNERSHIPS.—As a condition on
19 receipt of a grant under subsection (a), an academic insti-
20 tution shall agree to use the grant to develop a strategic
21 partnership with the community in which the institution
22 is located for the purposes of—

23 (1) strengthening connections between the insti-
24 tution and the community—

1 (A) to improve evaluation of and address
2 the community’s health and health workforce
3 needs; and

4 (B) to engage the community in health
5 workforce development;

6 (2) developing, enhancing, or accelerating inno-
7 vative undergraduate and graduate programs in the
8 biomedical sciences and health professions; and

9 (3) strengthening pipeline programs in the bio-
10 medical sciences and health professions, including by
11 developing partnerships between institutions of high-
12 er education and elementary and secondary schools
13 to recruit the next generation of health professionals
14 earlier in the pipeline to a health care career.

15 **SEC. 310. LOAN FORGIVENESS FOR MENTAL AND BEHAV-**
16 **IORAL HEALTH SOCIAL WORKERS.**

17 Section 455 of the Higher Education Act of 1965 (20
18 U.S.C. 1087e) is amended by adding at the end the fol-
19 lowing new subsection:

20 “(r) REPAYMENT PLAN FOR MENTAL AND BEHAV-
21 IORAL HEALTH SOCIAL WORKERS.—

22 “(1) IN GENERAL.—The Secretary shall cancel
23 the balance of interest and principal due on any eli-
24 gible Federal Direct Loan not in default for a bor-
25 rower who—

1 “(A) has made 120 monthly payments on
2 the eligible Federal Direct Loan after October
3 1, 2016, pursuant to any one or a combination
4 of the following—

5 “(i) payments under an income-based
6 repayment plan under section 493C;

7 “(ii) payments under a standard re-
8 payment plan under subsection (d)(1)(A),
9 based on a 10-year repayment period;

10 “(iii) monthly payments under a re-
11 payment plan under subsection (d)(1) or
12 (g) of not less than the monthly amount
13 calculated under subsection (d)(1)(A),
14 based on a 10-year repayment period; or

15 “(iv) payments under an income con-
16 tingent repayment plan under subsection
17 (d)(1)(D); and

18 “(B)(i) is employed as a mental health or
19 behavioral health social worker, as defined by
20 the Secretary by regulation, at the time of such
21 forgiveness; and

22 “(ii) has been employed as such a mental
23 health or behavioral health social worker during
24 the period in which the borrower makes each of

1 the 120 payments as described in subparagraph
2 (A).

3 “(2) LOAN CANCELLATION AMOUNT.—After the
4 conclusion of the employment period described in
5 paragraph (1), the Secretary shall cancel the obliga-
6 tion to repay the balance of principal and interest
7 due as of the time of such cancellation, on the eligi-
8 ble Federal Direct Loans made to the borrower
9 under this part.

10 “(3) INELIGIBILITY FOR DOUBLE BENEFITS.—
11 No borrower may, for the same employment as a
12 mental health or behavioral health social worker, re-
13 ceive a reduction of loan obligations under both this
14 subsection and section 455(m), 428J, 428K, 428L,
15 or 460.

16 “(4) DEFINITION OF ELIGIBLE FEDERAL DI-
17 RECT LOAN.—In this subsection, the term ‘eligible
18 Federal Direct Loan’ means a Federal Direct Staf-
19 ford Loan, Federal Direct PLUS Loan, Federal Di-
20 rect Unsubsidized Stafford Loan, or a Federal Di-
21 rect Consolidation Loan.”.

22 **SEC. 311. HEALTH PROFESSIONS WORKFORCE FUND.**

23 (a) PURPOSE.—It is the purpose of this section to
24 establish a Health Professions Workforce Fund to be ad-
25 ministered through the Health Resources and Services Ad-

1 ministration within the Department of Health and Human
2 Services to provide for expanded and sustained national
3 investment in the health professions and nursing work-
4 force development programs under title VII and title VIII
5 of the Public Health Service Act.

6 (b) ESTABLISHING THE HEALTH PROFESSIONS
7 WORKFORCE FUND.—There is authorized to be appro-
8 priated, and there is appropriated, out of any monies in
9 the Treasury not otherwise appropriated, to the Health
10 Professions Workforce Fund—

- 11 (1) \$355,000,000 for fiscal year 2017;
- 12 (2) \$375,000,000 for fiscal year 2018;
- 13 (3) \$392,000,000 for fiscal year 2019;
- 14 (4) \$412,000,000 for fiscal year 2020;
- 15 (5) \$432,000,000 for fiscal year 2021;
- 16 (6) \$454,000,000 for fiscal year 2022;
- 17 (7) \$476,000,000 for fiscal year 2023;
- 18 (8) \$500,000,000 for fiscal year 2024;
- 19 (9) \$525,000,000 for fiscal year 2025; and
- 20 (10) \$552,000,000 for fiscal year 2026.

21 (c) FUNDING.—

- 22 (1) For the purpose of carrying out health pro-
23 fessions education programs authorized under title
24 VII of the Public Health Service Act, in addition to
25 any other amounts authorized to be appropriated for

1 such purpose, there is authorized to be appropriated
2 out of any monies in the Health Professions Work-
3 force Fund, the following:

4 (A) \$240,000,000 for fiscal year 2017.

5 (B) \$253,000,000 for fiscal year 2018.

6 (C) \$265,000,000 for fiscal year 2019.

7 (D) \$278,000,000 for fiscal year 2020.

8 (E) \$292,000,000 for fiscal year 2021.

9 (F) \$307,000,000 for fiscal year 2022.

10 (G) \$322,000,000 for fiscal year 2023.

11 (H) \$338,000,000 for fiscal year 2024.

12 (I) \$355,000,000 for fiscal year 2025.

13 (J) \$373,000,000 for fiscal year 2026.

14 (2) For the purpose of carrying out nursing
15 workforce development programs authorized under
16 Title VIII of the Public Health Service Act, in addi-
17 tion to any other amounts authorized to be appro-
18 priated for such purpose, there is authorized to be
19 appropriated out of any monies in the Health Pro-
20 fessions Workforce Fund, the following:

21 (A) \$115,000,000 for fiscal year 2017.

22 (B) \$122,000,000 for fiscal year 2018.

23 (C) \$127,000,000 for fiscal year 2019.

24 (D) \$134,000,000 for fiscal year 2020.

25 (E) \$140,000,000 for fiscal year 2021.

1 (F) \$147,000,000 for fiscal year 2022.

2 (G) \$154,000,000 for fiscal year 2023.

3 (H) \$162,000,000 for fiscal year 2024.

4 (I) \$170,000,000 for fiscal year 2025.

5 (J) \$179,000,000 for fiscal year 2026.

6 **SEC. 312. FINDINGS; SENSE OF CONGRESS RELATING TO**
7 **GRADUATE MEDICAL EDUCATION.**

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

9 (1) Projections by the Association of American
10 Medical Colleges (AAMC) and other expert entities,
11 such as the Health Resources and Services Adminis-
12 tration (HRSA), have indicated a nationwide short-
13 age of up to 90,400 physicians, split evenly between
14 primary care and specialists, by 2025.

15 (2) Primarily due to the growing and aging
16 population, over the next decade, physician demand
17 is expected to grow up to 17 percent.

18 (3) The United States Census Bureau estimates
19 that the United States population will grow from
20 321 million in 2015 to 347 million in 2025. Further,
21 the number of Medicare beneficiaries is estimated to
22 increase from 47.8 million in 2015 to approximately
23 66 million in 2025.

1 (4) Approximately 36 percent of practicing phy-
2 sicians are over the age of 55 and are likely to retire
3 within the next decade.

4 (5) A nationwide physician shortage will result
5 in many Americans waiting longer and traveling far-
6 ther for health care; seeking nonemergent care in
7 emergency departments; and delaying treatment
8 until their health care needs become more serious,
9 complex, and costly.

10 (6) Changing demographics (such as an aging
11 population), new health care delivery models (such
12 as medical homes), and other factors (such as dis-
13 aster preparedness) are contributing to a shortage of
14 both generalist and specialist physicians.

15 (7) These shortages will have the most severe
16 impact on vulnerable and underserved populations,
17 including racial/ethnic minorities and the approxi-
18 mately 20 percent of Americans who live in rural or
19 inner-city locations designated as health professional
20 shortage areas.

21 (8) United States medical schools have com-
22 mitted to and have initiated a 30 percent increase
23 in enrollment by 2017 to help reduce the Nation's
24 shortage of quality physicians.

1 (9) An increase in United States medical school
2 graduates must be accompanied by an increase of
3 4,000 graduate medical education (GME) training
4 positions each year.

5 (10) Graduate medical education programs and
6 teaching hospitals provide venues in which the next
7 generation of physicians learns to work collaboratively
8 with other physicians and health professionals, adopt more
9 efficient care delivery models (such as care coordination
10 and medical homes), incorporate health information technology
11 and electronic health records in every aspect of their work,
12 apply new methods of assuring quality and safety,
13 and participate in groundbreaking clinical and public
14 health research.
15

16 (11) The Medicare Program under title XVIII
17 of the Social Security Act (having more beneficiaries
18 than any other health care program), supports its
19 “fair share” of the costs associated with graduate
20 medical education (GME).

21 (12) In general, the level of support of graduate
22 medical education by the Medicare Program has
23 been capped since 1997 and has not been increased
24 to support the expansion of graduate medical edu-
25 cation programs needed to avert the projected physi-

1 cian shortage or to accommodate the increase in
2 United States medical school graduates.

3 (b) SENSE OF CONGRESS.—It is the sense of Con-
4 gress that eliminating the limit of the number of residency
5 positions that receive some level of Medicare support
6 under section 1886(h) of the Social Security Act (42
7 U.S.C. 1395ww(h)), also referred to as the Medical grad-
8 uate medical education cap, is critical to—

9 (1) ensuring an appropriate supply of physi-
10 cians to meet the Nation’s health care needs;

11 (2) facilitating equitable access for all who seek
12 health care; and

13 (3) mitigating disparities in health and health
14 care.

15 **SEC. 313. CAREER SUPPORT FOR SKILLED, INTERNATION-**
16 **ALLY EDUCATED HEALTH PROFESSIONALS.**

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

18 (1) According to the Association of Schools of
19 Public Health, projections indicate a nationwide
20 shortage of up to 250,000 public health workers
21 needed by 2020.

22 (2) Similar trends are projected for other health
23 professions indicating shortages across disciplines,
24 including within the fields of nursing (500,000 by
25 2025), dentistry (15,000 by 2025), pharmacy

1 (38,000 by 2030), mental and behavioral health, pri-
2 mary care (46,000 by 2025), and community and al-
3 lied health.

4 (3) A nationwide health workforce shortage will
5 result in serious health threats and more severe and
6 costly health care needs, due to, in part, a delayed
7 response to food-borne outbreaks, emerging infec-
8 tious diseases, natural disasters, fewer cancer
9 screenings, and delayed treatment.

10 (4) Vulnerable and underserved populations and
11 health professional shortage areas will be most se-
12 verely impacted by the health workforce shortage.

13 (5) According to the Migration Policy Institute,
14 over 2,000,000 college-educated immigrants in the
15 United States today are unemployed or under-
16 employed in low- or semi-skilled jobs that fail to
17 draw on their education and expertise.

18 (6) Approximately 2 out of every 5 internation-
19 ally educated immigrants are unemployed or under-
20 employed.

21 (7) According to Drexel University Center for
22 Labor Markets and Policy, underemployment for
23 internationally educated immigrant women is 28 per-
24 cent higher than for their male counterparts.

1 (8) According to the Drexel University Center
2 for labor markets and policy, the mean annual earn-
3 ings of underemployed immigrants were \$32,000, or
4 43 percent less than United States born college
5 graduates employed in the college labor market.

6 (9) According to Upwardly Global and the Wel-
7 come Back Initiative, with proper guidance and sup-
8 port, underemployed skilled immigrants typically in-
9 crease their income by 215 percent to 900 percent.

10 (10) According to the Brookings Institution and
11 the Partnership for a New American Economy, im-
12 migrants working in the health workforce are, on av-
13 erage, better educated than United States-born
14 workers in the health workforce.

15 (b) GRANTS TO ELIGIBLE ENTITIES.—

16 (1) AUTHORITY TO PROVIDE GRANTS.—The
17 Secretary of Health and Human Services acting
18 through the Bureau of Health Workforce within the
19 Health Resources and Services Administration, the
20 National Institute on Minority Health and Health
21 Disparities, or the Office of Minority Health (in this
22 section referred to as the “Secretary”) may award
23 grants to eligible entities to carry out activities de-
24 scribed in subsection (c).

1 (2) ELIGIBILITY.—To be eligible to receive a
2 grant under this section, an entity shall—

3 (A) be a clinical, public health, or health
4 services organization, a community-based or
5 nonprofit entity, an academic institution, a
6 faith-based organization, a State, county, or
7 local government, an Area Health Education
8 Center, or another entity determined appro-
9 priate by the Secretary; and

10 (B) submit to the Secretary an application
11 at such time, in such manner, and containing
12 such information as the Secretary may require.

13 (c) AUTHORIZED ACTIVITIES.—A grant awarded
14 under this section shall be used—

15 (1) to provide services to assist unemployed and
16 underemployed skilled immigrants, residing in the
17 United States, who have legal, permanent work au-
18 thorization and who are internationally educated
19 health professionals, enter into the American health
20 workforce with employment matching their health
21 professional skills and education, and advance in em-
22 ployment to positions that better match their health
23 professional education and expertise;

24 (2) to provide training opportunities to reduce
25 barriers to entry and advancement in the health

1 workforce for skilled, internationally educated immi-
2 grants;

3 (3) to educate employers regarding the abilities
4 and capacities of internationally educated health
5 professionals;

6 (4) to assist in the evaluation of foreign creden-
7 tials; and

8 (5) to facilitate access to contextualized and ac-
9 celerated courses on English as a second language.

10 (d) DEFINITION.—In this section:

11 (1) The term “health professional” means an
12 individual trained for employment or intended em-
13 ployment in the field of public health, health man-
14 agement, dentistry, health administration, medicine,
15 nursing, pharmacy, psychology, social work, psychi-
16 atry, other mental and behavioral health, allied
17 health, community health or wellness work, including
18 fitness and nutrition, or other fields as determined
19 appropriate by the Secretary.

20 (2) The term “underemployed” means being
21 employed at less skilled tasks than an employee’s
22 training or abilities would otherwise permit.

23 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
24 authorized to be appropriated to carry out this section

1 such sums as may be necessary for each of fiscal years
2 2017 through 2021.

3 **TITLE IV—IMPROVEMENT OF**
4 **HEALTH CARE SERVICES**
5 **Subtitle A—Health Empowerment**
6 **Zones**

7 **SEC. 401. SHORT TITLE.**

8 This subtitle may be cited as the “Health Empower-
9 ment Zone Act of 2016”.

10 **SEC. 402. FINDINGS.**

11 The Congress finds the following:

12 (1) Numerous studies and reports, including
13 the 2012 National Healthcare Disparities Report of
14 the Administration on Healthcare Research and
15 Quality and the 2002 Unequal Treatment Report of
16 the Institute of Medicine, document the extensive-
17 ness to which health disparities exist across the
18 country.

19 (2) These studies have found that, on average,
20 racial and ethnic minorities are disproportionately
21 afflicted with chronic and acute conditions—such as
22 cancer, diabetes, musculoskeletal disease, obesity,
23 and hypertension—and suffer worse health out-
24 comes, worse health status, and higher mortality
25 rates than their White counterparts.

1 (3) Several recent studies also show that health
2 disparities are a function of not only access to health
3 care, but also the social determinants of health—in-
4 cluding the environment, the physical structure of
5 communities, nutrition and food options, educational
6 attainment, employment, race, ethnicity, geography,
7 and language preference—that directly and indi-
8 rectly affect the health, health care, and wellness of
9 individuals and communities.

10 (4) Integrally involving and fully supporting the
11 communities most affected by health inequities in
12 the assessment, planning, launch, and evaluation of
13 health disparity elimination efforts are among the
14 leading recommendations made to adequately ad-
15 dress and ultimately reduce health disparities.

16 (5) Recommendations also include supporting
17 the efforts of community stakeholders from a broad
18 cross section—including, but not limited to local
19 businesses, local departments of commerce, edu-
20 cation, labor, urban planning, and transportation,
21 and community-based and other nonprofit organiza-
22 tions, including national and regional intermediaries
23 with demonstrated capacity to serve low-income
24 urban communities—to find areas of common
25 ground around health disparity elimination and col-

1 laborate to improve the overall health and wellness
2 of a community and its residents.

3 **SEC. 403. DESIGNATION OF HEALTH EMPOWERMENT**
4 **ZONES.**

5 (a) **IN GENERAL.**—At the request of an eligible com-
6 munity partnership, the Secretary may designate an eligi-
7 ble area as a health empowerment zone.

8 (b) **ELIGIBILITY CRITERIA.**—

9 (1) **ELIGIBLE COMMUNITY PARTNERSHIP.**—A
10 community partnership is eligible to submit a re-
11 quest under this section if the partnership—

12 (A) demonstrates widespread public sup-
13 port from key individuals and entities in the eli-
14 gible area, including members of the target
15 community, State and local governments, non-
16 profit organizations including national and re-
17 gional intermediaries with demonstrated capaci-
18 ty to serve low-income urban communities, and
19 community and industry leaders, for designa-
20 tion of the eligible area as a health empower-
21 ment zone; and

22 (B) includes representatives of—

23 (i) a broad cross section of stake-
24 holders and residents from communities in
25 the eligible area experiencing disproport-

1 tionate disparities in health status and
2 health care; and

3 (ii) organizations, facilities, and insti-
4 tutions that have a history of working
5 within and serving such communities.

6 (2) ELIGIBLE AREA.—An area is eligible to be
7 designated as a health empowerment zone under this
8 section if one or more communities in the area expe-
9 rience disproportionate disparities in health status
10 and health care. In determining whether a commu-
11 nity experiences such disparities, the Secretary shall
12 consider the data collected by the Department of
13 Health and Human Services focusing on the fol-
14 lowing areas:

15 (A) Access to affordable, high-quality
16 health services.

17 (B) The prevalence of disproportionate
18 rates of certain illnesses or diseases including
19 the following:

20 (i) Arthritis, osteoporosis, chronic
21 back conditions, and other musculoskeletal
22 diseases.

23 (ii) Cancer.

24 (iii) Chronic kidney disease.

25 (iv) Diabetes.

- 1 (v) Injury (intentional and uninten-
2 tional).
- 3 (vi) Violence (intimate and non-
4 intimate).
- 5 (vii) Maternal and paternal illnesses
6 and diseases.
- 7 (viii) Infant mortality.
- 8 (ix) Mental illness and other disabil-
9 ities.
- 10 (x) Substance abuse treatment and
11 prevention, including underage drinking.
- 12 (xi) Nutrition, obesity, and overweight
13 conditions.
- 14 (xii) Heart disease.
- 15 (xiii) Hypertension.
- 16 (xiv) Cerebrovascular disease or
17 stroke.
- 18 (xv) Tuberculosis.
- 19 (xvi) HIV/AIDS and other sexually
20 transmitted infections.
- 21 (xvii) Viral hepatitis.
- 22 (xviii) Asthma.
- 23 (xix) Tooth decay and other oral
24 health issues.

1 (C) Within the target community, the his-
2 torical and persistent presence of conditions
3 that have been found to contribute to health
4 disparities including any such conditions re-
5 specting the following:

6 (i) Poverty.

7 (ii) Educational status and the quality
8 of community schools.

9 (iii) Income.

10 (iv) Access to high-quality affordable
11 health care.

12 (v) Work and work environment.

13 (vi) Environmental conditions in the
14 community, including with respect to clean
15 water, clean air, and the presence or ab-
16 sence of pollutants.

17 (vii) Language and English pro-
18 ficiency.

19 (viii) Access to affordable healthy
20 food.

21 (ix) Access to ethnically and culturally
22 diverse health and human service providers
23 and practitioners.

24 (x) Access to culturally and linguis-
25 tically competent health and human serv-

1 ices and health and human service pro-
2 viders.

3 (xi) Health-supporting infrastructure.

4 (xii) Health insurance that is ade-
5 quate and affordable.

6 (xiii) Race, racism, and bigotry (con-
7 scious and unconscious).

8 (xiv) Sexual orientation.

9 (xv) Health literacy.

10 (xvi) Place of residence (such as
11 urban areas, rural areas, and tribal res-
12 ervations).

13 (xvii) Stress.

14 (c) PROCEDURE.—

15 (1) REQUEST.—A request under subsection (a)
16 shall—

17 (A) describe the bounds of the area to be
18 designated as a health empowerment zone and
19 the process used to select those bounds;

20 (B) demonstrate that the partnership sub-
21 mitting the request is an eligible community
22 partnership described in subsection (b)(1);

23 (C) demonstrate that the area is an eligible
24 area described in subsection (b)(2);

1 (D) include a comprehensive assessment of
2 disparities in health status and health care ex-
3 perience by one or more communities in the
4 area;

5 (E) set forth—

6 (i) a vision and a set of values for the
7 area; and

8 (ii) a comprehensive and holistic set of
9 goals to be achieved in the area through
10 designation as a health empowerment zone;
11 and

12 (F) include a strategic plan and an action
13 plan for achieving the goals described in sub-
14 paragraph (E)(ii).

15 (2) APPROVAL.—Not later than 60 days after
16 the receipt of a request for designation of an area
17 as a health empowerment zone under this section,
18 the Secretary shall approve or disapprove the re-
19 quest.

20 (d) MINIMUM NUMBER.—The Secretary—

21 (1) shall designate not more than 110 health
22 empowerment zones under this section; and

23 (2) shall designate at least one health empower-
24 ment zone in each of the several States, the District

1 of Columbia, and each territory or possession of the
2 United States.

3 **SEC. 404. ASSISTANCE TO THOSE SEEKING DESIGNATION.**

4 At the request of any organization or entity seeking
5 to submit a request under section 403(a), the Secretary
6 shall provide technical assistance, and may award a grant,
7 to assist such organization or entity—

8 (1) to form an eligible community partnership
9 described in section 403(b)(1);

10 (2) to complete a health assessment, including
11 an assessment of health disparities under section
12 403(c)(1)(D); or

13 (3) to prepare and submit a request, including
14 a strategic plan, in accordance with section 403.

15 **SEC. 405. BENEFITS OF DESIGNATION.**

16 (a) PRIORITY.—In awarding any competitive grant,
17 a Federal official shall give priority to any applicant
18 that—

19 (1) meets the eligibility criteria for the grant;

20 (2) proposes to use the grant for activities in a
21 health empowerment zone; and

22 (3) demonstrates that such activities will di-
23 rectly and significantly further the goals of the stra-
24 tegic plan approved for such zone under section 403.

1 (b) GRANTS FOR INITIAL IMPLEMENTATION OF
2 STRATEGIC PLAN.—

3 (1) IN GENERAL.—Upon designating an eligible
4 area as a health empowerment zone at the request
5 of an eligible community partnership, the Secretary
6 shall, subject to the availability of appropriations,
7 make a grant to the community partnership for im-
8 plementation of the strategic plan for such zone.

9 (2) GRANT PERIOD.—A grant under paragraph
10 (1) for a health empowerment zone shall be for a pe-
11 riod of 2 years and may be renewed, except that the
12 total period of grants under paragraph (1) for such
13 zone may not exceed 10 years.

14 (3) LIMITATION.—In awarding grants under
15 this subsection, the Secretary shall not give less pri-
16 ority to an applicant or reduce the amount of a
17 grant because the Secretary rendered technical as-
18 sistance or made a grant to the same applicant
19 under section 404.

20 (4) REPORTING.—The Secretary shall require
21 each recipient of a grant under this subsection to re-
22 port to the Secretary not less than every 6 months
23 on the progress in implementing the strategic plan
24 for the health empowerment zone.

1 **SEC. 406. DEFINITION.**

2 In this subtitle, the term “Secretary” means the Sec-
3 retary of Health and Human Services, acting through the
4 Administrator of the Health Resources and Services Ad-
5 ministration and the Deputy Assistant Secretary for Mi-
6 nority Health, and in cooperation with the Director of the
7 Office of Community Services and the Director of the Na-
8 tional Institute for Minority Health and Health Dispari-
9 ties.

10 **SEC. 407. AUTHORIZATION OF APPROPRIATIONS.**

11 To carry out this subtitle, there is authorized to be
12 appropriated \$100,000,000 for fiscal year 2017.

13 **Subtitle B—Other Improvements of**
14 **Health Care Services**

15 **CHAPTER 1—EXPANSION OF COVERAGE**

16 **SEC. 411. AMENDMENT TO THE PUBLIC HEALTH SERVICE**

17 **ACT.**

18 Title XXXIV of the Public Health Service Act, as
19 amended by titles I, II, III, and IX of this Act, is further
20 amended by inserting after subtitle C the following:

1 **“Subtitle D—Reconstruction and**
2 **Improvement Grants for Public**
3 **Health Care Facilities Serving**
4 **Pacific Islanders and the Insu-**
5 **lar Areas**

6 **“SEC. 3451. GRANT SUPPORT FOR QUALITY IMPROVEMENT**
7 **INITIATIVES.**

8 “(a) IN GENERAL.—The Secretary, in collaboration
9 with the Administrator of the Health Resources and Serv-
10 ices Administration, the Director of the Agency for
11 Healthcare Research and Quality, and the Administrator
12 of the Centers for Medicare & Medicaid Services, shall
13 award grants to eligible entities for the conduct of dem-
14 onstration projects to improve the quality of and access
15 to health care.

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

18 “(1) be a health center, hospital, health plan,
19 health system, community clinic, or other health en-
20 tity determined appropriate by the Secretary—

21 “(A) that, by legal mandate or explicitly
22 adopted mission, provides patients with access
23 to services regardless of their ability to pay;

24 “(B) that provides care or treatment for a
25 substantial number of patients who are unin-

1 sured, are receiving assistance under a State
2 program under title XIX of the Social Security
3 Act, or are members of vulnerable populations,
4 as determined by the Secretary; and

5 “(C)(i) with respect to which, not less than
6 50 percent of the entity’s patient population is
7 made up of racial and ethnic minorities; or

8 “(ii) that—

9 “(I) serves a disproportionate percent-
10 age of local, minority racial and ethnic pa-
11 tients, or that has a patient population, at
12 least 50 percent of which is limited-
13 English-proficient; and

14 “(II) provides an assurance that
15 amounts received under the grant will be
16 used only to support quality improvement
17 activities in the racial and ethnic popu-
18 lation served; and

19 “(2) prepare and submit to the Secretary an
20 application at such time, in such manner, and con-
21 taining such information as the Secretary may re-
22 quire.

23 “(c) PRIORITY.—In awarding grants under sub-
24 section (a), the Secretary shall give priority to applicants
25 under subsection (b)(2) that—

1 “(1) demonstrate an intent to operate as part
2 of a health care partnership, network, collaborative,
3 coalition, or alliance where each member entity con-
4 tributes to the design, implementation, and evalua-
5 tion of the proposed intervention; or

6 “(2) intend to use funds to carry out system-
7 wide changes with respect to health care quality im-
8 provement, including—

9 “(A) improved systems for data collection
10 and reporting;

11 “(B) innovative collaborative or similar
12 processes;

13 “(C) group programs with behavioral or
14 self-management interventions;

15 “(D) case management services;

16 “(E) physician or patient reminder sys-
17 tems;

18 “(F) educational interventions; or

19 “(G) other activities determined appro-
20 priate by the Secretary.

21 “(d) USE OF FUNDS.—An entity shall use amounts
22 received under a grant under subsection (a) to support
23 the implementation and evaluation of health care quality
24 improvement activities or minority health and health care
25 disparity reduction activities that include—

1 “(1) with respect to health care systems, activi-
2 ties relating to improving—

3 “(A) patient safety;

4 “(B) timeliness of care;

5 “(C) effectiveness of care;

6 “(D) efficiency of care;

7 “(E) patient centeredness; and

8 “(F) health information technology; and

9 “(2) with respect to patients, activities relating
10 to—

11 “(A) staying healthy;

12 “(B) getting well, mentally and physically;

13 “(C) living effectively with illness or dis-
14 ability; and

15 “(D) coping with end-of-life issues.

16 “(e) COMMON DATA SYSTEMS.—The Secretary shall
17 provide financial and other technical assistance to grant-
18 ees under this section for the development of common data
19 systems.

20 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to carry out this section
22 such sums as may be necessary for each of fiscal years
23 2017 through 2022.

1 **“SEC. 3452. CENTERS OF EXCELLENCE.**

2 “(a) IN GENERAL.—The Secretary, acting through
3 the Administrator of the Health Resources and Services
4 Administration, shall designate centers of excellence at
5 public hospitals, and other health systems serving large
6 numbers of minority patients, that—

7 “(1) meet the requirements of section
8 3451(b)(1);

9 “(2) demonstrate excellence in providing care to
10 minority populations; and

11 “(3) demonstrate excellence in reducing dispari-
12 ties in health and health care.

13 “(b) REQUIREMENTS.—A hospital or health system
14 that serves as a center of excellence under subsection (a)
15 shall—

16 “(1) design, implement, and evaluate programs
17 and policies relating to the delivery of care in ra-
18 cially, ethnically, and linguistically diverse popu-
19 lations;

20 “(2) provide training and technical assistance
21 to other hospitals and health systems relating to the
22 provision of quality health care to minority popu-
23 lations; and

24 “(3) develop activities for graduate or con-
25 tinuing medical education that institutionalize a

1 focus on cultural competence training for health care
2 providers.

3 “(c) 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 2017 through 2022.

7 **“SEC. 3453. RECONSTRUCTION AND IMPROVEMENT GRANTS**
8 **FOR PUBLIC HEALTH CARE FACILITIES SERV-**
9 **ING PACIFIC ISLANDERS AND THE INSULAR**
10 **AREAS.**

11 “(a) IN GENERAL.—The Secretary shall provide di-
12 rect financial assistance to designated health care pro-
13 viders and community health centers in American Samoa,
14 Guam, the Commonwealth of the Northern Mariana Is-
15 lands, the United States Virgin Islands, Puerto Rico, and
16 Hawaii for the purposes of reconstructing and improving
17 health care facilities and services in a culturally competent
18 and sustainable manner.

19 “(b) ELIGIBILITY.—To be eligible to receive direct fi-
20 nancial assistance under subsection (a), an entity shall be
21 a public health facility or community health center located
22 in American Samoa, Guam, the Commonwealth of the
23 Northern Mariana Islands, the United States Virgin Is-
24 lands, Puerto Rico, or Hawaii that—

25 “(1) is owned or operated by—

1 “(A) the Government of American Samoa,
2 Guam, the Commonwealth of the Northern
3 Mariana Islands, the United States Virgin Is-
4 lands, Puerto Rico, or Hawaii or a unit of local
5 government; or

6 “(B) a nonprofit organization; and

7 “(2)(A) provides care or treatment for a sub-
8 stantial number of patients who are uninsured, re-
9 ceiving assistance under a State program under a
10 title XVIII of the Social Security Act, or a State
11 program under title XIX of such Act, or who are
12 members of a vulnerable population, as determined
13 by the Secretary; or

14 “(B) serves a disproportionate percentage of
15 local, minority racial and ethnic patients.

16 “(c) REPORT.—Not later than 180 days after the
17 date of enactment of this title and annually thereafter, the
18 Secretary shall submit to the Congress and the President
19 a report that includes an assessment of health resources
20 and facilities serving populations in American Samoa,
21 Guam, the Commonwealth of the Northern Mariana Is-
22 lands, the United States Virgin Islands, Puerto Rico, and
23 Hawaii. In preparing such report, the Secretary shall—

1 “(1) consult with and obtain information on all
2 health care facilities needs from the entities de-
3 scribed in subsection (b);

4 “(2) include all amounts of Federal assistance
5 received by each entity in the preceding fiscal year;

6 “(3) review the total unmet needs of each juris-
7 diction for health care facilities, including needs for
8 renovation and expansion of existing facilities;

9 “(4) include a strategic plan for addressing the
10 needs of each jurisdiction identified in the report;
11 and

12 “(5) evaluate the effectiveness of the care pro-
13 vided by measuring patient outcomes and cost meas-
14 ures.

15 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated such sums as necessary
17 to carry out this section.”.

18 **SEC. 412. REMOVING CITIZENSHIP AND IMMIGRATION BAR-**
19 **RIERS TO ACCESS TO AFFORDABLE HEALTH**
20 **CARE UNDER THE ACA.**

21 (a) IN GENERAL.—

22 (1) PREMIUM TAX CREDITS.—Section 36B of
23 the Internal Revenue Code of 1986 is amended—

24 (A) in subsection (c)(1)(B)—

1 (i) by amending the subparagraph
2 heading to read as follows: “SPECIAL RULE
3 FOR CERTAIN INDIVIDUALS INELIGIBLE
4 FOR MEDICAID DUE TO STATUS”, and

5 (ii) in clause (ii), by striking “lawfully
6 present in the United States, but” and in-
7 serting “who”, and

8 (B) by striking subsection (e).

9 (2) COST-SHARING REDUCTIONS.—Section 1402
10 of the Patient Protection and Affordable Care Act
11 (42 U.S.C. 18071) is amended by striking sub-
12 section (e).

13 (3) BASIC HEALTH PROGRAM ELIGIBILITY.—
14 Section 1331(e)(1)(B) of the Patient Protection and
15 Affordable Care Act (42 U.S.C. 18051(e)(1)(B)) is
16 amended by striking “lawfully present in the United
17 States”.

18 (4) RESTRICTIONS ON FEDERAL PAYMENTS.—
19 Section 1412 of the Patient Protection and Afford-
20 able Care Act (42 U.S.C. 18082) is amended by
21 striking subsection (d).

22 (5) REQUIREMENT TO MAINTAIN MINIMUM ES-
23 SENTIAL COVERAGE.—Subsection (d) of section
24 5000A of the Internal Revenue Code of 1986 is

1 amended by striking paragraph (3) and by redesignig-
2 nating paragraph (4) as paragraph (3).

3 (b) CONFORMING AMENDMENT.—

4 (1) Section 1411(a) of the Patient Protection
5 and Affordable Care Act (42 U.S.C. 18081(a)) is
6 amended by striking paragraph (1) and redesignig-
7 nating paragraphs (2), (3), and (4) as paragraphs
8 (1), (2), and (3), respectively.

9 (2) Section 1312(f) of the Patient Protection
10 and Affordable Care Act (42 U.S.C. 18032(f)) is
11 amended—

12 (A) in the subsection heading, by striking
13 “access limited to citizens and lawful resi-
14 dents”; and

15 (B) by striking paragraph (3).

16 **SEC. 413. STUDY ON THE UNINSURED.**

17 (a) IN GENERAL.—The Secretary of Health and
18 Human Services (in this section referred to as the “Sec-
19 retary”) shall—

20 (1) conduct a study, in accordance with the
21 standards under section 3101 of the Public Health
22 Service Act (42 U.S.C. 300kk), on the demographic
23 characteristics of the population of individuals who
24 do not have health insurance coverage; and

1 (2) predict, based on such study, the demo-
2 graphic characteristics of the population of individ-
3 uals who would remain without health insurance cov-
4 erage after the end of open enrollment or any special
5 enrollment period.

6 (b) REPORTING REQUIREMENTS.—

7 (1) IN GENERAL.—Not later than 12 months
8 after the date of the enactment of this Act, the Sec-
9 retary shall submit to the Congress the results of
10 the study under subsection (a)(1) and the prediction
11 made under subsection (a)(2).

12 (2) REPORTING OF DEMOGRAPHIC CHARACTER-
13 ISTICS.—The Secretary shall report the demographic
14 characteristics under paragraphs (1) and (2) of sub-
15 section (a) on the basis of racial and ethnic group,
16 and shall stratify the reporting on each racial and
17 ethnic group by other demographic characteristics
18 that can impact access to health insurance coverage,
19 such as sexual orientation, gender identity, primary
20 language, disability status, sex, socioeconomic sta-
21 tus, age group, and citizenship and immigration sta-
22 tus, in a manner consistent with title I of this Act.

1 **SEC. 414. MEDICAID PAYMENT PARITY FOR THE TERRI-**
2 **TORIES.**

3 (a) ELIMINATION OF FUNDING LIMITATIONS FOR
4 PUERTO RICO, THE UNITED STATES VIRGIN ISLANDS,
5 GUAM, THE COMMONWEALTH OF THE NORTHERN MAR-
6 IANA ISLANDS, AND AMERICAN SAMOA.—

7 (1) IN GENERAL.—Section 1108 of the Social
8 Security Act (42 U.S.C. 1308) is amended—

9 (A) in subsection (f), in the matter pre-
10 ceeding paragraph (1), by striking “subsection
11 (g)” and inserting “subsections (g) and (h)”;

12 (B) in subsection (g)(2), in the matter pre-
13 ceeding subparagraph (A)—

14 (i) by striking “Notwithstanding sub-
15 section (f) and subject to and” and insert-
16 ing “Notwithstanding subsection (f) and
17 subject to”; and

18 (ii) by striking “paragraphs (3) and
19 (5)” and inserting “, paragraphs (3) and
20 (5) of this subsection, and subsection (h)”;
21 and

22 (C) by adding at the end the following new
23 subsection:

24 “(h) SUNSET OF FUNDING LIMITATIONS FOR PUER-
25 TO RICO, THE UNITED STATES VIRGIN ISLANDS, GUAM,
26 THE COMMONWEALTH OF THE NORTHERN MARIANA IS-

1 LANDS, AND AMERICAN SAMOA.—Subsections (f) and (g)
2 shall not apply to Puerto Rico, the United States Virgin
3 Islands, Guam, the Commonwealth of the Northern Mar-
4 iana Islands, and American Samoa for any fiscal year
5 after fiscal year 2017.”.

6 (2) CONFORMING AMENDMENT.—Section
7 1903(u) of the Social Security Act (42 U.S.C.
8 1396c(u)) is amended by striking paragraph (4).

9 (3) EFFECTIVE DATE.—The amendments made
10 by this subsection shall apply beginning with fiscal
11 year 2018.

12 (b) PARITY IN FMAP.—

13 (1) IN GENERAL.—Section 1905(b) of the So-
14 cial Security Act (42 U.S.C. 1396d(b)) is amended
15 by inserting after “and American Samoa shall be 55
16 percent,” the following: “(except that, beginning
17 with fiscal year 2020, the Federal medical assistance
18 percentage for Puerto Rico, the United States Virgin
19 Islands, Guam, the Commonwealth of the Northern
20 Mariana Islands, and American Samoa shall be the
21 Federal medical assistance percentage determined by
22 the Secretary in consultation (for the United States
23 Virgin Islands, Guam, the Commonwealth of the
24 Northern Mariana Islands, and American Samoa)
25 with the Secretary of the Interior)”.

1 (2) 2-FISCAL-YEAR TRANSITION.—Notwith-
2 standing any other provision of law, during fiscal
3 years 2018 and 2019, the Federal medical assist-
4 ance percentage established under section 1905(b) of
5 the Social Security Act (42 U.S.C. 1396d(b)) for
6 Puerto Rico, the United States Virgin Islands,
7 Guam, the Commonwealth of the Northern Mariana
8 Islands, and American Samoa shall be the highest
9 such Federal medical assistance percentage applica-
10 ble to any of the 50 States or the District of Colum-
11 bia for the fiscal year involved.

12 (3) PER CAPITA INCOME DATA.—

13 (A) REPORT TO CONGRESS.—Not later
14 than October 1, 2018, the Secretary of Health
15 and Human Services shall submit to Congress
16 a report that describes the per capita income
17 data used to promulgate the Federal medical
18 assistance percentage in the territories and how
19 such data differ from the per capita income
20 data used to promulgate Federal medical assist-
21 ance percentages for the 50 States and the Dis-
22 trict of Columbia. The report should include
23 recommendations on how the Federal medical
24 assistance percentages can be calculated for the

1 territories to ensure parity with the 50 States
2 and the District of Columbia.

3 (B) APPLICATION.—Section 1101(a)(8)(B)
4 of the Social Security Act (42 U.S.C.
5 1308(a)(8)(B)) is amended—

6 (i) by striking “(other than Puerto
7 Rico, the United States Virgin Islands, and
8 Guam)” and inserting “(including Puerto
9 Rico, the United States Virgin Islands,
10 Guam, the Commonwealth of the Northern
11 Mariana Islands, and American Samoa)”;
12 and

13 (ii) by inserting “(or, if such satisfac-
14 tory data are not available in the case of
15 the United States Virgin Islands, Guam,
16 the Northern Mariana Islands, or Amer-
17 ican Samoa, satisfactory data available
18 from the Department of the Interior for
19 the same period, or if such satisfactory
20 data are not available in the case of Puerto
21 Rico, satisfactory data available from the
22 government of the Commonwealth of Puer-
23 to Rico for the same period)” after “De-
24 partment of Commerce”.

1 **SEC. 415. EXTENSION OF MEDICARE SECONDARY PAYER.**

2 (a) IN GENERAL.—Section 1862(b)(1)(C) of the So-
3 cial Security Act (42 U.S.C. 1395y(b)(1)(C)) is amend-
4 ed—

5 (1) in the last sentence, by inserting “, and be-
6 fore January 1, 2017” after “prior to such date”;
7 and

8 (2) by adding at the end the following new sen-
9 tence: “Effective for items and services furnished on
10 or after January 1, 2017 (with respect to periods
11 beginning on or after the date that is 42 months
12 prior to such date), clauses (i) and (ii) shall be ap-
13 plied by substituting ‘42-month’ for ‘12-month’ each
14 place it appears in the first sentence.”.

15 (b) EFFECTIVE DATE.—The amendments made by
16 this section shall take effect on the date of enactment of
17 this Act. For purposes of determining an individual’s sta-
18 tus under section 1862(b)(1)(C) of the Social Security Act
19 (42 U.S.C. 1395y(b)(1)(C)), as amended by subsection
20 (a), an individual who is within the coordinating period
21 as of the date of enactment of this Act shall have that
22 period extended to the full 42 months described in the last
23 sentence of such section, as added by the amendment
24 made by subsection (a)(2).

1 **SEC. 416. BORDER HEALTH GRANTS.**

2 (a) **ELIGIBLE ENTITY DEFINED.**—In this section,
3 the term “eligible entity” means a State, public institution
4 of higher education, local government, tribal government,
5 nonprofit health organization, community health center, or
6 community clinic receiving assistance under section 330
7 of the Public Health Service Act (42 U.S.C. 254b), that
8 is located in the border area.

9 (b) **AUTHORIZATION.**—From funds appropriated
10 under subsection (f), the Secretary of Health and Human
11 Services (in this section referred to as the “Secretary”),
12 acting through the United States members of the United
13 States-Mexico Border Health Commission, shall award
14 grants to eligible entities to address priorities and rec-
15 ommendations to improve the health of border area resi-
16 dents that are established by—

17 (1) the United States members of the United
18 States-Mexico Border Health Commission;

19 (2) the State border health offices; and

20 (3) the Secretary.

21 (c) **APPLICATION.**—An eligible entity that desires a
22 grant under subsection (b) shall submit an application to
23 the Secretary at such time, in such manner, and con-
24 taining such information as the Secretary may require.

1 (d) USE OF FUNDS.—An eligible entity that receives
2 a grant under subsection (b) shall use the grant funds
3 for—

4 (1) programs relating to—

5 (A) maternal and child health;

6 (B) primary care and preventative health;

7 (C) public health and public health infra-
8 structure;

9 (D) musculoskeletal health and obesity;

10 (E) health education and promotion;

11 (F) oral health;

12 (G) mental and behavioral health;

13 (H) substance abuse;

14 (I) health conditions that have a high prev-
15 alence in the border area;

16 (J) medical and health services research;

17 (K) workforce training and development;

18 (L) community health workers, patient
19 navigators, and promotoras;

20 (M) health care infrastructure problems in
21 the border area (including planning and con-
22 struction grants);

23 (N) health disparities in the border area;

24 (O) environmental health; and

1 (P) outreach and enrollment services with
2 respect to Federal programs (including pro-
3 grams authorized under titles XIX and XXI of
4 the Social Security Act (42 U.S.C. 1396 and
5 1397aa)); and

6 (2) other programs determined appropriate by
7 the Secretary.

8 (e) SUPPLEMENT, NOT SUPPLANT.—Amounts pro-
9 vided to an eligible entity awarded a grant under sub-
10 section (b) shall be used to supplement and not supplant
11 other funds available to the eligible entity to carry out the
12 activities described in subsection (d).

13 (f) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated to carry out this section,
15 \$200,000,000 for fiscal year 2017, and such sums as may
16 be necessary for each succeeding fiscal year.

17 **SEC. 417. REMOVING MEDICARE BARRIER TO HEALTH**
18 **CARE.**

19 (a) PART A.—Section 1818(a)(3) of the Social Secu-
20 rity Act (42 U.S.C. 1395i–2(a)(3)) is amended by striking
21 “an alien” and all that follows through “under this sec-
22 tion” and inserting “an individual who is lawfully present
23 in the United States”.

24 (b) PART B.—Section 1836(2) of the Social Security
25 Act (42 U.S.C. 1395o(2)) is amended by striking “an

1 alien” and all that follows through “under this part” and
2 inserting “an individual who is lawfully present in the
3 United States”.

4 **SEC. 418. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
5 **PROVIDED BY URBAN INDIAN HEALTH CEN-**
6 **TERS.**

7 (a) IN GENERAL.—The third sentence of section
8 1905(b) of the Social Security Act (42 U.S.C. 1396(b))
9 is amended by inserting “or are received through a pro-
10 gram operated by an urban Indian organization through
11 a grant or contract under title V of such Act” after “(as
12 defined in section 4 of the Indian Health Care Improve-
13 ment Act)”.

14 (b) EFFECTIVE DATE.—The amendment made by
15 this section shall apply to medical assistance provided on
16 or after the date of enactment of this Act.

17 **SEC. 419. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
18 **PROVIDED TO A NATIVE HAWAIIAN THROUGH**
19 **A FEDERALLY QUALIFIED HEALTH CENTER**
20 **OR A NATIVE HAWAIIAN HEALTH CARE SYS-**
21 **TEM UNDER THE MEDICAID PROGRAM.**

22 (a) IN GENERAL.—The third sentence of section
23 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)),
24 as amended by section 418(a), is amended by inserting
25 before the period the following: “; and, with respect to

1 medical assistance provided to a Native Hawaiian (as de-
2 fined in section 12(2) of the Native Hawaiian Health Care
3 Improvement Act) through a federally qualified health
4 center or a Native Hawaiian health care system (as de-
5 fined in section 12(6) of such Act), whether directly, by
6 referral, or under contract or other arrangement between
7 such federally qualified health center or Native Hawaiian
8 health care system and another health care provider”.

9 (b) EFFECTIVE DATE.—The amendment made by
10 this section shall apply to medical assistance provided on
11 or after the date of enactment of this Act.

12 **CHAPTER 2—EXPANSION OF ACCESS**

13 **SEC. 431. 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 Secretary
22 of Health and Human Services, acting through the Ad-
23 ministrator of the Health Resources and Services Admin-
24 istration, shall award grants to eligible entities to assist
25 in designing, implementing, and evaluating culturally and

1 linguistically appropriate, science-based, and community-
2 driven sustainable strategies to eliminate racial and ethnic
3 health and health care disparities.

4 (c) ELIGIBLE ENTITIES.—To be eligible to receive a
5 grant under this section, an entity shall—

6 (1) represent a coalition—

7 (A) whose principal purpose is to develop
8 and implement interventions to reduce or elimi-
9 nate a health or health care disparity in a tar-
10 geted racial or ethnic minority group in the
11 community served by the coalition; and

12 (B) that includes—

13 (i) members selected from among—

14 (I) public health departments;

15 (II) community-based organiza-
16 tions;

17 (III) university and research or-
18 ganizations;

19 (IV) American Indian tribal or-
20 ganizations, national American Indian
21 organizations, Indian Health Service,
22 or organizations serving Alaska Na-
23 tives; and

24 (V) interested public or private
25 health care providers or organizations

1 as deemed appropriate by the Sec-
2 retary; and

3 (ii) at least 1 member from a commu-
4 nity-based organization that represents the
5 targeted racial or ethnic minority group;
6 and

7 (2) submit to the Secretary an application at
8 such time, in such manner, and containing such in-
9 formation as the Secretary may require, which shall
10 include—

11 (A) a description of the targeted racial or
12 ethnic populations in the community to be
13 served under the grant;

14 (B) a description of at least 1 health dis-
15 parity that exists in the racial or ethnic tar-
16 geted populations, including health issues such
17 as infant mortality, breast and cervical cancer
18 screening and management, musculoskeletal
19 diseases and obesity, prostate cancer screening
20 and management, cardiovascular disease, diabe-
21 tes, child and adult immunization levels, or
22 other health priority areas as designated by the
23 Secretary; and

24 (C) a demonstration of a proven record of
25 accomplishment of the coalition members in

1 serving and working with the targeted commu-
2 nity.

3 (d) SUSTAINABILITY.—The Secretary shall give pri-
4 ority to an eligible entity under this section if the entity
5 agrees that, with respect to the costs to be incurred by
6 the entity in carrying out the activities for which the grant
7 was awarded, the entity (and each of the participating
8 partners in the coalition represented by the entity) will
9 maintain its expenditures of non-Federal funds for such
10 activities at a level that is not less than the level of such
11 expenditures during the fiscal year immediately preceding
12 the first fiscal year for which the grant is awarded.

13 (e) NONDUPLICATION.—Funds provided through this
14 grant program should supplement, not supplant, existing
15 Federal funding, and the funds should not be used to du-
16 plicate the activities of the other health disparity grant
17 programs in this Act.

18 (f) TECHNICAL ASSISTANCE.—The Secretary may,
19 either directly or by grant or contract, provide any entity
20 that receives a grant under this section with technical and
21 other nonfinancial assistance necessary to meet the re-
22 quirements of this section.

23 (g) DISSEMINATION.—The Secretary shall encourage
24 and enable grantees to share best practices, evaluation re-
25 sults, and reports with communities not affiliated with

1 grantees using the Internet, conferences, and other perti-
2 nent information regarding the projects funded by this
3 section, including the outreach efforts of the Office of Mi-
4 nority Health and Health Disparity Elimination and the
5 Centers for Disease Control and Prevention.

6 (h) ADMINISTRATIVE BURDENS.—The Secretary
7 shall make every effort to minimize duplicative or unneces-
8 sary administrative burdens on grantees.

9 (i) DEFINITION.—In this section, the term “Sec-
10 retary” means the Secretary of Health and Human Serv-
11 ices.

12 (j) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated such sums as may be
14 necessary to carry out this section.

15 **SEC. 432. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.**

16 (a) ELIMINATION OF ISOLATION TEST FOR COST-
17 BASED AMBULANCE REIMBURSEMENT.—

18 (1) IN GENERAL.—Section 1834(l)(8) of the
19 Social Security Act (42 U.S.C. 1395m(l)(8)) is
20 amended—

21 (A) in subparagraph (B)—

22 (i) by striking “owned and”; and

23 (ii) by inserting “(including when
24 such services are provided by the entity

1 under an arrangement with the hospital)”
2 after “hospital”; and

3 (B) by striking the comma at the end of
4 subparagraph (B) and all that follows and in-
5 serting a period.

6 (2) EFFECTIVE DATE.—The amendments made
7 by this subsection shall apply to services furnished
8 on or after January 1, 2015.

9 (b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE
10 TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT
11 REQUIREMENT.—

12 (1) IN GENERAL.—Section 1820(c)(2) of the
13 Social Security Act (42 U.S.C. 1395i–4(c)(2)) is
14 amended—

15 (A) in subparagraph (B)(iii), by striking
16 “provides not more than” and inserting “sub-
17 ject to subparagraph (F), provides not more
18 than”; and

19 (B) by adding at the end the following new
20 subparagraph:

21 “(F) ALTERNATIVE TO 25 INPATIENT BED
22 LIMIT REQUIREMENT.—

23 “(i) IN GENERAL.—A State may elect
24 to treat a facility, with respect to the des-
25 ignation of the facility for a cost-reporting

1 period, as satisfying the requirement of
2 subparagraph (B)(iii) relating to a max-
3 imum number of acute care inpatient beds
4 if the facility elects, in accordance with a
5 method specified by the Secretary and be-
6 fore the beginning of the cost reporting pe-
7 riod, to meet the requirement under clause
8 (ii).

9 “(ii) ALTERNATE REQUIREMENT.—
10 The requirement under this clause, with
11 respect to a facility and a cost-reporting
12 period, is that the total number of inpa-
13 tient bed days described in subparagraph
14 (B)(iii) during such period will not exceed
15 7,300. For purposes of this subparagraph,
16 an individual who is an inpatient in a bed
17 in the facility for a single day shall be
18 counted as one inpatient bed day.

19 “(iii) WITHDRAWAL OF ELECTION.—
20 The option described in clause (i) shall not
21 apply to a facility for a cost-reporting pe-
22 riod if the facility (for any two consecutive
23 cost-reporting periods during the previous
24 5 cost-reporting periods) was treated under
25 such option and had a total number of in-

1 patient bed days for each of such two cost-
2 reporting periods that exceeded the num-
3 ber specified in such clause.”.

4 (2) EFFECTIVE DATE.—The amendments made
5 by paragraph (1) shall apply to cost-reporting peri-
6 ods beginning on or after the date of the enactment
7 of this Act.

8 **SEC. 433. ESTABLISHMENT OF RURAL COMMUNITY HOS-**
9 **PITAL (RCH) PROGRAM.**

10 (a) IN GENERAL.—Section 1861 of the Social Secu-
11 rity Act (42 U.S.C. 1395x), as amended by section
12 205(b)(1), is amended by adding at the end of the fol-
13 lowing new subsection:

14 “Rural Community Hospital; Rural Community Hospital
15 Services

16 “(jjj)(1) The term ‘rural community hospital’ means
17 a hospital (as defined in subsection (e)) that—

18 “(A) is located in a rural area (as defined in
19 section 1886(d)(2)(D)) or treated as being so lo-
20 cated pursuant to section 1886(d)(8)(E);

21 “(B) subject to paragraph (2), has less than 51
22 acute care inpatient beds, as reported in its most re-
23 cent cost report;

24 “(C) makes available 24-hour emergency care
25 services;

1 “(D) subject to paragraph (3), has a provider
2 agreement in effect with the Secretary and is open
3 to the public as of January 1, 2010; and

4 “(E) applies to the Secretary for such designa-
5 tion.

6 “(2) For purposes of paragraph (1)(B), beds in a
7 psychiatric or rehabilitation unit of the hospital which is
8 a distinct part of the hospital shall not be counted.

9 “(3) Paragraph (1)(D) shall not be construed to pro-
10 hibit any of the following from qualifying as a rural com-
11 munity hospital:

12 “(A) A replacement facility (as defined by the
13 Secretary in regulations in effect on January 1,
14 2012) with the same service area (as defined by the
15 Secretary in regulations in effect on such date).

16 “(B) A facility obtaining a new provider num-
17 ber pursuant to a change of ownership.

18 “(C) A facility which has a binding written
19 agreement with an outside, unrelated party for the
20 construction, reconstruction, lease, rental, or financ-
21 ing of a building as of January 1, 2012.

22 “(4) Nothing in this subsection shall be construed as
23 prohibiting a critical access hospital from qualifying as a
24 rural community hospital if the critical access hospital

1 meets the conditions otherwise applicable to hospitals
2 under subsection (e) and section 1866.

3 “(5) Nothing in this subsection shall be construed as
4 prohibiting a rural community hospital participating in
5 the demonstration program under section 410A of the
6 Medicare Prescription Drug, Improvement, and Mod-
7 ernization Act of 2003 (Public Law 108–173; 117 Stat.
8 2313) from qualifying as a rural community hospital if
9 the rural community hospital meets the conditions other-
10 wise applicable to hospitals under subsection (e) and sec-
11 tion 1866.”.

12 (b) PAYMENT.—

13 (1) INPATIENT HOSPITAL SERVICES.—Section
14 1814 of the Social Security Act (42 U.S.C. 1395f)
15 is amended by adding at the end the following new
16 subsection:

17 “Payment for Inpatient Services Furnished in Rural
18 Community Hospitals

19 “(m) The amount of payment under this part for in-
20 patient hospital services furnished in a rural community
21 hospital, other than such services furnished in a psy-
22 chiatric or rehabilitation unit of the hospital which is a
23 distinct part, is, at the election of the hospital in the appli-
24 cation referred to in section 1861(jjj)(1)(E)—

1 “(1) 101 percent of the reasonable costs of pro-
2 viding such services, without regard to the amount
3 of the customary or other charge, or

4 “(2) the amount of payment provided for under
5 the prospective payment system for inpatient hos-
6 pital services under section 1886(d).”.

7 (2) OUTPATIENT SERVICES.—Section 1834 of
8 such Act (42 U.S.C. 1395m) is amended by adding
9 at the end the following new subsection:

10 “(p) PAYMENT FOR OUTPATIENT SERVICES FUR-
11 NISHED IN RURAL COMMUNITY HOSPITALS.—The
12 amount of payment under this part for outpatient services
13 furnished in a rural community hospital is, at the election
14 of the hospital in the application referred to in section
15 1861(jjj)(1)(E)—

16 “(1) 101 percent of the reasonable costs of pro-
17 viding such services, without regard to the amount
18 of the customary or other charge and any limitation
19 under section 1861(v)(1)(U), or

20 “(2) the amount of payment provided for under
21 the prospective payment system for covered OPD
22 services under section 1833(t).”.

23 (3) EXEMPTION FROM 30-PERCENT REDUCTION
24 IN REIMBURSEMENT FOR BAD DEBT.—Section
25 1861(v)(1)(T) of such Act (42 U.S.C.

1 1395x(v)(1)(T)) is amended by inserting “(other
2 than for a rural community hospital)” after “In de-
3 termining such reasonable costs for hospitals”.

4 (c) BENEFICIARY COST-SHARING FOR OUTPATIENT
5 SERVICES.—Section 1834(p) of such Act (as added by
6 subsection (b)(2)) is amended—

7 (1) by redesignating paragraphs (1) and (2) as
8 subparagraphs (A) and (B), respectively;

9 (2) by inserting “(1)” after “(p)”; and

10 (3) by adding at the end the following:

11 “(2) The amounts of beneficiary cost-sharing for out-
12 patient services furnished in a rural community hospital
13 under this part shall be as follows:

14 “(A) For items and services that would have
15 been paid under section 1833(t) if provided by a
16 hospital, the amount of cost-sharing determined
17 under paragraph (8) of such section.

18 “(B) For items and services that would have
19 been paid under section 1833(h) if furnished by a
20 provider or supplier, no cost-sharing shall apply.

21 “(C) For all other items and services, the
22 amount of cost-sharing that would apply to the item
23 or service under the methodology that would be used
24 to determine payment for such item or service if pro-

1 vided by a physician, provider, or supplier, as the
2 case may be.”.

3 (d) CONFORMING AMENDMENTS.—

4 (1) PART A PAYMENT.—Section 1814(b) of
5 such Act (42 U.S.C. 1395f(b)) is amended in the
6 matter preceding paragraph (1) by inserting “other
7 than inpatient hospital services furnished by a rural
8 community hospital,” after “critical access hospital
9 services,”.

10 (2) PART B PAYMENT.—Section 1833(a) of
11 such Act (42 U.S.C. 1395l(a)), as amended by sec-
12 tion 205(b)(3), is amended—

13 (A) in paragraph (2), in the matter before
14 subparagraph (A), by striking “and (I)” and in-
15 serting “(I), and (K)”;

16 (B) by striking “and” at the end of para-
17 graph (9);

18 (C) by striking the period at the end of
19 paragraph (10) and inserting “; and”; and

20 (D) by adding at the end the following:

21 “(11) in the case of outpatient services fur-
22 nished by a rural community hospital, the amounts
23 described in section 1834(p).”.

24 (3) TECHNICAL AMENDMENTS.—

1 (A) CONSULTATION WITH STATE AGEN-
2 CIES.—Section 1863 of such Act (42 U.S.C.
3 1395z) is amended by striking “and (dd)(2)”
4 and inserting “(dd)(2), (mm)(1), and (jjj)(1)”.

5 (B) PROVIDER AGREEMENTS.—Section
6 1866(a)(2)(A) of such Act (42 U.S.C.
7 1395cc(a)(2)(A)) is amended by inserting “sec-
8 tion 1834(p)(2),” after “section 1833(b),”.

9 (e) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to items and services furnished on
11 or after October 1, 2016.

12 **SEC. 434. MEDICARE REMOTE MONITORING PILOT**
13 **PROJECTS.**

14 (a) PILOT PROJECTS.—

15 (1) IN GENERAL.—Not later than 9 months
16 after the date of enactment of this Act, the Sec-
17 retary of Health and Human Services (in this sec-
18 tion referred to as the “Secretary”) shall conduct
19 pilot projects under title XVIII of the Social Secu-
20 rity Act for the purpose of providing incentives to
21 home health agencies to utilize home monitoring and
22 communications technologies that—

23 (A) enhance health outcomes for Medicare
24 beneficiaries; and

25 (B) reduce expenditures under such title.

1 (2) SITE REQUIREMENTS.—

2 (A) URBAN AND RURAL.—The Secretary
3 shall conduct the pilot projects under this sec-
4 tion in both urban and rural areas.

5 (B) SITE IN A SMALL STATE.—The Sec-
6 retary shall conduct at least 3 of the pilot
7 projects in a State with a population of less
8 than 1,000,000.

9 (3) DEFINITION OF HOME HEALTH AGENCY.—

10 In this section, the term “home health agency” has
11 the meaning given that term in section 1861(o) of
12 the Social Security Act (42 U.S.C. 1395x(o)).

13 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE
14 OF PROJECTS.—The Secretary shall specify the criteria
15 for identifying those Medicare beneficiaries who shall be
16 considered within the scope of the pilot projects under this
17 section for purposes of the application of subsection (c)
18 and for the assessment of the effectiveness of the home
19 health agency in achieving the objectives of this section.
20 Such criteria may provide for the inclusion in the projects
21 of Medicare beneficiaries who begin receiving home health
22 services under title XVIII of the Social Security Act after
23 the date of the implementation of the projects.

24 (c) INCENTIVES.—

1 (1) PERFORMANCE TARGETS.—The Secretary
2 shall establish for each home health agency partici-
3 pating in a pilot project under this section a per-
4 formance target using one of the following meth-
5 odologies, as determined appropriate by the Sec-
6 retary:

7 (A) ADJUSTED HISTORICAL PERFORMANCE
8 TARGET.—The Secretary shall establish for the
9 agency—

10 (i) a base expenditure amount equal
11 to the average total payments made to the
12 agency under parts A and B of title XVIII
13 of the Social Security Act for Medicare
14 beneficiaries determined to be within the
15 scope of the pilot project in a base period
16 determined by the Secretary; and

17 (ii) an annual per capita expenditure
18 target for such beneficiaries, reflecting the
19 base expenditure amount adjusted for risk
20 and adjusted growth rates.

21 (B) COMPARATIVE PERFORMANCE TAR-
22 GET.—The Secretary shall establish for the
23 agency a comparative performance target equal
24 to the average total payments under such parts
25 A and B during the pilot project for comparable

1 individuals in the same geographic area that
2 are not determined to be within the scope of the
3 pilot project.

4 (2) INCENTIVE.—Subject to paragraph (3), the
5 Secretary shall pay to each participating home care
6 agency an incentive payment for each year under the
7 pilot project equal to a portion of the Medicare sav-
8 ings realized for such year relative to the perform-
9 ance target under paragraph (1).

10 (3) LIMITATION ON EXPENDITURES.—The Sec-
11 retary shall limit incentive payments under this sec-
12 tion in order to ensure that the aggregate expendi-
13 tures under title XVIII of the Social Security Act
14 (including incentive payments under this subsection)
15 do not exceed the amount that the Secretary esti-
16 mates would have been expended if the pilot projects
17 under this section had not been implemented.

18 (d) WAIVER AUTHORITY.—The Secretary may waive
19 such provisions of titles XI and XVIII of the Social Secu-
20 rity Act as the Secretary determines to be appropriate for
21 the conduct of the pilot projects under this section.

22 (e) REPORT TO CONGRESS.—Not later than 5 years
23 after the date that the first pilot project under this section
24 is implemented, the Secretary shall submit to Congress a
25 report on the pilot projects. Such report shall contain a

1 detailed description of issues related to the expansion of
2 the projects under subsection (f) and recommendations for
3 such legislation and administrative actions as the Sec-
4 retary considers appropriate.

5 (f) EXPANSION.—If the Secretary determines that
6 any of the pilot projects under this section enhance health
7 outcomes for Medicare beneficiaries and reduce expendi-
8 tures under title XVIII of the Social Security Act, the Sec-
9 retary may initiate comparable projects in additional
10 areas.

11 (g) INCENTIVE PAYMENTS HAVE NO EFFECT ON
12 OTHER MEDICARE PAYMENTS TO AGENCIES.—An incen-
13 tive payment under this section—

14 (1) shall be in addition to the payments that a
15 home health agency would otherwise receive under
16 title XVIII of the Social Security Act for the provi-
17 sion of home health services; and

18 (2) shall have no effect on the amount of such
19 payments.

20 **SEC. 435. RURAL HEALTH QUALITY ADVISORY COMMISSION**
21 **AND DEMONSTRATION PROJECTS.**

22 (a) RURAL HEALTH QUALITY ADVISORY COMMIS-
23 SION.—

24 (1) ESTABLISHMENT.—Not later than 6
25 months after the date of the enactment of this sec-

1 tion, the Secretary of Health and Human Services
2 (in this section referred to as the “Secretary”) shall
3 establish a commission to be known as the Rural
4 Health Quality Advisory Commission (in this section
5 referred to as the “Commission”).

6 (2) DUTIES OF COMMISSION.—

7 (A) NATIONAL PLAN.—The Commission
8 shall develop, coordinate, and facilitate imple-
9 mentation of a national plan for rural health
10 quality improvement. The national plan shall—

11 (i) identify objectives for rural health
12 quality improvement;

13 (ii) identify strategies to eliminate
14 known gaps in rural health system capacity
15 and improve rural health quality; and

16 (iii) provide for Federal programs to
17 identify opportunities for strengthening
18 and aligning policies and programs to im-
19 prove rural health quality.

20 (B) DEMONSTRATION PROJECTS.—The
21 Commission shall design demonstration projects
22 to test alternative models for rural health qual-
23 ity improvement, including with respect to both
24 personal and population health.

1 (C) MONITORING.—The Commission shall
2 monitor progress toward the objectives identi-
3 fied pursuant to paragraph (1)(A).

4 (3) MEMBERSHIP.—

5 (A) NUMBER.—The Commission shall be
6 composed of 11 members appointed by the Sec-
7 retary.

8 (B) SELECTION.—The Secretary shall se-
9 lect the members of the Commission from
10 among individuals with significant rural health
11 care and health care quality expertise, including
12 expertise in clinical health care, health care
13 quality research, population or public health, or
14 purchaser organizations.

15 (4) CONTRACTING AUTHORITY.—Subject to the
16 availability of funds, the Commission may enter into
17 contracts and make other arrangements, as may be
18 necessary to carry out the duties described in para-
19 graph (2).

20 (5) STAFF.—Upon the request of the Commis-
21 sion, the Secretary may detail, on a reimbursable
22 basis, any of the personnel of the Office of Rural
23 Health Policy of the Health Resources and Services
24 Administration, the Agency for Healthcare Quality
25 and Research, or the Centers for Medicare & Med-

1 icaid Services to the Commission to assist in car-
2 rying out this subsection.

3 (6) REPORTS TO CONGRESS.—Not later than 1
4 year after the establishment of the Commission, and
5 annually thereafter, the Commission shall submit a
6 report to the Congress on rural health quality. Each
7 such report shall include the following:

8 (A) An inventory of relevant programs and
9 recommendations for improved coordination and
10 integration of policy and programs.

11 (B) An assessment of achievement of the
12 objectives identified in the national plan devel-
13 oped under paragraph (2) and recommenda-
14 tions for realizing such objectives.

15 (C) Recommendations on Federal legisla-
16 tion, regulations, or administrative policies to
17 enhance rural health quality and outcomes.

18 (b) RURAL HEALTH QUALITY DEMONSTRATION
19 PROJECTS.—

20 (1) IN GENERAL.—Not later than 270 days
21 after the date of the enactment of this section, the
22 Secretary, in consultation with the Rural Health
23 Quality Advisory Commission, the Office of Rural
24 Health Policy of the Health Resources and Services
25 Administration, the Agency for Healthcare Research

1 and Quality, and the Centers for Medicare & Med-
2 icaid Services, shall make grants to eligible entities
3 for 5 demonstration projects to implement and
4 evaluate methods for improving the quality of health
5 care in rural communities. Each such demonstration
6 project shall include—

7 (A) alternative community models that—

8 (i) will achieve greater integration of
9 personal and population health services;
10 and

11 (ii) address safety, effectiveness,
12 patient- or community-centeredness, timeli-
13 ness, efficiency, and equity (the 6 aims
14 identified by the Institute of Medicine of
15 the National Academies in its report enti-
16 tled “Crossing the Quality Chasm: A New
17 Health System for the 21st Century” re-
18 leased on March 1, 2001);

19 (B) innovative approaches to the financing
20 and delivery of health services to achieve rural
21 health quality goals; and

22 (C) development of quality improvement
23 support structures to assist rural health sys-
24 tems and professionals (such as workforce sup-
25 port structures, quality monitoring and report-

1 ing, clinical care protocols, and information
2 technology applications).

3 (2) ELIGIBLE ENTITIES.—In this subsection,
4 the term “eligible entity” means a consortium
5 that—

6 (A) shall include—

7 (i) at least one health care provider or
8 health care delivery system located in a
9 rural area; and

10 (ii) at least one organization rep-
11 resenting multiple community stakeholders;
12 and

13 (B) may include other partners such as
14 rural research centers.

15 (3) CONSULTATION.—In developing the pro-
16 gram for awarding grants under this subsection, the
17 Secretary shall consult with the Administrator of the
18 Agency for Healthcare Research and Quality, rural
19 health care providers, rural health care researchers,
20 and private and nonprofit groups (including national
21 associations) which are undertaking similar efforts.

22 (4) EXPEDITED WAIVERS.—The Secretary shall
23 expedite the processing of any waiver that—

1 (A) is authorized under title XVIII or XIX
2 of the Social Security Act (42 U.S.C. 1395 et
3 seq.); and

4 (B) is necessary to carry out a demonstra-
5 tion project under this subsection.

6 (5) DEMONSTRATION PROJECT SITES.—The
7 Secretary shall ensure that the 5 demonstration
8 projects funded under this subsection are conducted
9 at a variety of sites representing the diversity of
10 rural communities in the Nation.

11 (6) DURATION.—Each demonstration project
12 under this subsection shall be for a period of 4
13 years.

14 (7) INDEPENDENT EVALUATION.—The Sec-
15 retary shall enter into an arrangement with an enti-
16 ty that has experience working directly with rural
17 health systems for the conduct of an independent
18 evaluation of the program carried out under this
19 subsection.

20 (8) REPORT.—Not later than 1 year after the
21 conclusion of all of the demonstration projects fund-
22 ed under this subsection, the Secretary shall submit
23 a report to the Congress on the results of such
24 projects. The report shall include—

1 (A) an evaluation of patient access to care,
2 patient outcomes, and an analysis of the cost
3 effectiveness of each such project; and

4 (B) recommendations on Federal legisla-
5 tion, regulations, or administrative policies to
6 enhance rural health quality and outcomes.

7 (c) APPROPRIATION.—

8 (1) IN GENERAL.—Out of funds in the Treas-
9 ury not otherwise appropriated, there are appro-
10 priated to the Secretary to carry out this section
11 \$30,000,000 for the period of fiscal years 2017
12 through 2021.

13 (2) AVAILABILITY.—

14 (A) IN GENERAL.—Funds appropriated
15 under paragraph (1) shall remain available for
16 expenditure through fiscal year 2021.

17 (B) REPORT.—For purposes of carrying
18 out subsection (b)(8), funds appropriated under
19 paragraph (1) shall remain available for ex-
20 penditure through fiscal year 2022.

21 (3) RESERVATION.—Of the amount appro-
22 priated under paragraph (1), the Secretary shall re-
23 serve—

24 (A) \$5,000,000 to carry out subsection (a);
25 and

1 (B) \$25,000,000 to carry out subsection
2 (b), of which—

3 (i) 2 percent shall be for the provision
4 of technical assistance to grant recipients;
5 and

6 (ii) 5 percent shall be for independent
7 evaluation under subsection (b)(7).

8 **SEC. 436. RURAL HEALTH CARE SERVICES.**

9 Section 330A of the Public Health Service Act (42
10 U.S.C. 254c) is amended to read as follows:

11 **“SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH,**
12 **RURAL HEALTH NETWORK DEVELOPMENT,**
13 **DELTA RURAL DISPARITIES AND HEALTH**
14 **SYSTEMS DEVELOPMENT, AND SMALL RURAL**
15 **HEALTH CARE PROVIDER QUALITY IMPROVE-**
16 **MENT GRANT PROGRAMS.**

17 “(a) PURPOSE.—The purpose of this section is to
18 provide for grants—

19 “(1) under subsection (b), to promote rural
20 health care services outreach;

21 “(2) under subsection (c), to provide for the
22 planning and implementation of integrated health
23 care networks in rural areas;

24 “(3) under subsection (d), to assist rural com-
25 munities in the Delta Region to reduce health dis-

1 parities and to promote and enhance health system
2 development; and

3 “(4) under subsection (e), to provide for the
4 planning and implementation of small rural health
5 care provider quality improvement activities.

6 “(b) RURAL HEALTH CARE SERVICES OUTREACH
7 GRANTS.—

8 “(1) GRANTS.—The Director of the Office of
9 Rural Health Policy of the Health Resources and
10 Services Administration may award grants to eligible
11 entities to promote rural health care services out-
12 reach by expanding the delivery of health care serv-
13 ices to include new and enhanced services in rural
14 areas. The Director may award the grants for peri-
15 ods of not more than 3 years.

16 “(2) ELIGIBILITY.—To be eligible to receive a
17 grant under this subsection for a project, an enti-
18 ty—

19 “(A) shall be a rural public or rural non-
20 profit private entity, a facility that qualifies as
21 a rural health clinic under title XVIII of the
22 Social Security Act, a public or nonprofit entity
23 existing exclusively to provide services to mi-
24 grant and seasonal farm workers in rural areas,
25 or a tribal government whose grant-funded ac-

1 activities will be conducted within federally recog-
2 nized tribal areas;

3 “(B) shall represent a consortium com-
4 posed of members—

5 “(i) that include 3 or more independ-
6 ently owned health care entities; and

7 “(ii) that may be nonprofit or for-
8 profit entities; and

9 “(C) shall not previously have received a
10 grant under this subsection for the same or a
11 similar project, unless the entity is proposing to
12 expand the scope of the project or the area that
13 will be served through the project.

14 “(3) APPLICATIONS.—To be eligible to receive a
15 grant under this subsection, an eligible entity shall
16 prepare and submit to the Director an application at
17 such time, in such manner, and containing such in-
18 formation as the Director may require, including—

19 “(A) a description of the project that the
20 eligible entity will carry out using the funds
21 provided under the grant;

22 “(B) a description of the manner in which
23 the project funded under the grant will meet
24 the health care needs of rural populations in
25 the local community or region to be served;

1 “(C) a plan for quantifying how health
2 care needs will be met through identification of
3 the target population and benchmarks of service
4 delivery or health status, such as—

5 “(i) quantifiable measurements of
6 health status improvement for projects fo-
7 cusing on health promotion; or

8 “(ii) benchmarks of increased access
9 to primary care, including tracking factors
10 such as the number and type of primary
11 care visits, identification of a medical
12 home, or other general measures of such
13 access;

14 “(D) a description of how the local com-
15 munity or region to be served will be involved
16 in the development and ongoing operations of
17 the project;

18 “(E) a plan for sustaining the project after
19 Federal support for the project has ended;

20 “(F) a description of how the project will
21 be evaluated;

22 “(G) the administrative capacity to submit
23 annual performance data electronically as speci-
24 fied by the Director; and

1 “(H) other such information as the Direc-
2 tor determines to be appropriate.

3 “(c) RURAL HEALTH NETWORK DEVELOPMENT
4 GRANTS.—

5 “(1) GRANTS.—

6 “(A) IN GENERAL.—The Director may
7 award rural health network development grants
8 to eligible entities to promote, through planning
9 and implementation, the development of inte-
10 grated health care networks that have combined
11 the functions of the entities participating in the
12 networks in order to—

13 “(i) achieve efficiencies and economies
14 of scale;

15 “(ii) expand access to, coordinate, and
16 improve the quality of the health care de-
17 livery system through development of orga-
18 nizational efficiencies;

19 “(iii) implement health information
20 technology to achieve efficiencies, reduce
21 medical errors, and improve quality;

22 “(iv) coordinate care and manage
23 chronic illness; and

24 “(v) strengthen the rural health care
25 system as a whole in such a manner as to

1 show a quantifiable return on investment
2 to the participants in the network.

3 “(B) GRANT PERIODS.—The Director may
4 award such a rural health network development
5 grant—

6 “(i) for a period of 3 years for imple-
7 mentation activities; or

8 “(ii) for a period of 1 year for plan-
9 ning activities to assist in the initial devel-
10 opment of an integrated health care net-
11 work, if the proposed participants in the
12 network do not have a history of collabo-
13 rative efforts and a 3-year grant would be
14 inappropriate.

15 “(2) ELIGIBILITY.—To be eligible to receive a
16 grant under this subsection, an entity—

17 “(A) shall be a rural public or rural non-
18 profit private entity, a facility that qualifies as
19 a rural health clinic under title XVIII of the
20 Social Security Act, a public or nonprofit entity
21 existing exclusively to provide services to mi-
22 grant and seasonal farm workers in rural areas,
23 or a tribal government whose grant-funded ac-
24 tivities will be conducted within federally recog-
25 nized tribal areas;

1 “(B) shall represent a network composed
2 of participants—

3 “(i) that include 3 or more independ-
4 ently owned health care entities; and

5 “(ii) that may be nonprofit or for-
6 profit entities; and

7 “(C) shall not previously have received a
8 grant under this subsection (other than a 1-
9 year grant for planning activities) for the same
10 or a similar project.

11 “(3) APPLICATIONS.—To be eligible to receive a
12 grant under this subsection, an eligible entity, in
13 consultation with the appropriate State office of
14 rural health or another appropriate State entity,
15 shall prepare and submit to the Director an applica-
16 tion at such time, in such manner, and containing
17 such information as the Director may require, in-
18 cluding—

19 “(A) a description of the project that the
20 eligible entity will carry out using the funds
21 provided under the grant;

22 “(B) an explanation of the reasons why
23 Federal assistance is required to carry out the
24 project;

25 “(C) a description of—

1 “(i) the history of collaborative activi-
2 ties carried out by the participants in the
3 network;

4 “(ii) the degree to which the partici-
5 pants are ready to integrate their func-
6 tions; and

7 “(iii) how the local community or re-
8 gion to be served will benefit from and be
9 involved in the activities carried out by the
10 network;

11 “(D) a description of how the local com-
12 munity or region to be served will experience in-
13 creased access to quality health care services
14 across the continuum of care as a result of the
15 integration activities carried out by the net-
16 work, including a description of—

17 “(i) return on investment for the com-
18 munity and the network members; and

19 “(ii) other quantifiable performance
20 measures that show the benefit of the net-
21 work activities;

22 “(E) a plan for sustaining the project after
23 Federal support for the project has ended;

24 “(F) a description of how the project will
25 be evaluated;

1 “(G) the administrative capacity to submit
2 annual performance data electronically as speci-
3 fied by the Director; and

4 “(H) other such information as the Direc-
5 tor determines to be appropriate.

6 “(d) DELTA RURAL DISPARITIES AND HEALTH SYS-
7 TEMS DEVELOPMENT GRANTS.—

8 “(1) GRANTS.—The Director may award grants
9 to eligible entities to support reduction of health dis-
10 parities, improve access to health care, and enhance
11 rural health system development in the Delta Re-
12 gion.

13 “(2) ELIGIBILITY.—To be eligible to receive a
14 grant under this subsection, an entity shall be a
15 rural public or rural nonprofit private entity, a facil-
16 ity that qualifies as a rural health clinic under title
17 XVIII of the Social Security Act, a public or non-
18 profit entity existing exclusively to provide services
19 to migrant and seasonal farm workers in rural
20 areas, or a tribal government whose grant-funded
21 activities will be conducted within federally recog-
22 nized tribal areas.

23 “(3) APPLICATIONS.—To be eligible to receive a
24 grant under this subsection, an eligible entity shall
25 prepare and submit to the Director an application at

1 such time, in such manner, and containing such in-
2 formation as the Director may require, including—

3 “(A) a description of the project that the
4 eligible entity will carry out using the funds
5 provided under the grant;

6 “(B) an explanation of the reasons why
7 Federal assistance is required to carry out the
8 project;

9 “(C) a description of the manner in which
10 the project funded under the grant will meet
11 the health care needs of the Delta Region;

12 “(D) a description of how the local com-
13 munity or region to be served will experience in-
14 creased access to quality health care services as
15 a result of the activities carried out by the enti-
16 ty;

17 “(E) a description of how health dispari-
18 ties will be reduced or the health system will be
19 improved;

20 “(F) a plan for sustaining the project after
21 Federal support for the project has ended;

22 “(G) a description of how the project will
23 be evaluated including process and outcome
24 measures related to the quality of care provided

1 or how the health care system improves its per-
2 formance;

3 “(H) a description of how the grantee will
4 develop an advisory group made up of rep-
5 resentatives of the communities to be served to
6 provide guidance to the grantee to best meet
7 community need; and

8 “(I) other such information as the Director
9 determines to be appropriate.

10 “(e) SMALL RURAL HEALTH CARE PROVIDER QUAL-
11 ITY IMPROVEMENT GRANTS.—

12 “(1) GRANTS.—The Director may award grants
13 to provide for the planning and implementation of
14 small rural health care provider quality improvement
15 activities. The Director may award the grants for
16 periods of 1 to 3 years.

17 “(2) ELIGIBILITY.—To be eligible for a grant
18 under this subsection, an entity—

19 “(A) shall be—

20 “(i) a rural public or rural nonprofit
21 private health care provider or provider of
22 health care services, such as a rural health
23 clinic; or

24 “(ii) another rural provider or net-
25 work of small rural providers identified by

1 the Director as a key source of local care;
2 and

3 “(B) shall not previously have received a
4 grant under this subsection for the same or a
5 similar project.

6 “(3) PREFERENCE.—In awarding grants under
7 this subsection, the Director shall give preference to
8 facilities that qualify as rural health clinics under
9 title XVIII of the Social Security Act.

10 “(4) APPLICATIONS.—To be eligible to receive a
11 grant under this subsection, an eligible entity shall
12 prepare and submit to the Director an application at
13 such time, in such manner, and containing such in-
14 formation as the Director may require, including—

15 “(A) a description of the project that the
16 eligible entity will carry out using the funds
17 provided under the grant;

18 “(B) an explanation of the reasons why
19 Federal assistance is required to carry out the
20 project;

21 “(C) a description of the manner in which
22 the project funded under the grant will assure
23 continuous quality improvement in the provision
24 of services by the entity;

1 “(D) a description of how the local com-
2 munity or region to be served will experience in-
3 creased access to quality health care services as
4 a result of the activities carried out by the enti-
5 ty;

6 “(E) a plan for sustaining the project after
7 Federal support for the project has ended;

8 “(F) a description of how the project will
9 be evaluated including process and outcome
10 measures related to the quality of care pro-
11 vided; and

12 “(G) other such information as the Direc-
13 tor determines to be appropriate.

14 “(f) GENERAL REQUIREMENTS.—

15 “(1) PROHIBITED USES OF FUNDS.—An entity
16 that receives a grant under this section may not use
17 funds provided through the grant—

18 “(A) to build or acquire real property; or

19 “(B) for construction.

20 “(2) COORDINATION WITH OTHER AGENCIES.—

21 The Director shall coordinate activities carried out
22 under grant programs described in this section, to
23 the extent practicable, with Federal and State agen-
24 cies and nonprofit organizations that are operating

1 similar grant programs, to maximize the effect of
2 public dollars in funding meritorious proposals.

3 “(g) REPORT.—Not later than September 30, 2018,
4 the Secretary shall prepare and submit to the appropriate
5 committees of Congress a report on the progress and ac-
6 complishments of the grant programs described in sub-
7 sections (b), (c), (d), and (e).

8 “(h) DEFINITIONS.—In this section:

9 “(1) The term ‘Delta Region’ has the meaning
10 given to the term ‘region’ in section 382A of the
11 Consolidated Farm and Rural Development Act (7
12 U.S.C. 2009aa).

13 “(2) The term ‘Director’ means the Director of
14 the Office of Rural Health Policy of the Health Re-
15 sources and Services Administration.

16 “(i) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated to carry out this section
18 \$40,000,000 for fiscal year 2017, and such sums as may
19 be necessary for each of fiscal years 2018 through 2021.”.

20 **SEC. 437. COMMUNITY HEALTH CENTER COLLABORATIVE**
21 **ACCESS EXPANSION.**

22 Section 330 of the Public Health Service Act (42
23 U.S.C. 254b) is amended by adding at the end the fol-
24 lowing:

25 “(t) MISCELLANEOUS PROVISIONS.—

1 “(1) RULE OF CONSTRUCTION WITH RESPECT
2 TO RURAL HEALTH CLINICS.—Nothing in this sec-
3 tion shall be construed to prevent a community
4 health center from contracting with a federally cer-
5 tified rural health clinic (as defined by section
6 1861(aa)(2) of the Social Security Act) for the deliv-
7 ery of primary health care and other mental, dental,
8 and physical health services that are available at the
9 rural health clinic to individuals who would other-
10 wise be eligible for free or reduced cost care if that
11 individual were able to obtain that care at the com-
12 munity health center. Such services may be limited
13 in scope to those primary health care and other
14 mental, dental, and physical health services available
15 in that rural health clinic.

16 “(2) ENABLING SERVICES.—To the extent pos-
17 sible, enabling services such as transportation and
18 translation assistance shall be provided by rural
19 health clinics described in paragraph (1).

20 “(3) ASSURANCES.—In order for a rural health
21 clinic to receive funds under this section through a
22 contract with a community health center for the de-
23 livery of primary health care and other services de-
24 scribed in paragraph (1), such rural health clinic
25 shall establish policies to ensure—

1 “(A) nondiscrimination based upon the
2 ability of a patient to pay;

3 “(B) the establishment of a sliding fee
4 scale for low-income patients; and

5 “(C) any such services should be subject to
6 full reimbursement according to the Prospective
7 Payment System scale.”.

8 **SEC. 438. FACILITATING THE PROVISION OF TELEHEALTH**
9 **SERVICES ACROSS STATE LINES.**

10 (a) **IN GENERAL.**—For purposes of expediting the
11 provision of telehealth services, for which payment is made
12 under the Medicare Program, across State lines, the Sec-
13 retary of Health and Human Services shall, in consulta-
14 tion with representatives of States, physicians, health care
15 practitioners, and patient advocates, encourage and facili-
16 tate the adoption of provisions allowing for multistate
17 practitioner practice across State lines.

18 (b) **DEFINITIONS.**—In subsection (a):

19 (1) **TELEHEALTH SERVICE.**—The term “tele-
20 health service” has the meaning given that term in
21 subparagraph (F) of section 1834(m)(4) of the So-
22 cial Security Act (42 U.S.C. 1395m(m)(4)).

23 (2) **PHYSICIAN, PRACTITIONER.**—The terms
24 “physician” and “practitioner” have the meaning

1 given those terms in subparagraphs (D) and (E), re-
2 spectively, of such section.

3 (3) **MEDICARE PROGRAM.**—The term “Medicare
4 Program” means the program of health insurance
5 administered by the Secretary of Health and Human
6 Services under title XVIII of the Social Security Act
7 (42 U.S.C. 1395 et seq.).

8 **SEC. 439. SCORING OF PREVENTIVE HEALTH SAVINGS.**

9 Section 202 of the Congressional Budget and Im-
10 poundment Control Act of 1974 (2 U.S.C. 602) is amend-
11 ed by adding at the end the following new subsection:

12 “(h) **SCORING OF PREVENTIVE HEALTH SAVINGS.**—

13 “(1) **DETERMINATION BY THE DIRECTOR.**—

14 Upon a request by the chairman or ranking minority
15 member of the Committee on the Budget of the Sen-
16 ate, or by the chairman or ranking minority member
17 of the Committee on the Budget of the House of
18 Representatives, the Director shall determine if a
19 proposed measure would result in reductions in
20 budget outlays in budgetary outyears through the
21 use of preventive health and preventive health serv-
22 ices.

23 “(2) **PROJECTIONS.**—If the Director determines
24 that a measure would result in substantial reduc-

1 tions in budget outlays as described in paragraph
2 (1), the Director—

3 “(A) shall include, in any projection pre-
4 pared by the Director, a description and esti-
5 mate of the reductions in budget outlays in the
6 budgetary outyears and a description of the
7 basis for such conclusions; and

8 “(B) may prepare a budget projection that
9 includes some or all of the budgetary outyears,
10 notwithstanding the time periods for projections
11 described in subsection (e) and sections 308,
12 402, and 424.

13 “(3) DEFINITIONS.—As used in this sub-
14 section—

15 “(A) the term ‘preventive health’ means an
16 action that focuses on the health of the public,
17 individuals, and defined populations in order to
18 protect, promote, and maintain health, wellness,
19 and functional ability, and prevent disease, dis-
20 ability, and premature death that is dem-
21 onstrated by credible and publicly available epi-
22 demiological projection models, incorporating
23 clinical trials or observational studies in hu-
24 mans, to avoid future health care costs; and

1 “(B) the term ‘budgetary outyears’ means
2 the 2 consecutive 10-year periods beginning
3 with the first fiscal year that is 10 years after
4 the budget year provided for in the most re-
5 cently agreed to concurrent resolution on the
6 budget.”.

7 **SEC. 440. SENSE OF CONGRESS.**

8 It is the sense of the Congress that—

9 (1) the maintenance of effort provisions added
10 to sections 1902 and 2105(d) of the Social Security
11 Act by sections 2001(b) and 2101(b) of the Patient
12 Protection and Affordable Care Act were written to
13 maintain the eligibility standards for the Medicaid
14 program under title XIX of the Social Security Act
15 and Children’s Health Insurance Program under
16 title XXI of such Act until the American Health
17 Benefit Exchanges in the States are fully oper-
18 ational;

19 (2) it is imperative that the maintenance of ef-
20 fort provisions are enforced to the strict standard in-
21 tended by the Congress;

22 (3) waiving the maintenance of effort provisions
23 should not be permitted, except in the case of a re-
24 quest for a waiver that meets the explicit non-
25 application requirements;

1 (4) the maintenance of effort provisions ensure
2 the continued success of the Medicaid program and
3 Children’s Health Insurance Program and were writ-
4 ten deliberately to specifically protect vulnerable and
5 disabled individuals, children, and senior citizens,
6 many of whom are also members of communities of
7 color; and

8 (5) the maintenance of effort provisions must
9 be strictly enforced and proposals to weaken the
10 maintenance of effort provisions must not be consid-
11 ered.

12 **SEC. 441. REPEAL OF REQUIREMENT FOR DOCUMENTA-**
13 **TION EVIDENCING CITIZENSHIP OR NATION-**
14 **ALITY UNDER THE MEDICAID PROGRAM.**

15 (a) REPEAL.—Subsections (i)(22) and (x) of section
16 1903 of the Social Security Act (42 U.S.C. 1396b) are
17 each repealed.

18 (b) CONFORMING AMENDMENTS.—

19 (1) Section 1902 of the Social Security Act (42
20 U.S.C. 1396a) is amended—

21 (A) by amending paragraph (46) of sub-
22 section (a) to read as follows:

23 “(46) provide that information is requested and
24 exchanged for purposes of income and eligibility
25 verification in accordance with a State system which

1 meets the requirements of section 1137 of this
2 Act;”;

3 (B) in subsection (e)(13)(A)(i)—

4 (i) in the matter preceding subclause
5 (I), by striking “sections 1902(a)(46)(B)
6 and 1137(d)” and inserting “section
7 1137(d)”;

8 (ii) in subclause (IV), by striking
9 “1902(a)(46)(B) or”;

10 (C) by striking subsection (ee).

11 (2) Section 1903 of the Social Security Act (42
12 U.S.C. 1396b) is amended—

13 (A) in subsection (i), by redesignating
14 paragraphs (23) through (26) as paragraphs
15 (22) through (25), respectively; and

16 (B) by redesignating subsections (y) and
17 (z) as subsections (x) and (y), respectively.

18 (3) Subsection (c) of section 6036 of the Deficit
19 Reduction Act of 2005 (42 U.S.C. 1396b note) is re-
20 pealed.

21 (c) EFFECTIVE DATE.—The repeals and amend-
22 ments made by this section shall take effect as if included
23 in the enactment of the Deficit Reduction Act of 2005.

1 **SEC. 442. OFFICE OF MINORITY HEALTH IN VETERANS**
2 **HEALTH ADMINISTRATION OF DEPARTMENT**
3 **OF VETERANS AFFAIRS.**

4 (a) ESTABLISHMENT AND FUNCTIONS.—Subchapter
5 I of chapter 73 of title 38, United States Code, is amended
6 by adding at the end the following new section:

7 **“§ 7310. Office of Minority Health**

8 “(a) ESTABLISHMENT.—There is established in the
9 Department within the Office of the Under Secretary for
10 Health an office to be known as the ‘Office of Minority
11 Health’ (in this section referred to as the ‘Office’).

12 “(b) HEAD.—The Director of the Office of Minority
13 Health shall be the head of the Office. The Director of
14 the Office of Minority Health shall be appointed by the
15 Under Secretary of Health from among individuals quali-
16 fied to perform the duties of the position.

17 “(c) FUNCTIONS.—The functions of the Office are as
18 follows:

19 “(1) To establish short-range and long-range
20 goals and objectives and coordinate all other activi-
21 ties within the Veterans Health Administration that
22 relate to disease prevention, health promotion, health
23 care services delivery, and health care research con-
24 cerning veterans who are members of a racial or eth-
25 nic minority group.

1 “(2) To support research, demonstrations, and
2 evaluations to test new and innovative models for
3 the discharge of activities described in paragraph
4 (1).

5 “(3) To increase knowledge and understanding
6 of health risk factors for veterans who are members
7 of a racial or ethnic minority group.

8 “(4) To develop mechanisms that support bet-
9 ter health care information dissemination, education,
10 prevention, and services delivery to veterans from
11 disadvantaged backgrounds, including veterans who
12 are members of a racial or ethnic minority group.

13 “(5) To enter into contracts or agreements with
14 appropriate public and nonprofit private entities to
15 develop and carry out programs to provide bilingual
16 or interpretive services to assist veterans who are
17 members of a racial or ethnic minority group and
18 who lack proficiency in speaking the English lan-
19 guage in accessing and receiving health care services
20 through the Veterans Health Administration.

21 “(6) To carry out programs to improve access
22 to health care services through the Veterans Health
23 Administration for veterans with limited proficiency
24 in speaking the English language, including the de-

1 velopment and evaluation of demonstration and pilot
2 projects for that purpose.

3 “(7) To advise the Under Secretary of Health
4 on matters relating to the development, implementa-
5 tion, and evaluation of health professions education
6 in decreasing disparities in health care outcomes be-
7 tween veterans who are members of a racial or eth-
8 nic minority group and other veterans, including cul-
9 tural competency as a method of eliminating such
10 health disparities.

11 “(8) To perform such other functions and du-
12 ties as the Secretary or the Under Secretary for
13 Health considers appropriate.

14 “(d) DEFINITIONS.—In this section:

15 “(1) The term ‘racial or ethnic minority group’
16 means the following:

17 “(A) American Indians (including Alaska
18 Natives, Eskimos, and Aleuts).

19 “(B) Asian-Americans.

20 “(C) Native Hawaiians and other Pacific
21 Islanders.

22 “(D) Blacks.

23 “(E) Hispanics.

24 “(2) The term ‘Hispanic’ means individuals
25 whose origin is Mexican, Puerto Rican, Cuban, Cen-

1 tral or South American, or any other Spanish-speak-
2 ing country.”.

3 (b) CLERICAL AMENDMENT.—The table of sections
4 at the beginning of such chapter is amended by inserting
5 after the item relating to section 7309 the following new
6 item:

“7310. Office of Minority Health.”.

7 **SEC. 443. INDIAN DEFINED IN PPACA.**

8 (a) DEFINITION OF INDIAN.—Section 1304 of the
9 Patient Protection and Affordable Care Act (42 U.S.C.
10 18024) is amended by adding at the end the following:

11 “(f) INDIAN.—

12 “(1) IN GENERAL.—In this title, the term ‘In-
13 dian’ means any individual—

14 “(A) described in paragraph (13) or (28)
15 of section 4 of the Indian Health Care Improve-
16 ment Act (25 U.S.C. 1603);

17 “(B) who is eligible for health services pro-
18 vided by the Indian Health Service under sec-
19 tion 809 of the Indian Health Care Improve-
20 ment Act (25 U.S.C. 1679);

21 “(C) who is of Indian descent and belongs
22 to the Indian community served by the local fa-
23 cilities and program of the Indian Health Serv-
24 ice; or

25 “(D) who is described in paragraph (2).

1 “(2) INCLUDED INDIVIDUALS.—The following
2 individuals shall be considered to be an ‘Indian’:

3 “(A) A member of a federally recognized
4 Indian tribe.

5 “(B) A resident of an urban center who
6 meets 1 or more of the following 4 criteria:

7 “(i) Membership in a tribe, band, or
8 other organized group of Indians, including
9 those tribes, bands, or groups terminated
10 since 1940 and those recognized as of the
11 date of enactment of the Health Equity
12 and Accountability Act of 2016 or later by
13 the State in which they reside, or being a
14 descendant, in the first or second degree,
15 of any such member.

16 “(ii) Is an Eskimo or Aleut or other
17 Alaska Native.

18 “(iii) Is considered by the Secretary of
19 the Interior to be an Indian for any pur-
20 pose.

21 “(iv) Is determined to be an Indian
22 under regulations promulgated by the Sec-
23 retary.

1 “(C) An individual who is considered by
2 the Secretary of the Interior to be an Indian for
3 any purpose.

4 “(D) An individual who is considered by
5 the Secretary to be an Indian for purposes of
6 eligibility for Indian health care services, includ-
7 ing as a California Indian, Eskimo, Aleut, or
8 other Alaska Native.”.

9 (b) CONFORMING AMENDMENTS.—

10 (1) AFFORDABLE CHOICES HEALTH BENEFIT
11 PLANS.—Section 1311(c)(6)(D) of the Patient Pro-
12 tection and Affordable Care Act (42 U.S.C.
13 18031(c)(6)(D)) is amended by striking “section 4
14 of the Indian Health Care Improvement Act” and
15 inserting “section 1304(f)”.

16 (2) REDUCED COST-SHARING FOR INDIVIDUALS
17 ENROLLING IN QUALIFIED HEALTH PLANS.—Section
18 1402(d) of the Patient Protection and Affordable
19 Care Act (42 U.S.C. 18071(d)) is amended—

20 (A) in paragraph (1), in the matter pre-
21 ceding subparagraph (A), by striking “section
22 4(d) of the Indian Self-Determination and Edu-
23 cation Assistance Act (25 U.S.C. 450b(d))” and
24 inserting “section 1304(f)”; and

1 (B) in paragraph (2), in the matter pre-
2 ceding subparagraph (A), by striking “(as so
3 defined)” and inserting “(as defined in section
4 1304(f))”.

5 (3) EXEMPTION FROM PENALTY FOR NOT
6 MAINTAINING MINIMUM ESSENTIAL COVERAGE.—
7 Section 5000A(e) of the Internal Revenue Code of
8 1986 is amended by striking paragraph (3) and in-
9 serting the following:

10 “(3) INDIANS.—Any applicable individual who
11 is an Indian (as defined in section 1304(f) of the
12 Patient Protection and Affordable Care Act).”.

13 **SEC. 444. STUDY OF DSH PAYMENTS TO ENSURE HOSPITAL**
14 **ACCESS FOR LOW-INCOME PATIENTS.**

15 (a) IN GENERAL.—Not later than January 1, 2016,
16 the Comptroller General of the United States shall con-
17 duct a study on how certain amendments made by the Pa-
18 tient Protection and Affordable Care Act (Public Law
19 111–148) to titles XVIII and XIX of the Social Security
20 Act affect the timely access to health care services for low-
21 income patients. Such study shall—

22 (1) evaluate and examine whether States elect-
23 ing to make medical assistance available under sec-
24 tion 1902(a)(10)(A)(i)(VIII) of the Social Security
25 Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) (including

1 States making such an election through a waiver of
2 the State plan) to individuals described in such sec-
3 tion mitigates the need for payments to dispropor-
4 tionate share hospitals under section 1886(d)(5)(F)
5 of the Social Security Act (42 U.S.C.
6 1395ww(d)(5)(F)) and section 1923 of such Act (42
7 U.S.C. 1396r-4), including the impact of such
8 States electing to make medical assistance available
9 to such individuals on—

10 (A) the number of individuals in the
11 United States who are without health insurance
12 and the distribution of such individuals in rela-
13 tion to areas primarily served by dispropor-
14 tionate share hospitals; and

15 (B) the low-income utilization rate of such
16 hospitals and the resulting fiscal sustainability
17 of such hospitals;

18 (2) evaluate the appropriate level and distribu-
19 tion of such payments among disproportionate hos-
20 pitals for purposes of—

21 (A) sufficiently accounting for the level of
22 uncompensated care provided by such hospitals
23 to low-income patients; and

1 (B) providing timely access to health serv-
2 ices for individuals in medically underserved
3 areas; and

4 (3) assess, with respect to disproportionate hos-
5 pitals—

6 (A) the role played by such hospitals in
7 providing critical access to emergency, inpa-
8 tient, and outpatient health services, as well as
9 the location of such hospitals in relation to
10 medically underserved areas; and

11 (B) the extent to which such hospitals sat-
12 isfy the requirements established for charitable
13 hospital organizations under section 501(r) of
14 the Internal Revenue Code of 1986 with respect
15 to community health needs assessments, finan-
16 cial assistance policy requirements, limitations
17 on charges, and billing and collection require-
18 ments.

19 (b) REPORTS.—

20 (1) REPORT TO CONGRESS.—Not later than
21 180 days after the date on which the study under
22 subsection (a) is completed, the Comptroller General
23 of the United States shall submit to the Committee
24 on Energy and Commerce of the House of Rep-
25 resentatives and the Committee on Health, Edu-

1 cation, Labor, and Pensions of the Senate a report
2 that contains—

3 (A) the results of the study;

4 (B) recommendations to Congress for any
5 legislative changes to the payments to dis-
6 proportionate share hospitals under section
7 1886(d)(5)(F) of the Social Security Act (42
8 U.S.C. 1395ww(d)(5)(F)) and section 1923 of
9 such Act (42 U.S.C. 1396r-4) that are needed
10 to ensure access to health services for low-in-
11 come patients that—

12 (i) are based on the number of indi-
13 viduals without health insurance, the
14 amount of uncompensated care provided by
15 such hospitals, and the impact of reduced
16 payments levels on low-income commu-
17 nities; and

18 (ii) takes into account any reports
19 submitted by the Secretary of the Treas-
20 ury, in consultation with the Secretary of
21 Health and Human Services, to Congres-
22 sional committees regarding the costs in-
23 curred by charitable hospital organizations
24 for charity care, bad debt, nonreimbursed
25 expenses for services provided to individ-

1 uals under the Medicare Program under
2 title XVIII of the Social Security Act and
3 the Medicaid Program under title XIX of
4 such Act, and any community benefit ac-
5 tivities provided by such organizations.

6 (2) REPORT TO THE SECRETARY OF HEALTH
7 AND HUMAN SERVICES.—Not later than 180 days
8 after the date on which the study under subsection
9 (a) is completed, the Comptroller General of the
10 United States shall submit to the Secretary of
11 Health and Human Services a report that con-
12 tains—

13 (A) the results of the study; and

14 (B) any recommendations for purposes of
15 assisting in the development of the methodology
16 for the adjustment of payments to dispropor-
17 tionate share hospitals, as required under sec-
18 tion 1886(r) of the Social Security Act (42
19 U.S.C. 1395ww(r)) and the reduction of such
20 payments section 1923(f)(7) of such Act (42
21 U.S.C. 1396r-4(f)(7)), taking into account the
22 reports referred to in paragraph (1)(B)(ii).

1 **SEC. 445. ASSISTANT SECRETARY OF THE INDIAN HEALTH**
2 **SERVICE.**

3 (a) REFERENCES.—Any reference in a law, regula-
4 tion, document, paper, or other record of the United
5 States to the Director of the Indian Health Service shall
6 be deemed to be a reference to the Assistant Secretary
7 of the Indian Health Service.

8 (b) EXECUTIVE SCHEDULE.—Section 5315 of title 5,
9 United States Code, is amended in the matter relating to
10 the Assistant Secretaries of Health and Human Services
11 by striking “(6)” and inserting “(7), 1 of whom shall be
12 the Assistant Secretary of the Indian Health Service”.

13 (c) CONFORMING AMENDMENT.—Section 5316 of
14 title 5, United States Code, is amended by striking “Direc-
15 tor, Indian Health Service, Department of Health and
16 Human Services.”.

17 **SEC. 446. REAUTHORIZATION OF THE NATIVE HAWAIIAN**
18 **HEALTH CARE IMPROVEMENT ACT.**

19 (a) NATIVE HAWAIIAN HEALTH CARE SYSTEMS.—
20 Section 6(h)(1) of the Native Hawaiian Health Care Im-
21 provement Act (42 U.S.C. 11705(h)(1)) is amended by
22 striking “may be necessary for fiscal years 1993 through
23 2019” and inserting “are necessary”.

24 (b) ADMINISTRATIVE GRANT FOR PAPA OLA
25 LOKAHI.—Section 7(b) of the Native Hawaiian Health
26 Care Improvement Act (42 U.S.C. 11706(b)) is amended

1 by striking “may be necessary for fiscal years 1993
2 through 2019” and inserting “are necessary”.

3 (c) NATIVE HAWAIIAN HEALTH SCHOLARSHIPS.—
4 Section 10(c) of the Native Hawaiian Health Care Im-
5 provement Act (42 U.S.C. 11709(c)) is amended by strik-
6 ing “may be necessary for fiscal years 1993 through
7 2019” and inserting “are necessary”.

8 **SEC. 447. AVAILABILITY OF NON-ENGLISH LANGUAGE**
9 **SPEAKING PROVIDERS.**

10 (a) IN GENERAL.—Section 1311(c)(1)(B) of the Pa-
11 tient Protection and Affordable Care Act (42 U.S.C.
12 18031(c)(1)(B)) is amended by inserting before the semi-
13 colon the following: “and, with respect to such providers,
14 a provider’s ability to provide care in a language other
15 than English either through the provider speaking such
16 language or by the provider having a training medical in-
17 terpreter who speaks such language available during office
18 hours”.

19 (b) EFFECTIVE DATE.—The amendment made by
20 subsection (a) shall apply for plan years beginning more
21 than 1 year after the date of the enactment of this Act.

22 **SEC. 448. ACCESS TO ESSENTIAL COMMUNITY PROVIDERS.**

23 (a) ESSENTIAL COMMUNITY PROVIDERS.—Section
24 1311(c)(1)(C) of the Patient Protection and Affordable
25 Care Act (42 U.S.C. 18031(c)(1)(C)) is amended—

1 (1) by inserting “(i)” after “(C)”; and

2 (2) by adding at the end the following new
3 clauses:

4 “(ii) not later than 2018, increase the per-
5 centage of essential community providers in-
6 cluded in its network by 10 percent annually
7 (based on the level in the plan for 2016) until
8 90 percent of all federally qualified health cen-
9 ters and 75 percent of all other essential com-
10 munity providers in the contract service area
11 are in-network; and

12 “(iii) include one of each type of essential
13 community provider in network in each county
14 in their service area, where available;”.

15 (b) REPORTING REQUIREMENTS.—Section
16 1311(e)(3) of the Patient Protection and Affordable Care
17 Act (42 U.S.C. 18031(e)(3)(A)) is amended by adding at
18 the end the following new subparagraph:

19 “(E) DATA ON ESSENTIAL COMMUNITY
20 PROVIDERS.—The Secretary shall require quali-
21 fied health plans to submit annually to the Sec-
22 retary data on the percentage of essential com-
23 munity providers, by county, that contract with
24 each qualified health plan offered in that county
25 and the percentage of essential community pro-

1 viders, by type, that contract with each quali-
2 fied health plan offered in that county. Data so
3 submitted shall be made available to the general
4 public”.

5 (c) ESSENTIAL COMMUNITY PROVIDER PROVISIONS
6 APPLIED UNDER MEDICARE AND MEDICAID.—

7 (1) MEDICARE.—Section 1852(d)(1) of the So-
8 cial Security Act (42 U.S.C.1395w–22(d)(1)) is
9 amended—

10 (A) by striking “and” at the end of sub-
11 paragraph (D);

12 (B) by striking the period at the end of
13 subparagraph (E) and inserting “; and”; and

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

16 “(F) the plan meets the requirements of
17 clauses (ii) and (iii) of section 1311(e)(1)(C) of
18 the Patient Protection and Affordable Care Act
19 (relating to inclusion in networks of essential
20 community providers).”.

21 (2) MEDICAID.—Section 1932(b)(5) of the So-
22 cial Security Act (42 U.S.C. 1396u–2(b)(5)) is
23 amended—

24 (A) by striking “and” at the end of sub-
25 paragraph (A);

1 (B) by striking the period at the end of
2 subparagraph (B) and inserting “; and”; and

3 (C) by adding at the end the following new
4 subparagraph:

5 “(C) the plan meets the requirements of
6 clauses (ii) and (iii) of section 1311(c)(1)(C) of
7 the Patient Protection and Affordable Care Act
8 (relating to inclusion in networks of essential
9 community providers) with respect to services
10 offered in the service area involved.”.

11 **SEC. 449. PROVIDER NETWORK ADEQUACY IN COMMU-**
12 **NITIES OF COLOR.**

13 (a) IN GENERAL.—Section 1311(c)(1)(B) of the Pa-
14 tient Protection and Affordable Care Act (42 U.S.C.
15 18031(c)(1)(B)) is amended—

16 (1) by inserting “(i)” after “(B)”; and

17 (2) by adding at the end the following the fol-
18 lowing new clauses:

19 “(ii) meet such network adequacy
20 standards as the Secretary may establish
21 with regard to—

22 “(I) appointment wait time;

23 “(II) travel time and distance to
24 health care provider facilities and pro-
25 viders by public and private transit;

1 “(III) hours of operation to ac-
2 commodate individuals who cannot
3 come to provider appointments during
4 standard business hours; and

5 “(IV) other network adequacy
6 standards to ensure that care through
7 these plans is accessible to diverse
8 communities; and.

9 “(iii) provide coverage for services for
10 enrollees through out-of-network providers
11 at no additional cost to the enrollees in
12 cases where in-network providers are un-
13 able to comply with the standards estab-
14 lished under clause subclause (III) or (IV)
15 of clause (ii) for such services and the out-
16 of-network providers can deliver such serv-
17 ices in compliance with such standards..

18 “(b) EFFECTIVE DATE.—The amendments made by
19 subsection (a) shall apply to plan years beginning more
20 than 1 year after the date of the enactment of this Act..”.

21 **SEC. 450. IMPROVING ACCESS TO DENTAL CARE.**

22 (a) REPORTS TO CONGRESS.—

23 (1) GAO REPORT ON DENTAL THERAPIST PRO-
24 GRAMS.—Not later than 1 year after the date of the
25 enactment of this Act, the Comptroller General of

1 the United States shall submit to Congress a report
2 on the Alaska Dental Health Aide Therapists Pro-
3 gram and the Dental Therapist and Advanced Den-
4 tal Therapist programs in Minnesota, to assess den-
5 tal therapists' effectiveness in—

6 (A) improving access to timely dental care

7 among communities of color;

8 (B) providing high quality care; and

9 (C) providing culturally competent care.

10 (2) HRSA REPORT ON DENTAL SHORTAGE
11 AREAS.—Not later than 1 year after the date of the
12 enactment of this Act, the Secretary, acting through
13 the Administrator of the Health Resources Service
14 Administration, shall submit to Congress a report
15 which details geographic dental access shortages and
16 the preparedness of dental providers to offer cul-
17 turally and linguistically appropriate, affordable, ac-
18 cessible, and timely services.

19 (b) EXPANSION OF DENTAL HEALTH AID THERA-
20 PISTS IN TRIBAL COMMUNITIES.—Section 119(d) of the
21 Indian Health Care Improvement Act (U.S.C. 1616l(d))
22 is amended—

23 (1) in paragraph (2), by striking “Subject to”

24 and all that follows and inserting “Subject to para-

25 graph (3), in establishing a national program under

1 paragraph (1), the Secretary shall not reduce the
2 amounts provided for the Community Health Aide
3 Program described in subsections (a) and (b).”;

4 (2) by striking paragraph (3); and

5 (3) by redesignating paragraph (4) as para-
6 graph (3).

7 (c) COVERAGE OF DENTAL SERVICES UNDER THE
8 MEDICARE PROGRAM.—

9 (1) COVERAGE.—Section 1861(s)(2) of the So-
10 cial Security Act (42 U.S.C. 1395x(s)(2)) is amend-
11 ed—

12 (A) in subparagraph (EE), by striking
13 “and” after the semicolon at the end;

14 (B) in subparagraph (FF), by adding
15 “and” after the semicolon at the end; and

16 (C) by adding at the end the following new
17 subparagraph:

18 “(GG) oral health services (as defined in
19 subsection (kkk));”.

20 (2) ORAL HEALTH SERVICES DEFINED.—Sec-
21 tion 1861 of the Social Security Act (42 U.S.C.
22 1395x), as amended by sections 205(b) and 433(a),
23 is amended by adding at the end the following new
24 subsection:

1 “Oral Health Services

2 “(kkk)(1) The term ‘oral health services’ means serv-
3 ices (as defined by the Secretary) that are necessary to
4 prevent disease and promote oral health, restore oral
5 structures to health and function, and treat emergency
6 conditions.

7 “(2) For purposes of paragraph (1), such term shall
8 include mobile and portable oral health services (as de-
9 fined by the Secretary) that—

10 “(A) are provided for the purpose of over-
11 coming mobility, transportation, and access barriers
12 for individuals; and

13 “(B) satisfy the standards and certification re-
14 quirements established under section 1902(a)(82)(B)
15 for the State in which the services are provided.”.

16 (3) PAYMENT AND COINSURANCE.—Section
17 1833(a)(1) of the Social Security Act (42 U.S.C.
18 1395l(a)(1)) is amended—

19 (A) by striking “and” before “(Z)”; and

20 (B) by inserting before the semicolon at
21 the end the following: “, and (AA) with respect
22 to oral health services (as defined in section
23 1861(kkk)), the amount paid shall be (i) in the
24 case of such services that are preventive, 100
25 percent of the lesser of the actual charge for

1 the services or the amount determined under
2 the payment basis determined under section
3 1848, and (ii) in the case of all other such serv-
4 ices, 80 percent of the lesser of the actual
5 charge for the services or the amount deter-
6 mined under the payment basis determined
7 under section 1848”.

8 (4) PAYMENT UNDER PHYSICIAN FEE SCHED-
9 ULE.—Section 1848(j)(3) of the Social Security Act
10 (42 U.S.C. 1395w-4(j)(3)) is amended by inserting
11 “(2)(GG),” after “risk assessment),”.

12 (5) DENTURES.—Section 1861(s)(8) of the So-
13 cial Security Act (42 U.S.C. 1395x(s)(8)) is amend-
14 ed—

15 (A) by striking “(other than dental)” and
16 inserting “(including dentures)”; and

17 (B) by striking “internal body”.

18 (6) REPEAL OF GROUND FOR EXCLUSION.—
19 Section 1862(a) of the Social Security Act (42
20 U.S.C. 1395y) is amended by striking paragraph
21 (12).

22 (7) EFFECTIVE DATE.—The amendments made
23 by this section shall apply to services furnished on
24 or after January 1, 2017.

1 (d) COVERAGE OF DENTAL SERVICES UNDER THE
2 MEDICAID PROGRAM.—

3 (1) IN GENERAL.—Section 1905 of the Social
4 Security Act (42 U.S.C. 1396d) is amended—

5 (A) in subsection (a)(10), by striking “den-
6 tal services” and inserting “oral health services
7 (as defined in subsection (ee)(1))”; and

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

10 “(ee)(1) Subject to paragraphs (2) and (3), for pur-
11 poses of this title, the term ‘oral health services’ means
12 services (as defined by the Secretary) that are necessary
13 to prevent disease and promote oral health, restore oral
14 structures to health and function, and treat emergency
15 conditions. These services shall include, in the case of
16 pregnant or postpartum women, such services as are nec-
17 essary to address oral health conditions that exist or are
18 exacerbated by pregnancy or childbirth or which, if left
19 untreated, could adversely affect fetal or child develop-
20 ment.

21 “(2) For purposes of paragraph (1), such term shall
22 include—

23 “(A) dentures; and

24 “(B) mobile and portable oral health services
25 (as defined by the Secretary) that—

1 “(i) are provided for the purpose of over-
2 coming mobility, transportation, and access bar-
3 riers for individuals; and

4 “(ii) satisfy the standards and certification
5 requirements established under section
6 1902(a)(82)(C) for the State in which the serv-
7 ices are provided.

8 “(3) For purposes of paragraph (1), such term shall
9 not apply to dental care or services provided to individuals
10 under the age of 21 under subsection (r)(3).”.

11 (2) CONFORMING AMENDMENTS.—

12 (A) STATE PLAN REQUIREMENTS.—Section
13 1902(a) of the Social Security Act (42 U.S.C.
14 1396a(a)) is amended—

15 (i) in paragraph (10)(A), in the mat-
16 ter preceding clause (i), by inserting
17 “(10),” after “(5),”;

18 (ii) in paragraph (80), by striking
19 “and” at the end;

20 (iii) in paragraph (81), by striking the
21 period at the end and inserting “; and”;
22 and

23 (iv) by inserting after paragraph (81)
24 the following:

25 “(82) provide for—

1 “(A) informing, in writing, all individuals
2 who have been determined to be eligible for
3 medical assistance of the availability of oral
4 health services (as defined in section 1905(ee));

5 “(B) conducting targeted outreach to preg-
6 nant women who have been determined to be el-
7 igible for medical assistance about the avail-
8 ability of medical assistance for such dental
9 services and the importance of receiving dental
10 care while pregnant; and

11 “(C) establishing and maintaining stand-
12 ards for and certification of mobile and portable
13 oral health services (as described in subsections
14 (r)(3)(C) and (ee)(2)(B) of section 1905).”.

15 (B) DEFINITION OF MEDICAL ASSIST-
16 ANCE.—Section 1905(a)(12) of the Social Secu-
17 rity Act (42 U.S.C. 1396d(a)(12)) is amended
18 by striking “, dentures,”.

19 (3) MOBILE AND PORTABLE ORAL HEALTH
20 SERVICES UNDER EPSDT.—Section 1905(r)(3) of the
21 Social Security Act (42 U.S.C. 1396d(r)(3)) is
22 amended—

23 (A) in subparagraph (A)(ii), by striking “;
24 and” and inserting a semicolon;

1 (B) in subparagraph (B), by striking the
2 period at the end and inserting “; and”; and

3 (C) by adding at the end the following new
4 subparagraph:

5 “(C) which shall include mobile and port-
6 able oral health services (as defined by the Sec-
7 retary) that—

8 “(i) are provided for the purpose of
9 overcoming mobility, transportation, or ac-
10 cess barriers for children; and

11 “(ii) satisfy the standards and certifi-
12 cation requirements established under sec-
13 tion 1902(a)(82)(C) for the State in which
14 the services are provided.”.

15 (e) ORAL HEALTH SERVICES AS AN ESSENTIAL
16 HEALTH BENEFIT.—Section 1302(b) of the Patient Pro-
17 tection and Affordable Care Act (42 U.S.C. 18022(b)) is
18 amended—

19 (1) in paragraph (1)—

20 (A) in subparagraph (J), by striking “oral
21 and”; and

22 (B) by adding at the end the following:

23 “(K) Oral health services for children and
24 adults.”; and

25 (2) by adding at the end the following:

1 “(6) ORAL HEALTH SERVICES.—For purposes
2 of paragraph (1)(K), the term ‘oral health services’
3 means services (as defined by the Secretary), that
4 are necessary to prevent disease and promote oral
5 health, restore oral structures to health and func-
6 tion, and treat emergency conditions.”.

7 (f) DEMONSTRATION PROGRAM ON TRAINING AND
8 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
9 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
10 VETERANS IN RURAL AND OTHER UNDERSERVED COM-
11 MUNITIES.—

12 (1) DEMONSTRATION PROGRAM AUTHORIZED.—
13 The Secretary of Veterans Affairs may carry out a
14 demonstration program to establish programs to
15 train and employ alternative dental health care pro-
16 viders in order to increase access to dental health
17 care services for veterans who are entitled to such
18 services from the Department of Veterans Affairs
19 and reside in rural and other underserved commu-
20 nities.

21 (2) TELEHEALTH.—For purposes of alternative
22 dental health care providers and other dental care
23 providers who are licensed to provide clinical care,
24 dental services provided under the demonstration
25 program under this section may be administered by

1 such providers through telehealth-enabled collabora-
2 tion and supervision when appropriate and feasible.

3 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
4 VIDERS DEFINED.—In this section, the term “alter-
5 native dental health care providers” has the meaning
6 given that term in section 340G–1(a)(2) of the Pub-
7 lic Health Service Act (42 U.S.C. 256g–1(a)(2)).

8 (4) AUTHORIZATION OF APPROPRIATIONS.—
9 There are authorized to be appropriated such sums
10 as are necessary to carry out the demonstration pro-
11 gram under this subsection.

12 (g) DEMONSTRATION PROGRAM ON TRAINING AND
13 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
14 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
15 MEMBERS OF THE ARMED FORCES AND DEPENDENTS
16 LACKING READY ACCESS TO SUCH SERVICES.—

17 (1) DEMONSTRATION PROGRAM AUTHORIZED.—
18 The Secretary of Defense may carry out a dem-
19 onstration program to establish programs to train
20 and employ alternative dental health care providers
21 in order to increase access to dental health care
22 services for members of the Armed Forces and their
23 dependents who lack ready access to such services,
24 including the following:

1 (A) Members and dependents who reside in
2 rural areas or areas otherwise underserved by
3 dental health care providers.

4 (B) Members of the National Guard and
5 Reserves in active status who are potentially
6 deployable.

7 (2) TELEHEALTH.—For purposes of alternative
8 dental health care providers and other dental care
9 providers who are licensed to provide clinical care,
10 dental services provided under the demonstration
11 program under this section may be administered by
12 such providers through telehealth-enabled collabora-
13 tion and supervision when appropriate and feasible.

14 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
15 VIDERS DEFINED.—In this section, the term “alter-
16 native dental health care providers” has the meaning
17 given that term in section 340G–1(a)(2) of the Pub-
18 lic Health Service Act (42 U.S.C. 256g–1(a)(2)).

19 (4) AUTHORIZATION OF APPROPRIATIONS.—
20 There are authorized to be appropriated such sums
21 as are necessary to carry out the demonstration pro-
22 gram under this subsection.

23 (h) DEMONSTRATION PROGRAM ON TRAINING AND
24 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
25 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR

1 PRISONERS WITHIN THE CUSTODY OF THE BUREAU OF
2 PRISONS.—

3 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

4 The Attorney General, acting through the Director
5 of the Bureau of Prisons, may carry out a dem-
6 onstration program to establish programs to train
7 and employ alternative dental health care providers
8 in order to increase access to dental health services
9 for prisoners within the custody of the Bureau of
10 Prisons.

11 (2) TELEHEALTH.—For purposes of alternative
12 dental health care providers and any other dental
13 care providers who are licensed to provide clinical
14 care, dental services provided under the demonstra-
15 tion program under this section may be administered
16 by such providers through telehealth-enabled collabo-
17 ration and supervision when deemed appropriate and
18 feasible.

19 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
20 VIDERS DEFINED.—In this section, the term “alter-
21 native dental health care providers” has the meaning
22 given that term in section 340G–1(a)(2) of the Pub-
23 lic Health Service Act (42 U.S.C. 256g–1(a)(2)).

24 (4) AUTHORIZATION OF APPROPRIATIONS.—

25 There are authorized to be appropriated such sums

1 as are necessary to carry out the demonstration pro-
2 gram under this subsection.

3 (i) DEMONSTRATION PROGRAM ON TRAINING AND
4 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
5 PROVIDERS FOR DENTAL HEALTH CARE SERVICES
6 UNDER THE INDIAN HEALTH SERVICE.—

7 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

8 The Secretary of Health and Human Services, act-
9 ing through the Indian Health Service, may carry
10 out a demonstration program to establish programs
11 to train and employ alternative dental health care
12 providers in order to help eliminate oral health dis-
13 parities and increase access to dental services
14 through health programs operated by the Indian
15 Health Service, Indian tribes, tribal organizations,
16 and urban Indian organizations (as those terms are
17 defined in section 4 of the Indian Health Care Im-
18 provement Act (25 U.S.C. 1603)).

19 (2) TELEHEALTH.—For purposes of alternative
20 dental health care providers and any other dental
21 care providers who are licensed to provide clinical
22 care, dental services provided under the demonstra-
23 tion program under this section may be administered
24 by such providers through telehealth-enabled collabo-

1 ration and supervision when deemed appropriate and
2 feasible.

3 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
4 VIDERS DEFINED.—In this section, the term “alter-
5 native dental health care providers” has the meaning
6 given that term in section 340G–1(a)(2) of the Pub-
7 lic Health Service Act (42 U.S.C. 256g–1(a)(2)).

8 (4) AUTHORIZATION OF APPROPRIATIONS.—
9 There are authorized to be appropriated such sums
10 as are necessary to carry out the demonstration pro-
11 gram under this subsection.

12 **TITLE V—IMPROVING HEALTH**
13 **OUTCOMES FOR WOMEN,**
14 **CHILDREN, AND FAMILIES**

15 **SEC. 501. GRANTS TO PROMOTE POSITIVE HEALTH OUT-**
16 **COMES FOR WOMEN AND CHILDREN.**

17 Part Q of title III of the Public Health Service Act
18 (42 U.S.C. 280g et seq.) is amended by adding at the end
19 the following:

20 **“SEC. 399Z–2. GRANTS TO PROMOTE POSITIVE HEALTH**
21 **OUTCOMES FOR WOMEN AND CHILDREN.**

22 “(a) GRANTS AUTHORIZED.—The Secretary, in col-
23 laboration with the Administrator of the Health Resources
24 and Services Administration and other Federal officials
25 determined appropriate by the Secretary, is authorized to

1 award grants to eligible entities to promote positive health
2 outcomes for women and children in target populations,
3 especially racial and ethnic minority women and children
4 in medically underserved communities.

5 “(b) USE OF FUNDS.—Grants awarded pursuant to
6 subsection (a) may be used to support the activities of
7 community health workers, including such activities—

8 “(1) to educate and provide outreach regarding
9 enrollment in health insurance including the State
10 Children’s Health Insurance Program under title
11 XXI of the Social Security Act, Medicare under title
12 XVIII of such Act, and Medicaid under title XIX of
13 such Act;

14 “(2) to educate, guide, and provide outreach in
15 a community setting regarding health problems prev-
16 alent among women and children and especially
17 among racial and ethnic minority women and chil-
18 dren;

19 “(3) to educate, guide, and provide experiential
20 learning opportunities and target risk factors and
21 healthy behaviors that impede or contribute to
22 achieving positive health outcomes, including—

23 “(A) healthy nutrition;

24 “(B) physical activity;

25 “(C) overweight or obesity;

1 “(D) tobacco use;

2 “(E) alcohol and substance use;

3 “(F) injury and violence;

4 “(G) sexual health;

5 “(H) mental health;

6 “(I) musculoskeletal health and arthritis;

7 “(J) dental and oral health;

8 “(K) understanding informed consent; and

9 “(L) stigma;

10 “(4) to educate and guide regarding effective
11 strategies to promote positive health outcomes for
12 women and children;

13 “(5) to promote community wellness and aware-
14 ness; and

15 “(6) to educate and refer target populations to
16 appropriate health care agencies and community-
17 based programs and organizations in order to in-
18 crease access to quality health care services, includ-
19 ing preventive health services.

20 “(c) APPLICATION.—

21 “(1) IN GENERAL.—Each eligible entity that
22 desires to receive a grant under subsection (a) shall
23 submit an application to the Secretary, at such time,
24 in such manner, and accompanied by such additional
25 information as the Secretary may require.

1 “(2) CONTENTS.—Each application submitted
2 pursuant to paragraph (1) shall—

3 “(A) describe the activities for which as-
4 sistance under this section is sought;

5 “(B) contain an assurance that, with re-
6 spect to each community health worker pro-
7 gram receiving funds under the grant awarded,
8 such program provides in-language training and
9 supervision to community health workers to en-
10 able such workers to provide authorized pro-
11 gram activities in (at least) the most commonly
12 used languages within a particular geographic
13 region;

14 “(C) contain an assurance that the appli-
15 cant will evaluate the effectiveness of commu-
16 nity health worker programs receiving funds
17 under the grant;

18 “(D) contain an assurance that each com-
19 munity health worker program receiving funds
20 under the grant will provide culturally com-
21 petent services in the linguistic context most
22 appropriate for the individuals served by the
23 program;

24 “(E) contain a plan to document and dis-
25 seminate project descriptions and results to

1 other States and organizations as identified by
2 the Secretary; and

3 “(F) describe plans to enhance the capac-
4 ity of individuals to utilize health services and
5 health-related social services under Federal,
6 State, and local programs by—

7 “(i) assisting individuals in estab-
8 lishing eligibility under the programs and
9 in receiving the services or other benefits
10 of the programs; and

11 “(ii) providing other services, as the
12 Secretary determines to be appropriate,
13 which may include transportation and
14 translation services.

15 “(d) PRIORITY.—In awarding grants under sub-
16 section (a), the Secretary shall give priority to those appli-
17 cants—

18 “(1) who propose to target geographic areas
19 that—

20 “(A)(i) have a high percentage of residents
21 who are uninsured or underinsured (if the tar-
22 getted geographic area is located in a State that
23 has elected to make medical assistance available
24 under section 1902(a)(10)(A)(i)(VIII) of the

1 Social Security Act to individuals described in
2 such section);

3 “(ii) have a high percentage of under-
4 insured residents in a particular geographic
5 area (if the targeted geographic area is located
6 in a State that has not so elected); or

7 “(iii) have a high number of households ex-
8 perienceing extreme poverty; and

9 “(B) have a high percentage of families for
10 whom English is not their primary language or
11 including smaller limited-English-proficient
12 communities within the region that are not oth-
13 erwise reached by linguistically appropriate
14 health services;

15 “(2) with experience in providing health or
16 health-related social services to individuals who are
17 underserved with respect to such services; and

18 “(3) with documented community activity and
19 experience with community health workers.

20 “(e) COLLABORATION WITH ACADEMIC INSTITU-
21 TIONS.—The Secretary shall encourage community health
22 worker programs receiving funds under this section to col-
23 laborate with academic institutions, including minority-
24 serving institutions. Nothing in this section shall be con-
25 strued to require such collaboration.

1 “(f) QUALITY ASSURANCE AND COST EFFECTIVE-
2 NESS.—The Secretary shall establish guidelines for ensur-
3 ing the quality of the training and supervision of commu-
4 nity health workers under the programs funded under this
5 section and for ensuring the cost effectiveness of such pro-
6 grams.

7 “(g) MONITORING.—The Secretary shall monitor
8 community health worker programs identified in approved
9 applications and shall determine whether such programs
10 are in compliance with the guidelines established under
11 subsection (f).

12 “(h) TECHNICAL ASSISTANCE.—The Secretary may
13 provide technical assistance to community health worker
14 programs identified in approved applications with respect
15 to planning, developing, and operating programs under the
16 grant.

17 “(i) REPORT TO CONGRESS.—

18 “(1) IN GENERAL.—Not later than 4 years
19 after the date on which the Secretary first awards
20 grants under subsection (a), the Secretary shall sub-
21 mit to Congress a report regarding the grant
22 project.

23 “(2) CONTENTS.—The report required under
24 paragraph (1) shall include the following:

1 “(A) A description of the programs for
2 which grant funds were used.

3 “(B) The number of individuals served.

4 “(C) An evaluation of—

5 “(i) the effectiveness of these pro-
6 grams;

7 “(ii) the cost of these programs; and

8 “(iii) the impact of the project on the
9 health outcomes of the community resi-
10 dents.

11 “(D) Recommendations for sustaining the
12 community health worker programs developed
13 or assisted under this section.

14 “(E) Recommendations regarding training
15 to enhance career opportunities for community
16 health workers.

17 “(j) DEFINITIONS.—In this section:

18 “(1) COMMUNITY HEALTH WORKER.—The term
19 ‘community health worker’ means an individual who
20 promotes health or nutrition within the community
21 in which the individual resides—

22 “(A) by serving as a liaison between com-
23 munities and health care agencies;

24 “(B) by providing guidance and social as-
25 sistance to community residents;

1 “(C) by enhancing community residents’
2 ability to effectively communicate with health
3 care providers;

4 “(D) by providing culturally and linguis-
5 tically appropriate health or nutrition edu-
6 cation;

7 “(E) by advocating for individual and com-
8 munity health, including dental, oral, mental,
9 and environmental health, or nutrition needs;

10 “(F) by taking into consideration the
11 needs of the communities served, including the
12 prevalence rates of risk factors that impede
13 achieving positive healthy outcomes among
14 women and children, especially among racial
15 and ethnic minority women and children; and

16 “(G) by providing referral and followup
17 services.

18 “(2) COMMUNITY SETTING.—The term ‘commu-
19 nity setting’ means a home or a community organi-
20 zation that serves a population.

21 “(3) ELIGIBLE ENTITY.—The term ‘eligible en-
22 tity’ means—

23 “(A) a unit of State, territorial, local, or
24 tribal government (including a federally recog-
25 nized tribe or Alaska Native village); or

1 “(B) a community-based organization.

2 “(4) MEDICALLY UNDERSERVED COMMUNITY.—

3 The term ‘medically underserved community’ means
4 a community—

5 “(A) that has a substantial number of in-
6 dividuals who are members of a medically un-
7 derserved population, as defined by section
8 330(b)(3);

9 “(B) a significant portion of which is a
10 health professional shortage area as designated
11 under section 332; and

12 “(C) that includes populations that are lin-
13 guistically isolated, such as geographic areas
14 with a shortage of health professionals able to
15 provide linguistically appropriate services.

16 “(5) SUPPORT.—The term ‘support’ means the
17 provision of training, supervision, and materials
18 needed to effectively deliver the services described in
19 subsection (b), reimbursement for services, and
20 other benefits.

21 “(6) TARGET POPULATION.—The term ‘target
22 population’ means women of reproductive age, re-
23 gardless of their current childbearing status and
24 children under 21 years of age.

1 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 \$15,000,000 for each of fiscal years 2017 through 2021.”.

4 **SEC. 502. REMOVING BARRIERS TO HEALTH CARE AND NU-**
5 **TRITION ASSISTANCE FOR CHILDREN, PREG-**
6 **NANT WOMEN, AND LAWFULLY PRESENT IN-**
7 **DIVIDUALS.**

8 (a) MEDICAID.—Section 1903(v) of the Social Secu-
9 rity Act (42 U.S.C. 1396b(v)) is amended by striking
10 paragraph (4) and inserting the following new paragraph:

11 “(4)(A) Notwithstanding sections 401(a), 402(b),
12 403, and 421 of the Personal Responsibility and Work Op-
13 portunity Reconciliation Act of 1996 and paragraph (1),
14 payment shall be made to a State under this section for
15 medical assistance furnished to an alien under this title
16 (including an alien described in such paragraph) who
17 meets any of the following conditions:

18 “(i) The alien is otherwise eligible for such as-
19 sistance under the State plan approved under this
20 title (other than the requirement of the receipt of
21 aid or assistance under title IV, supplemental secu-
22 rity income benefits under title XVI, or a State sup-
23 plementary payment) within either or both of the
24 following eligibility categories:

1 “(I) Children under 21 years of age, in-
2 cluding any optional targeted low-income child
3 (as such term is defined in section
4 1905(u)(2)(B)).

5 “(II) Pregnant women during pregnancy
6 and during the 60-day period beginning on the
7 last day of the pregnancy.

8 “(ii) The alien is lawfully present in the United
9 States.

10 “(B) No debt shall accrue under an affidavit of sup-
11 port against any sponsor of an alien who meets the condi-
12 tions specified in subparagraph (A) on the basis of the
13 provision of medical assistance to such alien under this
14 paragraph and the cost of such assistance shall not be con-
15 sidered as an unreimbursed cost.”.

16 (b) SCHIP.—Subparagraph (J) of section
17 2107(e)(1) of the Social Security Act (42 U.S.C.
18 1397gg(e)(1)) is amended to read as follows:

19 “(J) Paragraph (4) of section 1903(v) (re-
20 lating to coverage of categories of children,
21 pregnant women, and other lawfully present in-
22 dividuals).”.

23 (c) SUPPLEMENTAL NUTRITION ASSISTANCE.—Not-
24 withstanding sections 401(a), 402(a), and 403(a) of the
25 Personal Responsibility and Work Opportunity Reconcili-

1 ation Act of 1996 (8 U.S.C. 1611(a); 1612(a); 1613(a))
2 and section 6(f) of the Food and Nutrition Act of 2008
3 (7 U.S.C. 2015(f)), persons who are lawfully present in
4 the United States shall be not be ineligible for benefits
5 under the supplemental nutrition assistance program on
6 the basis of their immigration status or date of entry into
7 the United States.

8 (d) ELIGIBILITY FOR FAMILIES WITH CHILDREN.—
9 Section 421(d)(3) of the Personal Responsibility and
10 Work Opportunity Reconciliation Act of 1996 (8 U.S.C.
11 1631(d)(3)) is amended by striking “to the extent that
12 a qualified alien is eligible under section 402(a)(2)(J)”
13 and inserting, “to the extent that a child is a member of
14 a household under the supplemental nutrition assistance
15 program”.

16 (e) ENSURING PROPER SCREENING.—Section
17 11(e)(2)(B) of the Food and Nutrition Act of 2008 (7
18 U.S.C. 2020(e)(2)(B)) is amended—

19 (1) by redesignating clauses (vi) and (vii) as
20 clauses (vii) and (viii); and

21 (2) by inserting after clause (v) the following:

22 “(vi) shall provide a method for imple-
23 menting section 421 of the Personal Re-
24 sponsibility and Work Opportunity Rec-
25 onciliation Act of 1996 (8 U.S.C. 1631)

1 that does not require any unnecessary in-
2 formation from persons who may be ex-
3 empt from that provision;”.

4 **SEC. 503. REPEAL OF DENIAL OF BENEFITS.**

5 Section 115 of the Personal Responsibility and Work
6 Opportunity Reconciliation Act of 1996 (21 U.S.C. 862a)
7 is amended—

8 (1) in subsection (a), by striking paragraph (2);

9 (2) in subsection (b), by striking paragraph (2);

10 and

11 (3) in subsection (e), by striking paragraph (2).

12 **SEC. 504. BIRTH DEFECTS PREVENTION, RISK REDUCTION,**
13 **AND AWARENESS.**

14 (a) **IN GENERAL.**—The Secretary shall establish and
15 implement a birth defects prevention and public awareness
16 program, consisting of the activities described in sub-
17 sections (c) and (d).

18 (b) **DEFINITIONS.**—In this section:

19 (1) The term “pregnancy and breastfeeding in-
20 formation services” includes only—

21 (A) information services to provide accu-
22 rate, evidence-based, clinical information re-
23 garding maternal exposures during pregnancy
24 that may be associated with birth defects or
25 other health risks, such as exposures to medica-

1 tions, chemicals, infections, foodborne patho-
2 gens, illnesses, nutrition, or lifestyle factors;

3 (B) information services to provide accu-
4 rate, evidence-based, clinical information re-
5 garding maternal exposures during breast-
6 feeding that may be associated with health risks
7 to a breast-fed infant, such as exposures to
8 medications, chemicals, infections, foodborne
9 pathogens, illnesses, nutrition, or lifestyle fac-
10 tors;

11 (C) the provision of accurate, evidence-
12 based information weighing risks of exposures
13 during breastfeeding against the benefits of
14 breastfeeding; and

15 (D) the provision of information described
16 in subparagraph (A), (B), or (C) through coun-
17 selors, Web sites, fact sheets, telephonic or elec-
18 tronic communication, community outreach ef-
19 forts, or other appropriate means.

20 (2) The term “Secretary” means the Secretary
21 of Health and Human Services, acting through the
22 Director of the Centers for Disease Control and Pre-
23 vention.

24 (c) NATIONWIDE MEDIA CAMPAIGN.—In carrying out
25 subsection (a), the Secretary shall conduct or support a

1 nationwide media campaign to increase awareness among
2 health care providers and at-risk populations about preg-
3 nancy and breastfeeding information services.

4 (d) GRANTS FOR PREGNANCY AND BREASTFEEDING
5 INFORMATION SERVICES.—

6 (1) IN GENERAL.—In carrying out subsection
7 (a), the Secretary shall award grants to State or re-
8 gional agencies or organizations for any of the fol-
9 lowing:

10 (A) INFORMATION SERVICES.—The provi-
11 sion of, or campaigns to increase awareness
12 about, pregnancy and breastfeeding information
13 services.

14 (B) SURVEILLANCE AND RESEARCH.—The
15 conduct or support of—

16 (i) surveillance of or research on—

17 (I) maternal exposures and ma-
18 ternal health conditions that may in-
19 fluence the risk of birth defects, pre-
20 maturity, or other adverse pregnancy
21 outcomes; and

22 (II) maternal exposures that may
23 influence health risks to a breastfed
24 infant; or

1 (ii) networking to facilitate surveil-
2 lance or research described in this sub-
3 paragraph.

4 (2) PREFERENCE FOR CERTAIN STATES.—The
5 Secretary, in making any grant under this sub-
6 section, shall give preference to States, otherwise
7 equally qualified, that have a pregnancy and
8 breastfeeding information service in place.

9 (3) MATCHING FUNDS.—The Secretary may
10 only award a grant under this subsection to a State
11 or regional agency or organization that agrees, with
12 respect to the costs to be incurred in carrying out
13 the grant activities, to make available (directly or
14 through donations from public or private entities)
15 non-Federal funds toward such costs in an amount
16 equal to not less than 25 percent of the amount of
17 the grant.

18 (4) COORDINATION.—The Secretary shall en-
19 sure that activities funded through a grant under
20 this subsection are coordinated, to the maximum ex-
21 tent practicable, with other birth defects prevention
22 and environmental health activities of the Federal
23 Government, including with respect to pediatric envi-
24 ronmental health specialty units and children’s envi-
25 ronmental health centers.

1 (e) EVALUATION.—In furtherance of the program
2 under subsection (a), the Secretary shall provide for an
3 evaluation of pregnancy and breastfeeding information
4 services to identify efficient and effective models of—

5 (1) providing information;

6 (2) raising awareness and increasing knowledge
7 about birth defects prevention measures and tar-
8 geting education to at-risk groups;

9 (3) modifying risk behaviors; or

10 (4) other outcome measures as determined ap-
11 propriate by the Secretary.

12 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
13 out this section, there are authorized to be appropriated
14 \$5,000,000 for fiscal year 2017, \$6,000,000 for fiscal year
15 2018, \$7,000,000 for fiscal year 2019, \$8,000,000 for fis-
16 cal year 2020, and \$9,000,000 for fiscal year 2021.

17 **SEC. 505. UNIFORM STATE MATERNAL MORTALITY REVIEW**
18 **COMMITTEES ON PREGNANCY-RELATED**
19 **DEATHS.**

20 (a) IN GENERAL.—Title V of the Social Security Act
21 (42 U.S.C. 701 et seq.) is amended by adding at the end
22 the following new section:

1 **“SEC. 514. UNIFORM STATE MATERNAL MORTALITY RE-**
2 **VIEW COMMITTEES ON PREGNANCY-RE-**
3 **LATED DEATHS.**

4 “(a) GRANTS.—

5 “(1) IN GENERAL.—Notwithstanding any other
6 provision of this title, for each of fiscal years 2017
7 through 2023, in addition to payments from allot-
8 ments for States under section 502 for such year,
9 the Secretary shall, subject to paragraph (3) and in
10 accordance with the criteria established under para-
11 graph (2), award grants to States to—

12 “(A) carry out the activities described in
13 subsection (b)(1);

14 “(B) establish a State maternal mortality
15 review committee, in accordance with subsection
16 (b)(2), to carry out the activities described in
17 subsection (b)(2)(A), and to establish the proc-
18 esses described in subsection (b)(1);

19 “(C) ensure the State department of
20 health carries out the applicable activities de-
21 scribed in subsection (b)(3), with respect to
22 pregnancy-related deaths occurring within the
23 State during such fiscal year;

24 “(D) implement and use the comprehensive
25 case abstraction form developed under sub-

1 section (c), in accordance with such subsection;
2 and

3 “(E) provide for public disclosure of infor-
4 mation, in accordance with subsection (e).

5 “(2) CRITERIA.—The Secretary shall establish
6 criteria for determining eligibility for and the
7 amount of a grant awarded to a State under para-
8 graph (1). Such criteria shall provide that in the
9 case of a State that receives such a grant for a fiscal
10 year and is determined by the Secretary to have not
11 used such grant in accordance with this section,
12 such State shall not be eligible for such a grant for
13 any subsequent fiscal year.

14 “(3) AUTHORIZATION OF APPROPRIATIONS.—
15 For purposes of carrying out the grant program
16 under this section, including for administrative pur-
17 poses, there is authorized to be appropriated
18 \$10,000,000 for each of fiscal years 2017 through
19 2023.

20 “(b) PREGNANCY-RELATED DEATH REVIEW.—

21 “(1) REVIEW OF PREGNANCY-RELATED DEATH
22 AND PREGNANCY-ASSOCIATED DEATH CASES.—For
23 purposes of subsection (a), with respect to a State
24 that receives a grant under subsection (a), the fol-
25 lowing shall apply:

1 “(A) MANDATORY REPORTING OF PREG-
2 NANCY-RELATED DEATHS.—

3 “(i) IN GENERAL.—The State shall,
4 through the State maternal mortality re-
5 view committee, develop a process, sepa-
6 rate from any reporting process established
7 by the State department of health prior to
8 the date of the enactment of this section,
9 that provides for mandatory and confiden-
10 tial case reporting by individuals and enti-
11 ties described in clause (ii) of pregnancy-
12 related deaths to the State department of
13 health.

14 “(ii) INDIVIDUALS AND ENTITIES DE-
15 SCRIBED.—Individuals and entities de-
16 scribed in this clause include each of the
17 following:

18 “(I) Health care providers.

19 “(II) Medical examiners.

20 “(III) Medical coroners.

21 “(IV) Hospitals.

22 “(V) Free-standing birth centers.

23 “(VI) Federally qualified health
24 centers.

1 “(VII) Other health care facili-
2 ties.

3 “(VIII) Any other individuals re-
4 sponsible for completing death certifi-
5 cates.

6 “(IX) Any other appropriate in-
7 dividuals or entities specified by the
8 Secretary.

9 “(B) VOLUNTARY REPORTING OF PREG-
10 NANCY-RELATED AND PREGNANCY-ASSOCIATED
11 DEATHS.—

12 “(i) The State shall, through the
13 State maternal mortality review committee,
14 develop a process for and encourage, sepa-
15 rate from any reporting process established
16 by the State department of health prior to
17 the date of the enactment of this section,
18 voluntary and confidential case reporting
19 by individuals described in clause (ii) of
20 pregnancy-associated deaths to the State
21 department of health.

22 “(ii) The State shall, through the
23 State maternal mortality review committee,
24 develop a process for voluntary and con-
25 fidential reporting by family members of

1 the deceased and by other individuals on
2 possible pregnancy-related and pregnancy-
3 associated deaths to the State department
4 of health. Such process shall include—

5 “(I) making publicly available on
6 the Internet Web site of the State de-
7 partment of health a telephone num-
8 ber, Internet Web link, and email ad-
9 dress for such reporting; and

10 “(II) publicizing to local profes-
11 sional organizations, community orga-
12 nizations, and social services agencies
13 the availability of the telephone num-
14 ber, Internet Web link, and email ad-
15 dress made available under subclause
16 (I).

17 “(C) DEVELOPMENT OF CASE-FINDING.—

18 The State, through the vital statistics unit of
19 the State, shall annually identify pregnancy-re-
20 lated and pregnancy-associated deaths occur-
21 ring in such State during the year involved
22 by—

23 “(i) matching all death records, with
24 respect to such year, for women of child-
25 bearing age to live birth certificates and in-

1 fant death certificates to identify deaths of
2 women that occurred during pregnancy
3 and within one year after the end of a
4 pregnancy;

5 “(ii) identifying deaths reported dur-
6 ing such year as having an underlying or
7 contributing cause of death related to
8 pregnancy, regardless of the time that has
9 passed between the end of the pregnancy
10 and the death;

11 “(iii) collecting data from medical ex-
12 aminer and coroner reports; and

13 “(iv) any other methods the States
14 may devise to identify maternal deaths,
15 such as through review of a random sam-
16 ple of reported deaths of women of child-
17 bearing age to ascertain cases of preg-
18 nancy-related and pregnancy-associated
19 deaths that are not discernable from a re-
20 view of death certificates alone.

21 When feasible and for purposes of effectively
22 collecting and obtaining data on pregnancy-re-
23 lated and pregnancy-associated deaths, the
24 State shall adopt the most recent standardized
25 birth and death certificates, as issued by the

1 National Center for Vital Health Statistics, in-
2 cluding the recommended checkbox section for
3 pregnancy on the death certificates.

4 “(D) CASE INVESTIGATION AND DEVELOP-
5 MENT OF CASE SUMMARIES.—Following receipt
6 of reports by the State department of health
7 pursuant to subparagraph (A) or (B) and col-
8 lection by the vital statistics unit of the State
9 of possible cases of pregnancy-related and preg-
10 nancy-associated deaths pursuant to subpara-
11 graph (C), the State, through the State mater-
12 nal mortality review committee established
13 under subsection (a), shall investigate each
14 case, utilizing the case abstraction form de-
15 scribed in subsection (c), and prepare de-identi-
16 fied case summaries, which shall be reviewed by
17 the committee and included in applicable re-
18 ports. For purposes of subsection (a), under the
19 processes established under subparagraphs (A),
20 (B), and (C), a State department of health or
21 vital statistics unit of a State shall provide to
22 the State maternal mortality review committee
23 access to information collected pursuant to such
24 subparagraphs as necessary to carry out this
25 subparagraph. Data and information collected

1 for the case summary and review are for pur-
2 poses of public health activities, in accordance
3 with HIPAA privacy and security law (as de-
4 fined in section 3009(a)(2) of the Public Health
5 Service Act). Such case investigations shall in-
6 clude data and information obtained through—

7 “(i) medical examiner and autopsy re-
8 ports of the woman involved;

9 “(ii) medical records of the woman,
10 including such records related to health
11 care prior to pregnancy, prenatal and post-
12 natal care, labor and delivery care, emer-
13 gency room care, hospital discharge
14 records including immunization status and
15 screening status for prevalent diseases, and
16 any care delivered up until the time of
17 death of the woman for purposes of public
18 health activities, in accordance with
19 HIPAA privacy and security law (as de-
20 fined in section 3009(a)(2) of the Public
21 Health Service Act);

22 “(iii) oral and written interviews of in-
23 dividuals directly involved in the maternal
24 care of the woman during and immediately
25 following the pregnancy of the woman, in-

1 cluding health care, mental health, and so-
2 cial service providers in-language when
3 possible, as applicable;

4 “(iv) optional oral or written inter-
5 views of the family of the woman;

6 “(v) socioeconomic and other relevant
7 background information about the woman;

8 “(vi) information collected in subpara-
9 graph (C)(i); and

10 “(vii) other information on the cause
11 of death of the woman, such as social serv-
12 ices and child welfare reports, including ex-
13 periences with intimate partner violence.

14 “(2) STATE MATERNAL MORTALITY REVIEW
15 COMMITTEES.—

16 “(A) DUTIES.—

17 “(i) REQUIRED COMMITTEE ACTIVI-
18 TIES.—For purposes of subsection (a), a
19 maternal mortality review committee estab-
20 lished by a State pursuant to a grant
21 under such subsection shall carry out the
22 following pregnancy-related death and
23 pregnancy-associated death review activi-
24 ties and shall include all information rel-
25 evant to the death involved on the case ab-

1 straction form developed under subsection
2 (d):

3 “(I) With respect to a case of
4 pregnancy-related or pregnancy-asso-
5 ciated death of a woman, review the
6 case summaries prepared under sub-
7 paragraphs (A), (B), (C), and (D) of
8 paragraph (1).

9 “(II) Review aggregate statistical
10 reports developed by the vital statis-
11 tics unit of the State under paragraph
12 (1)(C) regarding pregnancy-related
13 and pregnancy-associated deaths to
14 identify trends, patterns, and dispari-
15 ties in adverse outcomes and address
16 medical, nonmedical, and system-re-
17 lated factors that may have contrib-
18 uted to such pregnancy-related and
19 pregnancy-associated deaths and dis-
20 parities.

21 “(III) Develop recommendations,
22 based on the review of the case sum-
23 maries under paragraph (1)(D) and
24 aggregate statistical reports under
25 subclause (II), to improve maternal

1 care, social and health services, and
2 public health policy and institutions,
3 including with respect to improving
4 access to maternal care, improving the
5 availability of social services, and
6 eliminating disparities in maternal
7 care and outcomes.

8 “(ii) OPTIONAL COMMITTEE ACTIVI-
9 TIES.—For purposes of subsection (a), a
10 maternal mortality review committee estab-
11 lished by a State under such subsection
12 may present findings and recommendations
13 regarding a specific case or set of cir-
14 cumstances directly to a health care facil-
15 ity or its local or State professional organi-
16 zation for the purpose of instituting policy
17 changes, educational activities, or other-
18 wise improving the quality of care provided
19 by the facilities.

20 “(B) COMPOSITION OF MATERNAL MOR-
21 TALITY REVIEW COMMITTEES.—

22 “(i) IN GENERAL.—Each State mater-
23 nal mortality review committee established
24 pursuant to a grant under subsection (a)
25 shall be multidisciplinary, consisting of

1 health care, behavioral health, and social
2 service providers, public health officials,
3 other persons with professional expertise
4 on maternal health and mortality, and pa-
5 tient and community advocates who rep-
6 resent those communities within such State
7 that are the most affected by maternal
8 mortality. Membership on such a com-
9 mittee of a State shall be reviewed annu-
10 ally by the State department of health to
11 ensure that membership representation re-
12 quirements are being fulfilled in accord-
13 ance with this paragraph.

14 “(ii) REQUIRED MEMBERSHIP.—Each
15 such review committee shall include—

16 “(I) representatives from medical
17 specialties providing care to pregnant
18 and postpartum patients, including
19 obstetricians (including generalists
20 and maternal fetal medicine special-
21 ists), and family practice physicians;

22 “(II) representatives from mid-
23 wifery specialties (including certified
24 professional midwives and certified
25 midwives);

1 “(III) advanced practice nurses;

2 “(IV) hospital-based nurses;

3 “(V) representatives of the State
4 department of health maternal and
5 child health department;

6 “(VI) social service providers or
7 social workers;

8 “(VII) the chief medical exam-
9 iners or designees;

10 “(VIII) facility representatives,
11 such as from hospitals or free-stand-
12 ing birth centers; and

13 “(IX) community or patient ad-
14 vocates who represent those commu-
15 nities within the State that are the
16 most affected by maternal mortality.

17 “(iii) ADDITIONAL MEMBERS.—Each
18 such review committee may also include
19 representatives from other relevant aca-
20 demic, health, social service, or policy pro-
21 fessions, or community organizations, on
22 an ongoing basis, or as needed, as deter-
23 mined beneficial by the review committee,
24 including—

25 “(I) anesthesiologists;

- 1 “(II) emergency physicians;
- 2 “(III) pathologists;
- 3 “(IV) epidemiologists or biostat-
- 4 isticians;
- 5 “(V) intensivists;
- 6 “(VI) orthopedic surgeons and/or
- 7 orthopedic physicians;
- 8 “(VII) vital statistics officers;
- 9 “(VIII) nutritionists;
- 10 “(IX) mental health profes-
- 11 sionals;
- 12 “(X) substance abuse treatment
- 13 specialists;
- 14 “(XI) representatives of relevant
- 15 advocacy groups;
- 16 “(XII) academics;
- 17 “(XIII) representatives of bene-
- 18 ficiaries of the State plan under the
- 19 Medicaid Program under title XIX;
- 20 “(XIV) paramedics;
- 21 “(XV) lawyers;
- 22 “(XVI) risk management special-
- 23 ists;
- 24 “(XVII) representatives of the
- 25 departments of health or public health

1 of major cities in the State involved;
2 and

3 “(XVIII) policymakers.

4 “(iv) DIVERSE COMMUNITY MEMBER-
5 SHIP.—The composition of such a com-
6 mittee, with respect to a State, shall in-
7 clude—

8 “(I) representatives from diverse
9 communities, particularly those com-
10 munities within such State most se-
11 verely affected by pregnancy-related
12 deaths or pregnancy-associated deaths
13 and by a lack of access to relevant
14 maternal care services, from commu-
15 nity maternal child health organiza-
16 tions, and from minority advocacy
17 groups;

18 “(II) members, including health
19 care providers, from different geo-
20 graphic regions in the State, including
21 any rural, urban, and tribal areas;
22 and

23 “(III) health care and social serv-
24 ice providers who work in commu-
25 nities that are diverse with regard to

1 race, ethnicity, immigration status, in-
2 digenous status, and English pro-
3 ficiency.

4 “(v) MATERNAL MORTALITY REVIEW
5 STAFF.—Staff of each such review com-
6 mittee shall include—

7 “(I) vital health statisticians, ma-
8 ternal child health statisticians, or
9 epidemiologists;

10 “(II) a coordinator of the State
11 maternal mortality review committee,
12 to be designated by the State; and

13 “(III) administrative staff.

14 “(C) OPTION FOR STATES TO FORM RE-
15 GIONAL MATERNAL MORTALITY REVIEWS.—
16 States with a low rate of occurrence of preg-
17 nancy-associated or pregnancy-related deaths
18 may choose to partner with one or more neigh-
19 boring States to fulfill the activities described in
20 paragraph (1)(C). In such a case, with respect
21 to States in such a partnership, any require-
22 ment under this section relating to the report-
23 ing of information related to such activities
24 shall be deemed to be fulfilled by each such

1 State if a single such report is submitted for
2 the partnership.

3 “(3) STATE DEPARTMENT OF HEALTH ACTIVI-
4 TIES.—For purposes of subsection (a), a State de-
5 partment of health of a State receiving a grant
6 under such subsection shall—

7 “(A) in consultation with the maternal
8 mortality review committee of the State and in
9 conjunction with relevant professional organiza-
10 tions, develop a plan for ongoing health care
11 provider education, based on the findings and
12 recommendations of the committee, in order to
13 improve the quality of maternal care; and

14 “(B) take steps to widely disseminate the
15 findings and recommendations of the State ma-
16 ternal mortality review committees of the State
17 and to implement the recommendations of such
18 committee.

19 “(c) CASE ABSTRACTION FORM.—

20 “(1) DEVELOPMENT.—The Director of the Cen-
21 ters for Disease Control and Prevention shall de-
22 velop a uniform, comprehensive case abstraction
23 form and make such form available to States for
24 State maternal mortality review committees for use
25 by such committees in order to—

1 “(A) ensure that the cases and information
2 collected and reviewed by such committees can
3 be pooled for review by the Department of
4 Health and Human Services and its agencies;
5 and

6 “(B) preserve the uniformity of the infor-
7 mation and its use for Federal public health
8 purposes.

9 “(2) PERMISSIBLE STATE MODIFICATION.—
10 Each State may modify the form developed under
11 paragraph (1) for implementation and use by such
12 State or by the State maternal mortality review com-
13 mittee of such State by including on such form addi-
14 tional information to be collected, but may not alter
15 the standard questions on such form, in order to en-
16 sure that the information can be collected and re-
17 viewed centrally at the Federal level.

18 “(d) TREATMENT AS PUBLIC HEALTH AUTHORITY
19 FOR PURPOSES OF HIPAA.—For purposes of applying
20 HIPAA privacy and security law (as defined in section
21 3009(a)(2) of the Public Health Service Act), a State ma-
22 ternal mortality review committee of a State established
23 pursuant to this section to carry out activities described
24 in subsection (b)(2)(A) shall be deemed to be a public
25 health authority described in section 164.501 (and ref-

1 erenced in section 164.512(b)(1)(i) of title 45, Code of
2 Federal Regulations (or any successor regulation), car-
3 rying out public health activities and purposes described
4 in such section 164.512(b)(1)(i) (or any such successor
5 regulation).

6 “(e) PUBLIC DISCLOSURE OF INFORMATION.—

7 “(1) IN GENERAL.—For fiscal year 2017 or a
8 subsequent fiscal year, each State receiving a grant
9 under this section for such year shall, subject to
10 paragraph (3), provide for the public disclosure, and
11 submission to the information clearinghouse estab-
12 lished under paragraph (2), of the information in-
13 cluded in the report of the State under section
14 506(a)(2)(F) for such year (relating to the findings
15 for such year of the State maternal mortality review
16 committee established by the State under this sec-
17 tion).

18 “(2) INFORMATION CLEARINGHOUSE.—The
19 Secretary of Health and Human Services shall es-
20 tablish an information clearinghouse, that shall be
21 administered by the Director of the Centers for Dis-
22 ease Control and Prevention, that will maintain find-
23 ings and recommendations submitted pursuant to
24 paragraph (1) and provide such findings and rec-
25 ommendations for public review and research pur-

1 poses by State health departments, maternal mor-
2 tality review committees, and health providers and
3 institutions.

4 “(3) CONFIDENTIALITY OF INFORMATION.—In
5 no case shall any individually identifiable health in-
6 formation be provided to the public, or submitted to
7 the information clearinghouse, under paragraph (1).

8 “(f) CONFIDENTIALITY OF REVIEW COMMITTEE
9 PROCEEDINGS.—

10 “(1) IN GENERAL.—All proceedings and activi-
11 ties of a State maternal mortality review committee
12 under this section, opinions of members of such a
13 committee formed as a result of such proceedings
14 and activities, and records obtained, created, or
15 maintained pursuant to this section, including
16 records of interviews, written reports, and state-
17 ments procured by the Department of Health and
18 Human Services or by any other person, agency, or
19 organization acting jointly with the Department, in
20 connection with morbidity and mortality reviews
21 under this section, shall be confidential, and not sub-
22 ject to discovery, subpoena, or introduction into evi-
23 dence in any civil, criminal, legislative, or other pro-
24 ceeding. Such records shall not be open to public in-
25 spection.

1 “(2) TESTIMONY OF MEMBERS OF COM-
2 MITTEE.—

3 “(A) IN GENERAL.—Members of a State
4 maternal mortality review committee under this
5 section may not be questioned in any civil,
6 criminal, legislative, or other proceeding regard-
7 ing information presented in, or opinions
8 formed as a result of, a meeting or communica-
9 tion of the committee.

10 “(B) CLARIFICATION.—Nothing in this
11 subsection shall be construed to prevent a mem-
12 ber of such a committee from testifying regard-
13 ing information that was obtained independent
14 of such member’s participation on the com-
15 mittee, or that is public information.

16 “(3) AVAILABILITY OF INFORMATION FOR RE-
17 SEARCH PURPOSES.—Nothing in this subsection
18 shall prohibit the publishing by such a committee or
19 the Department of Health and Human Services of
20 statistical compilations and research reports that—

21 “(A) are based on confidential information,
22 relating to morbidity and mortality review; and

23 “(B) do not contain identifying informa-
24 tion or any other information that could be

1 used to ultimately identify the individuals con-
2 cerned.

3 “(g) DEFINITIONS.—For purposes of this section:

4 “(1) The term ‘pregnancy-associated death’
5 means the death of a woman while pregnant or dur-
6 ing the one-year period following the date of the end
7 of pregnancy, irrespective of the cause of such death.

8 “(2) The term ‘pregnancy-related death’ means
9 the death of a woman while pregnant or during the
10 one-year period following the date of the end of
11 pregnancy, irrespective of the duration or site of the
12 pregnancy, from any cause related to or aggravated
13 by the pregnancy or its management, but not from
14 any accidental or incidental cause.

15 “(3) The term ‘woman of childbearing age’
16 means a woman who is at least 10 years of age and
17 not more than 54 years of age.”.

18 (b) INCLUSION OF FINDINGS OF REVIEW COMMIT-
19 TEES IN REQUIRED REPORTS.—

20 (1) STATE TRIENNIAL REPORTS.—Paragraph
21 (2) of section 506(a) of the Social Security Act (42
22 U.S.C. 706(a)) is amended by inserting after sub-
23 paragraph (E) the following new subparagraph:

24 “(F) In the case of a State receiving a
25 grant under section 514, beginning for the first

1 fiscal year beginning after 3 years after the
2 date of establishment of the State maternal
3 mortality review committee established by the
4 State pursuant to such grant and once every 3
5 years thereafter, information containing the
6 findings and recommendations of such com-
7 mittee and information on the implementation
8 of such recommendations during the period in-
9 volved.”.

10 (2) ANNUAL REPORTS TO CONGRESS.—Para-
11 graph (3) of such section is amended—

12 (A) in subparagraph (D) by striking “and”
13 at the end;

14 (B) in subparagraph (E) by striking the
15 period at the end and inserting “; and”; and

16 (C) by adding at the end the following new
17 subparagraph:

18 “(F) For fiscal year 2017 and each subsequent
19 fiscal year, taking into account the findings, rec-
20 ommendations, and implementation information sub-
21 mitted by States pursuant to paragraph (2)(F), on
22 the status of pregnancy-related deaths and preg-
23 nancy-associated deaths in the United States and in-
24 cluding recommendations on methods to prevent
25 such deaths in the United States.”.

1 **SEC. 506. ELIMINATING DISPARITIES IN MATERNITY**
2 **HEALTH OUTCOMES.**

3 Part B of title III of the Public Health Service Act
4 is amended by inserting after section 317V, as added, the
5 following new section:

6 **“SEC. 317W. ELIMINATING DISPARITIES IN MATERNITY**
7 **HEALTH OUTCOMES.**

8 “(a) IN GENERAL.—The Secretary (in consultation
9 with the Deputy Assistant Secretary for Minority Health,
10 the Director of the National Institutes of Health, the Di-
11 rector of the Centers for Disease Control and Prevention,
12 the Administrator of the Centers for Medicare & Medicaid
13 Services, and the Administrator of the Agency for
14 Healthcare Research & Quality, and in consultation with
15 relevant national stakeholder organizations such as na-
16 tional medical specialty organizations, national maternal
17 child health organizations, national groups that represent
18 minority populations, and national health disparity organi-
19 zations) shall carry out the following activities to eliminate
20 disparities in maternal health outcomes:

21 “(1) Conduct research into the determinants
22 and the distribution of disparities in maternal care,
23 health risks, and health outcomes, and improve the
24 capacity of the performance measurement infrastruc-
25 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 types 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, 2017, and end on December 31,
10 2021.

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, 2022, 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, nu-
14 trition professionals focusing on women, infants, and chil-
15 dren, and other individuals and groups determined nec-
16 essary by the Secretary for such establishment and imple-
17 mentation.

18 (d) GRANTS.—

19 (1) IN GENERAL.—In carrying out the cam-
20 paign under subsection (a), the Secretary shall
21 award grants to national organizations, State and
22 local health departments, and community-based or-
23 ganizations for the conduct of education and out-
24 reach programs for nurses, parents, child care pro-

1 viders, public health agencies, and community orga-
2 nizations.

3 (2) APPLICATION.—To be eligible to receive a
4 grant under paragraph (1), an entity shall submit to
5 the Secretary an application at such time, in such
6 manner, and containing such information as the Sec-
7 retary may require.

8 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
9 authorized to be appropriated to carry out this section
10 such sums as may be necessary for each of fiscal years
11 2017 through 2021.

12 **SEC. 508. REDUCING UNINTENDED TEENAGE PREG-**
13 **NANCIES.**

14 Title III of the Public Health Service Act (42 U.S.C.
15 241 et seq.) is amended by adding at the end the following
16 new part:

17 **“PART W—YOUTH PREGNANCY PREVENTION**
18 **PROGRAMS**

19 **“SEC. 3990O. PURPOSE.**

20 “It is the purpose of this part to develop and carry
21 out research and multimedia campaigns on new and exist-
22 ing program interventions to provide youth in communities
23 at disproportionate risk for unintended teen pregnancy
24 (particularly young people of color, immigrant commu-
25 nities, youth in the foster care system, youth in the juve-

1 nile justice system, rural youth, and LGBTQ youth) the
2 information and skills needed to prevent unintended teen-
3 age pregnancies, build healthy relationships, and improve
4 overall health and well-being.

5 **“SEC. 39900-1. LIMITATION.**

6 “No Federal funds provided under this Act may be
7 used for media awareness campaigns that—

8 “(1) withhold health-promoting or life-saving
9 information about sexuality-related topics;

10 “(2) undermine young people’s confidence in
11 the effectiveness of contraception;

12 “(3) are medically inaccurate or have been sci-
13 entifically shown to be ineffective;

14 “(4) promote gender, racial, or ethnic stereo-
15 types;

16 “(5) are insensitive and unresponsive to the
17 needs of sexually active youth, LGBTQ youth, or
18 youth survivors of sexual violence;

19 “(6) are inconsistent with the ethical impera-
20 tives of medicine and public health; or

21 “(7) stigmatize and shame youth who are par-
22 enting or choose to parent.

1 **“SEC. 39900-2. MULTIMEDIA CAMPAIGNS TO PROMOTE**
2 **TEEN SEXUAL HEALTH.**

3 “(a) IN GENERAL.—The Secretary shall award com-
4 petitive grants to public and private entities, including na-
5 tional or regional intermediaries with affiliates located in
6 urban communities, to carry out multimedia campaigns to
7 provide public education and increase public awareness re-
8 garding teen sexual health, including unintended preg-
9 nancy, sexually transmitted infections including HIV, sex-
10 ual violence, and related relationship, emotional, social,
11 and cultural issues.

12 “(b) PRIORITY.—In awarding grants under this sec-
13 tion, the Secretary shall give priority to applicants pro-
14 posing to carry out campaigns developed for communities
15 with a high prevalence of unintended teen pregnancy (par-
16 ticularly young people of color, immigrant communities,
17 youth in the foster care system, youth in the juvenile jus-
18 tice system, rural youth, and LGBTQ youth).

19 “(c) INFORMATION TO BE PROVIDED.—As a condi-
20 tion of receipt of a grant under this section, an entity shall
21 agree to use the grant to carry out multimedia campaigns
22 described in subsection (a) that—

23 “(1) at a minimum, shall provide information
24 on—

25 “(A) human development;

1 “(B) healthy relationships and personal
2 skills including communication, consent, and vi-
3 olence prevention; and

4 “(C) sexual behavior and health, including
5 abstinence, prevention of unintended teen preg-
6 nancy, and HIV and other sexually transmitted
7 infections; and

8 “(2) may provide information on the prevention
9 of dating violence and sexual assault.

10 **“SEC. 39900-3. RESEARCH ON REDUCING UNINTENDED**
11 **TEENAGE PREGNANCIES AND TEENAGE DAT-**
12 **ING VIOLENCE AND IMPROVING HEALTHY**
13 **RELATIONSHIPS.**

14 “(a) IN GENERAL.—The Secretary, acting through
15 the Director of the Centers for Disease Control and Pre-
16 vention, shall make grants to public and private entities
17 to conduct, support, or coordinate research on teen sexual
18 health (including unintended teen pregnancy, dating vio-
19 lence, and healthy relationships among persons of color
20 and immigrant communities) that—

21 “(1) improves data collection on—

22 “(A) sexual and reproductive health, in-
23 cluding unintended teenage pregnancies and
24 births, among all minority communities and
25 subpopulations in which such data are not col-

1 lected, including American Indian and Alaska
2 Native youth;

3 “(B) sexual behavior, reproductive and sex-
4 ual coercion, and teenage contraceptive use pat-
5 terns at the State level, as appropriate;

6 “(C) unintended teenage pregnancies
7 among youth in and aging out of foster care or
8 juvenile justice systems and the underlying fac-
9 tors that lead to unintended teenage pregnancy
10 among youth in foster care or juvenile justice
11 systems; and

12 “(D) sexual and reproductive health, in-
13 cluding teenage pregnancies and births, sexual
14 behavior, reproductive and sexual coercion, and
15 teenage contraceptive use among—

16 “(i) LGBTQ youth; and

17 “(ii) rural youth;

18 “(2) investigates—

19 “(A) the variance in the rates of unin-
20 tended teenage pregnancy by—

21 “(i) racial and ethnic group (such as
22 Hispanic, Asian-American, African-Amer-
23 ican, Pacific Islander, American Indian,
24 and Alaska Native); and

1 “(ii) socioeconomic status, based on
2 the income of the family and education at-
3 tainment;

4 “(B) factors affecting the risk for youth of
5 unintended teenage pregnancy or dating vio-
6 lence, including the physical and social environ-
7 ment, level of acculturation, access to health
8 care, aspirations for the future, and history of
9 physical or sexual violence or abuse;

10 “(C) the role that violence and abuse play
11 in teenage sex, pregnancy, and childbearing;

12 “(D) strategies to address the dispropor-
13 tionate rates of unintended teenage pregnancies
14 and dating violence in racial or ethnic minority
15 or immigrant communities;

16 “(E) how effective interventions can be
17 replicated or adapted in other settings to serve
18 racial or ethnic minority or immigrant commu-
19 nities in a culturally appropriate manner; and

20 “(F) the effectiveness of media campaigns
21 in addressing healthy relationship development,
22 dating violence prevention, and unintended
23 teenage pregnancy; and

24 “(3) tests research-based strategies for address-
25 ing high rates of unintended teenage pregnancy

1 through programs that emphasize healthy relation-
2 ships and violence prevention.

3 “(b) PRIORITY.—In carrying out this section, the
4 Secretary shall give priority to research that incor-
5 porates—

6 “(1) interdisciplinary approaches;

7 “(2) a strong emphasis on community-based
8 participatory research;

9 “(3) consideration and assessment of State and
10 local education and health policies that may impact
11 teen sexual health; or

12 “(4) translational research.

13 **“SEC. 39900–4. HHS ADOLESCENT HEALTH WORK GROUP.**

14 “(a) PURPOSE.—Not later than 30 days after the
15 date of the enactment of this part, the Secretary shall di-
16 rect the interagency adolescent health workgroup within
17 the Office of Adolescent Health of the Department of
18 Health and Human Services to—

19 “(1) include in the work of the group strategies
20 for teenage dating violence prevention and healthy
21 teenage relationships with a particular focus among
22 racial or ethnic minority or immigrant communities;
23 and

24 “(2) with respect to including such strategies,
25 consult, to the greatest extent possible, with the

1 Federal Interagency Workgroup on Teen Dating Vi-
2 olence formed under the leadership of the National
3 Institute of Justice of the Department of Justice.

4 “(b) REPORT REQUIREMENT.—The Secretary,
5 through the Office of Adolescent Health, shall periodically
6 submit to Congress a report that—

7 “(1) includes a review of the evidence-based
8 programs on preventing unintended teenage preg-
9 nancy, which are carried out and identified by the
10 Office; and

11 “(2) identifies the programs of the Department
12 of Health and Human Services that include teenage
13 dating violence prevention and the promotion of
14 healthy teenage relationships as part of a strategy to
15 prevent unintended teenage pregnancy.

16 **“SEC. 39900-5. GENERAL GRANT PROVISIONS.**

17 “(a) APPLICATIONS.—To seek a grant under this
18 part, an entity shall submit an application to the Secretary
19 in such form, in such manner, and containing such agree-
20 ments, assurances, and information as the Secretary may
21 require.

22 “(b) ADDITIONAL REQUIREMENTS.—A grant may be
23 made under this part only if the applicant involved agrees
24 that information, activities, and services provided under
25 the grant—

1 “(1) will be evidence-based or evidence-in-
2 formed;

3 “(2) will be factually and medically accurate
4 and complete; and

5 “(3) if directed to a particular population
6 group, will be provided in an appropriate language
7 and cultural context.

8 “(c) TRAINING AND TECHNICAL ASSISTANCE.—

9 “(1) IN GENERAL.—Of the total amount made
10 available to carry out this part for a fiscal year, the
11 Secretary shall use 10 percent to provide, directly or
12 through a competitive grant process, training and
13 technical assistance to the grant recipients under
14 this part, including by disseminating research and
15 information regarding effective and promising prac-
16 tices, providing consultation and resources on a
17 broad array of teenage and unintended pregnancy
18 and violence prevention strategies, and developing
19 resources and materials.

20 “(2) COLLABORATION.—In carrying out this
21 subsection, the Secretary shall collaborate with Fed-
22 eral, State, public, and private entities that have ex-
23 pertise in sexual health education, prevention of un-
24 intended teen pregnancy, healthy relationship devel-

1 opment, minority health and health disparities, and
2 violence prevention.

3 **“SEC. 39900–6. DEFINITIONS.**

4 “In this part:

5 “(1) EVIDENCE-BASED OR EVIDENCE-IN-
6 FORMED.—The terms ‘evidence-based or evidence-in-
7 formed’ mean having been proven through rigorous
8 evaluation to change sexual behavior or incorporate
9 characteristics of effective programs, including devel-
10 opment, content, and implementation of such pro-
11 grams, that—

12 “(A) have been shown to be effective in
13 terms of increasing knowledge, clarifying values
14 and attitudes, increasing skills, and impacting
15 upon behavior; and

16 “(B) are widely recognized by leading med-
17 ical and public health agencies to be effective in
18 changing sexual behaviors that lead to unin-
19 tended pregnancy, sexually transmitted infec-
20 tions including HIV, and dating violence and
21 sexual assault among young people.

22 “(2) LGBTQ YOUTH.—The term ‘LGBTQ
23 youth’ means lesbian, gay, bisexual, transgender,
24 queer, and questioning (LGBTQ) youth.

1 “(3) MEDICALLY ACCURATE AND COMPLETE.—

2 The term ‘medically accurate and complete’ means,
3 with respect to information, activities, or services,
4 verified or supported by the weight of research con-
5 ducted in compliance with accepted scientific meth-
6 ods and—

7 “(A) published in peer-reviewed journals,
8 where applicable; or

9 “(B) comprising information that leading
10 professional organizations and agencies with
11 relevant expertise in the field recognize as accu-
12 rate, objective, and complete.

13 “(4) RACIAL OR ETHNIC MINORITY OR IMMI-
14 GRANT COMMUNITIES.—The term ‘racial or ethnic
15 minority or immigrant communities’ means commu-
16 nities with a substantial number of residents who
17 are members of racial or ethnic minority groups or
18 who are immigrants.

19 “(5) REPRODUCTIVE AND SEXUAL COERCION.—
20 The term ‘reproductive and sexual coercion’—

21 “(A) means, with respect to a person, coer-
22 cive behavior that interferes with the ability of
23 such person to control the reproductive deci-
24 sionmaking of such person, such as inten-
25 tionally exposing such person to sexually trans-

1 mitted infections; attempting to impregnate
2 such person against their will; intentionally
3 interfering with the person’s birth control; or
4 threatening or acting violent if the person does
5 not comply with the perpetrator’s wishes re-
6 garding contraception or the decision whether
7 to terminate or continue a pregnancy; and

8 “(B) includes a range of behaviors that a
9 partner may use related to sexual decision-mak-
10 ing to pressure or coerce a person to have sex
11 without using physical force, such as repeatedly
12 pressuring a partner to have sex when they do
13 not want to; threatening to end a relationship
14 if a person does not have sex; and threatening
15 retaliation if notified of a positive sexually
16 transmitted infection test result.

17 “(6) YOUTH.—The term ‘youth’ means individ-
18 uals who are 11 to 19 years of age.

19 **“SEC. 39900-7. REPORTS.**

20 “(a) REPORT ON USE OF FUNDS.—Not later than
21 1 year after the date of the enactment of this part, the
22 Secretary shall submit to Congress a report on the use
23 of funds provided pursuant to this part.

24 “(b) REPORT ON IMPACT OF PROGRAMS.—Not later
25 than March 1, 2021, the Secretary shall submit to Con-

1 gress a report on the impact of the programs under this
2 part on reducing unintended teenage pregnancies.

3 **“SEC. 39900–8. AUTHORIZATION OF APPROPRIATIONS.**

4 “(a) IN GENERAL.—There are authorized to be ap-
5 propriated to carry out this part such sums as may be
6 necessary for each of the fiscal years 2017 through 2021.

7 “(b) AVAILABILITY.—Amounts appropriated pursu-
8 ant to subsection (a)—

9 “(1) are authorized to remain available until ex-
10 pended; and

11 “(2) are in addition to amounts otherwise made
12 available for such purposes.”.

13 **SEC. 509. GESTATIONAL DIABETES.**

14 Part B of title III of the Public Health Service Act
15 (42 U.S.C. 243 et seq.) is amended by adding after section
16 317H the following:

17 **“SEC. 317H–1. GESTATIONAL DIABETES.**

18 “(a) UNDERSTANDING AND MONITORING GESTA-
19 TIONAL DIABETES.—

20 “(1) IN GENERAL.—The Secretary, acting
21 through the Director of the Centers for Disease
22 Control and Prevention, in consultation with the Di-
23 abetes Mellitus Interagency Coordinating Committee
24 established under section 429 and representatives of
25 appropriate national health organizations, shall de-

1 velop a multisite gestational diabetes research
2 project within the diabetes program of the Centers
3 for Disease Control and Prevention to expand and
4 enhance surveillance data and public health research
5 on gestational diabetes.

6 “(2) AREAS TO BE ADDRESSED.—The research
7 project developed under paragraph (1) shall ad-
8 dress—

9 “(A) procedures to establish accurate and
10 efficient systems for the collection of gestational
11 diabetes data within each State and common-
12 wealth, territory, or possession of the United
13 States;

14 “(B) the progress of collaborative activities
15 with the National Vital Statistics System, the
16 National Center for Health Statistics, and
17 State health departments with respect to the
18 standard birth certificate, in order to improve
19 surveillance of gestational diabetes;

20 “(C) postpartum methods of tracking
21 women with gestational diabetes after delivery
22 as well as targeted interventions proven to
23 lower the incidence of type 2 diabetes in that
24 population;

1 “(D) variations in the distribution of diag-
2 nosed and undiagnosed gestational diabetes,
3 and of impaired fasting glucose tolerance and
4 impaired fasting glucose, within and among
5 groups of women; and

6 “(E) factors and culturally sensitive inter-
7 ventions that influence risks and reduce the in-
8 cidence of gestational diabetes and related com-
9 plications during childbirth, including cultural,
10 behavioral, racial, ethnic, geographic, demo-
11 graphic, socioeconomic, and genetic factors.

12 “(3) REPORT.—Not later than 2 years after the
13 date of the enactment of this section, and annually
14 thereafter, the Secretary shall generate a report on
15 the findings and recommendations of the research
16 project including prevalence of gestational diabetes
17 in the multisite area and disseminate the report to
18 the appropriate Federal and non-Federal agencies.

19 “(b) EXPANSION OF GESTATIONAL DIABETES RE-
20 SEARCH.—

21 “(1) IN GENERAL.—The Secretary shall expand
22 and intensify public health research regarding gesta-
23 tional diabetes. Such research may include—

24 “(A) developing and testing novel ap-
25 proaches for improving postpartum diabetes

1 testing or screening and for preventing type 2
2 diabetes in women with a history of gestational
3 diabetes; and

4 “(B) conducting public health research to
5 further understanding of the epidemiologic,
6 socioenvironmental, behavioral, translation, and
7 biomedical factors and health systems that in-
8 fluence the risk of gestational diabetes and the
9 development of type 2 diabetes in women with
10 a history of gestational diabetes.

11 “(2) AUTHORIZATION OF APPROPRIATIONS.—
12 There is authorized to be appropriated to carry out
13 this subsection \$5,000,000 for each of fiscal years
14 2017 through 2021.

15 “(c) DEMONSTRATION GRANTS TO LOWER THE
16 RATE OF GESTATIONAL DIABETES.—

17 “(1) IN GENERAL.—The Secretary, acting
18 through the Director of the Centers for Disease
19 Control and Prevention, shall award grants, on a
20 competitive basis, to eligible entities for demonstra-
21 tion projects that implement evidence-based inter-
22 ventions to reduce the incidence of gestational diabe-
23 tes, the recurrence of gestational diabetes in subse-
24 quent pregnancies, and the development of type 2 di-

1 abetes in women with a history of gestational diabe-
2 tes.

3 “(2) PRIORITY.—In making grants under this
4 subsection, the Secretary shall give priority to
5 projects focusing on—

6 “(A) helping women who have 1 or more
7 risk factors for developing gestational diabetes;

8 “(B) working with women with a history of
9 gestational diabetes during a previous preg-
10 nancy;

11 “(C) providing postpartum care for women
12 with gestational diabetes;

13 “(D) tracking cases where women with a
14 history of gestational diabetes developed type 2
15 diabetes;

16 “(E) educating mothers with a history of
17 gestational diabetes about the increased risk of
18 their child developing diabetes;

19 “(F) working to prevent gestational diabe-
20 tes and prevent or delay the development of
21 type 2 diabetes in women with a history of ges-
22 tational diabetes; and

23 “(G) achieving outcomes designed to assess
24 the efficacy and cost-effectiveness of interven-
25 tions that can inform decisions on long-term

1 sustainability, including third-party reimburse-
2 ment.

3 “(3) APPLICATION.—An eligible entity desiring
4 to receive a grant under this subsection shall submit
5 to the Secretary—

6 “(A) an application at such time, in such
7 manner, and containing such information as the
8 Secretary may require; and

9 “(B) a plan to—

10 “(i) lower the rate of gestational dia-
11 betes during pregnancy; or

12 “(ii) develop methods of tracking
13 women with a history of gestational diabe-
14 tes and develop effective interventions to
15 lower the incidence of the recurrence of
16 gestational diabetes in subsequent preg-
17 nancies and the development of type 2 dia-
18 betes.

19 “(4) USES OF FUNDS.—An eligible entity re-
20 ceiving a grant under this subsection shall use the
21 grant funds to carry out demonstration projects de-
22 scribed in paragraph (1), including—

23 “(A) expanding community-based health
24 promotion education, activities, and incentives
25 focused on the prevention of gestational diabe-

1 tes and development of type 2 diabetes in
2 women with a history of gestational diabetes;

3 “(B) aiding State- and tribal-based diabe-
4 tes prevention and control programs to collect,
5 analyze, disseminate, and report surveillance
6 data on women with, and at risk for, gesta-
7 tional diabetes, the recurrence of gestational di-
8 abetes in subsequent pregnancies, and, for
9 women with a history of gestational diabetes,
10 the development of type 2 diabetes; and

11 “(C) training and encouraging health care
12 providers—

13 “(i) to promote risk assessment, high-
14 quality care, and self-management for ges-
15 tational diabetes and the recurrence of ges-
16 tational diabetes in subsequent preg-
17 nancies; and

18 “(ii) to prevent the development of
19 type 2 diabetes in women with a history of
20 gestational diabetes, and its complications
21 in the practice settings of the health care
22 providers.

23 “(5) REPORT.—Not later than 4 years after the
24 date of the enactment of this section, the Secretary
25 shall prepare and submit to the Congress a report

1 concerning the results of the demonstration projects
2 conducted through the grants awarded under this
3 subsection.

4 “(6) DEFINITION OF ELIGIBLE ENTITY.—In
5 this subsection, the term ‘eligible entity’ means a
6 nonprofit organization (such as a nonprofit academic
7 center or community health center) or a State, trib-
8 al, or local health agency.

9 “(7) AUTHORIZATION OF APPROPRIATIONS.—
10 There is authorized to be appropriated to carry out
11 this subsection \$5,000,000 for each of fiscal years
12 2017 through 2021.

13 “(d) POSTPARTUM FOLLOWUP REGARDING GESTA-
14 TIONAL DIABETES.—The Secretary, acting through the
15 Director of the Centers for Disease Control and Preven-
16 tion, shall work with the State- and tribal-based diabetes
17 prevention and control programs assisted by the Centers
18 to encourage postpartum followup after gestational diabe-
19 tes, as medically appropriate, for the purpose of reducing
20 the incidence of gestational diabetes, the recurrence of
21 gestational diabetes in subsequent pregnancies, the devel-
22 opment of type 2 diabetes in women with a history of ges-
23 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 medically accurate and complete
9 information on emergency contraception.

10 (2) DISSEMINATION.—The Secretary may dis-
11 seminate medically accurate and complete informa-
12 tion under paragraph (1) directly or through ar-
13 rangements with nonprofit organizations, community
14 health workers including promotoras, consumer
15 groups, institutions of higher education, clinics, the
16 media, and Federal, State, and local agencies.

17 (3) INFORMATION.—The information dissemi-
18 nated under paragraph (1) shall—

19 (A) include, at a minimum, a description
20 of emergency contraception and an explanation
21 of the use, safety, efficacy, and availability of
22 such contraception; and

23 (B) be pilot tested for consumer com-
24 prehension, cultural and linguistic appropriate-
25 ness, and acceptance of the messages across

1 geographically, racially, ethnically, and linguis-
2 tically diverse populations.

3 (b) EMERGENCY CONTRACEPTION INFORMATION
4 PROGRAM FOR HEALTH CARE PROVIDERS.—

5 (1) IN GENERAL.—The Secretary, acting
6 through the Administrator of the Health Resources
7 and Services Administration and in consultation
8 with major medical and public health organizations,
9 shall develop and disseminate to health care pro-
10 viders information on emergency contraception.

11 (2) INFORMATION.—The information dissemi-
12 nated under paragraph (1) shall include, at a min-
13 imum—

14 (A) information describing the use, safety,
15 efficacy, and availability of emergency contra-
16 ception;

17 (B) a recommendation regarding the use of
18 such contraception; and

19 (C) information explaining how to obtain
20 copies of the information developed under sub-
21 section (a) for distribution to the patients of
22 the providers.

23 (c) DEFINITIONS.—In this section:

24 (1) EMERGENCY CONTRACEPTION.—The term
25 “emergency contraception” means a drug or device

1 (as the terms are defined in section 201 of the Fed-
2 eral Food, Drug, and Cosmetic Act (21 U.S.C. 321))
3 or a drug regimen that—

4 (A) is used postcoitally;

5 (B) prevents pregnancy primarily by pre-
6 venting or delaying ovulation, and does not ter-
7 minate an established pregnancy; and

8 (C) is approved by the Food and Drug Ad-
9 ministration.

10 (2) HEALTH CARE PROVIDER.—The term
11 “health care provider” means an individual who is li-
12 censed or certified under State law to provide health
13 care services and who is operating within the scope
14 of such license. Such term shall include a phar-
15 macist.

16 (3) INSTITUTION OF HIGHER EDUCATION.—The
17 term “institution of higher education” has the same
18 meaning given such term in section 101(a) of the
19 Higher Education Act of 1965 (20 U.S.C. 1001(a)).

20 (4) MEDICALLY ACCURATE AND COMPLETE.—
21 The term “medically accurate and complete” means,
22 with respect to information, activities, or services
23 verified or supported by the weight of research con-
24 ducted in compliance with accepted scientific meth-
25 ods and—

1 (A) published in peer-reviewed journals,
2 where applicable; or

3 (B) comprising information that leading
4 professional organizations and agencies with
5 relevant expertise in the field recognize as accu-
6 rate, objective, and complete.

7 (5) SECRETARY.—The term “Secretary” means
8 the Secretary of Health and Human Services.

9 (d) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated to carry out this section
11 such sums as may be necessary for each of the fiscal years
12 2017 through 2021.

13 **SEC. 511. SUPPORTING HEALTHY ADOLESCENT DEVELOP-**
14 **MENT.**

15 (a) IN GENERAL.—The Secretary may award a grant
16 to each eligible State to conduct programs of sex education
17 described in subsection (b), including education on both
18 abstinence and contraception for the prevention of teenage
19 pregnancy and sexually transmitted infections, including
20 HIV/AIDS and viral hepatitis.

21 (b) REQUIREMENTS FOR SEX EDUCATION PRO-
22 GRAMS.—A program of sex education described in this
23 subsection is a program that—

24 (1) is age appropriate and medically accurate;

1 (2) stresses the value of abstinence while not ig-
2 noring those young people who have been or are sex-
3 ually active;

4 (3) includes information providing a factual un-
5 derstanding of male and female reproductive anat-
6 omy;

7 (4) provides medically accurate and complete
8 information about the health benefits side effects,
9 and availability of contraceptive and barrier methods
10 used—

11 (A) as a means to prevent pregnancy; and

12 (B) to reduce the risk of contracting a sex-
13 ually transmitted infection, including HIV/
14 AIDS and viral hepatitis;

15 (5) encourages family communication between
16 parent and child about sexuality;

17 (6) cultivates a respectful dialogue about sexu-
18 ality, including sexual orientation and gender iden-
19 tity, and embraces the principles of nondiscrimina-
20 tion based on sexual orientation and gender identity;

21 (7) counters the perpetuation of narrow gender
22 roles, including the sexualization of female children,
23 adolescents, and adults;

24 (8) teaches young people the skills to make re-
25 sponsible decisions about sexuality, including how to

1 avoid unwanted verbal, physical, and sexual ad-
2 vances and how to avoid making verbal, physical,
3 and sexual advances that are not wanted by the
4 other party;

5 (9) develops healthy relationships, including the
6 prevention of dating and sexual violence;

7 (10) teaches young people how alcohol and drug
8 use can affect responsible decisionmaking; and

9 (11) does not teach or promote religion.

10 (c) ADDITIONAL ACTIVITIES.—In carrying out a pro-
11 gram of sex education, a State may expend grant funds
12 awarded under subsection (a) to carry out educational and
13 motivational activities that help young people—

14 (1) gain knowledge about the physical, emo-
15 tional, biological, and hormonal changes of adoles-
16 cence and subsequent stages of human maturation;

17 (2) develop the knowledge and skills nec-
18 essary—

19 (A) to ensure and protect their sexual and
20 reproductive health from unintended pregnancy
21 and sexually transmitted infection, including
22 HIV/AIDS, throughout their lifespan;

23 (B) to be aware that certain racial and
24 ethnic groups are more affected by certain sex-
25 ually transmitted infections; and

1 (C) to receive the education to prevent fur-
2 ther transmission;

3 (3) gain knowledge about the specific involve-
4 ment and responsibility of each individual in sexual
5 decisionmaking;

6 (4) develop healthy attitudes and values about
7 adolescent growth and development, body image,
8 gender roles, racial and ethnic diversity, sexual ori-
9 entation and gender identity, and other subjects;

10 (5) develop and practice healthy life skills in-
11 cluding goal-setting, decisionmaking, negotiation,
12 communication, and stress management; and

13 (6) promote self-esteem and positive inter-
14 personal skills focusing on relationship dynamics, in-
15 cluding friendships, dating, romantic involvement,
16 marriage, and family interactions.

17 (d) MATCHING FUNDS.—The Secretary may not
18 make payments to a State under this section in an amount
19 exceeding Federal medical assistance percentage for such
20 State (as such term is defined in section 1905(b) of the
21 Social Security Act (42 U.S.C. 1396d(b))) of the costs of
22 the programs conducted by the State under this section.

23 (e) EVALUATION OF PROGRAMS.—

24 (1) IN GENERAL.—For the purpose of evalu-
25 ating the effectiveness of programs of sex education

1 carried out with a grant under this section, evalua-
2 tions shall be carried out in accordance with para-
3 graphs (2) and (3).

4 (2) NATIONAL EVALUATION.—

5 (A) METHOD.—The Secretary shall pro-
6 vide for a national evaluation of a representa-
7 tive sample of programs of sex education car-
8 ried out with grants under this section to deter-
9 mine—

10 (i) the effectiveness of such programs
11 in helping to delay the initiation of sexual
12 intercourse and other high-risk behaviors;

13 (ii) the effectiveness of such programs
14 in preventing adolescent pregnancy;

15 (iii) the effectiveness of such pro-
16 grams in preventing sexually transmitted
17 infection, including HIV/AIDS and viral
18 hepatitis;

19 (iv) the effectiveness of such programs
20 in increasing contraceptive knowledge and
21 contraceptive behaviors when sexual inter-
22 course occurs; and

23 (v) a list of best practices that—

24 (I) is based upon essential pro-
25 grammatic components of evaluated

1 programs that have led to success de-
2 scribed in clauses (i) through (iv); and
3 (II) documents the racial and
4 ethnic minority populations that are
5 recipients of grant funds under this
6 section or are served by programs of
7 sex education funded under this sec-
8 tion.

9 (B) GRANT CONDITION.—A condition for
10 the receipt of a grant to a State under this sec-
11 tion is that the State cooperate with the evalua-
12 tion under subparagraph (A).

13 (C) REPORT.—The Secretary shall submit
14 to the Congress—

15 (i) not later than the end of each fis-
16 cal year during the 5-year period beginning
17 with fiscal year 2017, an interim report on
18 the national evaluation under subpara-
19 graph (A); and

20 (ii) not later than March 31, 2020, a
21 final report providing the results of such
22 national evaluation.

23 (3) INDIVIDUAL STATE EVALUATIONS.—A con-
24 dition for the receipt of a grant under this section
25 is that the State evaluate the programs of sex edu-

1 cation funded through such grant in accordance with
2 the following requirements:

3 (A) The evaluation will be conducted by an
4 external, independent entity.

5 (B) The purposes of the evaluation will be
6 the determination of—

7 (i) the effectiveness of such programs
8 in helping to delay the initiation of sexual
9 intercourse and other high-risk behaviors;

10 (ii) the effectiveness of such programs
11 in preventing adolescent pregnancy;

12 (iii) the effectiveness of such pro-
13 grams in preventing sexually transmitted
14 infection, including HIV/AIDS; and

15 (iv) the effectiveness of such programs
16 in increasing contraceptive and barrier
17 method knowledge and contraceptive be-
18 haviors when sexual intercourse occurs.

19 (f) LIMITATIONS ON USE OF FUNDS.—

20 (1) LIMITATIONS ON SECRETARY.—Of the
21 amounts appropriated for a fiscal year for purposes
22 of this section, the Secretary may not use more
23 than—

1 (A) 7 percent of such amounts for admin-
2 istrative expenses related to carrying out this
3 section for that fiscal year; and

4 (B) 10 percent of such amounts for the
5 national evaluation under subsection (e)(2).

6 (2) LIMITATIONS TO STATES.—Of amounts pro-
7 vided to an eligible State under this subsection, the
8 State may not use more than 10 percent of the
9 grant to conduct any evaluation under subsection
10 (e)(3).

11 (g) NONDISCRIMINATION REQUIRED.—Programs
12 funded under this section shall not discriminate on the
13 basis of sex, race, ethnicity, national origin, disability, reli-
14 gion, marital status, familial status, sexual orientation, or
15 gender identity. Nothing in this section shall be construed
16 to invalidate or limit rights, remedies, procedures, or legal
17 standards available to victims of discrimination under any
18 other Federal law or any law of a State or a political sub-
19 division of a State, including title VI of the Civil Rights
20 Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the
21 Education Amendments of 1972 (20 U.S.C. 1681 et seq.),
22 section 504 of the Rehabilitation Act of 1973 (29 U.S.C.
23 794), and the Americans with Disabilities Act of 1990 (42
24 U.S.C. 12101 et seq.).

25 (h) DEFINITIONS.—For purposes of this section:

1 (1) The term “age appropriate” means, with re-
2 spect to topics, messages, and teaching methods,
3 those suitable to particular ages or age groups of
4 children, adolescents, and adults, based on devel-
5 oping cognitive, emotional, and behavioral capacity
6 typical for the age or age group.

7 (2) The term “eligible State” means a State
8 that submits to the Secretary an application for a
9 grant under this section that is in such form, is
10 made in such manner, and contains such agree-
11 ments, assurances, and information as the Secretary
12 determines to be necessary to carry out this section.

13 (3) The term “HIV/AIDS” means the human
14 immunodeficiency virus, and includes acquired im-
15 mune deficiency syndrome.

16 (4) The term “medically accurate”, with respect
17 to information, means information that is supported
18 by research, recognized as accurate and objective by
19 leading medical, psychological, psychiatric, and pub-
20 lic health organizations and agencies, and, published
21 in journals that are peer reviewed.

22 (5) The term “State” means the 50 States, the
23 District of Columbia, the Commonwealth of Puerto
24 Rico, the Commonwealth of the Northern Mariana
25 Islands, American Samoa, Guam, the United States

1 Virgin Islands, and any other territory or possession
2 of the United States.

3 (i) AUTHORIZATION OF APPROPRIATIONS.—For the
4 purpose of carrying out this section, there is authorized
5 to be appropriated \$50,000,000 for each of the fiscal years
6 2017 through 2021.

7 **SEC. 512. COMPASSIONATE ASSISTANCE FOR RAPE EMER-**
8 **GENCIES.**

9 (a) MEDICARE.—

10 (1) LIMITATION ON PAYMENT.—Section
11 1866(a)(1) of the Social Security Act (42 U.S.C.
12 1395cc(a)(1)) is amended—

13 (A) in the subparagraph (W) added by sec-
14 tion 3005(1)(C) of Public Law 111–148—

15 (i) by striking the period at the end
16 and inserting a comma;

17 (ii) by moving the indentation 2 ems
18 to the left; and

19 (iii) by moving such subparagraph to
20 immediately follow subparagraph (V);

21 (B) in the subparagraph (W) added by sec-
22 tion 6406(b)(3) of Public Law 111–148—

23 (i) by striking the period at the end
24 and inserting “, and”;

1 (ii) by moving the indentation 2 ems
2 to the left;

3 (iii) by redesignating such subpara-
4 graph as subparagraph (X); and

5 (iv) by moving such subparagraph to
6 immediately follow subparagraph (W), as
7 moved under paragraph (2)(C); and

8 (C) by inserting after the subparagraph
9 (X), as redesignated and moved under para-
10 graph (3), the following:

11 “(Y) in the case of a hospital or critical ac-
12 cess hospital, to adopt and enforce a policy to
13 ensure compliance with the requirements of
14 subsection (l) and to meet the requirements of
15 such subsection.”.

16 (2) ASSISTANCE TO VICTIMS.—Section 1866 of
17 the Social Security Act (42 U.S.C. 1395cc) is
18 amended by adding at the end the following new
19 subsection:

20 “(l) COMPASSIONATE ASSISTANCE FOR RAPE EMER-
21 GENCIES.—

22 “(1) IN GENERAL.—For purposes of section
23 1866(a)(1)(Y), a hospital meets the requirements of
24 this subsection if the hospital provides each of the
25 services described in paragraph (2) to each indi-

1 vidual, whether or not eligible for benefits under this
2 title or under any other form of health insurance.
3 who comes to the hospital on or after January 1,
4 2017, and—

5 “(A) who states to hospital personnel that
6 they are victims of sexual assault;

7 “(B) who is accompanied by an individual
8 who states to hospital personnel that the indi-
9 vidual is a victim of sexual assault; or

10 “(C) whom hospital personnel, during the
11 course of treatment and care for the individual,
12 have reason to believe is a victim of sexual as-
13 sault.

14 “(2) REQUIRED SERVICES DESCRIBED.—For
15 purposes of paragraph (1), the services described in
16 this subparagraph are the following:

17 “(A) Provision of medically and factually
18 accurate and unbiased written and oral infor-
19 mation about emergency contraception that—

20 “(i) is written in clear and concise
21 language;

22 “(ii) is readily comprehensible;

23 “(iii) includes an explanation that—

24 “(I) emergency contraception has
25 been approved by the Food and Drug

1 Administration as an over-the-counter
2 medication for individuals, and is a
3 safe and effective way to prevent
4 pregnancy after unprotected inter-
5 course or contraceptive failure if
6 taken in a timely manner;

7 “(II) emergency contraception is
8 more effective the sooner it is taken;
9 and

10 “(III) emergency contraception
11 does not cause an abortion and cannot
12 interrupt an established pregnancy;

13 “(iv) meets such conditions regarding
14 the provision of such information in lan-
15 guages other than English as the Secretary
16 may establish; and

17 “(v) is provided without regard to the
18 ability of the individual or their family to
19 pay costs associated with the provision of
20 such information to the individual.

21 “(B) Immediate offer to provide emergency
22 contraception to the individual at the hospital
23 and, in the case that the individual accepts such
24 offer, immediate provision to the individual of
25 such contraception on the same day it is re-

1 quested without regard to the inability of the
2 individual or their family to pay costs associ-
3 ated with the offer and provision of such con-
4 traception.

5 “(C) Development and implementation of a
6 written policy to ensure that an individual is
7 present at the hospital, or on-call, who—

8 “(i) has authority to dispense or pre-
9 scribe emergency contraception, independ-
10 ently, or under a protocol prepared by a
11 physician for the administration of emer-
12 gency contraception at the hospital to a
13 victim of sexual assault; and

14 “(ii) is trained to comply with the re-
15 quirements of this section.

16 “(3) DEFINITIONS.—For purposes of this para-
17 graph:

18 “(A) The term ‘emergency contraception’
19 means a drug or device (as such terms are de-
20 fined in section 201 of the Federal Food, Drug,
21 and Cosmetic Act (21 U.S.C. 321)) or a drug
22 regimen that—

23 “(i) is used postcoitally;

24 “(ii) prevents pregnancy primarily by
25 preventing or delaying ovulation, and does

1 not terminate an established pregnancy;
2 and

3 “(iii) is approved by the Food and
4 Drug Administration.

5 “(B) The term ‘hospital’ includes a critical
6 access hospital, as defined in section
7 1861(mm)(1).

8 “(C) The term ‘sexual assault’ means co-
9 itus in which the individual involved does not
10 consent or lacks the legal capacity to consent.”.

11 (b) LIMITATION ON PAYMENT UNDER MEDICAID.—
12 Section 1903(i) of the Social Security Act (42 U.S.C.
13 1396b(i)) is amended by inserting after paragraph (11)
14 the following new paragraph:

15 “(12) with respect to any amount expended for
16 care or services furnished under the plan by a hos-
17 pital on or after January 1, 2017, unless such hos-
18 pital meets the requirements specified in section
19 1866(l) for purposes of title XVIII.”.

20 **SEC. 513. ACCESS TO BIRTH CONTROL DUTIES OF PHAR-**
21 **MACIES TO ENSURE PROVISION OF FDA-AP-**
22 **PROVED CONTRACEPTION.**

23 Part B of title II of the Public Health Service Act
24 (42 U.S.C. 238 et seq.) is amended by adding at the end
25 the following:

1 **“SEC. 249. DUTIES OF PHARMACIES TO ENSURE PROVISION**
2 **OF FDA-APPROVED CONTRACEPTION.**

3 “(a) IN GENERAL.—Subject to subsection (c), a
4 pharmacy that receives Food and Drug Administration-
5 approved drugs or devices in interstate commerce shall
6 maintain compliance with the following:

7 “(1) If a customer requests a contraceptive, in-
8 cluding emergency contraception, that is in stock,
9 the pharmacy shall ensure that the contraceptive is
10 provided to the customer—

11 “(A) without delay;

12 “(B) without regard to the customer’s age,
13 gender, gender identity, or sexual orientation;

14 “(C) without a requirement that identifica-
15 tion be presented; and

16 “(D) despite any conflicts of employees to
17 filling a prescription and dispensing a par-
18 ticular prescription drug or device due to sin-
19 cerely held moral, philosophical, or religious be-
20 liefs.

21 “(2) If a customer requests a contraceptive that
22 is not in stock and the pharmacy in the normal
23 course of business stocks contraception, the phar-
24 macy shall immediately inform the customer that the
25 contraceptive is not in stock and without delay offer
26 the customer the following options:

1 “(A) If the customer prefers to obtain the
2 contraceptive through a referral or transfer, the
3 pharmacy shall—

4 “(i) locate a pharmacy of the cus-
5 tomer’s choice or the closest pharmacy
6 confirmed to have the contraceptive in
7 stock; and

8 “(ii) refer the customer or transfer
9 the prescription to that pharmacy.

10 “(B) If the customer prefers for the phar-
11 macy to order the contraceptive, the pharmacy
12 shall obtain the contraceptive under the phar-
13 macy’s standard procedure for expedited order-
14 ing of medication and notify the customer when
15 the contraceptive arrives.

16 “(3) The pharmacy shall ensure that its em-
17 ployees do not—

18 “(A) intimidate, threaten, or harass cus-
19 tomers in the delivery of services relating to a
20 request for contraception;

21 “(B) interfere with or obstruct the delivery
22 of services relating to a request for contracep-
23 tion;

1 “(C) intentionally misrepresent or deceive
2 customers about the availability of contracep-
3 tion or its mechanism of action;

4 “(D) breach medical confidentiality with
5 respect to a request for contraception or threat-
6 en to breach such confidentiality; or

7 “(E) refuse to return a valid, lawful pre-
8 scription for contraception upon customer re-
9 quest.

10 “(b) CONTRACEPTIVES NOT ORDINARILY
11 STOCKED.—Nothing in subsection (a)(2) shall be con-
12 strued to require any pharmacy to comply with such sub-
13 section if the pharmacy does not ordinarily stock contra-
14 ceptives in the normal course of business.

15 “(c) REFUSALS PURSUANT TO STANDARD PHAR-
16 MACY PRACTICE.—This section does not prohibit a phar-
17 macy from refusing to provide a contraceptive to a cus-
18 tomer in accordance with any of the following:

19 “(1) If it is unlawful to dispense the contracep-
20 tive to the customer without a valid, lawful prescrip-
21 tion and no such prescription is presented.

22 “(2) If the customer is unable to pay for the
23 contraceptive.

1 “(3) If the employee of the pharmacy refuses to
2 provide the contraceptive on the basis of a profes-
3 sional clinical judgment.

4 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
5 tion shall be construed to invalidate or limit rights, rem-
6 edies, procedures, or legal standards under title VII of the
7 Civil Rights Act of 1964.

8 “(e) PREEMPTION.—This section does not preempt
9 any provision of State law or any professional obligation
10 made applicable by a State board or other entity respon-
11 sible for licensing or discipline of pharmacies or phar-
12 macists, to the extent that such State law or professional
13 obligation provides protections for customers that are
14 greater than the protections provided by this section.

15 “(f) ENFORCEMENT.—

16 “(1) CIVIL PENALTY.—A pharmacy that vio-
17 lates a requirement of subsection (a) is liable to the
18 United States for a civil penalty in an amount not
19 exceeding \$1,000 per day of violation, not to exceed
20 \$100,000 for all violations adjudicated in a single
21 proceeding.

22 “(2) PRIVATE CAUSE OF ACTION.—Any person
23 aggrieved as a result of a violation of a requirement
24 of subsection (a) may, in any court of competent ju-
25 risdiction, commence a civil action against the phar-

1 macy involved to obtain appropriate relief, including
2 actual and punitive damages, injunctive relief, and a
3 reasonable attorney’s fee and cost.

4 “(3) LIMITATIONS.—A civil action under para-
5 graph (1) or (2) may not be commenced against a
6 pharmacy after the expiration of the 5-year period
7 beginning on the date on which the pharmacy alleg-
8 edly engaged in the violation involved.

9 “(g) DEFINITIONS.—In this section:

10 “(1) The term ‘contraception’ or ‘contraceptive’
11 means any drug or device approved by the Food and
12 Drug Administration to prevent pregnancy.

13 “(2) The term ‘employee’ means a person hired,
14 by contract or any other form of an agreement, by
15 a pharmacy.

16 “(3) The term ‘pharmacy’ means an entity
17 that—

18 “(A) is authorized by a State to engage in
19 the business of selling prescription drugs at re-
20 tail; and

21 “(B) employs one or more employees.

22 “(4) The term ‘product’ means a Food and
23 Drug Administration-approved drug or device.

24 “(5) The term ‘professional clinical judgment’
25 means the use of professional knowledge and skills

1 to form a clinical judgment, in accordance with pre-
2 vailing medical standards.

3 “(6) The term ‘without delay’, with respect to
4 a pharmacy providing, providing a referral for, or
5 ordering contraception, or transferring the prescrip-
6 tion for contraception, means within the usual and
7 customary timeframe at the pharmacy for providing,
8 providing a referral for, or ordering other products,
9 or transferring the prescription for other products,
10 respectively.

11 “(h) EFFECTIVE DATE.—This section shall take ef-
12 fect on the 31st day after the date of the enactment of
13 this section, without regard to whether the Secretary has
14 issued any guidance or final rule regarding this section.”.

15 **SEC. 514. ADDITIONAL FOCUS AREA FOR THE OFFICE ON**
16 **WOMEN’S HEALTH.**

17 Section 229(b) of the Public Health Service Act (42
18 U.S.C. 237a(b)) is amended—

19 (1) in paragraph (6), at the end, by striking
20 “and”;

21 (2) in paragraph (7), at the end, by striking the
22 period and inserting a semicolon; and

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

1 “(8) facilitate policymakers, health system lead-
2 ers and providers, consumers, and other stake-
3 holders in understanding optimal maternity care and
4 support for the provision of such care, including the
5 priorities of—

6 “(A) protecting, promoting, and supporting
7 the innate capacities of childbearing women and
8 their newborns for childbirth, breastfeeding,
9 and attachment;

10 “(B) using obstetric interventions only
11 when such interventions are supported by
12 strong, high-quality evidence, and minimizing
13 overuse of maternity practices that have been
14 shown to have benefit in limited situations and
15 that can expose women, infants, or both to risk
16 of harm if used routinely and indiscriminately,
17 including continuous electronic fetal monitoring,
18 labor induction, epidural analgesia, primary ce-
19 sarean section, and routine repeat cesarean
20 birth;

21 “(C) reliably incorporating noninvasive,
22 evidence-based practices that have documented
23 correlation with considerable improvement in
24 outcomes with no detrimental side effects, such
25 as smoking cessation programs in pregnancy

1 and proven models of group prenatal care that
2 integrate health assessment, education, and
3 support into a unified program;

4 “(D) a shared understanding of the quali-
5 fications of licensed providers of maternity care
6 and the best evidence about the safety, satisfac-
7 tion, outcomes, and costs of their care, and ap-
8 propriate deployment of such caregivers within
9 the maternity care workforce to address the
10 needs of childbearing women and newborns and
11 the growing shortage of maternity caregivers;

12 “(E) a shared understanding of the results
13 of the best available research comparing hos-
14 pital, birth center, and planned home births, in-
15 cluding information about each setting’s safety,
16 satisfaction, outcomes, and costs; and

17 “(F) high-quality, evidence-based child-
18 birth education that promotes a natural,
19 healthy, and safe approach to pregnancy, child-
20 birth, and early parenting; is taught by certified
21 educators, peer counselors, and health profes-
22 sionals; and promotes informed decisionmaking
23 by childbearing women; and”.

1 **SEC. 515. INTERAGENCY COORDINATING COMMITTEE ON**
2 **THE PROMOTION OF OPTIMAL MATERNITY**
3 **OUTCOMES.**

4 (a) IN GENERAL.—Part A of title II of the Public
5 Health Service Act (42 U.S.C. 202 et seq.) is amended
6 by adding at the end the following new section:

7 **“SEC. 229A. INTERAGENCY COORDINATING COMMITTEE ON**
8 **THE PROMOTION OF OPTIMAL MATERNITY**
9 **OUTCOMES.**

10 “(a) IN GENERAL.—The Secretary of Health and
11 Human Services, acting through the Deputy Assistant
12 Secretary for Women’s Health under section 229 and in
13 collaboration with the Federal officials specified in sub-
14 section (b), shall establish the Interagency Coordinating
15 Committee on the Promotion of Optimal Maternity Out-
16 comes (referred to in this subsection as the ‘ICCPOM’).

17 “(b) OTHER AGENCIES.—The officials specified in
18 this subsection are the Secretary of Labor, the Secretary
19 of Defense, the Secretary of Veterans Affairs, the Surgeon
20 General, the Director of the Centers for Disease Control
21 and Prevention, the Administrator of the Health Re-
22 sources and Services Agency, the Administrator of the
23 Centers for Medicare & Medicaid Services, the Director
24 of the Indian Health Service, the Administrator of the
25 Substance Abuse and Mental Health Services Administra-
26 tion, the Director of the National Institute on Child

1 Health and Development, the Director of the Agency for
2 Healthcare Research and Quality, the Assistant Secretary
3 for Children and Families, the Deputy Assistant Secretary
4 for Minority Health, the Director of the Office of Per-
5 sonnel Management, and such other Federal officials as
6 the Secretary of Health and Human Services determines
7 to be appropriate.

8 “(c) CHAIR.—The Deputy Assistant Secretary for
9 Women’s Health shall serve as the chair of the ICCPOM.

10 “(d) DUTIES.—The ICCPOM shall guide policy and
11 program development across the Federal Government with
12 respect to promotion of optimal maternity care, provided,
13 however, that nothing in this section shall be construed
14 as transferring regulatory or program authority from an
15 agency to the ICCPOM.

16 “(e) CONSULTATIONS.—The ICCPOM shall actively
17 seek the input of, and shall consult with, all appropriate
18 and interested stakeholders, including State health depart-
19 ments, public health research and interest groups, founda-
20 tions, childbearing women and their advocates, and mater-
21 nity care professional associations and organizations, re-
22 flecting racially, ethnically, demographically, and geo-
23 graphically diverse communities.

24 “(f) ANNUAL REPORT.—

1 “(1) IN GENERAL.—The Secretary, on behalf of
2 the ICCPOM, shall annually submit to Congress a
3 report that summarizes—

4 “(A) all programs and policies of Federal
5 agencies (including the Medicare Program
6 under title XVIII of the Social Security Act and
7 the Medicaid program under title XIX of such
8 Act) designed to promote optimal maternity
9 care, focusing particularly on programs and
10 policies that support the adoption of evidence
11 based maternity care, as defined by timely, sci-
12 entifically sound systematic reviews;

13 “(B) all programs and policies of Federal
14 agencies (including the Medicare Program
15 under title XVIII of the Social Security Act and
16 the Medicaid program under title XIX of such
17 Act) designed to address the problems of mater-
18 nal mortality and morbidity, infant mortality,
19 prematurity, and low birth weight, including
20 such programs and policies designed to address
21 racial and ethnic disparities with respect to
22 each of such problems;

23 “(C) the extent of progress in reducing
24 maternal mortality and infant mortality, low

1 birth weight, and prematurity at State and na-
2 tional levels; and

3 “(D) such other information regarding op-
4 timal maternity care as the Secretary deter-
5 mines to be appropriate.

6 The information specified in subparagraph (C) shall
7 be included in each such report in a manner that
8 disaggregates such information by race, ethnicity,
9 and indigenous status in order to determine the ex-
10 tent of progress in reducing racial and ethnic dis-
11 parities and disparities related to indigenous status.

12 “(2) CERTAIN INFORMATION.—Each report
13 under paragraph (1) shall include information
14 (disaggregated by race, ethnicity, and indigenous
15 status, as applicable) on the following rates and
16 costs by State:

17 “(A) The rate of primary cesarean deliv-
18 eries and repeat cesarean deliveries.

19 “(B) The rate of vaginal births after cesar-
20 ean.

21 “(C) The rate of vaginal breech births.

22 “(D) The rate of induction of labor.

23 “(E) The rate of freestanding birth center
24 births.

1 “(F) The rate of planned and unplanned
2 home birth.

3 “(G) The rate of attended births by pro-
4 vider, including by an obstetrician-gynecologist,
5 family practice physician, obstetrician-gyne-
6 cologist physician assistant, certified nurse-mid-
7 wife, certified midwife, and certified profes-
8 sional midwife.

9 “(H) The cost of maternity care
10 disaggregated by place of birth and provider of
11 care, including—

12 “(i) uncomplicated vaginal birth;

13 “(ii) complicated vaginal birth;

14 “(iii) uncomplicated cesarean birth;

15 and

16 “(iv) complicated cesarean birth.

17 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
18 is authorized to be appropriated, in addition to amounts
19 authorized to be appropriated under section 229(e), to
20 carry out this section \$1,000,000 for each of the fiscal
21 years 2017 through 2021.”.

22 (b) CONFORMING AMENDMENTS.—

23 (1) INCLUSION AS DUTY OF HHS OFFICE ON
24 WOMEN’S HEALTH.—Section 229(b) of such Act (42
25 U.S.C. 237a(b)), as amended by section 514, is fur-

1 ther amended by adding at the end the following
2 new paragraph:

3 “(9) establish the Interagency Coordinating
4 Committee on the Promotion of Optimal Maternity
5 Outcomes in accordance with section 229A.”.

6 (2) TREATMENT OF BIENNIAL REPORTS.—Sec-
7 tion 229(d) of such Act (42 U.S.C. 237a(d)) is
8 amended by inserting “(other than under subsection
9 (b)(9))” after “under this section”.

10 **SEC. 516. CONSUMER EDUCATION CAMPAIGN.**

11 Section 229 of the Public Health Service Act (42
12 U.S.C. 237a), as amended, is further amended in sub-
13 section (b)—

14 (1) in paragraph (8), at the end, by striking
15 “and”;

16 (2) in paragraph (9), at the end, by striking the
17 period and inserting “; and”; and

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

20 “(10) not later than one year after the date of
21 the enactment of the Health Equity and Account-
22 ability Act of 2016, develop and implement a 4-year
23 culturally and linguistically appropriate multimedia
24 consumer education campaign that is designed to
25 promote understanding and acceptance of evidence-

1 based maternity practices and models of care for op-
2 timal maternity outcomes among women of child-
3 bearing ages and families of such women and that—

4 “(A) highlights the importance of pro-
5 tecting, promoting, and supporting the innate
6 capacities of childbearing women and their
7 newborns for childbirth, breastfeeding, and at-
8 tachment;

9 “(B) promotes understanding of the impor-
10 tance of using obstetric interventions when
11 medically necessary and when supported by
12 strong, high-quality evidence;

13 “(C) highlights the widespread overuse of
14 maternity practices that have been shown to
15 have benefit when used appropriately in situa-
16 tions of medical necessity, but which can expose
17 women, infants, or both to risk of harm if used
18 routinely and indiscriminately, including contin-
19 uous fetal monitoring, labor induction, epidural
20 anesthesia, elective primary cesarean section,
21 and repeat cesarean delivery;

22 “(D) emphasizes the noninvasive maternity
23 practices that have strong proven correlation or
24 may be associated with considerable improve-
25 ment in outcomes with no detrimental side ef-

1 fects, and are significantly underused in the
2 United States, including smoking cessation pro-
3 grams in pregnancy, group model prenatal care,
4 continuous labor support, nonsupine positions
5 for birth, and external version to turn breech
6 babies at term;

7 “(E) educates consumers about the quali-
8 fications of licensed providers of maternity care
9 and the best evidence about their safety, satis-
10 faction, outcomes, and costs;

11 “(F) informs consumers about the best
12 available research comparing birth center
13 births, planned home births, and hospital
14 births, including information about each set-
15 ting’s safety, satisfaction, outcomes, and costs;

16 “(G) fosters participation in high-quality,
17 evidence-based childbirth education that pro-
18 motes a natural, healthy, and safe approach to
19 pregnancy, childbirth, and early parenting; is
20 taught by certified educators, peer counselors,
21 and health professionals; and promotes in-
22 formed decisionmaking by childbearing women;
23 and

24 “(H) is pilot tested for consumer com-
25 prehension, cultural sensitivity, and acceptance

1 of the messages across geographically, racially,
2 ethnically, and linguistically diverse popu-
3 lations.”.

4 **SEC. 517. BIBLIOGRAPHIC DATABASE OF SYSTEMATIC RE-**
5 **VIEWS FOR CARE OF CHILDBEARING WOMEN**
6 **AND NEWBORNS.**

7 (a) IN GENERAL.—Not later than one year after the
8 date of the enactment of this Act, the Secretary of Health
9 and Human Services, through the Agency for Healthcare
10 Research and Quality, shall—

11 (1) make publicly available an online biblio-
12 graphic database identifying systematic reviews, in-
13 cluding an explanation of the level and quality of
14 evidence, for care of childbearing women and
15 newborns; and

16 (2) initiate regular updates that incorporate
17 newly issued and updated systematic reviews.

18 (b) SOURCES.—To aim for a comprehensive inventory
19 of systematic reviews relevant to maternal and newborn
20 care, the database shall identify reviews from diverse
21 sources, including—

22 (1) scientific peer-reviewed journals;

23 (2) databases, including Cochrane Database of
24 Systematic Reviews, Clinical Evidence, and Data-
25 base of Abstracts of Reviews of Effects; and

1 (3) Internet Web sites of agencies and organi-
2 zations throughout the world that produce such sys-
3 tematic reviews.

4 (c) FEATURES.—The database shall—

5 (1) provide bibliographic citations for each
6 record within the database, and for each such cita-
7 tion include an explanation of the level and quality
8 of evidence;

9 (2) include abstracts, as available;

10 (3) provide reference to companion documents
11 as may exist for each review, such as evidence tables
12 and guidelines or consumer educational materials de-
13 veloped from the review;

14 (4) provide links to the source of the full review
15 and to any companion documents;

16 (5) provide links to the source of a previous
17 version or update of the review;

18 (6) be searchable by intervention or other topic
19 of the review, reported outcomes, author, title, and
20 source; and

21 (7) offer to users periodic electronic notification
22 of database updates relating to users' topics of inter-
23 est.

24 (d) OUTREACH.—Not later than the first date the
25 database is made publicly available and periodically there-

1 after, the Secretary of Health and Human Services shall
2 publicize the availability, features, and uses of the data-
3 base under this section to the stakeholders described in
4 subsection (e).

5 (e) CONSULTATION.—For purposes of developing the
6 database under this section and maintaining and updating
7 such database, the Secretary of Health and Human Serv-
8 ices shall convene and consult with an advisory committee
9 composed of relevant stakeholders, including—

10 (1) Federal Medicaid administrators and State
11 agencies administering State plans under title XIX
12 of the Social Security Act pursuant to section
13 1902(a)(5) of such Act (42 U.S.C. 1396a(a)(5));

14 (2) providers of maternity and newborn care
15 from both academic and community-based settings,
16 including obstetrician-gynecologists, family physi-
17 cians, certified nurse midwives, certified midwives,
18 certified professional midwives, physician assistants,
19 perinatal nurses, pediatricians, and nurse practi-
20 tioners;

21 (3) maternal-fetal medicine specialists;

22 (4) neonatologists;

23 (5) childbearing women and advocates for such
24 women, including childbirth educators certified by a
25 nationally accredited program, representing commu-

1 nities that are diverse in terms of race, ethnicity, in-
2 digenous status, and geographic area;

3 (6) employers and purchasers;

4 (7) health facility and system leaders, including
5 both hospital and birth center facilities;

6 (8) journalists; and

7 (9) bibliographic informatics specialists.

8 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
9 authorized to be appropriated \$2,500,000 for each of the
10 fiscal years 2017 through 2019 for the purpose of devel-
11 oping the database and such sums as may be necessary
12 for each subsequent fiscal year for updating the database
13 and providing outreach and notification to users, as de-
14 scribed in this section.

15 **SEC. 518. MATERNITY CARE HEALTH PROFESSIONAL**
16 **SHORTAGE AREAS.**

17 Section 332 of the Public Health Service Act (42
18 U.S.C. 254e) is amended by adding at the end the fol-
19 lowing new subsection:

20 “(k)(1) The Secretary, acting through the Adminis-
21 trator of the Health Resources and Services Administra-
22 tion, shall designate maternity care health professional
23 shortage areas in the States, publish a descriptive list of
24 the area’s population groups, medical facilities, and other

1 public facilities so designated, and at least annually review
2 and, as necessary, revise such designations.

3 “(2) For purposes of paragraph (1), a complete de-
4 scriptive list shall be published in the Federal Register not
5 later than one year after the date of the enactment of the
6 Health Equity and Accountability Act of 2016 and annu-
7 ally thereafter.

8 “(3) The provisions of subsections (b), (c), (e), (f),
9 (g), (h), (i), and (j) (other than (j)(1)(B)) of this section
10 shall apply to the designation of a maternity care health
11 professional shortage area in a similar manner and extent
12 as such provisions apply to the designation of health pro-
13 fessional shortage areas, except in applying subsection
14 (b)(3), the reference in such subsection to ‘physicians’
15 shall be deemed to be a reference to nationally certified
16 and State licensed obstetricians, family practice physicians
17 who practice full-scope maternity care, certified nurse
18 midwives, certified midwives, certified professional mid-
19 wives, and physician’s assistants who practice full scope
20 maternity care.

21 “(4) For purposes of this subsection, the term ‘ma-
22 ternity care health professional shortage area’ means—

23 “(A) an area in an urban or rural area (which
24 need not conform to the geographic boundaries of a
25 political subdivision and which is a rational area for

1 the delivery of health services) which the Secretary
2 determines has a shortage of providers of maternity
3 care health services including those referenced in
4 paragraph (3) or an urban or rural area that the
5 Secretary determines has lost a significant number
6 of such providers during the 10-year period begin-
7 ning with 2004 or has no obstetrical providers li-
8 censed to provide operative obstetrical services;

9 “(B) an area in an urban or rural area (which
10 need not conform to the geographic boundaries of a
11 political subdivision and which is a rational area for
12 the delivery of health services) which the Secretary
13 determines has a shortage of hospital or labor and
14 delivery units, hospital birth center units, or free-
15 standing birth centers or an area that lost a signifi-
16 cant number of these units during the 10-year pe-
17 riod beginning with 2004; or

18 “(C) a population group which the Secretary
19 determines has such a shortage of providers or fa-
20 cilities.”.

21 **SEC. 519. EXPANSION OF CDC PREVENTION RESEARCH**
22 **CENTERS PROGRAM TO INCLUDE CENTERS**
23 **ON OPTIMAL MATERNITY OUTCOMES.**

24 (a) IN GENERAL.—Not later than one year after the
25 date of the enactment of this Act, the Secretary of Health

1 and Human Services, shall support the establishment of
2 additional Prevention Research Centers under the Preven-
3 tion Research Center Program administered by the Cen-
4 ters for Disease Control and Prevention. Such additional
5 centers shall each be known as a Center for Excellence
6 on Optimal Maternity Outcomes.

7 (b) RESEARCH.—Each Center for Excellence on Opti-
8 mal Maternity Outcomes shall—

9 (1) conduct at least one focused program of re-
10 search to improve maternity outcomes, including the
11 reduction of cesarean birth rates, elective inductions,
12 prematurity rates, and low birth weight rates within
13 an underserved population that has a disproportion-
14 ately large burden of suboptimal maternity out-
15 comes, including maternal mortality and morbidity,
16 infant mortality, prematurity, or low birth weight;

17 (2) work with partners on special interest
18 projects, as specified by the Centers for Disease
19 Control and Prevention and other relevant agencies
20 within the Department of Health and Human Serv-
21 ices, and on projects funded by other sources; and

22 (3) involve a minimum of two distinct birth set-
23 ting models, such as a hospital labor and delivery
24 model and freestanding birth center model; or a hos-

1 pital labor and delivery model and planned home
2 birth model.

3 (c) INTERDISCIPLINARY PROVIDERS.—Each Center
4 for Excellence on Optimal Maternity Outcomes shall in-
5 clude the following interdisciplinary providers of maternity
6 care:

7 (1) Obstetrician-gynecologists.

8 (2) At least two of the following providers:

9 (A) Family practice physicians.

10 (B) Nurse practitioners.

11 (C) Physician assistants.

12 (D) Certified professional midwives.

13 (d) SERVICES.—Research conducted by each Center
14 for Excellence on Optimal Maternity Outcomes shall in-
15 clude at least 2 (and preferably more) of the following sup-
16 portive provider services:

17 (1) Mental health.

18 (2) Doula labor support.

19 (3) Nutrition education.

20 (4) Childbirth education.

21 (5) Social work.

22 (6) Physical therapy or occupation therapy.

23 (7) Substance abuse services.

24 (8) Home visiting.

1 (e) COORDINATION.—The programs of research at
2 each of the two Centers of Excellence on Optimal Mater-
3 nity Outcomes shall compliment and not replicate the
4 work of the other.

5 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
6 authorized to be appropriated to carry out this section
7 \$2,000,000 for each of the fiscal years 2017 through
8 2021.

9 **SEC. 520. EXPANDING MODELS ALLOWED TO BE TESTED BY**
10 **CENTER FOR MEDICARE AND MEDICAID IN-**
11 **NOVATION TO INCLUDE MATERNITY CARE**
12 **MODELS.**

13 Section 1115A(b)(2)(B) of the Social Security Act
14 (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the
15 end the following new clause:

16 “(xxv) Promoting evidence-based mod-
17 els of care that have been associated with
18 reductions in maternal and infant health
19 disparities, including incorporating the use
20 of doula and promotoras support for preg-
21 nant and childbearing women into evi-
22 dence-based models of prenatal care, labor
23 and delivery, and postpartum care, and
24 supporting the appropriate use of out-of-

1 hospital birth models, including births at
2 home and in freestanding birth centers.”.

3 **SEC. 521. DEVELOPMENT OF INTERPROFESSIONAL MATER-**
4 **NITY CARE EDUCATIONAL MODELS AND**
5 **TOOLS.**

6 (a) IN GENERAL.—Not later than 6 months after the
7 date of the enactment of this Act, the Secretary of Health
8 and Human Services, acting in conjunction with the Ad-
9 ministrator of Health Resources and Services Administra-
10 tion, shall convene, for a 1-year period, an Interprofes-
11 sional Maternity Provider Education Commission to dis-
12 cuss and make recommendations for—

13 (1) a consensus standard physiologic maternity
14 care curriculum that takes into account the core
15 competencies for basic midwifery practice such as
16 those developed by the American College of Nurse
17 Midwives and the North American Registry of Mid-
18 wives, and the educational objectives for physicians
19 practicing in obstetrics and gynecology as deter-
20 mined by the Council on Resident Education in Ob-
21 stetrics and Gynecology;

22 (2) suggestions for multidisciplinary use of the
23 consensus physiologic curriculum;

24 (3) strategies to integrate and coordinate edu-
25 cation across maternity care disciplines, including

1 recommendations to increase medical and midwifery
2 student exposure to out-of-hospital birth; and

3 (4) pilot demonstrations of interprofessional
4 educational models.

5 (b) PARTICIPANTS.—The Commission shall include
6 maternity care educators, curriculum developers, service
7 leaders, certification leaders, and accreditation leaders
8 from the various professions that provide maternity care
9 in this country. Such professions shall include obstetrician
10 gynecologists, certified nurse midwives or certified mid-
11 wives, family practice physicians, nurse practitioners, phy-
12 sician assistants, certified professional midwives, and
13 perinatal nurses. Additionally, the Commission shall in-
14 clude representation from maternity care consumer advo-
15 cates.

16 (c) CURRICULUM.—The consensus standard physio-
17 logic maternity care curriculum described in subsection
18 (a)(1) shall—

19 (1) have a public health focus with a foundation
20 in health promotion and disease prevention;

21 (2) foster physiologic childbearing and woman
22 and family centered care;

23 (3) integrate strategies to reduce maternal and
24 infant morbidity and mortality;

1 (4) incorporate recommendations to ensure re-
2 spectful, safe, and seamless consultation, referral,
3 transport, and transfer of care when necessary; and

4 (5) include cultural sensitivity and strategies to
5 decrease disparities in maternity outcomes.

6 (d) REPORT.—Not later than 6 months after the final
7 meeting of the Commission, the Secretary of Health and
8 Human Services shall—

9 (1) submit to Congress a report containing the
10 recommendations made by the Commission under
11 this section; and

12 (2) make such report publicly available.

13 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
14 authorized to be appropriated to carry out this section
15 \$1,000,000 for each of the fiscal years 2017 and 2018,
16 and such sums as are necessary for each of the fiscal years
17 2019 through 2021.

18 **SEC. 522. INCLUDING WITHIN INPATIENT HOSPITAL SERV-**
19 **ICES UNDER MEDICARE SERVICES FUR-**
20 **NISHED BY CERTAIN STUDENTS, INTERNS,**
21 **AND RESIDENTS SUPERVISED BY CERTIFIED**
22 **NURSE MIDWIVES.**

23 (a) IN GENERAL.—Section 1861(b) of the Social Se-
24 curity Act (42 U.S.C. 1395x(b)) is amended—

1 (1) in paragraph (6), by striking “; or” and in-
2 serting “, or in the case of services in a hospital or
3 osteopathic hospital by a student midwife or an in-
4 tern or resident-in-training under a teaching pro-
5 gram previously described in this paragraph who is
6 in the field of obstetrics and gynecology, if such stu-
7 dent midwife, intern, or resident-in-training is super-
8 vised by a certified nurse-midwife to the extent per-
9 mitted under applicable State law and as may be au-
10 thorized by the hospital;”;

11 (2) in paragraph (7), by striking the period at
12 the end and inserting “; or”; and

13 (3) by adding at the end the following new
14 paragraph:

15 “(8) a certified nurse-midwife where the hos-
16 pital has a teaching program approved as specified
17 in paragraph (6), if—

18 “(A) the hospital elects to receive any pay-
19 ment due under this title for reasonable costs of
20 such services; and

21 “(B) all certified nurse-midwives in such
22 hospital agree not to bill charges for profes-
23 sional services rendered in such hospital to indi-
24 viduals covered under the insurance program
25 established by this title.”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply to services furnished on or after
3 the date of the enactment of this Act.

4 **SEC. 523. GRANTS TO PROFESSIONAL ORGANIZATIONS TO**
5 **INCREASE DIVERSITY IN MATERNITY CARE**
6 **PROFESSIONALS.**

7 (a) IN GENERAL.—The Secretary of Health and
8 Human Services, through the Administrator of the Health
9 Resources and Services Administration, shall carry out a
10 grant program under which the Secretary may make to
11 eligible health professional organizations—

12 (1) for fiscal year 2017, planning grants de-
13 scribed in subsection (b); and

14 (2) for the subsequent 4-year period, implemen-
15 tation grants described in subsection (c).

16 (b) PLANNING GRANTS.—

17 (1) IN GENERAL.—Planning grants described in
18 this subsection are grants for the following purposes:

19 (A) To collect data and identify any work-
20 force disparities, with respect to a health pro-
21 fession, at each of the following areas along the
22 health professional continuum:

23 (i) Pipeline availability with respect to
24 students at the high school and college or

1 university levels considering and working
2 toward entrance in the profession.

3 (ii) Entrance into the training pro-
4 gram for the profession.

5 (iii) Graduation from such training
6 program.

7 (iv) Entrance into practice.

8 (v) Retention in practice for more
9 than a 5-year period.

10 (B) To develop one or more strategies to
11 address the workforce disparities within the
12 health profession, as identified under (and in
13 response to the findings pursuant to) subpara-
14 graph (A).

15 (2) APPLICATION.—To be eligible to receive a
16 grant under this subsection, an eligible health pro-
17 fessional organization shall submit to the Secretary
18 of Health and Human Services an application in
19 such form and manner and containing such informa-
20 tion as specified by the Secretary.

21 (3) AMOUNT.—Each grant awarded under this
22 subsection shall be for an amount not to exceed
23 \$300,000.

1 (4) REPORT.—Each recipient of a grant under
2 this subsection shall submit to the Secretary of
3 Health and Human Services a report containing—

4 (A) information on the extent and distribu-
5 tion of workforce disparities identified through
6 the grant; and

7 (B) reasonable objectives and strategies
8 developed to address such disparities within a
9 5-, 10-, and 25-year period.

10 (c) IMPLEMENTATION GRANTS.—

11 (1) IN GENERAL.—Implementation grants de-
12 scribed in this subsection are grants to implement
13 one or more of the strategies developed pursuant to
14 a planning grant awarded under subsection (b).

15 (2) APPLICATION.—To be eligible to receive a
16 grant under this subsection, an eligible health pro-
17 fessional organization shall submit to the Secretary
18 of Health and Human Services an application in
19 such form and manner as specified by the Secretary.
20 Each such application shall contain information on
21 the capability of the organization to carry out a
22 strategy described in paragraph (1), involvement of
23 partners or coalitions, plans for developing sustain-
24 ability of the efforts after the culmination of the

1 grant cycle, and any other information specified by
2 the Secretary.

3 (3) AMOUNT.—Each grant awarded under this
4 subsection shall be for an amount not to exceed
5 \$500,000 each year during the 4-year period of the
6 grant.

7 (4) REPORTS.—For each of the first 3 years for
8 which an eligible health professional organization is
9 awarded a grant under this subsection, the organiza-
10 tion shall submit to the Secretary of Health and
11 Human Services a report on the activities carried
12 out by such organization through the grant during
13 such year and objectives for the subsequent year.
14 For the fourth year for which an eligible health pro-
15 fessional organization is awarded a grant under this
16 subsection, the organization shall submit to the Sec-
17 retary a report that includes an analysis of all the
18 activities carried out by the organization through the
19 grant and a detailed plan for continuation of out-
20 reach efforts.

21 (d) ELIGIBLE HEALTH PROFESSIONAL ORGANIZA-
22 TION DEFINED.—For purposes of this section, the term
23 “eligible health professional organization” means a profes-
24 sional organization representing obstetrician-gyne-
25 cologists, certified nurse midwives, certified midwives,

1 family practice physicians, nurse practitioners whose scope
2 of practice includes maternity care, physician assistants
3 whose scope of practice includes obstetrical care, or cer-
4 tified professional midwives.

5 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
6 authorized to be appropriated to carry out this section
7 \$2,000,000 for fiscal year 2017 and \$3,000,000 for each
8 of the fiscal years 2018 through 2021.

9 **TITLE VI—MENTAL HEALTH**

10 **SEC. 601. COVERAGE OF MARRIAGE AND FAMILY THERA-** 11 **PIST SERVICES, MENTAL HEALTH COUN-** 12 **SELOR SERVICES, AND SUBSTANCE ABUSE** 13 **COUNSELOR SERVICES UNDER PART B OF** 14 **THE MEDICARE PROGRAM.**

15 (a) COVERAGE OF SERVICES.—

16 (1) IN GENERAL.—Section 1861(s)(2) of the
17 Social Security Act (42 U.S.C. 1395x(s)(2)), as
18 amended by section 450(c)(1), is amended—

19 (A) in subparagraph (FF), by striking
20 “and” at the end;

21 (B) in subparagraph (GG), by inserting
22 “and” at the end; and

23 (C) by adding at the end the following new
24 subparagraph:

1 “(HH) marriage and family therapist services
2 (as defined in subsection (lll)(1)) and mental health
3 counselor services (as defined in subsection (lll)(3))
4 and substance abuse counselor services (as defined
5 in subsection (lll)(5));”.

6 (2) DEFINITIONS.—Section 1861 of such Act
7 (42 U.S.C. 1395x), as amended by sections
8 205(b)(1)(A), 423(a), and 470(a), is amended by
9 adding at the end the following new subsection:

10 “Marriage and Family Therapist Services; Marriage and
11 Family Therapist; Mental Health Counselor Serv-
12 ices; Mental Health Counselor

13 “(lll)(1) The term ‘marriage and family therapist
14 services’ means services performed by a marriage and
15 family therapist (as defined in paragraph (2)) for the diag-
16 nosis and treatment of mental illnesses, which the mar-
17 riage and family therapist is legally authorized to perform
18 under State law (or the State regulatory mechanism pro-
19 vided by State law) of the State in which such services
20 are performed, as would otherwise be covered if furnished
21 by a physician or as an incident to a physician’s profes-
22 sional service, but only if no facility or other provider
23 charges or is paid any amounts with respect to the fur-
24 nishing of such services.

1 “(2) The term ‘marriage and family therapist’ means
2 an individual who—

3 “(A) possesses a master’s or doctoral degree
4 which qualifies for licensure or certification as a
5 marriage and family therapist pursuant to State
6 law;

7 “(B) after obtaining such degree has performed
8 at least 2 years of clinical supervised experience in
9 marriage and family therapy; and

10 “(C) in the case of an individual performing
11 services in a State that provides for licensure or cer-
12 tification of marriage and family therapists, is li-
13 censed or certified as a marriage and family thera-
14 pist in such State.

15 “(3) The term ‘mental health counselor services’
16 means services performed by a mental health counselor (as
17 defined in paragraph (4)) for the diagnosis and treatment
18 of mental illnesses which the mental health counselor is
19 legally authorized to perform under State law (or the
20 State regulatory mechanism provided by the State law) of
21 the State in which such services are performed, as would
22 otherwise be covered if furnished by a physician or as inci-
23 dent to a physician’s professional service, but only if no
24 facility or other provider charges or is paid any amounts
25 with respect to the furnishing of such services.

1 “(4) The term ‘mental health counselor’ means an
2 individual who—

3 “(A) possesses a master’s or doctor’s degree in
4 mental health counseling or a related field;

5 “(B) after obtaining such a degree has per-
6 formed at least 2 years of supervised mental health
7 counselor practice; and

8 “(C) in the case of an individual performing
9 services in a State that provides for licensure or cer-
10 tification of mental health counselors or professional
11 counselors, is licensed or certified as a mental health
12 counselor or professional counselor in such State.

13 “(5) The term ‘substance abuse counselor services’
14 means services performed by a substance abuse counselor
15 (as defined in paragraph (6)) for the diagnosis and treat-
16 ment of substance abuse and addiction which the sub-
17 stance abuse counselor is legally authorized to perform
18 under State law (or the State regulatory mechanism pro-
19 vided by the State law) of the State in which such services
20 are performed, as would otherwise be covered if furnished
21 by a physician or as incident to a physician’s professional
22 service, but only if no facility or other provider charges
23 or is paid any amounts with respect to the furnishing of
24 such services.

1 “(6) The term ‘substance abuse counselor’ means an
2 individual who—

3 “(A) has performed at least 2 years of super-
4 vised substance abuse counselor practice;

5 “(B) in the case of an individual performing
6 services in a State that provides for licensure or cer-
7 tification of substance abuse counselors or profes-
8 sional counselors, is licensed or certified as a sub-
9 stance abuse counselor or professional counselor in
10 such State; or

11 “(C) the individual is a drug and alcohol coun-
12 selor as defined in section 40.281 of title 49, Code
13 of Federal Regulations.”.

14 (3) PROVISION FOR PAYMENT UNDER PART
15 B.—Section 1832(a)(2)(B) of such Act (42 U.S.C.
16 1395k(a)(2)(B)) is amended—

17 (A) by striking “and” at the end of clause
18 (iv); and

19 (B) by adding at the end the following new
20 clause:

21 “(v) marriage and family therapist
22 services, mental health counselor services,
23 and substance abuse counselor services;
24 and”.

1 (4) AMOUNT OF PAYMENT.—Section 1833(a)(1)
2 of such Act (42 U.S.C. 1395l(a)(1)), as amended by
3 section 450(c)(1), is amended—

4 (A) by striking “and (AA)” and inserting
5 “(AA)”; and

6 (B) by inserting before the semicolon at
7 the end the following: “, and (BB) with respect
8 to marriage and family therapist services, men-
9 tal health counselor services, and substance
10 abuse counselor services under section
11 1861(s)(2)(HH), the amounts paid shall be 80
12 percent of the lesser of the actual charge for
13 the services or 75 percent of the amount deter-
14 mined for payment of a psychologist under sub-
15 paragraph (L)”.

16 (5) EXCLUSION OF MARRIAGE AND FAMILY
17 THERAPIST SERVICES AND MENTAL HEALTH COUN-
18 SELOR SERVICES FROM SKILLED NURSING FACILITY
19 PROSPECTIVE PAYMENT SYSTEM.—Section
20 1888(e)(2)(A)(ii) of such Act (42 U.S.C.
21 1395yy(e)(2)(A)(ii)) is amended by inserting “mar-
22 riage and family therapist services (as defined in
23 section 1861(III)(1)), mental health counselor serv-
24 ices (as defined in section 1861(III)(3)),” after
25 “qualified psychologist services,”.

1 (6) INCLUSION OF MARRIAGE AND FAMILY
2 THERAPISTS, MENTAL HEALTH COUNSELORS, AND
3 SUBSTANCE ABUSE COUNSELORS AS PRACTITIONERS
4 FOR ASSIGNMENT OF CLAIMS.—Section
5 1842(b)(18)(C) of such Act (42 U.S.C.
6 1395u(b)(18)(C)) is amended by adding at the end
7 the following new clauses:

8 “(vii) A marriage and family therapist (as de-
9 fined in section 1861(III)(2)).

10 “(viii) A mental health counselor (as defined in
11 section 1861(III)(4)).

12 “(ix) A substance abuse counselor (as defined
13 in section 1861 (III)(6)).”.

14 (b) COVERAGE OF CERTAIN MENTAL HEALTH SERV-
15 ICES PROVIDED IN CERTAIN SETTINGS.—

16 (1) RURAL HEALTH CLINICS AND FEDERALLY
17 QUALIFIED HEALTH CENTERS.—Section
18 1861(aa)(1)(B) of the Social Security Act (42
19 U.S.C. 1395x(aa)(1)(B)) is amended by striking “or
20 by a clinical social worker (as defined in subsection
21 (hh)(1)),” and inserting “, by a clinical social worker
22 (as defined in subsection (hh)(1)), by a marriage
23 and family therapist (as defined in subsection
24 (III)(2)), or by a mental health counselor (as defined

1 in subsection (lll)(4)), or by a substance abuse coun-
2 selor (as defined in section 1861 (lll)(6)).”.

3 (2) HOSPICE PROGRAMS.—Section
4 1861(dd)(2)(B)(i)(III) of such Act (42 U.S.C.
5 1395x(dd)(2)(B)(i)(III)) is amended by inserting “or
6 one marriage and family therapist (as defined in
7 subsection (lll)(2))” after “social worker”.

8 (c) AUTHORIZATION OF MARRIAGE AND FAMILY
9 THERAPISTS TO DEVELOP DISCHARGE PLANS FOR POST-
10 HOSPITAL SERVICES.—Section 1861(ee)(2)(G) of the So-
11 cial Security Act (42 U.S.C. 1395x(ee)(2)(G)) is amended
12 by inserting “marriage and family therapist (as defined
13 in subsection (lll)(2)),” after “social worker,”.

14 (d) EFFECTIVE DATE.—The amendments made by
15 this section shall apply with respect to services furnished
16 on or after January 1, 2017.

17 **SEC. 602. MINORITY FELLOWSHIP PROGRAM.**

18 Title V of the Public Health Service Act is amended
19 by inserting after section 506B (42 U.S.C. 290aa–5b) the
20 following:

21 **“SEC. 506C. MINORITY FELLOWSHIP PROGRAM.**

22 “(a) FELLOWSHIPS.—The Administrator shall main-
23 tain a program, to be known as the Minority Fellowship
24 Program, under which the Administrator awards grants
25 or contracts to national associations or other appropriate

1 entities for the financial support of graduate students,
2 postdoctoral fellows, and residents in the professions of
3 psychology, psychiatry, social work, psychiatric advance-
4 practice nursing, marriage and family therapy, and profes-
5 sional counseling to students who demonstrate a commit-
6 ment to clinical or research careers focused on racial and
7 ethnic minority populations.

8 “(b) **TERM OF FINANCIAL SUPPORT.**—Financial sup-
9 port provided to an individual pursuant to subsection (a)
10 shall be for a term of not more than 12 months and may
11 be renewed thereafter.

12 “(c) **AUTHORIZATION OF APPROPRIATIONS.**—To
13 carry out this section, there is authorized to be appro-
14 priated \$10,000,000 for each of fiscal years 2017 through
15 2021.”

16 **SEC. 603. INTEGRATED HEALTH CARE DEMONSTRATION**
17 **PROGRAM.**

18 Part D of title V of the Public Health Service Act
19 (42 U.S.C. 290dd et seq.) is amended by adding at the
20 end the following:

21 **“SEC. 544. INTERPROFESSIONAL HEALTH CARE TEAMS FOR**
22 **PROVISION OF BEHAVIORAL HEALTH CARE**
23 **IN PRIMARY CARE SETTINGS.**

24 “(a) **GRANTS.**—The Secretary, acting through the
25 Deputy Assistant Secretary for Minority Health, shall

1 award grants to eligible entities for the purpose of pro-
2 viding technical assistance and training regarding the ef-
3 fective development and implementation of integrated
4 interprofessional health care teams that provide behavioral
5 health care.

6 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
7 a grant under this section, an entity shall be a federally
8 qualified health center (as defined in section 1861(aa) of
9 the Social Security Act) serving a high proportion of indi-
10 viduals from racial and ethnic minority groups (as defined
11 in section 1707(g)).

12 “(c) SCIENTIFICALLY BASED.—The technical assist-
13 ance and training funded through this section shall be sci-
14 entifically based, taking into consideration the results of
15 the most recent peer-reviewed research available.

16 “(d) AUTHORIZATION OF APPROPRIATIONS.—To
17 carry out this section, there is authorized to be appro-
18 priated \$20,000,000 for each of fiscal years 2017 through
19 2019.”.

20 **SEC. 604. ADDRESSING RACIAL AND ETHNIC MINORITY**
21 **MENTAL HEALTH DISPARITIES RESEARCH**
22 **GAPS.**

23 Not later than 6 months after the date of the enact-
24 ment of this Act, the Director of the National Institute
25 on Minority Health and Health Disparities shall enter into

1 an arrangement with the Institute of Medicine (or, if the
2 Institute declines to enter into such an arrangement, an-
3 other appropriate entity)—

4 (1) to conduct a study with respect to mental
5 and behavioral health disparities in racial and ethnic
6 minority groups (as defined in section 1707(g) of
7 the Public Health Service Act (42 U.S.C. 300u-
8 6(g)); and

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

11 (A) a compilation of information on the dy-
12 namics of mental disorders in such racial and
13 ethnic minority groups; and

14 (B) a compilation of information on the
15 impact of exposure to community violence, ad-
16 verse childhood experiences, and other psycho-
17 logical traumas on mental disorders in such ra-
18 cial and minority groups.

19 **SEC. 605. HEALTH PROFESSIONS COMPETENCIES TO AD-**
20 **DRESS RACIAL AND ETHNIC MINORITY MEN-**
21 **TAL HEALTH DISPARITIES.**

22 (a) IN GENERAL.—The Secretary of Health and
23 Human Services, acting through the Administrator of the
24 Substance Abuse and Mental Health Services Administra-

1 tion, shall award grants to qualified national organizations
2 for the purposes of—

3 (1) developing, and disseminating to health pro-
4 fessional educational programs curricula or core
5 competencies addressing mental health disparities
6 among racial and ethnic minority groups for use in
7 the training of students in the professions of social
8 work, psychology, psychiatry, marriage and family
9 therapy, peer wellness specialist, mental health coun-
10 seling, and substance abuse counseling; and

11 (2) certifying community health workers and
12 peer wellness specialists with respect to such cur-
13 ricula and core competencies and integrating and ex-
14 panding the use of such workers and specialists into
15 health care to address mental health disparities
16 among racial and ethnic minority groups.

17 (b) CURRICULA; CORE COMPETENCIES.—Organiza-
18 tions receiving funds under subsection (a) may use the
19 funds to engage in the following activities related to the
20 development and dissemination of curricula or core com-
21 petencies described in subsection (a)(1):

22 (1) Formation of committees or working groups
23 comprised of experts from accredited health profes-
24 sions schools to identify core competencies relating

1 to mental health disparities among racial and ethnic
2 minority groups.

3 (2) Planning of workshops in national fora to
4 allow for public input into the educational needs as-
5 sociated with mental health disparities among racial
6 and ethnic minority groups.

7 (3) Dissemination and promotion of the use of
8 curricula or core competencies in undergraduate and
9 graduate health professions training programs na-
10 tionwide.

11 (c) DEFINITIONS.—In this section:

12 (1) The term “qualified national organization”
13 means a national organization that focuses on the
14 education of students in programs of social work,
15 psychology, psychiatry, and marriage and family
16 therapy.

17 (2) The term “racial and ethnic minority
18 group” has the meaning given to such term in sec-
19 tion 1707(g) of the Public Health Service Act (42
20 U.S.C. 300u–6(g)).

21 (d) 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 2017 through 2021.

1 **TITLE VII—ADDRESSING HIGH**
2 **IMPACT MINORITY DISEASES**
3 **Subtitle A—Cancer**

4 **SEC. 701. LUNG CANCER MORTALITY REDUCTION.**

5 (a) **SHORT TITLE.**—This section may be cited as the
6 “Lung Cancer Mortality Reduction Act of 2016”.

7 (b) **FINDINGS.**—Congress makes the following find-
8 ings:

9 (1) Lung cancer is the leading cause of cancer
10 death for both men and women, accounting for 28
11 percent of all cancer deaths.

12 (2) Lung cancer kills more people annually
13 than breast cancer, prostate cancer, colon cancer,
14 liver cancer, melanoma, and kidney cancer combined.

15 (3) Since the National Cancer Act of 1971
16 (Public Law 92–218; 85 Stat. 778), coordinated and
17 comprehensive research has raised the 5-year sur-
18 vival rates for breast cancer to 88 percent, for pros-
19 tate cancer to 99 percent, and for colon cancer to
20 64 percent.

21 (4) However, the 5-year survival rate for lung
22 cancer is still only 15 percent and a similar coordi-
23 nated and comprehensive research effort is required
24 to achieve increases in lung cancer survivability
25 rates.

1 (5) Sixty percent of lung cancer cases are now
2 diagnosed nonsmokers or former smokers.

3 (6) Two-thirds of nonsmokers diagnosed with
4 lung cancer are women.

5 (7) Certain minority populations, such as Afri-
6 can-American males, have disproportionately high
7 rates of lung cancer incidence and mortality, not-
8 withstanding their similar smoking rate.

9 (8) Members of the baby boomer generation are
10 entering their sixties, the most common age at which
11 people develop lung cancer.

12 (9) Tobacco addiction and exposure to other
13 lung cancer carcinogens such as Agent Orange and
14 other herbicides and battlefield emissions are serious
15 problems among military personnel and war vet-
16 erans.

17 (10) Significant and rapid improvements in
18 lung cancer mortality can be expected through great-
19 er use and access to lung cancer screening tests for
20 at-risk individuals.

21 (11) Recent research has shown that screening
22 with low-dose computed tomography (CT) scan im-
23 proved lung cancer death mortality by 20 percent for
24 those with a high risk of lung cancer through early
25 detection. The Centers for Medicare & Medicaid

1 Services supports annual lung cancer screening for
2 high-risk patients with low-dose computed tomog-
3 raphy.

4 (12) Additional strategies are necessary to fur-
5 ther enhance the existing tests and therapies avail-
6 able to diagnose and treat lung cancer in the future.

7 (13) The August 2001 Report of the Lung
8 Cancer Progress Review Group of the National Can-
9 cer Institute stated that funding for lung cancer re-
10 search was “far below the levels characterized for
11 other common malignancies and far out of propor-
12 tion to its massive health impact”.

13 (14) The Report of the Lung Cancer Progress
14 Review Group identified as its “highest priority” the
15 creation of integrated, multidisciplinary, multi-insti-
16 tutional research consortia organized around the
17 problem of lung cancer rather than around specific
18 research disciplines.

19 (15) The United States must enhance its re-
20 sponse to the issues raised in the Report of the
21 Lung Cancer Progress Review Group, and this can
22 be accomplished through the establishment of a co-
23 ordinated effort designed to reduce the lung cancer
24 mortality rate by 50 percent by 2020 and targeted
25 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 701 of the Health Equity and Accountability
4 Act of 2016, shall implement a comprehensive program,
5 to be known as the Lung Cancer Mortality Reduction Pro-
6 gram, to achieve a reduction of at least 25 percent in the
7 mortality rate of lung cancer by 2020.

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 530 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 promotion (including education) of
7 lung cancer screening within minority and rural pop-
8 ulations and the study of the effectiveness of efforts
9 to increase such screening.

10 “(6) The cooperation and coordination of all
11 minority and health disparity programs within the
12 Department of Health and Human Services to en-
13 sure that all aspects of the Lung Cancer Mortality
14 Reduction Program under this section adequately
15 address the burden of lung cancer on minority and
16 rural populations.

17 “(7) The cooperation and coordination of all to-
18 bacco control and cessation programs within agen-
19 cies of the Department of Health and Human Serv-
20 ices to achieve the goals of the Lung Cancer Mor-
21 tality Reduction Program under this section with
22 particular emphasis on the coordination of drug and
23 other cessation treatments with early detection pro-
24 tocols.”.

1 (2) FEDERAL FOOD, DRUG, AND COSMETIC
2 ACT.—Subchapter B of chapter V of the Federal
3 Food, Drug, and Cosmetic Act (21 U.S.C. 360aaa et
4 seq.) is amended by adding at the end the following:

5 “DRUGS RELATING TO LUNG CANCER

6 “SEC. 530. (a) IN GENERAL.—The provisions of this
7 subchapter shall apply to a drug described in subsection
8 (b) to the same extent and in the same manner as such
9 provisions apply to a drug for a rare disease or condition.

10 “(b) QUALIFIED DRUGS.—A drug described in this
11 subsection is—

12 “(1) a chemoprevention drug for precancerous
13 conditions of the lung;

14 “(2) a drug for targeted therapeutic treat-
15 ments, including any vaccine, for lung cancer; and

16 “(3) a drug to curtail or prevent nicotine addic-
17 tion.

18 “(c) BOARD.—The Board established under the
19 Health Equity and Accountability Act of 2016 shall mon-
20 itor the program implemented under this section.”.

21 (3) ACCESS TO UNAPPROVED THERAPIES.—Sec-
22 tion 561(e) of the Federal Food, Drug, and Cos-
23 metic Act (21 U.S.C. 360bbb(e)) is amended by in-
24 serting before the period the following: “and shall
25 include expanding access to drugs under section
26 530, with substantial consideration being given to

1 whether the totality of information available to the
2 Secretary regarding the safety and effectiveness of
3 an investigational drug, as compared to the risk of
4 morbidity and death from the disease, indicates that
5 a patient may obtain more benefit than risk if treat-
6 ed with the drug”.

7 (4) CDC.—Title XV of the Public Health Serv-
8 ice Act (42 U.S.C. 300k et seq.) is amended by add-
9 ing at the end the following:

10 **“SEC. 1511. EARLY DISEASE RESEARCH AND MANAGEMENT**
11 **PROGRAM.**

12 “The Secretary shall establish and implement an
13 early disease research and management program targeted
14 at the high incidence and mortality rates of lung cancer
15 among minority and low-income populations.”.

16 (e) DEPARTMENT OF DEFENSE AND THE DEPART-
17 MENT OF VETERANS AFFAIRS.—The Secretary of Defense
18 and the Secretary of Veterans Affairs shall coordinate
19 with the Secretary of Health and Human Services—

20 (1) in the development of the Lung Cancer
21 Mortality Reduction Program under section 417H;

22 (2) in the implementation within the Depart-
23 ment of Defense and the Department of Veterans
24 Affairs of an early detection and disease manage-
25 ment research program for military personnel and

1 veterans whose smoking history and exposure to car-
2 cinogens during active duty service has increased
3 their risk for lung cancer; and

4 (3) in the implementation of coordinated care
5 programs for military personnel and veterans diag-
6 nosed with lung cancer.

7 (f) LUNG CANCER ADVISORY BOARD.—

8 (1) IN GENERAL.—The Secretary of Health and
9 Human Services shall convene a Lung Cancer Advi-
10 sory Board (referred to in this section as the
11 “Board”)—

12 (A) to monitor the programs established
13 under this section (and the amendments made
14 by this section); and

15 (B) to provide annual reports to the Con-
16 gress concerning benchmarks, expenditures,
17 lung cancer statistics, and the public health im-
18 pact of such programs.

19 (2) COMPOSITION.—The Board shall be com-
20 posed of—

21 (A) the Secretary of Health and Human
22 Services;

23 (B) the Secretary of Defense;

24 (C) the Secretary of Veterans Affairs; and

1 (D) two representatives each from the
2 fields of clinical medicine focused on lung can-
3 cer, lung cancer research, imaging, drug devel-
4 opment, and lung cancer advocacy, to be ap-
5 pointed by the Secretary of Health and Human
6 Services.

7 (g) AUTHORIZATION OF APPROPRIATIONS.—

8 (1) IN GENERAL.—To carry out this section
9 (and the amendments made by this section), there
10 are authorized to be appropriated such sums as may
11 be necessary for each of fiscal years 2017 through
12 2021.

13 (2) LUNG CANCER MORTALITY REDUCTION PRO-
14 GRAM.—Of the amounts authorized to be appro-
15 priated by subsection (a), there are authorized to be
16 appropriated—

17 (A) \$25,000,000 for fiscal year 2017, and
18 such sums as may be necessary for each of fis-
19 cal years 2018 through 2021, for the activities
20 described in section 417H(b)(1)(B) of the Pub-
21 lic Health Service Act, as added by subsection
22 (d)(1);

23 (B) \$25,000,000 for fiscal year 2017, and
24 such sums as may be necessary for each of fis-

1 cal years 2018 through 2021, for the activities
2 described in section 417H(b)(1)(C) of such Act;

3 (C) \$10,000,000 for fiscal year 2017, and
4 such sums as may be necessary for each of fis-
5 cal years 2018 through 2021, for the activities
6 described in section 417H(b)(1)(D) of such Act;
7 and

8 (D) \$15,000,000 for fiscal year 2017, and
9 such sums as may be necessary for each of fis-
10 cal years 2018 through 2021, for the activities
11 described in section 417H(b)(3) of such Act.

12 **SEC. 702. EXPANDING PROSTATE CANCER RESEARCH, OUT-**
13 **REACH, SCREENING, TESTING, ACCESS, AND**
14 **TREATMENT EFFECTIVENESS.**

15 (a) **SHORT TITLE.**—This section may be cited as the
16 “Prostate Research, Outreach, Screening, Testing, Access,
17 and Treatment Effectiveness Act of 2016” or the “PROS-
18 TATE Act”.

19 (b) **FINDINGS.**—Congress makes the following find-
20 ings:

21 (1) Prostate cancer is the second leading cause
22 of cancer death among men.

23 (2) In 2010, more than 217,730 new patients
24 were diagnosed with prostate cancer and more than
25 32,000 men died from this disease.

1 (3) Roughly 2,000,000 Americans are living
2 with a diagnosis of prostate cancer and its con-
3 sequences.

4 (4) While prostate cancer generally affects older
5 individuals, younger men are also at risk for the dis-
6 ease, and when prostate cancer appears in early
7 middle age it frequently takes on a more aggressive
8 form.

9 (5) There are significant racial and ethnic dis-
10 parities that demand attention, namely African-
11 Americans have prostate cancer mortality rates that
12 are more than double those in the White population.

13 (6) Underserved rural populations have higher
14 rates of mortality compared to their urban counter-
15 parts, and innovative and cost-efficient methods to
16 improve rural access to high quality care should take
17 advantage of advances in telehealth to diagnose and
18 treat prostate cancer when appropriate.

19 (7) Certain veterans populations may have
20 nearly twice the incidence of prostate cancer as the
21 general population of the United States.

22 (8) Urologists may constitute the specialists
23 who diagnose and treat the vast majority of prostate
24 cancer patients.

1 (9) Although much basic and translational re-
2 search has been completed and much is currently
3 known, there are still many unanswered questions.
4 For example, it is not fully understood how much of
5 known disparities are attributable to disease eti-
6 ology, access to care, or education and awareness in
7 the community.

8 (10) Causes of prostate cancer are not known.
9 There is not good information regarding how to dif-
10 ferentiate accurately, early on, between aggressive
11 and indolent forms of the disease. As a result, there
12 is significant overtreatment in prostate cancer.
13 There are no treatments that can durably arrest
14 growth or cure prostate cancer once it has metasta-
15 sized.

16 (11) A significant proportion (roughly 23 to 54
17 percent) of cases may be clinically indolent and
18 “overdiagnosed”, resulting in significant overtreat-
19 ment. More accurate tests will allow men and their
20 families to face less physical, psychological, financial,
21 and emotional trauma and billions of dollars could
22 be saved in private and public health care systems
23 in an area that has been identified by the Medicare
24 Program as one of eight high-volume, high-cost
25 areas in the Resource Utilization Report Program

1 authorized by Congress under the Medicare Im-
2 provements for Patients and Providers Act of 2008.

3 (12) Prostate cancer research and health care
4 programs across Federal agencies should be coordi-
5 nated to improve accountability and actively encour-
6 age the translation of research into practice, to iden-
7 tify and implement best practices, in order to foster
8 an integrated and consistent focus on effective pre-
9 vention, diagnosis, and treatment of this disease.

10 (c) PROSTATE CANCER COORDINATION AND EDU-
11 CATION.—

12 (1) INTERAGENCY PROSTATE CANCER COORDI-
13 NATION AND EDUCATION TASK FORCE.—Not later
14 than 180 days after the date of the enactment of
15 this section, the Secretary of Veterans Affairs, in co-
16 operation with the Secretary of Defense and the Sec-
17 retary of Health and Human Services, shall estab-
18 lish an Interagency Prostate Cancer Coordination
19 and Education Task Force (in this section referred
20 to as the “Prostate Cancer Task Force”).

21 (2) DUTIES.—The Prostate Cancer Task Force
22 shall—

23 (A) develop a summary of advances in
24 prostate cancer research supported or con-
25 ducted by Federal agencies relevant to the diag-

1 nosis, prevention, and treatment of prostate
2 cancer, including psychosocial impairments re-
3 lated to prostate cancer treatment, and compile
4 a list of best practices that warrant broader
5 adoption in health care programs;

6 (B) consider establishing, and advocating
7 for, a guidance to enable physicians to allow
8 screening of men who are over age 74, on a
9 case-by-case basis, taking into account quality
10 of life and family history of prostate cancer;

11 (C) share and coordinate information on
12 Federal research and health care program ac-
13 tivities, including activities related to—

14 (i) determining how to improve re-
15 search and health care programs, including
16 psychosocial impairments related to pros-
17 tate cancer treatment;

18 (ii) identifying any gaps in the overall
19 research inventory and in health care pro-
20 grams;

21 (iii) identifying opportunities to pro-
22 mote translation of research into practice;
23 and

24 (iv) maximizing the effects of Federal
25 efforts by identifying opportunities for col-

1 laboration and leveraging of resources in
2 research and health care programs that
3 serve those susceptible to or diagnosed
4 with prostate cancer;

5 (D) develop a comprehensive interagency
6 strategy and advise relevant Federal agencies in
7 the solicitation of proposals for collaborative,
8 multidisciplinary research and health care pro-
9 grams, including proposals to evaluate factors
10 that may be related to the etiology of prostate
11 cancer, that would—

12 (i) result in innovative approaches to
13 study emerging scientific opportunities or
14 eliminate knowledge gaps in research to
15 improve the prostate cancer research port-
16 folio of the Federal Government;

17 (ii) outline key research questions,
18 methodologies, and knowledge gaps; and

19 (iii) ensure consistent action, as out-
20 lined by section 402(b) of the Public
21 Health Service Act;

22 (E) develop a coordinated message related
23 to screening and treatment for prostate cancer
24 to be reflected in educational and beneficiary

1 materials for Federal health programs as such
2 documents are updated; and

3 (F) not later than 2 years after the date
4 of the establishment of the Prostate Cancer
5 Task Force, submit to the Expert Advisory
6 Panel to be reviewed and returned within 30
7 days, and then within 90 days submitted to
8 Congress recommendations—

9 (i) regarding any appropriate changes
10 to research and health care programs, in-
11 cluding recommendations to improve the
12 research portfolio of the Department of
13 Veterans Affairs, Department of Defense,
14 National Institutes of Health, and other
15 Federal agencies to ensure that scientif-
16 ically based strategic planning is imple-
17 mented in support of research and health
18 care program priorities;

19 (ii) designed to ensure that the re-
20 search and health care programs and ac-
21 tivities of the Department of Veterans Af-
22 fairs, the Department of Defense, the De-
23 partment of Health and Human Services,
24 and other Federal agencies are free of un-
25 necessary duplication;

1 (iii) regarding public participation in
2 decisions relating to prostate cancer re-
3 search and health care programs to in-
4 crease the involvement of patient advo-
5 cates, community organizations, and med-
6 ical associations representing a broad geo-
7 graphical area;

8 (iv) on how to best disseminate infor-
9 mation on prostate cancer research and
10 progress achieved by health care programs;

11 (v) about how to expand partnerships
12 between public entities, including Federal
13 agencies, and private entities to encourage
14 collaborative, cross-cutting research and
15 health care delivery;

16 (vi) assessing any cost savings and ef-
17 ficiencies realized through the efforts iden-
18 tified and supported in this section and
19 recommending expansion of those efforts
20 that have proved most promising while also
21 ensuring against any conflicts in directives
22 from other congressional or statutory man-
23 dates or enabling statutes;

1 (vii) identifying key priority action
2 items from among the recommendations;
3 and

4 (viii) with respect to the level of fund-
5 ing needed by each agency to implement
6 the recommendations contained in the re-
7 port.

8 (3) MEMBERS OF THE PROSTATE CANCER TASK
9 FORCE.—The Prostate Cancer Task Force described
10 in subsection (a) shall be composed of representa-
11 tives from such Federal agencies, as each Secretary
12 determines necessary, to coordinate a uniform mes-
13 sage relating to prostate cancer screening and treat-
14 ment where appropriate, including representatives of
15 the following:

16 (A) The Department of Veterans Affairs,
17 including representatives of each relevant pro-
18 gram areas of the Department of Veterans Af-
19 fairs.

20 (B) The Prostate Cancer Research Pro-
21 gram of the Congressionally Directed Medical
22 Research Program of the Department of De-
23 fense.

1 (C) The Department of Health and
2 Human Services, including at a minimum rep-
3 resentatives of the following:

4 (i) The National Institutes of Health.

5 (ii) National research institutes and
6 centers, including the National Cancer In-
7 stitute, the National Institute of Allergy
8 and Infectious Diseases, and the Office of
9 Minority Health.

10 (iii) The Centers for Medicare & Med-
11 icaid Services.

12 (iv) The Food and Drug Administra-
13 tion.

14 (v) The Centers for Disease Control
15 and Prevention.

16 (vi) The Agency for Healthcare Re-
17 search and Quality.

18 (vii) The Health Resources and Serv-
19 ices Administration.

20 (4) APPOINTING EXPERT ADVISORY PANELS.—

21 The Prostate Cancer Task Force shall appoint ex-
22 pert advisory panels, as determined appropriate, to
23 provide input and concurrence from individuals and
24 organizations from the medical, prostate cancer pa-
25 tient and advocate, research, and delivery commu-

1 nities with expertise in prostate cancer diagnosis,
2 treatment, and research, including practicing urolo-
3 gists, primary care providers, and others and indi-
4 viduals with expertise in education and outreach to
5 underserved populations affected by prostate cancer.

6 (5) MEETINGS.—The Prostate Cancer Task
7 Force shall convene not less than twice a year, or
8 more frequently as the Secretary determines to be
9 appropriate.

10 (6) SUBMISSION OF RECOMMENDATIONS TO
11 CONGRESS.—The Secretary of Veterans Affairs shall
12 submit to Congress any recommendations submitted
13 to the Secretary under paragraph (2)(E).

14 (7) FEDERAL ADVISORY COMMITTEE ACT.—

15 (A) IN GENERAL.—Except as provided in
16 subparagraph (B), the Federal Advisory Com-
17 mittee Act (5 U.S.C. App.) shall apply to the
18 Prostate Cancer Task Force.

19 (B) EXCEPTION.—Section 14(a)(2)(B) of
20 such Act (relating to the termination of advi-
21 sory committees) shall not apply to the Prostate
22 Cancer Task Force.

23 (8) SUNSET DATE.—The Prostate Cancer Task
24 Force shall terminate at the end of fiscal year 2021.

25 (d) PROSTATE CANCER RESEARCH.—

1 (1) RESEARCH COORDINATION.—The Secretary
2 of Veterans Affairs, in coordination with the Secre-
3 taries of Defense and of Health and Human Serv-
4 ices, shall establish and carry out a program to co-
5 ordinate and intensify prostate cancer research as
6 needed. Specifically, such research program shall—

7 (A) develop advances in diagnostic and
8 prognostic methods and tests, including bio-
9 markers and an improved prostate cancer
10 screening blood test, including improvements or
11 alternatives to the prostate specific antigen test
12 and additional tests to distinguish indolent from
13 aggressive disease;

14 (B) better understand the etiology of the
15 disease (including an analysis of lifestyle factors
16 proven to be involved in higher rates of prostate
17 cancer, such as obesity and diet, and in dif-
18 ferent ethnic, racial, and socioeconomic groups,
19 such as the African-American, Latino or His-
20 panic, and American Indian populations and
21 men with a family history of prostate cancer) to
22 improve prevention efforts;

23 (C) expand basic research into prostate
24 cancer, including studies of fundamental molec-
25 ular and cellular mechanisms;

1 (D) identify and provide clinical testing of
2 novel agents for the prevention and treatment
3 of prostate cancer;

4 (E) establish clinical registries for prostate
5 cancer;

6 (F) use the National Institute of Bio-
7 medical Imaging and Bioengineering and the
8 National Cancer Institute for assessment of ap-
9 propriate imaging modalities; and

10 (G) address such other matters relating to
11 prostate cancer research as may be identified by
12 the Federal agencies participating in the pro-
13 gram under this section.

14 (2) PROSTATE CANCER ADVISORY BOARD.—

15 There is established in the Office of the Chief Sci-
16 entist of the Food and Drug Administration a Pros-
17 tate Cancer Scientific Advisory Board. Such board
18 shall be responsible for accelerating real-time shar-
19 ing of the latest research data and accelerating
20 movement of new medicines to patients.

21 (3) UNDERSERVED MINORITY GRANT PRO-
22 GRAM.—In carrying out such program, the Secretary
23 shall—

1 (A) award grants to eligible entities to
2 carry out components of the research outlined
3 in paragraph (1);

4 (B) integrate and build upon existing
5 knowledge gained from comparative effective-
6 ness research; and

7 (C) recognize and address—

8 (i) the racial and ethnic disparities in
9 the incidence and mortality rates of pros-
10 tate cancer and men with a family history
11 of prostate cancer;

12 (ii) any barriers in access to care and
13 participation in clinical trials that are spe-
14 cific to racial, ethnic, and other under-
15 served minorities and men with a family
16 history of prostate cancer;

17 (iii) needed outreach and educational
18 efforts to raise awareness in these commu-
19 nities; and

20 (iv) appropriate access and utilization
21 of imaging modalities.

22 (e) TELEHEALTH AND RURAL ACCESS PILOT
23 PROJECT.—

24 (1) IN GENERAL.—The Secretary of Veterans
25 Affairs, the Secretary of Defense, and the Secretary

1 of Health and Human Services (in this section re-
2 ferred to as the “Secretaries”) shall establish 4-year
3 telehealth pilot projects for the purpose of analyzing
4 the clinical outcomes and cost effectiveness associ-
5 ated with telehealth services in a variety of geo-
6 graphic areas that contain high proportions of medi-
7 cally underserved populations, including African-
8 Americans, Latino or Hispanic, American Indians/
9 Alaska Natives, and those in rural areas. Such
10 projects shall promote efficient use of specialist care
11 through better coordination of primary care and
12 physician extender teams in underserved areas and
13 more effectively employ tumor boards to better coun-
14 sel patients.

15 (2) ELIGIBLE ENTITIES.—

16 (A) IN GENERAL.—The Secretaries shall
17 select eligible entities to participate in the pilot
18 projects under this section.

19 (B) PRIORITY.—In selecting eligible enti-
20 ties to participate in the pilot projects under
21 this section, the Secretaries shall give priority
22 to such entities located in medically under-
23 served areas, particularly those that include Af-
24 rican-Americans, Latinos and Hispanics, and
25 facilities of the Indian Health Service, including

1 Indian Health Service operated facilities, trib-
2 ally operated facilities, and Urban Indian Clin-
3 ics, and those in rural areas.

4 (3) EVALUATION.—The Secretaries shall,
5 through the pilot projects, evaluate—

6 (A) the effective and economic delivery of
7 care in diagnosing and treating prostate cancer
8 with the use of telehealth services in medically
9 underserved and tribal areas including collabo-
10 rative uses of health professionals and integra-
11 tion of the range of telehealth and other tech-
12 nologies;

13 (B) the effectiveness of improving the ca-
14 pacity of nonmedical providers and nonspecial-
15 ized medical providers to provide health services
16 for prostate cancer in medically underserved
17 and tribal areas, including the exploration of in-
18 novative medical home models with collabora-
19 tion between urologists, other relevant medical
20 specialists, including oncologists, radiologists,
21 and primary care teams and coordination of
22 care through the efficient use of primary care
23 teams and physician extenders; and

24 (C) the effectiveness of using telehealth
25 services to provide prostate cancer treatment in

1 medically underserved areas, including the use
2 of tumor boards to facilitate better patient
3 counseling.

4 (4) REPORT.—Not later than 12 months after
5 the completion of the pilot projects under this sub-
6 section, the Secretaries shall submit to Congress a
7 report describing the outcomes of such pilot projects,
8 including any cost savings and efficiencies realized,
9 and providing recommendations, if any, for expand-
10 ing the use of telehealth services.

11 (f) EDUCATION AND AWARENESS.—

12 (1) IN GENERAL.—The Secretary of Veterans
13 Affairs shall develop a national education campaign
14 for prostate cancer. Such campaign shall involve the
15 use of written educational materials and public serv-
16 ice announcements consistent with the findings of
17 the Prostate Cancer Task Force under subsection
18 (c), that are intended to encourage men to seek
19 prostate cancer screening when appropriate.

20 (2) RACIAL DISPARITIES AND THE POPULATION
21 OF MEN WITH A FAMILY HISTORY OF PROSTATE
22 CANCER.—In developing the national campaign
23 under paragraph (1), the Secretary shall ensure that
24 such educational materials and public service an-
25 nouncements are more readily available in commu-

1 nities experiencing racial disparities in the incidence
2 and mortality rates of prostate cancer and by men
3 of any race classification with a family history of
4 prostate cancer.

5 (3) GRANTS.—In carrying out the national
6 campaign under this section, the Secretary shall
7 award grants to nonprofit private entities to enable
8 such entities to test alternative outreach and edu-
9 cation strategies.

10 (g) AUTHORIZATION OF APPROPRIATIONS.—

11 (1) IN GENERAL.—There is authorized to be
12 appropriated to carry out this section for the period
13 of fiscal years 2017 through 2021 an amount equal
14 to the savings described in paragraph (2).

15 (2) CORRESPONDING REDUCTION.—The
16 amount authorized to be appropriated by provisions
17 of law other than this section for the period of fiscal
18 years 2017 through 2021 for Federal research and
19 health care program activities related to prostate
20 cancer is reduced by the amount of Federal savings
21 projected to be achieved over such period by imple-
22 mentation of subsection (c)(2)(C) of this section.

1 **SEC. 703. IMPROVED MEDICAID COVERAGE FOR CERTAIN**
2 **BREAST AND CERVICAL CANCER PATIENTS**
3 **IN THE TERRITORIES.**

4 (a) **ELIMINATION OF FUNDING LIMITATIONS.**—

5 (1) **IN GENERAL.**—Section 1108(g)(4) of the
6 Social Security Act (42 U.S.C. 1308(g)(4)) is
7 amended by adding at the end the following: “With
8 respect to fiscal years beginning with fiscal year
9 2017, payment for medical assistance for individuals
10 who are eligible for such assistance only on the basis
11 of section 1902(a)(10)(A)(ii)(XVIII) shall not be
12 taken into account in applying subsection (f) (as in-
13 creased in accordance with paragraphs (1), (2), (3),
14 and (5) of this subsection) to such commonwealth or
15 territory for such fiscal year.”.

16 (2) **TECHNICAL AMENDMENT.**—Such section is
17 further amended by striking “(3), and (4)” and in-
18 serting “(3), and (5)”.

19 (b) **APPLICATION OF ENHANCED FMAP FOR HIGH-**
20 **EST STATE.**—Section 1905(b) of such Act (42 U.S.C.
21 1396d(b)) is amended by adding at the end the following:
22 “Notwithstanding the first sentence of this subsection,
23 with respect to medical assistance described in clause (4)
24 of such sentence that is furnished in Puerto Rico, the
25 United States Virgin Islands, Guam, the Commonwealth
26 of the Northern Mariana Islands, or American Samoa in

1 a fiscal year, the Federal medical assistance percentage
2 is equal to the highest such percentage applied under such
3 clause for such fiscal year for any of the 50 States or the
4 District of Columbia that provides such medical assistance
5 for any portion of such fiscal year.”

6 (c) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to payment for medical assistance
8 for items and services furnished on or after October 1,
9 2016.

10 **SEC. 704. CANCER PREVENTION AND TREATMENT DEM-**
11 **ONSTRATION FOR ETHNIC AND RACIAL MI-**
12 **NORITIES.**

13 (a) DEMONSTRATION.—

14 (1) IN GENERAL.—The Secretary of Health and
15 Human Services (in this section referred to as the
16 “Secretary”) shall conduct demonstration projects
17 (in this section referred to as “demonstration
18 projects”) for the purpose of developing models and
19 evaluating methods that—

20 (A) improve the quality of items and serv-
21 ices provided to target individuals in order to
22 facilitate reduced disparities in early detection
23 and treatment of cancer;

24 (B) improve clinical outcomes, satisfaction,
25 quality of life, appropriate use of items and

1 services covered under the Medicare Program
2 under title XVIII of the Social Security Act (42
3 U.S.C. 1395 et seq.), and referral patterns with
4 respect to target individuals with cancer;

5 (C) eliminate disparities in the rate of pre-
6 ventive cancer screening measures, such as Pap
7 smears, prostate cancer screenings, colon cancer
8 screenings, breast cancer screenings, and com-
9 puted tomography (CT) scans, for lung cancer
10 among target individuals;

11 (D) promote collaboration with community-
12 based organizations to ensure cultural com-
13 petency of health care professionals and lin-
14 guistic access for target individuals who are
15 persons with limited-English proficiency; and

16 (E) encourage the incorporation of commu-
17 nity health workers to increase the efficiency
18 and appropriateness of cancer screening pro-
19 grams.

20 (2) COMMUNITY HEALTH WORKER DEFINED.—

21 In this section, the term “community health worker”
22 includes a community health advocate, a lay health
23 worker, a community health representative, a peer
24 health promotor, a community health outreach work-
25 er, and a promotore de salud, who promotes health

1 or nutrition within the community in which the indi-
2 vidual resides.

3 (3) TARGET INDIVIDUAL DEFINED.—In this
4 section, the term “target individual” means an indi-
5 vidual of a racial and ethnic minority group, as de-
6 fined in section 1707(g)(1) of the Public Health
7 Service Act (42 U.S.C. 300u–6(g)(1)), who is enti-
8 tled to benefits under part A, and enrolled under
9 part B, of title XVIII of the Social Security Act.

10 (b) PROGRAM DESIGN.—

11 (1) INITIAL DESIGN.—Not later than 1 year
12 after the date of the enactment of this Act, the Sec-
13 retary shall evaluate best practices in the private
14 sector, community programs, and academic research
15 of methods that reduce disparities among individuals
16 of racial and ethnic minority groups in the preven-
17 tion and treatment of cancer and shall design the
18 demonstration projects based on such evaluation.

19 (2) NUMBER AND PROJECT AREAS.—Not later
20 than 2 years after the date of the enactment of this
21 Act, the Secretary shall implement at least nine
22 demonstration projects, including the following:

23 (A) Two projects, each of which shall tar-
24 get different ethnic subpopulations, for each of

1 the four following major racial and ethnic mi-
2 nority groups:

3 (i) American Indians and Alaska Na-
4 tives, Eskimos and Aleuts.

5 (ii) Asian-Americans.

6 (iii) Blacks/African-Americans.

7 (iv) Latinos or Hispanics.

8 (v) Native Hawaiians and other Pa-
9 cific Islanders.

10 (B) One project within the Pacific Islands
11 or United States insular areas.

12 (C) At least one project each in a rural
13 area and inner-city area.

14 (3) EXPANSION OF PROJECTS; IMPLEMENTA-
15 TION OF DEMONSTRATION PROJECT RESULTS.—If
16 the initial report under subsection (c) contains an
17 evaluation that demonstration projects—

18 (A) reduce expenditures under the Medi-
19 care Program under title XVIII of the Social
20 Security Act (42 U.S.C. 1395 et seq.); or

21 (B) do not increase expenditures under the
22 Medicare Program and reduce racial and ethnic
23 health disparities in the quality of health care
24 services provided to target individuals and in-

1 crease satisfaction of Medicare beneficiaries and
2 health care providers;
3 the Secretary shall continue the existing demonstra-
4 tion projects and may expand the number of dem-
5 onstration projects.

6 (c) REPORT TO CONGRESS.—

7 (1) IN GENERAL.—Not later than 2 years after
8 the date the Secretary implements the initial dem-
9 onstration projects, and biannually thereafter, the
10 Secretary shall submit to Congress a report regard-
11 ing the demonstration projects.

12 (2) CONTENTS OF REPORT.—Each report under
13 paragraph (1) shall include the following:

14 (A) A description of the demonstration
15 projects.

16 (B) An evaluation of—

17 (i) the cost effectiveness of the dem-
18 onstration projects;

19 (ii) the quality of the health care serv-
20 ices provided to target individuals under
21 the demonstration projects; and

22 (iii) beneficiary and health care pro-
23 vider satisfaction under the demonstration
24 projects.

1 (C) Any other information regarding the
2 demonstration projects that the Secretary de-
3 termines to be appropriate.

4 (d) WAIVER AUTHORITY.—The Secretary shall waive
5 compliance with the requirements of title XVIII of the So-
6 cial Security Act (42 U.S.C. 1395 et seq.) to such extent
7 and for such period as the Secretary determines is nec-
8 essary to conduct demonstration projects.

9 **SEC. 705. REDUCING CANCER DISPARITIES WITHIN MEDI-**
10 **CARE.**

11 (a) DEVELOPMENT OF MEASURES OF DISPARITIES
12 IN QUALITY OF CANCER CARE.—

13 (1) DEVELOPMENT OF MEASURES.—The Sec-
14 retary of Health and Human Services (in this sec-
15 tion referred to as the “Secretary”) shall enter into
16 an agreement with an entity that specializes in de-
17 veloping quality measures for cancer care under
18 which the entity shall develop a uniform set of meas-
19 ures to evaluate disparities in the quality of cancer
20 care and annually update such set of measures.

21 (2) MEASURES TO BE INCLUDED.—Such set of
22 measures shall include, with respect to the treatment
23 of cancer, measures of patient outcomes, the process
24 for delivering medical care related to such treat-
25 ment, patient counseling and engagement in deci-

1 sionmaking, patient experience of care, resource use,
2 and practice capabilities, such as care coordination.

3 (b) ESTABLISHMENT OF REPORTING PROCESS.—

4 (1) IN GENERAL.—The Secretary shall establish
5 a reporting process that requires and provides for a
6 method for health care providers specified under
7 paragraph (2) to submit to the Secretary and make
8 public data on the performance of such providers
9 during each reporting period through use of the
10 measures developed pursuant to subsection (a). Such
11 data shall be submitted in a form and manner and
12 at a time specified by the Secretary.

13 (2) SPECIFICATION OF PROVIDERS TO REPORT
14 ON MEASURES.—The Secretary shall specify the
15 classes of Medicare providers of services and sup-
16 pliers, including hospitals, cancer centers, physi-
17 cians, primary care providers, and specialty pro-
18 viders, that will be required under such process to
19 publicly report on the measures specified under sub-
20 section (a).

21 (3) ASSESSMENT OF CHANGES.—Under such
22 reporting process, the Secretary shall establish a for-
23 mat that assesses changes in both the absolute and
24 relative disparities in cancer care over time. These
25 measures shall be presented in an easily comprehen-

1 sible format, such as those presented in the final
2 publications relating to Healthy People 2010 or the
3 National Healthcare Disparities Report.

4 (4) INITIAL IMPLEMENTATION.—The Secretary
5 shall implement the reporting process under this
6 subsection for reporting periods beginning not later
7 than 6 months after the date that measures are first
8 established under subsection (a).

9 **Subtitle B—Viral Hepatitis and**
10 **Liver Cancer Control and Pre-**
11 **vention**

12 **SEC. 711. VIRAL HEPATITIS AND LIVER CANCER CONTROL**
13 **AND PREVENTION.**

14 (a) SHORT TITLE.—This subtitle may be cited as the
15 “Viral Hepatitis and Liver Cancer Control and Prevention
16 Act of 2016”.

17 (b) FINDINGS.—Congress finds the following:

18 (1) Approximately 5,300,000 Americans are
19 chronically infected with the hepatitis B virus (re-
20 ferred to in this section as “HBV”), the hepatitis C
21 virus (referred to in this section as “HCV”), or
22 both.

23 (2) In the United States, chronic HBV and
24 HCV are the most common cause of liver cancer,
25 one of the most lethal and fastest growing cancers

1 in this country. It is the most common cause of
2 chronic liver disease, liver cirrhosis, and the most
3 common indication for liver transplantation. At least
4 21,000 deaths per year in the United States can be
5 attributed to chronic HBV and HCV. Chronic HCV
6 is also a leading cause of death in Americans living
7 with HIV/AIDS, many of those living with HIV/
8 AIDS are coinfectd with chronic HBV, chronic
9 HCV, or both.

10 (3) According to the Centers for Disease Con-
11 trol and Prevention (referred to in this section as
12 the “CDC”), approximately 2 percent of the popu-
13 lation of the United States is living with chronic
14 HBV, chronic HCV, or both. The CDC has recog-
15 nized HCV as the Nation’s most common chronic
16 bloodborne virus infection and HBV as the deadliest
17 vaccine-preventable disease.

18 (4) HBV is easily transmitted and is 100 times
19 more infectious than HIV. According to the CDC,
20 HBV is transmitted through contact with infectious
21 blood, semen, or other body fluids. HCV is trans-
22 mitted by contact with infectious blood, particularly
23 through percutaneous exposures (i.e. puncture
24 through the skin).

1 (5) The CDC conservatively estimates that in
2 2013 approximately 29,700 Americans were newly
3 infected with HCV and more than 19,800 Americans
4 were newly infected with HBV. These estimates
5 could be much higher due to many reasons, includ-
6 ing lack of screening education and awareness, and
7 perceived marginalization of the populations at risk.

8 (6) In 2012, CDC released new guidelines rec-
9 ommending every person born between 1945 and
10 1965 receive a one-time test. Among the estimated
11 102 million (1.6 million chronically HCV-infected)
12 eligible for screening, birth-cohort screening leads to
13 84,000 fewer cases of decompensated cirrhosis,
14 46,000 fewer cases of hepatocellular carcinoma,
15 10,000 fewer liver transplants, and 78,000 fewer
16 HCV-related deaths gained versus risk-based screen-
17 ing.

18 (7) In 2013, the United States Preventive Serv-
19 ices Task Force (USPSTF) issued a Grade B rating
20 for screening for the hepatitis C virus (HCV) infec-
21 tion in persons at high risk for infection and adults
22 born between 1945 and 1965. In 2014, the
23 USPSTF issued a Grade B for screening for the
24 hepatitis B virus (HBV) in persons at high-risk of
25 hepatitis B infection. In 2009, the USPSTF issued

1 a Grade A for screening pregnant women for the
2 hepatitis B virus (HBV) during their first prenatal
3 visit.

4 (8) There were 44 outbreaks (23 of HBV, 22
5 of HCV) reported to CDC for investigation from
6 2008 through 2014 related to health care acquired
7 infection of HBV and HCV, 42 of which occurred in
8 nonhospital settings. There were more than 101,100
9 patients potentially exposed to one of the viruses.

10 (9) Chronic HBV and chronic HCV usually do
11 not cause symptoms early in the course of the dis-
12 ease, but after many years of a clinically “silent”
13 phase, CDC estimates show more than 33 percent of
14 infected individuals will develop cirrhosis, end-stage
15 liver disease, or liver cancer. Since most individuals
16 with chronic HBV, HCV, or both are unaware of
17 their infection, they do not know to take precautions
18 to prevent the spread of their infection and can un-
19 knowingly exacerbate their own disease progression.

20 (10) HBV and HCV disproportionately affect
21 certain populations in the United States. Although
22 representing only 6 percent of the population, Asian-
23 Americans and Pacific Islanders account for over
24 half of the 1,400,000 domestic chronic HBV cases.
25 Baby boomers (those born between 1945 and 1965)

1 account for approximately 75 percent of domestic
2 chronic hepatitis C cases. In addition, African-Amer-
3 icans, Latinos (Latinas), and American Indian/Na-
4 tive Alaskans are among the groups which have dis-
5 proportionately high rates of HBV and/or HCV in-
6 fections in the United States.

7 (11) For both chronic HBV and chronic HCV,
8 behavioral changes can slow disease progression if
9 diagnosis is made early. Early diagnosis, which is
10 determined through simple blood tests, can reduce
11 the risk of transmission and disease progression
12 through education and vaccination of household
13 members and other susceptible persons at risk.

14 (12) Advancements have led to the development
15 of improved diagnostic tests for viral hepatitis.
16 These tests, including rapid, point of care testing
17 and others in development, can facilitate testing, no-
18 tification of results and post-test counseling, and re-
19 ferral to care at the time of the testing visit. In par-
20 ticular, these tests are also advantageous because
21 they can be used simultaneously with HIV rapid
22 testing for persons at risk for both HCV and HIV
23 infections.

24 (13) For those chronically infected with HBV
25 or HCV, regular monitoring can lead to the early de-

1 tection of liver cancer at a stage where a cure is still
2 possible. Liver cancer is the second deadliest cancer
3 in the United States; however, liver cancer has re-
4 ceived little funding for research, prevention, or
5 treatment.

6 (14) Treatment for chronic HCV can eradicate
7 the disease in approximately 90 percent of those cur-
8 rently treated. The treatment of chronic HBV can
9 effectively suppress viral replication in the over-
10 whelming majority (over 80 percent) of those treat-
11 ed, thereby reducing the risk of transmission and
12 progression to liver scarring or liver cancer, even
13 though a complete cure is much less common than
14 for HCV.

15 (15) To combat the viral hepatitis epidemic in
16 the United States, in May 2011, the Department of
17 Health and Human Services released “Combating
18 the Silent Epidemic of Viral Hepatitis: Action Plan
19 for the Prevention, Care & Treatment of Viral Hepa-
20 titis” (hereafter referred to as the HHS Action
21 Plan). The Institute of Medicine (IOM) of the Na-
22 tional Academies produced a 2010 report on the
23 Federal response to HBV and HCV titled: “Hepa-
24 titis and Liver Cancer: A National Strategy for Pre-
25 vention and Control of Hepatitis B and C”. These

1 recommendations and guidelines provide a frame-
2 work for HBV and HCV prevention, education, con-
3 trol, research, and medical management programs.

4 (16) The annual health care costs attributable
5 to HBV and HCV in the United States are signifi-
6 cant. For HBV, it is estimated to be approximately
7 \$2,500,000,000 (\$2,000 per infected person). In
8 2000, the lifetime cost of HBV—before the avail-
9 ability of most current therapies—was approximately
10 \$80,000 per chronically infected person, totaling
11 more than \$100,000,000,000. For HCV, medical
12 costs for patients are expected to increase from
13 \$30,000,000,000 in 2009 to over \$85,000,000,000
14 in 2024. Avoiding these costs by screening and diag-
15 nosing individuals earlier—and connecting them to
16 appropriate treatment and care, will save lives and
17 critical health care dollars. Currently, without a
18 comprehensive screening, testing, and diagnosis pro-
19 gram, most patients are diagnosed too late when
20 they need a liver transplant costing at least
21 \$314,000 for uncomplicated cases or when they have
22 liver cancer or end stage liver disease which costs
23 \$30,980 to \$110,576 per hospital admission. As
24 health care costs continue to grow, it is critical that

1 the Federal Government invests in effective mecha-
2 nisms to avoid documented cost drivers.

3 (17) According to the IOM report in 2010 (de-
4 scribed in paragraph (15)), chronic HBV and HCV
5 infections cause substantial morbidity and mortality
6 despite being preventable and treatable. Deficiencies
7 in the implementation of established guidelines for
8 the prevention, diagnosis, and medical management
9 of chronic HBV and HCV infections perpetuate per-
10 sonal and economic burdens. Existing grants are not
11 sufficient for the scale of the health burden pre-
12 sented by HBV and HCV.

13 (18) Screening and testing for HBV and HCV
14 is aligned with the Healthy People 2020 goal to in-
15 crease immunization rates and reduce preventable
16 infectious diseases. Awareness of disease and access
17 to prevention and treatment remain essential compo-
18 nents for reducing infectious disease transmission.

19 (19) Federal support is necessary to increase
20 knowledge and awareness of HBV and HCV and to
21 assist State and local prevention and control efforts
22 in reducing the morbidity and mortality of these
23 epidemics.

24 (20) The Secretary of Health and Human Serv-
25 ices has the discretion to carry out this Act directly

1 and through whichever of the agencies of the Public
2 Health Service the Secretary determines to be ap-
3 propriate, which may (in the Secretary's discretion)
4 include the Centers for Disease Control and Preven-
5 tion, the Health Resources and Services Administra-
6 tion, the Substance Abuse and Mental Health Serv-
7 ices Administration, the National Institutes of
8 Health (including the National Institute on Minority
9 Health and Health Disparities), and other agencies
10 of such Service.

11 (21) The Centers for Disease Control and Pre-
12 vention reported a 151 percent increase in hepatitis
13 C cases from 2010–2013, stemming from the opioid,
14 heroin, and overdose epidemics affecting commu-
15 nities nationwide.

16 (c) BIENNIAL ASSESSMENT OF HHS HEPATITIS B
17 AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH,
18 AND MEDICAL MANAGEMENT PLAN.—Title III of the
19 Public Health Service Act (42 U.S.C. 241 et seq.) is
20 amended—

21 (1) by striking section 317N (42 U.S.C. 247b–
22 15); and

23 (2) by adding at the end the following:

1 **“PART W—BIENNIAL ASSESSMENT OF HHS HEPA-**
2 **TITIS B AND HEPATITIS C PREVENTION, EDU-**
3 **CATION, RESEARCH, AND MEDICAL MANAGE-**
4 **MENT PLAN**

5 **“SEC. 399NN. BIENNIAL UPDATE OF THE PLAN.**

6 “(a) IN GENERAL.—The Secretary shall conduct a bi-
7 ennial assessment of the Secretary’s plan for the preven-
8 tion, control, and medical management of, and education
9 and research relating to, hepatitis B and hepatitis C, for
10 the purposes of—

11 “(1) incorporating into such plan new knowl-
12 edge or observations relating to hepatitis B and hep-
13 atitis C (such as knowledge and observations that
14 may be derived from clinical, laboratory, and epide-
15 miological research and disease detection, preven-
16 tion, and surveillance outcomes);

17 “(2) addressing gaps in the coverage or effec-
18 tiveness of the plan; and

19 “(3) evaluating and, if appropriate, updating
20 recommendations, guidelines, or educational mate-
21 rials of the Centers for Disease Control and Preven-
22 tion or the National Institutes of Health for health
23 care providers or the public on viral hepatitis in
24 order to be consistent with the plan.

25 “(b) PUBLICATION OF NOTICE OF ASSESSMENTS.—
26 Not later than October 1 of the first even-numbered year

1 beginning after the date of the enactment of this part,
2 and October 1 of each even-numbered year thereafter, the
3 Secretary shall publish in the Federal Register a notice
4 of the results of the assessments conducted under para-
5 graph (1). Such notice shall include—

6 “(1) a description of any revisions to the plan
7 referred to in subsection (a) as a result of the as-
8 sessment;

9 “(2) an explanation of the basis for any such
10 revisions, including the ways in which such revisions
11 can reasonably be expected to further promote the
12 original goals and objectives of the plan; and

13 “(3) in the case of a determination by the Sec-
14 retary that the plan does not need revision, an expla-
15 nation of the basis for such determination.

16 **“SEC. 399NN-1. ELEMENTS OF PROGRAM.**

17 “(a) EDUCATION AND AWARENESS PROGRAMS.—The
18 Secretary, acting through the Director of the Centers for
19 Disease Control and Prevention, the Administrator of the
20 Health Resources and Services Administration, and the
21 Administrator of the Substance Abuse and Mental Health
22 Services Administration, and in accordance with the plan
23 referred to in section 399NN(a), shall implement pro-
24 grams to increase awareness and enhance knowledge and

1 understanding of hepatitis B and hepatitis C. Such pro-
2 grams shall include—

3 “(1) the conduct of culturally and language ap-
4 propriate health education in primary and secondary
5 schools, college campuses, public awareness cam-
6 paigns, and community outreach activities (especially
7 to the ethnic communities with high rates of chronic
8 hepatitis B and chronic hepatitis C and other high-
9 risk groups) to promote public awareness and knowl-
10 edge about the value of hepatitis A and hepatitis B
11 immunization, risk factors, the transmission and
12 prevention of hepatitis B and hepatitis C, the value
13 of screening for the early detection of hepatitis B
14 and hepatitis C, and options available for the treat-
15 ment of chronic hepatitis B and chronic hepatitis C;

16 “(2) the promotion of immunization programs
17 that increase awareness and access to hepatitis A
18 and hepatitis B vaccines for susceptible adults and
19 children;

20 “(3) the training of health care professionals
21 regarding the importance of vaccinating individuals
22 infected with hepatitis C and individuals who are at
23 risk for hepatitis C infection against hepatitis A and
24 hepatitis B;

1 “(4) the training of health care professionals
2 regarding the importance of vaccinating individuals
3 chronically infected with hepatitis B and individuals
4 who are at risk for chronic hepatitis B infection
5 against the hepatitis A virus;

6 “(5) the training of health care professionals
7 and health educators to make them aware of the
8 high rates of chronic hepatitis B and chronic hepa-
9 titis C in certain adult ethnic populations, and the
10 importance of prevention, detection, and medical
11 management of hepatitis B and hepatitis C and of
12 liver cancer screening;

13 “(6) the development and distribution of health
14 education curricula (including information relating
15 to the special needs of individuals infected with hep-
16 atitis B and hepatitis C, such as the importance of
17 prevention and early intervention, regular moni-
18 toring, the recognition of psychosocial needs, appro-
19 priate treatment, and liver cancer screening) for in-
20 dividuals providing hepatitis B and hepatitis C coun-
21 seling; and

22 “(7) support for the implementation curricula
23 described in paragraph (6) by State and local public
24 health agencies.

1 “(b) IMMUNIZATION, PREVENTION, AND CONTROL
2 PROGRAMS.—

3 “(1) IN GENERAL.—The Secretary, acting
4 through the Director of the Centers for Disease
5 Control and Prevention, shall support the integra-
6 tion of activities described in paragraph (3) into ex-
7 isting clinical and public health programs at State,
8 local, territorial, and tribal levels (including commu-
9 nity health clinics, programs for the prevention and
10 treatment of HIV/AIDS, sexually transmitted infec-
11 tions, and substance abuse, and programs for indi-
12 viduals in correctional settings).

13 “(2) COORDINATION OF DEVELOPMENT OF
14 FEDERAL SCREENING GUIDELINES.—

15 “(A) REFERENCES.—For purposes of this
16 subsection, the term ‘CDC Director’ means the
17 Director of the Centers for Disease Control and
18 Prevention, and the term ‘AHRQ Director’
19 means the Director of the Agency for
20 Healthcare Research and Quality.

21 “(B) AGENCY FOR HEALTHCARE RE-
22 SEARCH AND QUALITY.—Due to the rapidly
23 evolving standard of care associated with diag-
24 nosing and treating viral hepatitis infection, the
25 AHRQ Director shall convene the Preventive

1 Services Task Force under section 915(a) of
2 the Public Health Service Act to review its rec-
3 ommendation for screening for HBV and HCV
4 infection every 3 years.

5 “(3) ACTIVITIES.—

6 “(A) VOLUNTARY TESTING PROGRAMS.—

7 “(i) IN GENERAL.—The Secretary
8 shall establish a mechanism by which to
9 support and promote the development of
10 State, local, territorial, and tribal vol-
11 untary hepatitis B and hepatitis C testing
12 programs to screen the high-prevalence
13 populations to aid in the early identifica-
14 tion of chronically infected individuals.

15 “(ii) CONFIDENTIALITY OF THE TEST
16 RESULTS.—The Secretary shall prohibit
17 the use of the results of a hepatitis B or
18 hepatitis C test conducted by a testing pro-
19 gram developed or supported under this
20 subparagraph for any of the following:

21 “(I) Issues relating to health in-
22 surance.

23 “(II) To screen or determine
24 suitability for employment.

1 “(III) To discharge a person
2 from employment.

3 “(B) COUNSELING REGARDING VIRAL HEP-
4 ATITIS.—The Secretary shall support State,
5 local, territorial, and tribal programs in a wide
6 variety of settings, including those providing
7 primary and specialty health care services in
8 nonprofit private and public sectors, to—

9 “(i) provide individuals with ongoing
10 risk factors for hepatitis B and hepatitis C
11 infection with client-centered education
12 and counseling which concentrates on—

13 “(I) promoting testing of individ-
14 uals that have been exposed to their
15 blood, family members, and their sex-
16 ual partners; and

17 “(II) changing behaviors that
18 place individuals at risk for infection;

19 “(ii) provide individuals chronically in-
20 fected with hepatitis B or hepatitis C with
21 education, health information, and coun-
22 seling to reduce their risk of—

23 “(I) dying from end-stage liver
24 disease and liver cancer; and

1 “(II) transmitting viral hepatitis
2 to others; and

3 “(iii) provide women chronically in-
4 fected with hepatitis B or hepatitis C who
5 are pregnant or of childbearing age with
6 culturally and linguistically appropriate
7 health information, such as how to prevent
8 hepatitis B perinatal infection, and to al-
9 leviate fears associated with pregnancy or
10 raising a family.

11 “(C) IMMUNIZATION.—The Secretary shall
12 support State, local, territorial, and tribal ef-
13 forts to expand the current vaccination pro-
14 grams to protect every child in the country and
15 all susceptible adults, particularly those infected
16 with hepatitis C and high-prevalence ethnic
17 populations and other high-risk groups, from
18 the risks of acute and chronic hepatitis B infec-
19 tion by—

20 “(i) ensuring continued funding for
21 hepatitis B vaccination for all children 19
22 years of age or younger through the Vac-
23 cines for Children Program;

24 “(ii) ensuring that the recommenda-
25 tions of the Advisory Committee on Immu-

1 nization Practices are followed regarding
2 the birth dose of hepatitis B vaccinations
3 for newborns;

4 “(iii) requiring proof of hepatitis B
5 vaccination for entry into public or private
6 daycare, preschool, elementary school, sec-
7 ondary school, and institutions of higher
8 education;

9 “(iv) expanding the availability of
10 hepatitis B vaccination for all susceptible
11 adults to protect them from becoming
12 acutely or chronically infected, including
13 ethnic and other populations with high
14 prevalence rates of chronic hepatitis B in-
15 fection;

16 “(v) expanding the availability of hep-
17 atitis B vaccination for all susceptible
18 adults, particularly those in their reproduc-
19 tive age (women and men less than 45
20 years of age), to protect them from the
21 risk of hepatitis B infection;

22 “(vi) ensuring the vaccination of indi-
23 viduals infected, or at risk for infection,
24 with hepatitis C against hepatitis A, hepa-
25 titis B, and other infectious diseases, as

1 appropriate, for which such individuals
2 may be at increased risk; and

3 “(vii) ensuring the vaccination of indi-
4 viduals infected, or at risk for infection,
5 with hepatitis B against hepatitis A virus
6 and other infectious diseases, as appro-
7 priate, for which such individuals may be
8 at increased risk.

9 “(D) MEDICAL REFERRAL.—The Secretary
10 shall support State, local, territorial, and tribal
11 programs that support—

12 “(i) referral of persons chronically in-
13 fected with hepatitis B or hepatitis C—

14 “(I) for medical evaluation to de-
15 termine the appropriateness for
16 antiviral treatment to reduce the risk
17 of progression to cirrhosis and liver
18 cancer; and

19 “(II) for ongoing medical man-
20 agement including regular monitoring
21 of liver function and screening for
22 liver cancer; and

23 “(ii) referral of persons infected with
24 acute or chronic hepatitis B infection or
25 acute or chronic hepatitis C infection for

1 drug and alcohol abuse treatment where
2 appropriate.

3 “(4) INCREASED SUPPORT FOR ADULT VIRAL
4 HEPATITIS PREVENTION COORDINATORS.—The Sec-
5 retary, acting through the Director of the Centers
6 for Disease Control and Prevention, shall provide in-
7 creased support to adult viral hepatitis prevention
8 coordinators in State, local, territorial, and tribal
9 health departments in order to enhance the addi-
10 tional management, networking, and technical exper-
11 tise needed to ensure successful integration of hepa-
12 titis B and hepatitis C prevention and control activi-
13 ties into existing public health programs.

14 “(c) EPIDEMIOLOGICAL SURVEILLANCE.—

15 “(1) IN GENERAL.—The Secretary, acting
16 through the Director of the Centers for Disease
17 Control and Prevention, shall support the establish-
18 ment and maintenance of a national chronic and
19 acute hepatitis B and hepatitis C surveillance pro-
20 gram, in order to identify—

21 “(A) trends in the incidence of acute and
22 chronic hepatitis B and acute and chronic hepa-
23 titis C;

24 “(B) trends in the prevalence of acute and
25 chronic hepatitis B and acute and chronic hepa-

1 titis C infection among groups that may be dis-
2 proportionately affected; and

3 “(C) trends in liver cancer and end-stage
4 liver disease incidence and deaths, caused by
5 chronic hepatitis B and chronic hepatitis C in
6 the high-risk ethnic populations.

7 “(2) SEROPREVALENCE AND LIVER CANCER
8 STUDIES.—The Secretary, acting through the Direc-
9 tor of the Centers for Disease Control and Preven-
10 tion, shall prepare a report outlining the population-
11 based seroprevalence studies currently underway, fu-
12 ture planned studies, the criteria involved in deter-
13 mining which seroprevalence studies to conduct,
14 defer, or suspend, and the scope of those studies, the
15 economic and clinical impact of hepatitis B and hep-
16 atitis C, and the impact of chronic hepatitis B and
17 chronic hepatitis C infections on the quality of life.
18 Not later than one year after the date of the enact-
19 ment of this part, the Secretary shall submit the re-
20 port to the Committee on Energy and Commerce of
21 the House of Representatives and the Committee on
22 Health, Education, Labor, and Pensions of the Sen-
23 ate.

24 “(3) CONFIDENTIALITY.—The Secretary shall
25 not disclose any individually identifiable information

1 identified under paragraph (1) or derived through
2 studies under paragraph (2).

3 “(d) RESEARCH.—The Secretary, acting through the
4 Director of the Centers for Disease Control and Preven-
5 tion, the Director of the National Cancer Institute, and
6 the Director of the National Institutes of Health, shall—

7 “(1) conduct epidemiologic and community-
8 based research to develop, implement, and evaluate
9 best practices for hepatitis B and hepatitis C pre-
10 vention especially in the ethnic populations with high
11 rates of chronic hepatitis B and chronic hepatitis C
12 and other high-risk groups;

13 “(2) conduct research on hepatitis B and hepa-
14 titis C natural history, pathophysiology, improved
15 treatments and prevention (such as the hepatitis C
16 vaccine), and noninvasive tests that help to predict
17 the risk of progression to liver cirrhosis and liver
18 cancer;

19 “(3) conduct research that will lead to better
20 noninvasive or blood tests to screen for liver cancer,
21 and more effective treatments of liver cancer caused
22 by chronic hepatitis B and chronic hepatitis C; and

23 “(4) conduct research comparing the effective-
24 ness of screening, diagnostic, management, and
25 treatment approaches for chronic hepatitis B, chron-

1 ic hepatitis C, and liver cancer in the affected com-
2 munities.

3 “(e) **UNDERSERVED AND DISPROPORTIONATELY AF-**
4 **FECTED POPULATIONS.**—In carrying out this section, the
5 Secretary shall provide expanded support for individuals
6 with limited access to health education, testing, and health
7 care services and groups that may be disproportionately
8 affected by hepatitis B and hepatitis C.

9 “(f) **EVALUATION OF PROGRAM.**—The Secretary
10 shall develop benchmarks for evaluating the effectiveness
11 of the programs and activities conducted under this sec-
12 tion and make determinations as to whether such bench-
13 marks have been achieved.

14 **“SEC. 399NN-2. GRANTS.**

15 “(a) **IN GENERAL.**—The Secretary may award grants
16 to, or enter into contracts or cooperative agreements with,
17 States, political subdivisions of States, territories, Indian
18 tribes, or nonprofit entities that have special expertise re-
19 lating to hepatitis B, hepatitis C, or both, to carry out
20 activities under this part.

21 “(b) **APPLICATION.**—To be eligible for a grant, con-
22 tract, or cooperative agreement under subsection (a), an
23 entity shall prepare and submit to the Secretary an appli-
24 cation at such time, in such manner, and containing such
25 information as the Secretary may require.

1 **“SEC. 399NN-3. AUTHORIZATION OF APPROPRIATIONS.**

2 “There are authorized to be appropriated to carry out
3 this part \$90,000,000 for fiscal year 2017, \$90,000,000
4 for fiscal year 2018, \$110,000,000 for fiscal year 2019,
5 \$130,000,000 for fiscal year 2020, and \$150,000,000 for
6 fiscal year 2021.”.

7 (d) ENHANCING SAMHSA’S ROLE IN HEPATITIS AC-
8 TIVITIES.—Paragraph (6) of section 501(d) of the Public
9 Health Service Act (42 U.S.C. 290aa(d)) is amended by
10 striking “HIV or tuberculosis” and inserting “HIV, tuber-
11 culosis, or hepatitis”.

12 **Subtitle C—Acquired Bone Marrow**
13 **Failure Diseases**

14 **SEC. 721. ACQUIRED BONE MARROW FAILURE DISEASES.**

15 (a) SHORT TITLE.—This subtitle may be cited as the
16 “Bone Marrow Failure Disease Research and Treatment
17 Act of 2016”.

18 (b) FINDINGS.—The Congress finds the following:

19 (1) Between 20,000 and 30,000 Americans are
20 diagnosed each year with myelodysplastic syndromes,
21 aplastic anemia, paroxysmal nocturnal hemo-
22 globinuria, and other acquired bone marrow failure
23 diseases.

24 (2) Acquired bone marrow failure diseases have
25 a debilitating and often fatal impact on those diag-
26 nosed with these diseases.

1 (3) While some treatments for acquired bone
2 marrow failure diseases can prolong and improve the
3 quality of patients' lives, there is no single cure for
4 these diseases.

5 (4) The prevalence of acquired bone marrow
6 failure diseases in the United States will continue to
7 grow as the general public ages.

8 (5) Evidence exists suggesting that acquired
9 bone marrow failure diseases occur more often in
10 minority populations, particularly in Asian-American
11 and Latino or Hispanic populations.

12 (6) The National Heart, Lung, and Blood Insti-
13 tute and the National Cancer Institute have con-
14 ducted important research into the causes of and
15 treatments for acquired bone marrow failure dis-
16 eases.

17 (7) The National Marrow Donor Program Reg-
18 istry has made significant contributions to the fight
19 against bone marrow failure diseases by connecting
20 millions of potential marrow donors with individuals
21 and families suffering from these conditions.

22 (8) Despite these advances, a more comprehen-
23 sive Federal strategic effort among numerous Fed-
24 eral agencies is needed to discover a cure for ac-
25 quired bone marrow failure disorders.

1 (9) Greater Federal surveillance of acquired
2 bone marrow failure diseases is needed to gain a bet-
3 ter understanding of the causes of acquired bone
4 marrow failure diseases.

5 (10) The Federal Government should increase
6 its research support for and engage with public and
7 private organizations in developing a comprehensive
8 approach to combat and cure acquired bone marrow
9 failure diseases.

10 (c) NATIONAL ACQUIRED BONE MARROW FAILURE
11 DISEASE REGISTRY.—Part B of the Public Health Service
12 Act (42 U.S.C. 311 et seq.) is amended by inserting after
13 section 317W, as added, the following:

14 **“SEC. 317X. NATIONAL ACQUIRED BONE MARROW FAILURE**
15 **DISEASE REGISTRY.**

16 “(a) ESTABLISHMENT OF REGISTRY.—

17 “(1) IN GENERAL.—Not later than 6 months
18 after the date of the enactment of this section, the
19 Secretary, acting through the Director of the Cen-
20 ters for Disease Control and Prevention, shall—

21 “(A) develop a system to collect data on
22 acquired bone marrow failure diseases; and

23 “(B) establish and maintain a national and
24 publicly available registry, to be known as the
25 National Acquired Bone Marrow Failure Dis-

1 ease Registry, in accordance with paragraph
2 (3).

3 “(2) RECOMMENDATIONS OF ADVISORY COM-
4 MITTEE.—In carrying out this subsection, the Sec-
5 retary shall take into consideration the recommenda-
6 tions of the Advisory Committee on Acquired Bone
7 Marrow Failure Diseases established under sub-
8 section (b).

9 “(3) PURPOSES OF REGISTRY.—The National
10 Acquired Bone Marrow Failure Disease Registry—

11 “(A) shall identify the incidence and preva-
12 lence of acquired bone marrow failure diseases
13 in the United States;

14 “(B) shall be used to collect and store data
15 on acquired bone marrow failure diseases, in-
16 cluding data concerning—

17 “(i) the age, race or ethnicity, general
18 geographic location, sex, and family history
19 of individuals who are diagnosed with ac-
20 quired bone marrow failure diseases, and
21 any other characteristics of such individ-
22 uals determined appropriate by the Sec-
23 retary;

24 “(ii) the genetic and environmental
25 factors that may be associated with devel-

1 oping acquired bone marrow failure dis-
2 eases;

3 “(iii) treatment approaches for deal-
4 ing with acquired bone marrow failure dis-
5 eases;

6 “(iv) outcomes for individuals treated
7 for acquired bone marrow failure diseases,
8 including outcomes for recipients of stem
9 cell therapeutic products as contained in
10 the database established pursuant to sec-
11 tion 379A; and

12 “(v) any other factors pertaining to
13 acquired bone marrow failure diseases de-
14 termined appropriate by the Secretary; and

15 “(C) shall be made available—

16 “(i) to the general public; and

17 “(ii) to researchers to facilitate fur-
18 ther research into the causes of, and treat-
19 ments for, acquired bone marrow failure
20 diseases in accordance with standard prac-
21 tices of the Centers for Disease Control
22 and Preventions.

23 “(b) ADVISORY COMMITTEE.—

24 “(1) ESTABLISHMENT.—Not later than 6
25 months after the date of the enactment of this sec-

1 tion, the Secretary, acting through the Director of
2 the Centers for Disease Control and Prevention,
3 shall establish an advisory committee, to be known
4 as the Advisory Committee on Acquired Bone Mar-
5 row Failure Diseases.

6 “(2) MEMBERS.—The members of the Advisory
7 Committee on Acquired Bone Marrow Failure Dis-
8 eases shall be appointed by the Secretary, acting
9 through the Director of the Centers for Disease
10 Control and Prevention, and shall include at least
11 one representative from each of the following:

12 “(A) A national patient advocacy organiza-
13 tion with experience advocating on behalf of pa-
14 tients suffering from acquired bone marrow
15 failure diseases.

16 “(B) The National Institutes of Health, in-
17 cluding at least one representative from each
18 of—

19 “(i) the National Cancer Institute;

20 “(ii) the National Heart, Lung, and
21 Blood Institute; and

22 “(iii) the Office of Rare Diseases.

23 “(C) The Centers for Disease Control and
24 Prevention.

25 “(D) Clinicians with experience in—

1 “(i) diagnosing or treating acquired
2 bone marrow failure diseases; and

3 “(ii) medical data registries.

4 “(E) Epidemiologists who have experience
5 with data registries.

6 “(F) Publicly or privately funded research-
7 ers who have experience researching acquired
8 bone marrow failure diseases.

9 “(G) The entity operating the C.W. Bill
10 Young Cell Transplantation Program estab-
11 lished pursuant to section 379 and the entity
12 operating the C.W. Bill Young Cell Transplan-
13 tation Program Outcomes Database.

14 “(3) RESPONSIBILITIES.—The Advisory Com-
15 mittee on Acquired Bone Marrow Failure Diseases
16 shall provide recommendations to the Secretary on
17 the establishment and maintenance of the National
18 Acquired Bone Marrow Failure Disease Registry, in-
19 cluding recommendations on the collection, mainte-
20 nance, and dissemination of data.

21 “(4) PUBLIC AVAILABILITY.—The Secretary
22 shall make the recommendations of the Advisory
23 Committee on Acquired Bone Marrow Failure Dis-
24 ease publicly available.

1 “(c) GRANTS.—The Secretary, acting through the
2 Director of the Centers for Disease Control and Preven-
3 tion, may award grants to, and enter into contracts and
4 cooperative agreements with, public or private nonprofit
5 entities for the management of, as well as the collection,
6 analysis, and reporting of data to be included in, the Na-
7 tional Acquired Bone Marrow Failure Disease Registry.

8 “(d) DEFINITION.—In this section, the term ‘ac-
9 quired bone marrow failure disease’ means—

10 “(1) myelodysplastic syndromes (MDS);

11 “(2) aplastic anemia;

12 “(3) paroxysmal nocturnal hemoglobinuria
13 (PNH);

14 “(4) pure red cell aplasia;

15 “(5) acute myeloid leukemia that has pro-
16 gressed from myelodysplastic syndromes; or

17 “(6) large granular lymphocytic leukemia.

18 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
19 is authorized to be appropriated to carry out this section
20 \$3,000,000 for each of fiscal years 2017 through 2021.”.

21 (d) PILOT STUDIES THROUGH THE AGENCY FOR
22 TOXIC SUBSTANCES AND DISEASE REGISTRY.—

23 (1) PILOT STUDIES.—The Secretary of Health
24 and Human Services, acting through the Adminis-
25 trator of the Agency for Toxic Substances and Dis-

1 ease Registry, shall conduct pilot studies to deter-
2 mine which environmental factors, including expo-
3 sure to toxins, may cause acquired bone marrow fail-
4 ure diseases.

5 (2) COLLABORATION WITH THE RADIATION IN-
6 JURY TREATMENT NETWORK.—In carrying out the
7 directives of this section, the Secretary may collabo-
8 rate with the Radiation Injury Treatment Network
9 of the C.W. Bill Young Cell Transplantation Pro-
10 gram established pursuant to section 379 of the
11 Public Health Service Act (42 U.S.C. 274j) to—

12 (A) augment data for the pilot studies au-
13 thorized by this section;

14 (B) access technical assistance that may be
15 provided by the Radiation Injury Treatment
16 Network; or

17 (C) perform joint research projects.

18 (3) AUTHORIZATION OF APPROPRIATIONS.—
19 There is authorized to be appropriated to carry out
20 this section \$1,000,000 for each of fiscal years 2017
21 through 2021.

22 (e) MINORITY-FOCUSED PROGRAMS ON ACQUIRED
23 BONE MARROW FAILURE DISEASES.—Title XVII of the
24 Public Health Service Act (42 U.S.C. 300u et seq.) is
25 amended by inserting after section 1707A the following:

1 “MINORITY-FOCUSED PROGRAMS ON ACQUIRED BONE
2 MARROW FAILURE DISEASES

3 “SEC. 1707B. (a) INFORMATION AND REFERRAL
4 SERVICES.—

5 “(1) IN GENERAL.—Not later than 6 months
6 after the date of the enactment of this section, the
7 Secretary, acting through the Deputy Assistant Sec-
8 retary for Minority Health, shall establish and co-
9 ordinate outreach and informational programs tar-
10 geted to minority populations affected by acquired
11 bone marrow failure diseases.

12 “(2) PROGRAM REQUIREMENTS.—Minority-fo-
13 cused outreach and informational programs author-
14 ized by this section—

15 “(A) shall make information about treat-
16 ment options and clinical trials for acquired
17 bone marrow failure diseases publicly available,
18 and

19 “(B) shall provide referral services for
20 treatment options and clinical trials,
21 at the National Minority Health Resource Center
22 supported under section 1707(b)(8) (including by
23 means of the Center’s Web site, through appropriate
24 locations such as the Center’s knowledge center, and
25 through appropriate programs such as the Center’s

1 resource persons network) and through minority
2 health consultants located at each Department of
3 Health and Human Services regional office.

4 “(b) HISPANIC AND ASIAN-AMERICAN AND PACIFIC
5 ISLANDER OUTREACH.—

6 “(1) IN GENERAL.—The Secretary, acting
7 through the Deputy Assistant Secretary for Minority
8 Health, shall undertake a coordinated outreach ef-
9 fort to connect Hispanic, Asian-American, and Pa-
10 cific Islander communities with comprehensive serv-
11 ices focused on treatment of, and information about,
12 acquired bone marrow failure diseases.

13 “(2) COLLABORATION.—In carrying out this
14 subsection, the Secretary may collaborate with public
15 health agencies, nonprofit organizations, community
16 groups, and online entities to disseminate informa-
17 tion about treatment options and clinical trials for
18 acquired bone marrow failure diseases.

19 “(c) GRANTS AND COOPERATIVE AGREEMENTS.—

20 “(1) IN GENERAL.—Not later than 6 months
21 after the date of the enactment of this section, the
22 Secretary, acting through the Deputy Assistant Sec-
23 retary for Minority Health, shall award grants to, or
24 enter into cooperative agreements with, entities to

1 perform research on acquired bone marrow failure
2 diseases.

3 “(2) REQUIREMENT.—Grants and cooperative
4 agreements authorized by this subsection shall be
5 awarded or entered into on a competitive, peer-re-
6 viewed basis.

7 “(3) SCOPE OF RESEARCH.—Research funded
8 under this section shall examine factors affecting the
9 incidence of acquired bone marrow failure diseases
10 in minority populations.

11 “(d) DEFINITION.—In this section, the term ‘ac-
12 quired bone marrow failure disease’ has the meaning given
13 to such term in section 317X(d).

14 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
15 is authorized to be appropriated to carry out this section
16 \$2,000,000 for each of fiscal years 2017 through 2021.”.

17 (f) DIAGNOSIS AND QUALITY OF CARE FOR AC-
18 QUIRED BONE MARROW FAILURE DISEASES.—

19 (1) GRANTS.—The Secretary of Health and
20 Human Services, acting through the Director of the
21 Agency for Healthcare Research and Quality, shall
22 award grants to entities to improve diagnostic prac-
23 tices and quality of care with respect to patients
24 with acquired bone marrow failure diseases.

1 (2) AUTHORIZATION OF APPROPRIATIONS.—

2 There is authorized to be appropriated to carry out
3 this section \$2,000,000 for each of fiscal years 2017
4 through 2021.

5 (g) DEFINITION.—In this section, the term “acquired
6 bone marrow failure disease” means—

7 (1) myelodysplastic syndromes (MDS);

8 (2) aplastic anemia;

9 (3) paroxysmal nocturnal hemoglobinuria
10 (PNH);

11 (4) pure red cell aplasia;

12 (5) acute myeloid leukemia that progressed
13 from myelodysplastic syndromes; or

14 (6) large granular lymphocytic leukemia.

15 **Subtitle D—Cardiovascular Dis-**
16 **ease, Chronic Disease, and**
17 **Other Disease Issues**

18 **SEC. 731. GUIDELINES FOR DISEASE SCREENING FOR MI-**
19 **NORITY PATIENTS.**

20 (a) IN GENERAL.—The Secretary, acting through the
21 Director of the Agency for Healthcare Research and Qual-
22 ity, shall convene a series of meetings to develop guidelines
23 for disease screening for minority patient populations
24 which have a higher than average risk for many chronic
25 diseases and cancers.

1 (b) PARTICIPANTS.—In convening meetings under
2 subsection (a), the Secretary shall ensure that meeting
3 participants include representatives of—

4 (1) professional societies and associations;

5 (2) minority health organizations;

6 (3) health care researchers and providers, in-
7 cluding those with expertise in minority health;

8 (4) Federal health agencies, including the Of-
9 fice of Minority Health, the National Institute on
10 Minority Health and Health Disparities, and the
11 National Institutes of Health; and

12 (5) other experts determined appropriate by the
13 Secretary.

14 (c) DISEASES.—Screening guidelines for minority
15 populations shall be developed as appropriate under sub-
16 section (a) for—

17 (1) hypertension;

18 (2) hypercholesterolemia;

19 (3) diabetes;

20 (4) cardiovascular disease;

21 (5) cancers, including breast, prostate, colon,
22 cervical, and lung cancer;

23 (6) other pulmonary problems including sleep
24 apnea;

25 (7) asthma;

- 1 (8) diabetes;
- 2 (9) kidney diseases;
- 3 (10) eye diseases and disorders, including glau-
- 4 coma;
- 5 (11) HIV/AIDS and sexually transmitted infec-
- 6 tions;
- 7 (12) uterine fibroids;
- 8 (13) autoimmune disease;
- 9 (14) mental health conditions;
- 10 (15) dental health conditions and oral diseases,
- 11 including oral cancer;
- 12 (16) environmental and related health illnesses
- 13 and conditions;
- 14 (17) sickle cell disease and sickle cell trait;
- 15 (18) violence and injury prevention and control;
- 16 (19) genetic and related conditions;
- 17 (20) heart disease and stroke;
- 18 (21) tuberculosis;
- 19 (22) chronic obstructive pulmonary disease;
- 20 (23) musculoskeletal diseases, arthritis, and
- 21 obesity; and
- 22 (24) other diseases determined appropriate by
- 23 the Secretary.
- 24 (d) DISSEMINATION.—Not later than 24 months
- 25 after the date of enactment of this title, the Secretary

1 shall publish and disseminate to health care provider orga-
2 nizations the guidelines developed under subsection (a).

3 (e) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section,
5 such sums as may be necessary for each of fiscal years
6 2017 through 2021.

7 **SEC. 732. CDC WISEWOMAN SCREENING PROGRAM.**

8 Section 1509 of the Public Health Service Act (42
9 U.S.C. 300n-4a) is amended—

10 (1) in subsection (a)—

11 (A) by striking the heading and inserting
12 “IN GENERAL.—”; and

13 (B) in the matter preceding paragraph (1),
14 by striking “may make grants” and all that fol-
15 lows through “purpose” and inserting the fol-
16 lowing: “may make grants to such States for
17 the purpose”; and

18 (2) in subsection (d)(1), by striking “there are
19 authorized” and all that follows through the period
20 and inserting “there are authorized to be appro-
21 priated \$23,000,000 for fiscal year 2017,
22 \$25,300,000 for fiscal year 2018, \$27,800,000 for
23 fiscal year 2019, \$30,800,000 for fiscal year 2020,
24 and \$34,000,000 for fiscal year 2021.”.

1 **SEC. 733. REPORT ON CARDIOVASCULAR CARE FOR WOMEN**
2 **AND MINORITIES.**

3 Part P of title III of the Public Health Service Act
4 (42 U.S.C. 280g et seq.) is amended by adding at the end
5 the following:

6 **“SEC. 399V-6. REPORT ON CARDIOVASCULAR CARE FOR**
7 **WOMEN AND MINORITIES.**

8 “Not later than September 30, 2017, and annually
9 thereafter, the Secretary shall prepare and submit to the
10 Congress a report on the quality of and access to care
11 for women and minorities with heart disease, stroke, and
12 other cardiovascular diseases. The report shall contain rec-
13 ommendations for eliminating disparities in, and improv-
14 ing the treatment of, heart disease, stroke, and other car-
15 diovascular diseases in women, racial and ethnic minori-
16 ties, those for whom English is not their primary lan-
17 guage, and individuals with disabilities.”.

18 **SEC. 734. COVERAGE OF COMPREHENSIVE TOBACCO CES-**
19 **SATION SERVICES IN MEDICAID AND IN ACA**
20 **ESSENTIAL HEALTH BENEFITS .**

21 (a) REQUIRING COVERAGE OF COUNSELING AND
22 PHARMACOTHERAPY FOR CESSATION OF TOBACCO
23 USE.—Section 1905 of the Social Security Act (42 U.S.C.
24 1396d) is amended—

25 (1) in subsection (a)(4)(D), is amended by
26 striking “by pregnant women”; and

1 (2) in subsection (bb)—

2 (A) by striking “by pregnant women” each
3 place it appears;

4 (B) in paragraph (1), in the matter before
5 subparagraph (A), by inserting “by individuals”
6 before “who use tobacco”; and

7 (C) in paragraph (2)(A), by striking “with
8 respect to pregnant women”.

9 (b) EXCEPTION FROM OPTIONAL RESTRICTION
10 UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—
11 Section 1927(d)(2)(F) of the Social Security Act (42
12 U.S.C. 1396r–8(d)(2)(F)) is amended by striking “in the
13 case of pregnant women”.

14 (c) STATE MONITORING AND PROMOTING OF COM-
15 PREHENSIVE TOBACCO CESSATION SERVICES UNDER
16 MEDICAID.—Section 1902(a) of the Social Security Act
17 (42 U.S.C. 1395a(a)), as amended by section 450(c), is
18 amended—

19 (1) by striking “and” at the end of paragraph
20 (81);

21 (2) by striking the period at the end of para-
22 graph (82) and inserting “; and”; and

23 (3) by inserting after paragraph (82) the fol-
24 lowing new paragraph:

1 “(83) provide for the State to monitor and pro-
2 mote the use of comprehensive tobacco cessation
3 services under the State plan;”.

4 (d) REMOVAL OF COST SHARING FOR COUNSELING
5 AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO
6 USE UNDER MEDICAID.—

7 (1) GENERAL COST SHARING LIMITATIONS.—
8 Section 1916 of the Social Security Act (42 U.S.C.
9 1396o) is amended—

10 (A) in subsections (a)(2)(B) and (b)(2)(B),
11 by striking “and counseling and pharmacothe-
12 rapy for cessation of tobacco use by pregnant
13 women (as defined in section 1905(bb)) and
14 covered outpatient drugs (as defined in sub-
15 section (k)(2) of section 1927 and including
16 nonprescription drugs described in subsection
17 (d)(2) of such section) that are prescribed for
18 purposes of promoting, and when used to pro-
19 mote, tobacco cessation by pregnant women in
20 accordance with the Guideline referred to in
21 section 1905(bb)(2)(A)” each place it appears;
22 and

23 (B) in each of subsections (a)(2)(D) and
24 (b)(2)(D) by inserting “and counseling and
25 pharmacotherapy for cessation of tobacco use

1 (as defined in section 1905(bb)) and covered
2 outpatient drugs (as defined in subsection
3 (k)(2) of section 1927 and including non-
4 prescription drugs described in subsection
5 (d)(2) of such section) that are prescribed for
6 purposes of promoting, and when used to pro-
7 mote, tobacco cessation in accordance with the
8 Guideline referred to in section
9 1905(bb)(2)(A),” after “section
10 1905(a)(4)(C),”.

11 (2) APPLICATION TO ALTERNATIVE COST SHAR-
12 ING.—Section 1916A(b)(3)(B) of such Act (42
13 U.S.C. 1396o–1(b)(3)(B)42 U.S.C. 1396o–
14 1(b)(3)(B)) is amended—

15 (A) in clause (iii), by striking “, and coun-
16 seling and pharmacotherapy for cessation of to-
17 bacco use by pregnant women (as defined in
18 section 1905(bb))”; and

19 (B) by adding at the end the following:

20 “(xi) Counseling and pharmacothe-
21 rapy for cessation of tobacco use (as defined
22 in section 1905(bb)) and covered out-
23 patient drugs (as defined in subsection
24 (k)(2) of section 1927 and including non-
25 prescription drugs described in subsection

1 (d)(2) of such section) that are prescribed
2 for purposes of promoting, and when used
3 to promote, tobacco cessation in accord-
4 ance with the Guideline referred to in sec-
5 tion 1905(bb)(2)(A).”.

6 (e) COMPREHENSIVE COVERAGE UNDER ACA ES-
7 SENTIAL HEALTH BENEFITS.—

8 (1) COVERAGE.—Section 1302(b)(1) of the Pa-
9 tient Protection and Affordable Care Act (42 U.S.C.
10 18022(b)(1)) is amended by adding at the end the
11 following new subparagraph:

12 “(K) Comprehensive tobacco cessation
13 services and medications, including all evidence-
14 based tobacco cessation counseling and all
15 medications for tobacco cessation approved by
16 the Food and Drug Administration.”.

17 (2) NO COST SHARING.—Section 1302(c) of the
18 Patient Protection and Affordable Care Act (42
19 U.S.C. 18022(c)) is amended by inserting after
20 paragraph (1) the following new paragraph:

21 “(2) NO COST SHARING OR PRIOR AUTHORIZA-
22 TION FOR COMPREHENSIVE TOBACCO CESSATION
23 COVERAGE.—There shall be no cost sharing or prior
24 authorization requirement imposed with respect to
25 services described in subsection (b)(1)(K).”.

1 (f) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to items and services furnished on
3 or after January 1, 2017.

4 **SEC. 735. CLINICAL RESEARCH FUNDING FOR ORAL**
5 **HEALTH.**

6 (a) IN GENERAL.—The Secretary of Health and
7 Human Services shall expand and intensify the conduct
8 and support of the research activities of the National In-
9 stitutes of Health and the National Institute of Dental
10 and Craniofacial Research to improve the oral health of
11 the population through the prevention and management
12 of oral diseases and conditions.

13 (b) INCLUDED RESEARCH ACTIVITIES.—Research
14 activities under subsection (a) shall include—

15 (1) comparative effectiveness research and clin-
16 ical disease management research addressing early
17 childhood caries and oral cancer; and

18 (2) awarding of grants and contracts to support
19 the training and development of health services re-
20 searchers, comparative effectiveness researchers, and
21 clinical researchers whose research improves the oral
22 health of the population.

1 **SEC. 736. PARTICIPATION BY MEDICAID BENEFICIARIES IN**
2 **APPROVED CLINICAL TRIALS.**

3 (a) IN GENERAL.—Title XIX of the Social Security
4 Act (42 U.S.C. 1396 et seq.) is amended by inserting after
5 section 1943 the following new section:

6 **“SEC. 1944. PARTICIPATION IN AN APPROVED CLINICAL**
7 **TRIAL.**

8 “(a) COVERAGE OF ROUTINE PATIENT COSTS ASSO-
9 CIATED WITH APPROVED CLINICAL TRIALS.—

10 “(1) INCLUSION.—Subject to paragraph (2),
11 routine patient costs shall include all items and serv-
12 ices consistent with the medical assistance provided
13 under the State plan that would otherwise be pro-
14 vided to the individual under such State plan if such
15 individual was not enrolled in an approved clinical
16 trial, including any items or services related to the
17 prevention, detection, and treatment of any medical
18 complications that arise as a result of participation
19 in the approved clinical trial.

20 “(2) EXCLUSION.—For purposes of paragraph
21 (1), routine patient costs does not include—

22 “(A) the investigational item, device, or
23 service itself;

24 “(B) items and services that are provided
25 solely to satisfy data collection and analysis

1 needs and that are not used in the direct clin-
2 ical management of the patient; or

3 “(C) a service that is clearly inconsistent
4 with widely accepted and established standards
5 of care for a particular diagnosis.

6 “(3) INFORMATION CONCERNING CLINICAL
7 TRIALS.—

8 “(A) IN GENERAL.—Subject to subpara-
9 graph (B), the Secretary, in consultation with
10 relevant stakeholders, shall develop a single
11 standardized electronic form for use by the indi-
12 vidual or the referring health care provider to
13 submit to the State agency administering the
14 State plan in order to verify that the clinical
15 trial meets the conditions established for an ap-
16 proved clinical trial (as defined in subsection
17 (c)).

18 “(B) EXCLUDED INFORMATION.—For pur-
19 poses of subparagraph (A) or any such request
20 by the State agency for information regarding
21 a clinical trial, an individual or referring health
22 care provider shall not be required to submit—

23 “(i) the clinical protocol document for
24 the clinical trial; or

1 “(ii) subject to subparagraph (C), any
2 additional information other than such in-
3 formation as is required pursuant to the
4 form described in subparagraph (A).

5 “(C) OPTIONAL INFORMATION.—For pur-
6 poses of subparagraphs (A) and (B)(ii), the
7 form may include a requirement that the refer-
8 ring health care provider attest that the indi-
9 vidual is eligible to participate in the clinical
10 trial pursuant to the trial protocol and that
11 their participation in such trial would be appro-
12 priate.

13 “(D) REVIEW OF INFORMATION.—

14 “(i) IN GENERAL.—A State plan
15 under this title shall establish a process for
16 timely review by the State agency of the
17 form and information submitted pursuant
18 to subparagraph (A) and, not later than
19 48 hours after receipt of such form, con-
20 firmation that the information provided in
21 such form satisfies the requirements estab-
22 lished under such subparagraph, with such
23 process to include establishment and oper-
24 ation of a 24-hour, toll-free telephone num-

1 ber and e-mail address to provide for expedited communication.

2
3 “(ii) FAILURE TO RESPOND.—If an
4 individual or the referring health care provider does not receive a response or request for additional information from the
5 State agency following the 48-hour period
6 described in clause (i), the information
7 provided in the form may be presumed to
8 satisfy the requirements established under
9 this paragraph.
10
11

12 “(b) ENCOURAGEMENT OF PARTICIPATION IN APPROVED CLINICAL TRIALS.—

13
14 “(1) REASONABLY ACCESSIBLE PROVIDER.—
15 For purposes of participation in an approved clinical
16 trial by an individual eligible for medical assistance
17 under this title, the State agency administering the
18 State plan shall make reasonable efforts to ensure
19 that the individual is provided with access to a provider who is—
20

21 “(A) participating in the approved clinical
22 trial;

23 “(B) located not more than 25 miles from
24 the residence of the individual (or, if no such

1 provider is available, as close as possible to the
2 residence of the individual); and

3 “(C) a participating provider under the
4 State plan or has been deemed to be a partici-
5 pating provider under the State plan for pur-
6 poses of providing medical assistance to the in-
7 dividual during their participation in the ap-
8 proved clinical trial.

9 “(2) INFORMATIONAL MATERIALS.—The State
10 agency administering the plan approved under this
11 title shall develop informational materials and pro-
12 grams to encourage participating providers to make
13 appropriate referrals to physicians and other appro-
14 priate health care professionals who can provide in-
15 dividuals with access to approved clinical trials.

16 “(c) DEFINITION OF APPROVED CLINICAL TRIAL.—
17 The term ‘approved clinical trial’ has the same meaning
18 as provided under section 2709(d) of the Public Health
19 Service Act.”

20 (b) CONFORMING AMENDMENT.—Section 1902(a) of
21 the Social Security Act (42 U.S.C. 1396a(a)) is amended
22 by inserting after paragraph (77) the following new para-
23 graph:

24 “(78) provide that participation in an approved
25 clinical trial and coverage of routine patient costs

1 associated with such trial for an individual eligible
2 for medical assistance under this title is conducted
3 in accordance with the requirements under section
4 1944;”.

5 (c) EFFECTIVE DATE.—

6 (1) IN GENERAL.—Except as provided in para-
7 graph (2), the amendments made by this section
8 shall apply to calendar quarters beginning on or
9 after October 1, 2016.

10 (2) DELAY PERMITTED FOR STATE PLAN
11 AMENDMENT.—In the case of a State plan for med-
12 ical assistance under title XIX of the Social Security
13 Act which the Secretary of Health and Human Serv-
14 ices determines requires State legislation (other than
15 legislation appropriating funds) in order for the plan
16 to meet the additional requirements imposed by the
17 amendments made by this section, the State plan
18 shall not be regarded as failing to comply with the
19 requirements of such title solely on the basis of its
20 failure to meet these additional requirements before
21 the first day of the first calendar quarter beginning
22 after the close of the first regular session of the
23 State legislature that begins after the date of enact-
24 ment of this Act. For purposes of the previous sen-
25 tence, in the case of a State that has a 2-year legis-

1 lative session, each year of such session shall be
2 deemed to be a separate regular session of the State
3 legislature.

4 **Subtitle E—HIV/AIDS**

5 **SEC. 741. STATEMENT OF POLICY.**

6 It is the policy of the United States to achieve an
7 AIDS-free generation, and to—

8 (1) expand access to lifesaving antiretroviral
9 therapy for people living with HIV/AIDS and imme-
10 diately link people to continuous and coordinated
11 high-quality care when they learn they are infected
12 with HIV;

13 (2) expand targeted efforts to prevent HIV in-
14 fection using a combination of effective, evidence-
15 based approaches, including routine HIV screening,
16 and universal access to HIV prevention tools in the
17 communities where HIV/AIDS is most heavily con-
18 centrated, particularly communities of color;

19 (3) ensure laws, policies, and regulations do not
20 impede access to prevention, treatment, and care for
21 people living with HIV/AIDS or at risk for acquiring
22 HIV;

23 (4) accelerate research for more efficacious HIV
24 prevention and treatments tools, a cure, and a vac-
25 cine; and

1 (5) respect the human rights and dignity of
2 persons living with HIV/AIDS.

3 **SEC. 742. FINDINGS.**

4 The Congress finds the following:

5 (1) Over one million people are estimated to be
6 living with HIV in the United States according to
7 the Centers for Disease Control and Prevention, 16
8 percent of whom are unaware of their HIV-positive
9 status.

10 (2) Annually there are over 50,000 new HIV in-
11 fections and 20,000 deaths in people with an HIV
12 diagnoses in 50 States and 6 dependent areas of the
13 United States.

14 (3) The Centers for Disease Control and Pre-
15 vention estimates that in 2010 there were approxi-
16 mately 47,500 people newly diagnosed with HIV.
17 Though this number seems to be staying relatively
18 stable, the number of new infections is rapidly in-
19 creasing among certain populations especially among
20 young African-American men who have sex with men
21 (MSM). CDC data show that since 2006, HIV inci-
22 dence has increased among Black and Latino gay
23 men/MSM, notably those aged 13 to 24 years. Even
24 more concerning is that there are more new HIV in-

1 infections among young African American gay men/
2 MSM than any other subgroup of gay men/MSM.

3 (4) HIV disproportionately affects certain popu-
4 lations in the United States. Though African-Ameri-
5 cans represent approximately 14 percent of the pop-
6 ulation, African-Americans account for almost half
7 (44 percent) of all people living with HIV in the
8 United States. Men who have sex with men (MSM)
9 make up approximately 4 percent of the population,
10 but account for 78 percent of all new HIV infections
11 and are the only risk group in which HIV infections
12 continue to increase.

13 (5) Disparities exist among Latinos/Hispanics;
14 they make up 16 percent of the United States popu-
15 lation and 21 percent of new infections (2010).

16 (6) Though American Indians/Alaska Natives
17 represent less than 2 percent of the total number of
18 HIV/AIDS cases, American Indians and Alaska Na-
19 tives rank fifth in rates of HIV/AIDS diagnosis, still
20 higher than their White counterparts.

21 (7) While Asian-Americans, Native Hawaiians,
22 and Pacific Islanders HIV/AIDS cases account for
23 approximately 1 percent of cases nationally, between
24 2010 and 2011, the rate of new HIV diagnoses in-
25 creased for Asian-Americans by 22 percent.

1 (8) The latest data from the CDC (2013) indi-
2 cate that women account for 1 in 5 (20 percent) new
3 HIV infections in the United States. Women of
4 color, particularly Black women, have been especially
5 hard hit and represent the majority of women living
6 with the disease and women newly infected. In addi-
7 tion, Black women accounted for nearly two-thirds
8 (64 percent) of all estimated new HIV infections
9 among women, while only accounting for 13 percent
10 of the female population; White women accounted
11 for 18 percent and Latinas 15 percent of new infec-
12 tions among women.

13 (9) The history of HIV shows that culturally
14 relevant and gender-responsive supportive services,
15 including psychosocial support, treatment literacy,
16 case management, and transportation are necessary
17 strategies to reach and engage women and girls in
18 medical care.

19 (10) The limited data available on transgender
20 individuals point to a disproportionate burden of
21 HIV infection.

22 (11) Stigma and discrimination contribute to
23 these disparities.

24 (12) The Centers for Disease Control and Pre-
25 vention has determined that increasing the propor-

1 tion of people who know their HIV status is an es-
2 sential component of comprehensive HIV/AIDS
3 treatment and prevention efforts and that early di-
4 agnosis is critical in order for people with HIV/
5 AIDS to receive life-extending therapy. Additionally,
6 the Centers for Disease Control and Prevention rec-
7 ommend routine HIV screening in health care set-
8 tings for all patients aged 13 to 64, regardless of
9 risk.

10 (13) In 1998, Congress created the National
11 Minority AIDS Initiative to provide technical assist-
12 ance, build capacity, and strengthen outreach efforts
13 among local institutions and community-based orga-
14 nizations that serve racial and ethnic minorities liv-
15 ing with or vulnerable to HIV/AIDS.

16 (14) To combat the HIV epidemic in the United
17 States, the National HIV/AIDS Strategy (NHAS)
18 from the White House Office of National AIDS Pol-
19 icy provides a framework of increasing access to
20 care, reducing new infections, and eliminating HIV-
21 related health disparities. The vision of NHAS is
22 “‘The United States will become a place where new
23 HIV infections are rare and when they do occur,
24 every person, regardless of age, gender, race/eth-
25 nicity, gender identity, or socioeconomic cir-

1 cumstance, will have unfettered access to high qual-
2 ity, life-extending care, free from stigma and dis-
3 crimination.”.

4 (15) In recent years, several thousand people
5 across the country were waiting to receive AIDS
6 treatment through the AIDS Drug Assistance Pro-
7 gram authorized by the provisions popularly known
8 as the Ryan White CARE Act.

9 (16) At present, 32 States and 2 United States
10 territories have criminal statutes based on “expo-
11 sure” to HIV. Most of these laws were adopted be-
12 fore the availability of effective antiretroviral treat-
13 ment for HIV/AIDS.

14 (17) Although the cost of education, treatment
15 and care, and research are not inconsequential, they
16 are substantially less than the annual health care
17 cost attributable to HIV in the United States. The
18 lifetime cost of HIV care and treatment was esti-
19 mated to be \$326,500 to \$435,000 dollars in a life-
20 time. Preventing 50,000 new infections in the
21 United States each year could save \$22 billion.

22 (18) According to the Centers for Disease Con-
23 trol and Prevention (CDC), latex condoms, when
24 used consistently and correctly, are highly effective
25 in preventing the transmission of HIV. Latex

1 condoms also reduce the risk of other STIs. Despite
2 the effectiveness of condoms in reducing the spread
3 of STIs, the Bureau of Prisons does not recommend
4 their use in correctional facilities.

5 (19) The distribution of condoms in correctional
6 facilities is currently legal in certain parts of the
7 United States and the world. The States of Vermont
8 and Mississippi, the District of Columbia, and the
9 cities of New York, San Francisco, Los Angeles,
10 Washington, DC, and Philadelphia allow condom
11 distribution in their correctional facilities. However,
12 these States and cities operate fewer than 1 percent
13 of all correctional facilities.

14 (20) Many correctional facilities in the United
15 States do not provide comprehensive testing and
16 treatment programs to reduce the spread of STIs.
17 Fewer than half of correctional facilities provide
18 counseling to HIV-positive incarcerated persons.

19 (21) Incarcerated individuals living with HIV/
20 AIDS who are eligible for Medicaid would benefit
21 from prompt and automatic enrollment upon their
22 release in order to ensure their continued ability to
23 access health services, including antiretroviral treat-
24 ment.

1 (22) Research shows that stable housing leads
2 to better health outcomes for those living with HIV.
3 Inadequate or unstable housing is not only a barrier
4 to effective treatment, but also increases the likeli-
5 hood of engaging in risky behaviors leading to HIV
6 infection. Insecure housing puts people with HIV/
7 AIDS at risk of premature death from exposure to
8 other diseases, poor nutrition, and lack of medical
9 care.

10 (23) Due to advances in treatment, many peo-
11 ple living with HIV/AIDS (PLWHA) today are liv-
12 ing healthy lives and have the ability and desire to
13 fully participate in all aspects of community life, in-
14 cluding employment. Research associates being em-
15 ployed with tremendous economic, social, and health
16 benefits for many people living with HIV/AIDS.

17 (24) The common benefits associated with em-
18 ployment include income, autonomy, productivity,
19 and status within society, daily structure, making a
20 contribution to one's community, and increased skills
21 and self-esteem. Research also indicates that many
22 people with disabilities, including PLWHA, report
23 perceiving themselves as being less disabled or not
24 disabled at all, when working. Furthermore, some
25 studies link working with better physical and mental

1 health outcomes for PLWHA when compared to
2 those who are not working. Preliminary data also
3 suggest that transitioning to employment is associ-
4 ated with reduced HIV-related health risk behavior
5 for many people.

6 (25) On July 16, 2012, the Food and Drug Ad-
7 ministration approved the first drug to reduce the
8 risk of HIV infection in uninfected individuals who
9 are at high risk of HIV infection and who may en-
10 engage in sexual activity with HIV-infected partners.

11 **SEC. 743. ADDITIONAL FUNDING FOR AIDS DRUG ASSIST-**
12 **ANCE PROGRAM TREATMENTS.**

13 Section 2623 of the Public Health Service Act (42
14 U.S.C. 300ff–31b) is amended by adding at the end the
15 following:

16 “(c) ADDITIONAL FUNDING FOR AIDS DRUG AS-
17 SISTANCE PROGRAM TREATMENTS.—In addition to
18 amounts otherwise authorized to be appropriated for car-
19 rying out this subpart, there are authorized to be appro-
20 priated such sums as may be necessary to carry out sec-
21 tions 2612(b)(3)(B) and 2616 for each of fiscal years
22 2017 through 2020.”.

1 **SEC. 744. ENHANCING THE NATIONAL HIV SURVEILLANCE**
2 **SYSTEM.**

3 (a) GRANTS.—The Secretary of Health and Human
4 Services, acting through the Director of the Centers for
5 Disease Control and Prevention, shall make grants to
6 States to support integration of public health surveillance
7 systems into all electronic health records in order to allow
8 rapid communications between the clinical setting and
9 health departments, by means that include—

10 (1) providing technical assistance and policy
11 guidance to State and local health departments, clin-
12 ical providers, and other agencies serving individuals
13 with HIV to improve the interoperability of data sys-
14 tems relevant to monitoring HIV care and sup-
15 portive services;

16 (2) capturing longitudinal data pertaining to
17 the initiation and ongoing prescription or dispensing
18 of antiretroviral therapy for individuals diagnosed
19 with HIV (such as through pharmacy-based report-
20 ing);

21 (3) obtaining information—

22 (A) on a voluntary basis, on sexual orienta-
23 tion and gender identity; and

24 (B) on sources of coverage (or the lack
25 thereof) for medical treatment (including cov-
26 erage through Medicaid, Medicare, the program

1 under title XXVI of the Public Health Service
2 Act (42 U.S.C. 300ff–11 et seq.; commonly re-
3 ferred to as the “Ryan White HIV/AIDS Pro-
4 gram”), other public funding, private insurance,
5 and health maintenance organizations); and

6 (4) obtaining and using current geographic
7 markers of residence (such as current address, zip
8 code, partial zip code, and census block).

9 (b) PRIVACY AND SECURITY SAFEGUARDS.—In car-
10 rying out this section, the Secretary of Health and Human
11 Services shall ensure that appropriate privacy and security
12 safeguards are met to prevent unauthorized disclosure of
13 protected health information and compliance with the
14 HIPAA privacy and security law (as defined in section
15 3009 of the Public Health Service Act (42 U.S.C. 300jj–
16 19)) and other relevant laws and regulations.

17 (c) PROHIBITION AGAINST IMPROPER USE OF
18 DATA.—No grant under this section may be used to allow
19 or facilitate the collection or use of surveillance or clinical
20 data or records—

21 (1) for punitive measures of any kind, civil or
22 criminal, against the subject of such data or records;
23 or

1 (2) for imposing any requirement or restriction
2 with respect to an individual without the individual's
3 written consent.

4 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
5 out this section, there are authorized to be appropriated
6 such sums as may be necessary for each of fiscal years
7 2017 through 2021.

8 **SEC. 745. EVIDENCE-BASED STRATEGIES FOR IMPROVING**
9 **LINKAGE TO AND RETENTION IN APPRO-**
10 **PRIATE CARE.**

11 (a) STRATEGIES.—The Secretary of Health and
12 Human Services, in collaboration with the Director of the
13 Centers for Disease Control and Prevention, the Adminis-
14 trator of the Substance Abuse and Mental Health Services
15 Administration, the Director of the Office of AIDS Re-
16 search, the Administrator of the Health Resources and
17 Services Administration, and the Administrator of the
18 Centers for Medicare & Medicaid Services, shall—

19 (1) identify evidence-based strategies most ef-
20 fective at addressing the multifaceted issues that im-
21 pede disease status awareness and linkage to and re-
22 tention in appropriate care, taking into consideration
23 health care systems issues, clinic and provider
24 issues, and individual psychosocial, environmental,
25 and other contextual factors;

1 (2) support the wide-scale implementation of
2 the evidence-based strategies identified pursuant to
3 paragraph (1), including through incorporating such
4 strategies into health care coverage supported by the
5 Medicaid program under title XIX of the Social Se-
6 curity Act (42 U.S.C. 1396 et seq.), the program
7 under title XXVI of the Public Health Service Act
8 (42 U.S.C. 300ff–11 et seq.; commonly referred to
9 as the “Ryan White HIV/AIDS Program”), and
10 health plans purchased through an American Health
11 Benefit Exchange established pursuant to section
12 1311 of the Patient Protection and Affordable Care
13 Act (42 U.S.C. 18031); and

14 (3) not later than 12 months after the date of
15 the enactment of this Act, submit a report to the
16 Congress on the status of activities under para-
17 graphs (1) and (2).

18 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
19 out this section, there are authorized to be appropriated
20 such sums as may be necessary for fiscal years 2017
21 through 2021.

1 **SEC. 746. IMPROVING ENTRY INTO AND RETENTION IN**
2 **CARE AND ANTIRETROVIRAL ADHERENCE**
3 **FOR PERSONS WITH HIV.**

4 (a) SENSE OF CONGRESS.—It is the sense of the Con-
5 gress that AIDS research has led to scientific advance-
6 ments that have—

7 (1) saved the lives of millions of people with
8 HIV/AIDS;

9 (2) prevented millions of people from being in-
10 fected; and

11 (3) had broad benefits that extend far beyond
12 helping people at risk for or living with HIV.

13 (b) IN GENERAL.—The Secretary of Health and
14 Human Services, acting through the Director of the Na-
15 tional Institutes of Health, shall expand, intensify, and co-
16 ordinate operational and translational research and other
17 activities of the National Institutes of Health regarding
18 methods—

19 (1) to increase adoption of evidence-based ad-
20 herence strategies within HIV care and treatment
21 programs;

22 (2) to increase HIV testing and case detection
23 rates;

24 (3) to reduce HIV-related health disparities;

1 (4) to ensure that research to improve adher-
2 ence to HIV care and treatment programs address
3 the unique concerns of women;

4 (5) to integrate HIV/AIDS prevention and care
5 services with mental health and substance use pre-
6 vention and treatment delivery systems; and

7 (6) to increase knowledge on the implementa-
8 tion of preexposure prophylaxis (PrEP), including
9 with respect to—

10 (A) who can benefit most from PrEP;

11 (B) how to provide PrEP safely and effi-
12 ciently;

13 (C) how to integrate PrEP with other es-
14 sential prevention methods such as condoms;
15 and

16 (D) how to ensure high levels of adherence.

17 (c) **AUTHORIZATION OF APPROPRIATIONS.**—To carry
18 out this section, there are authorized to be appropriated
19 such sums as may be necessary for fiscal years 2017
20 through 2021.

21 **SEC. 747. SERVICES TO REDUCE HIV/AIDS IN RACIAL AND**
22 **ETHNIC MINORITY COMMUNITIES.**

23 (a) **IN GENERAL.**—For the purpose of reducing HIV/
24 AIDS in racial and ethnic minority communities, the Sec-
25 retary, acting through the Deputy Assistant Secretary for

1 Minority Health, may make grants to public health agen-
2 cies and faith-based organizations to conduct—

- 3 (1) outreach activities related to HIV/AIDS
4 prevention and testing activities;
- 5 (2) HIV/AIDS prevention activities; and
- 6 (3) HIV/AIDS testing activities.

7 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
8 out this section, there are authorized to be appropriated
9 such sums as may be necessary for fiscal years 2017
10 through 2021.

11 **SEC. 748. MINORITY AIDS INITIATIVE.**

12 (a) EXPANDED FUNDING.—The Secretary, in col-
13 laboration with the Deputy Assistant Secretary for Minor-
14 ity Health, the Director of the Centers for Disease Control
15 and Prevention, the Administrator of the Health Re-
16 sources and Services Administration, and the Adminis-
17 trator of the Substance Abuse and Mental Health Services
18 Administration, shall provide funds and carry out activi-
19 ties to expand the Minority HIV/AIDS Initiative.

20 (b) USE OF FUNDS.—The additional funds made
21 available under this section may be used, through the Mi-
22 nority AIDS Initiative, to support the following activities:

- 23 (1) Providing technical assistance and infra-
24 structure support to reduce HIV/AIDS in minority
25 populations.

1 (2) Increasing minority populations' access to
2 HIV/AIDS prevention and care services.

3 (3) Building strong community programs and
4 partnerships to address HIV prevention and the
5 health care needs of specific racial and ethnic minor-
6 ity populations.

7 (c) PRIORITY INTERVENTIONS.—Within the racial
8 and ethnic minority populations referred to in subsection
9 (b), priority in conducting intervention services shall be
10 given to—

11 (1) men who have sex with men;

12 (2) youth;

13 (3) persons who engage in intravenous drug
14 abuse;

15 (4) women;

16 (5) homeless individuals; and

17 (6) individuals incarcerated or in the penal sys-
18 tem.

19 (d) AUTHORIZATION OF APPROPRIATIONS.—For car-
20 rying out this section, there are authorized to be appro-
21 priated \$610,000,000 for fiscal year 2017 and such sums
22 as may be necessary for each of fiscal years 2018 through
23 2021.

1 **SEC. 749. HEALTH CARE PROFESSIONALS TREATING INDI-**
2 **VIDUALS WITH HIV/AIDS.**

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services, acting through the Administrator of the
5 Health Resources and Services Administration, shall ex-
6 pand, intensify, and coordinate workforce initiatives of the
7 Health Resources and Services Administration to increase
8 the capacity of the health workforce focusing primarily on
9 HIV/AIDS to meet the demand for culturally competent
10 care, and may award grants for any of the following:

11 (1) Development of curricula for training pri-
12 mary care providers in HIV/AIDS prevention and
13 care, including routine HIV testing.

14 (2) Support to expand access to culturally and
15 linguistically accessible benefits counselors, trained
16 peer navigators, and mental and behavioral health
17 professionals with expertise in HIV/AIDS.

18 (3) Training health care professionals to pro-
19 vide care to individuals with HIV/AIDS.

20 (4) Development by grant recipients under title
21 XXVI of the Public Health Service Act (42 U.S.C.
22 300ff–11 et seq.; commonly referred to as the Ryan
23 White HIV/AIDS Program) and other persons, of
24 policies for providing culturally relevant and sen-
25 sitive treatment to individuals with HIV/AIDS, with
26 particular emphasis on treatment to racial and eth-

1 nic minorities, men who have sex with men, and
2 women, young people, and children with HIV/AIDS.

3 (5) Development and implementation of pro-
4 grams to increase the use of telehealth to respond to
5 HIV/AIDS-specific health care needs in rural and
6 minority communities, with particular emphasis
7 given to medically underserved communities and in-
8 sular areas.

9 (6) Evaluating interdisciplinary medical pro-
10 vider care team models that promote high quality
11 care, with particular emphasis on care to racial and
12 ethnic minorities.

13 (7) Training health care professionals to make
14 them aware of the high rates of chronic hepatitis B
15 and chronic hepatitis C in adult racial and ethnic
16 populations, and the importance of prevention, de-
17 tection, and medical management of hepatitis B and
18 hepatitis C and of liver cancer screening.

19 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
20 out this section, there are authorized to be appropriated
21 such sums as may be necessary for fiscal years 2017
22 through 2021.

1 **SEC. 750. HIV/AIDS PROVIDER LOAN REPAYMENT PRO-**
2 **GRAM.**

3 (a) IN GENERAL.—The Secretary may enter into an
4 agreement with any physician, nurse practitioner, or phy-
5 sician assistant under which—

6 (1) the physician, nurse practitioner, or physi-
7 cian assistant agrees to serve as a medical provider
8 for a period of not less than 2 years—

9 (A) at a Ryan White-funded or title X-
10 funded facility with a critical shortage of doc-
11 tors (as determined by the Secretary); or

12 (B) in an area with a high incidence of
13 HIV/AIDS; and

14 (2) the Secretary agrees to make payments in
15 accordance with subsection (b) on the professional
16 education loans of the physician, nurse practitioner,
17 or physician assistant.

18 (b) MANNER OF PAYMENTS.—The payments de-
19 scribed in subsection (a) shall be made by the Secretary
20 as follows:

21 (1) Upon completion by the physician, nurse
22 practitioner, or physician assistant for whom the
23 payments are to be made of the first year of the
24 service specified in the agreement entered into with
25 the Secretary under subsection (a), the Secretary
26 shall pay 30 percent of the principal of and the in-

1 terest on the individual's professional education
2 loans.

3 (2) Upon completion by the physician, nurse
4 practitioner, or physician assistant of the second
5 year of such service, the Secretary shall pay another
6 30 percent of the principal of and the interest on
7 such loans.

8 (3) Upon completion by that individual of a
9 third year of such service, the Secretary shall pay
10 another 25 percent of the principal of and the inter-
11 est on such loans.

12 (c) APPLICABILITY OF CERTAIN PROVISIONS.—The
13 provisions of subpart III of part D of title III of the Public
14 Health Service Act (42 U.S.C. 254l et seq.) shall, except
15 as inconsistent with this section, apply to the program car-
16 ried out under this section in the same manner and to
17 the same extent as such provisions apply to the National
18 Health Service Corps Loan Repayment Program.

19 (d) REPORTS.—Not later than 18 months after the
20 date of the enactment of this Act, and annually thereafter,
21 the Secretary shall prepare and submit to the Congress
22 a report describing the program carried out under this sec-
23 tion, including statements regarding the following:

1 (1) The number of physicians, nurse practi-
2 tioners, and physician assistants enrolled in the pro-
3 gram.

4 (2) The number and amount of loan repay-
5 ments.

6 (3) The placement location of loan repayment
7 recipients at facilities described in subsection (a)(1).

8 (4) The default rate and actions required.

9 (5) The amount of outstanding default funds.

10 (6) To the extent that it can be determined, the
11 reason for the default.

12 (7) The demographics of individuals partici-
13 pating in the program.

14 (8) An evaluation of the overall costs and bene-
15 fits of the program.

16 (e) DEFINITIONS.—In this section:

17 (1) The term “HIV/AIDS” means human im-
18 munodeficiency virus and acquired immune defi-
19 ciency syndrome.

20 (2) The term “nurse practitioner” means a reg-
21 istered nurse who has completed an accredited grad-
22 uate degree program in advanced nurse practice and
23 has successfully passed a national certification exam.

1 (3) The term “physician” means a graduate of
2 a school of medicine who has completed post-
3 graduate training in general or pediatric medicine.

4 (4) The term “physician assistant” means a
5 medical provider who completed an accredited physi-
6 cian assistant training program and successfully
7 passed the Physician Assistant National Certifying
8 Examination.

9 (5) The term “professional education loan”—

10 (A) means a loan that is incurred for the
11 cost of attendance (including tuition, other rea-
12 sonable educational expenses, and reasonable
13 living costs) at a school of medicine, nursing, or
14 physician assistant training program; and

15 (B) includes only the portion of the loan
16 that is outstanding on the date the physician,
17 nurse practitioner, or physician assistant in-
18 volved begins the service specified in the agree-
19 ment under subsection (a).

20 (6) The term “Ryan White-funded” means,
21 with respect to a facility, receiving funds under title
22 XXVI of the Public Health Service Act (42 U.S.C.
23 300ff–11 et seq.).

24 (7) The term “Secretary” means the Secretary
25 of Health and Human Services.

1 (8) The term “school of medicine” has the
2 meaning given to that term in section 799B of the
3 Public Health Service Act (42 U.S.C. 295p).

4 (9) The term “title X-funded” means, with re-
5 spect to a facility, receiving funds under title X of
6 the Public Health Service Act (42 U.S.C. 300 et
7 seq.).

8 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
9 out this section, there are authorized to be appropriated
10 such sums as may be necessary for fiscal years 2017
11 through 2021.

12 **SEC. 751. DENTAL EDUCATION LOAN REPAYMENT PRO-**
13 **GRAM.**

14 (a) IN GENERAL.—The Secretary of Health and
15 Human Services may enter into an agreement with any
16 dentist under which—

17 (1) the dentist agrees to serve as a dentist for
18 a period of not less than 2 years at a facility with
19 a critical shortage of dentists (as determined by the
20 Secretary) in an area with a high incidence of HIV/
21 AIDS; and

22 (2) the Secretary agrees to make payments in
23 accordance with subsection (b) on the dental edu-
24 cation loans of the dentist.

1 (b) MANNER OF PAYMENTS.—The payments de-
2 scribed in subsection (a) shall be made by the Secretary
3 as follows:

4 (1) Upon completion by the dentist for whom
5 the payments are to be made of the first year of the
6 service specified in the agreement entered into with
7 the Secretary under subsection (a), the Secretary
8 shall pay 30 percent of the principal of and the in-
9 terest on the dental education loans of the dentist.

10 (2) Upon completion by the dentist of the sec-
11 ond year of such service, the Secretary shall pay an-
12 other 30 percent of the principal of and the interest
13 on such loans.

14 (3) Upon completion by that individual of a
15 third year of such service, the Secretary shall pay
16 another 25 percent of the principal of and the inter-
17 est on such loans.

18 (c) APPLICABILITY OF CERTAIN PROVISIONS.—The
19 provisions of subpart III of part D of title III of the Public
20 Health Service Act (42 U.S.C. 2541 et seq.) shall, except
21 as inconsistent with this section, apply to the program car-
22 ried out under this section in the same manner and to
23 the same extent as such provisions apply to the National
24 Health Service Corps Loan Repayment Program.

1 (d) REPORTS.—Not later than 18 months after the
2 date of the enactment of this Act, and annually thereafter,
3 the Secretary shall prepare and submit to the Congress
4 a report describing the program carried out under this sec-
5 tion, including statements regarding the following:

6 (1) The number of dentists enrolled in the pro-
7 gram.

8 (2) The number and amount of loan repay-
9 ments.

10 (3) The placement location of loan repayment
11 recipients at facilities described in subsection (a)(1).

12 (4) The default rate and actions required.

13 (5) The amount of outstanding default funds.

14 (6) To the extent that it can be determined, the
15 reason for the default.

16 (7) The demographics of individuals partici-
17 pating in the program.

18 (8) An evaluation of the overall costs and bene-
19 fits of the program.

20 (e) DEFINITIONS.—In this section:

21 (1) The term “dental education loan”—

22 (A) means a loan that is incurred for the
23 cost of attendance (including tuition, other rea-
24 sonable educational expenses, and reasonable
25 living costs) at a school of dentistry; and

1 (B) includes only the portion of the loan
2 that is outstanding on the date the dentist in-
3 volved begins the service specified in the agree-
4 ment under subsection (a).

5 (2) The term “dentist” means a graduate of a
6 school of dentistry who has completed postgraduate
7 training in general or pediatric dentistry.

8 (3) The term “HIV/AIDS” means human im-
9 munodeficiency virus and acquired immune defi-
10 ciency syndrome.

11 (4) The term “school of dentistry” has the
12 meaning given to that term in section 799B of the
13 Public Health Service Act (42 U.S.C. 295p).

14 (5) The term “Secretary” means the Secretary
15 of Health and Human Services.

16 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
17 out this section, there are authorized to be appropriated
18 such sums as may be necessary for each of fiscal years
19 2017 through 2021.

20 **SEC. 752. REDUCING NEW HIV INFECTIONS AMONG INJECT-**
21 **ING DRUG USERS.**

22 (a) SENSE OF CONGRESS.—It is the sense of the Con-
23 gress that providing sterile syringes and sterilized equip-
24 ment to injecting drug users substantially reduces risk of

1 HIV infection, increases the probability that they will ini-
2 tiate drug treatment, and does not increase drug use.

3 (b) IN GENERAL.—The Secretary of Health and
4 Human Services may provide grants and technical assist-
5 ance for the purpose of reducing the rate of HIV infections
6 among injecting drug users through a comprehensive
7 package of services for such users, including the provision
8 of sterile syringes, education and outreach, access to infec-
9 tious disease testing, overdose prevention, and treatment
10 for drug dependence.

11 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
12 out this section, there are authorized to be appropriated
13 such sums as may be necessary for fiscal years 2017
14 through 2021.

15 **SEC. 753. SUPPORT FOR EXPANSION OF COMPREHENSIVE**
16 **SEXUAL HEALTH AND EDUCATION PRO-**
17 **GRAMS.**

18 (a) SENSE OF CONGRESS.—It is the sense of Con-
19 gress that—

20 (1) federally funded sex education programs
21 should aim to—

22 (A) reduce unintended pregnancy and sex-
23 ually transmitted infections, including HIV;

24 (B) promote safe and healthy relation-
25 ships;

1 (C) use, and be informed by, the best sci-
2 entific information available;

3 (D) be built on characteristics of effective
4 programs;

5 (E) expand the existing body of evidence
6 on comprehensive sex education programs
7 through program evaluation;

8 (F) expand training programs for teachers
9 of comprehensive sex education;

10 (G) build on the personal responsibility
11 education programs funded under section 513
12 of the Social Security Act (42 U.S.C. 713) and
13 the President's Teen Pregnancy Prevention pro-
14 gram, funded under title II of the Consolidated
15 Appropriations Act, 2010 (Public Law 111-
16 117; 123 Stat. 3253); and

17 (H) promote and uphold the rights of
18 young people to information in order to make
19 healthy and responsible decisions about their
20 sexual health; and

21 (2) no Federal funds should be used for health
22 education programs that—

23 (A) deliberately withhold life-saving infor-
24 mation about HIV;

1 (B) are medically inaccurate or have been
2 scientifically shown to be ineffective;

3 (C) promote gender stereotypes;

4 (D) are insensitive and unresponsive to the
5 needs of sexually active adolescents;

6 (E) are insensitive and unresponsive to the
7 needs of lesbian, gay, bisexual, transgender,
8 queer, or questioning youth; or

9 (F) are inconsistent with the ethical im-
10 peratives of medicine and public health.

11 (b) GRANTS FOR COMPREHENSIVE SEX EDUCATION
12 FOR ADOLESCENTS.—

13 (1) PROGRAM AUTHORIZED.—The Secretary, in
14 coordination with the Director of the Office of Ado-
15 lescent Health, shall award grants, on a competitive
16 basis, to eligible entities to enable such eligible enti-
17 ties to carry out programs that provide adolescents
18 with comprehensive sex education, as described in
19 paragraph (6).

20 (2) DURATION.—Grants awarded under this
21 subsection shall be for a period of 5 years.

22 (3) ELIGIBLE ENTITY.—In this subsection, the
23 term “eligible entity” means a public or private enti-
24 ty that focuses on adolescent health or education or

1 has experience working with adolescents, which may
2 include—

3 (A) a State educational agency;

4 (B) a local educational agency;

5 (C) a tribe or tribal organization, as de-
6 fined in section 4 of the Indian Self-Determina-
7 tion and Education Assistance Act (25 U.S.C.
8 450b);

9 (D) a State or local department of health;

10 (E) a State or local department of edu-
11 cation;

12 (F) a nonprofit organization;

13 (G) a nonprofit or public institution of
14 higher education; or

15 (H) a hospital.

16 (4) APPLICATIONS.—An eligible entity desiring
17 a grant under this subsection shall submit an appli-
18 cation to the Secretary at such time, in such man-
19 ner, and containing such information as the Sec-
20 retary may require, including the evaluation plan de-
21 scribed in paragraph (7)(A).

22 (5) PRIORITY.—In awarding grants under this
23 subsection, the Secretary shall give priority to eligi-
24 ble entities that—

1 (A) are State or local public entities, with
2 an additional priority for State or local edu-
3 cational agencies; and

4 (B) address health disparities among
5 young people that are at highest risk for not
6 less than 1 of the following:

7 (i) Unintended pregnancies.

8 (ii) Sexually transmitted infections,
9 including HIV.

10 (iii) Dating violence and sexual as-
11 sult.

12 (6) USE OF FUNDS.—

13 (A) IN GENERAL.—Each eligible entity
14 that receives a grant under this subsection shall
15 use grant funds to carry out a program that
16 provides adolescents with comprehensive sex
17 education that—

18 (i) replicates evidence-based sex edu-
19 cation programs;

20 (ii) substantially incorporates ele-
21 ments of evidence-based sex education pro-
22 grams; or

23 (iii) creates a demonstration project
24 based on generally accepted characteristics
25 of effective sex education programs.

1 (B) CONTENTS OF SEX EDUCATION PRO-
2 GRAMS.—The sex education programs funded
3 under this subsection shall include curricula
4 and program materials that address—

5 (i) abstinence and delaying sexual ini-
6 tiation;

7 (ii) the health benefits and side effects
8 of all contraceptive and barrier methods as
9 a means to prevent pregnancy and sexually
10 transmitted infections, including HIV;

11 (iii) healthy relationships, including
12 the development of healthy attitudes and
13 skills necessary for understanding—

14 (I) healthy relationships between
15 oneself and family, others, and soci-
16 ety; and

17 (II) the prevention of sexual
18 abuse, teen dating violence, bullying,
19 harassment, and suicide;

20 (iv) healthy life skills including goal-
21 setting, decisionmaking, interpersonal skills
22 (such as communication, assertiveness, and
23 peer refusal skills), critical thinking, self-
24 esteem and self-efficacy, and stress man-
25 agement;

1 (v) how to make responsible decisions
2 about sex and sexuality, including—

3 (I) how to avoid, and how to
4 avoid making, unwanted verbal, phys-
5 ical, and sexual advances; and

6 (II) how alcohol and drug use
7 can affect responsible decisionmaking;

8 (vi) the development of healthy atti-
9 tudes and values about such topics as ado-
10 lescent growth and development, body
11 image, gender roles and gender identity,
12 racial and ethnic diversity, and sexual ori-
13 entation; and

14 (vii) referral services for local health
15 clinics and services where adolescents can
16 obtain additional information and services
17 related to sexual and reproductive health,
18 dating violence and sexual assault, and sui-
19 cide prevention.

20 (7) EVALUATION; REPORT.—

21 (A) INDEPENDENT EVALUATION.—Each
22 eligible entity applying for a grant under this
23 subsection shall develop and submit to the Sec-
24 retary a plan for a rigorous independent evalua-

1 tion of such grant program. The plan shall de-
2 scribe an independent evaluation that—

3 (i) uses sound statistical methods and
4 techniques relating to the behavioral
5 sciences, including random assignment
6 methodologies, whenever possible;

7 (ii) uses quantitative data for assess-
8 ments and impact evaluations, whenever
9 possible; and

10 (iii) is carried out by an entity inde-
11 pendent from such eligible entity.

12 (B) SELECTION OF EVALUATED PRO-
13 GRAMS; BUDGET.—

14 (i) SELECTION OF EVALUATED PRO-
15 GRAMS.—The Secretary shall select, at
16 random, a subset of the eligible entities
17 that the Secretary has selected to receive a
18 grant under this subsection to receive addi-
19 tional funding to carry out the evaluation
20 plan described in subparagraph (A).

21 (ii) BUDGET FOR EVALUATION ACTIVI-
22 TIES.—The Secretary, in coordination with
23 the Director of the Office of Adolescent
24 Health, shall establish a budget for each
25 eligible entity selected under clause (i) for

1 the costs of carrying out the evaluation
2 plan described in subparagraph (A).

3 (C) FUNDS FOR EVALUATION.—The Sec-
4 retary shall provide eligible entities who are se-
5 lected under subparagraph (B)(i) with addi-
6 tional funds, in accordance with the budget de-
7 scribed in subparagraph (B)(ii), to carry out
8 and report to the Secretary on the evaluation
9 plan described in subparagraph (A).

10 (D) PERFORMANCE MEASURES.—The Sec-
11 retary, in coordination with the Director of the
12 Centers for Disease Control and Prevention,
13 shall establish a common set of performance
14 measures to assess the implementation and im-
15 pact of grant programs funded under this sub-
16 section. Such performance measures shall in-
17 clude—

18 (i) output measures, such as the num-
19 ber of individuals served and the number
20 of hours of service delivery;

21 (ii) outcome measures, including
22 measures relating to—

23 (I) the knowledge that youth par-
24 ticipating in the grant program have
25 gained about—

- 1 (aa) adolescent growth and
2 development;
3 (bb) relationship dynamics;
4 (cc) ways to prevent unin-
5 tended pregnancy and sexually
6 transmitted infections, including
7 HIV; and
8 (dd) sexual health;
- 9 (II) the skills that adolescents
10 participating in the grant program
11 have gained regarding—
- 12 (aa) negotiation and commu-
13 nication;
14 (bb) decisionmaking and
15 goal-setting;
16 (cc) interpersonal skills and
17 healthy relationships; and
18 (dd) condom use; and
- 19 (III) the behaviors of adolescents
20 participating in the grant program,
21 including data about—
- 22 (aa) age of first intercourse;
23 (bb) number of sexual part-
24 ners;

1 (cc) condom and contracep-
2 tive use at first intercourse;

3 (dd) recent condom and con-
4 traceptive use; and

5 (ee) dating abuse and life-
6 time history of domestic violence,
7 sexual assault, dating violence,
8 bullying, harassment, and stalk-
9 ing.

10 (E) REPORT TO THE SECRETARY.—Eligi-
11 ble entities receiving a grant under this sub-
12 section who have been selected to receive funds
13 to carry out the evaluation plan described in
14 subparagraph (A), in accordance with subpara-
15 graph (B)(i), shall collect and report to the Sec-
16 retary—

17 (i) the results of the independent eval-
18 uation described in subparagraph (A); and

19 (ii) information about the perform-
20 ance measures described in subparagraph
21 (B).

22 (F) EFFECTIVE PROGRAMS.—The Sec-
23 retary, in coordination with the Director of the
24 Centers for Disease Control and Prevention,
25 shall publish on the Web site of the Centers for

1 Disease Control and Prevention, a list of pro-
2 grams funded under this subsection that the
3 Secretary has determined to be effective pro-
4 grams.

5 (c) GRANTS FOR COMPREHENSIVE SEX EDUCATION
6 AT INSTITUTIONS OF HIGHER EDUCATION.—

7 (1) PROGRAM AUTHORIZED.—The Secretary, in
8 coordination with the Office of Adolescent Health
9 and the Secretary of Education, shall award grants,
10 on a competitive basis, to institutions of higher edu-
11 cation to enable such institutions to provide young
12 people with comprehensive sex education, described
13 in paragraph (5)(B), with an emphasis on reducing
14 HIV, other sexually transmitted infections, and un-
15 intended pregnancy through instruction about—

- 16 (A) abstinence and contraception;
17 (B) reducing dating violence, sexual as-
18 sault, bullying, and harassment;
19 (C) increasing healthy relationships; and
20 (D) academic achievement.

21 (2) DURATION.—Grants awarded under this
22 subsection shall be for a period of 5 years.

23 (3) APPLICATIONS.—An institution of higher
24 education desiring a grant under this subsection
25 shall submit an application to the Secretary at such

1 time, in such manner, and containing such informa-
2 tion as the Secretary may require.

3 (4) PRIORITY.—In awarding grants under this
4 subsection, the Secretary shall give priority to an in-
5 stitution of higher education that—

6 (A) has an enrollment of needy students as
7 defined in section 318(b) of the Higher Edu-
8 cation Act of 1965 (20 U.S.C. 1059e(b));

9 (B) is a Hispanic-serving institution, as
10 defined in section 502(a) of such Act (20
11 U.S.C. 1101a(a));

12 (C) is a Tribal College or University, as
13 defined in section 316(b) of such Act (20
14 U.S.C. 1059e(b));

15 (D) is an Alaska Native-serving institution,
16 as defined in section 317(b) of such Act (20
17 U.S.C. 1059d(b));

18 (E) is a Native Hawaiian-serving institu-
19 tion, as defined in section 317(b) of such Act
20 (20 U.S.C. 1059d(b));

21 (F) is a Predominately Black Institution,
22 as defined in section 318(b) of such Act (20
23 U.S.C. 1059e(b));

1 (G) is a Native American-serving, non-
2 tribal institution, as defined in section 319(b)
3 of such Act (20 U.S.C. 1059f(b));

4 (H) is an Asian American and Native
5 American Pacific Islander-serving institution, as
6 defined in section 320(b) of such Act (20
7 U.S.C. 1059g(b)); or

8 (I) is a minority institution, as defined in
9 section 365 of such Act (20 U.S.C. 1067k),
10 with an enrollment of needy students, as de-
11 fined in section 312 of such Act (20 U.S.C.
12 1058).

13 (5) USES OF FUNDS.—

14 (A) IN GENERAL.—An institution of higher
15 education receiving a grant under this sub-
16 section may use grant funds to integrate issues
17 relating to comprehensive sex education into the
18 academic or support sectors of the institution of
19 higher education in order to reach a large num-
20 ber of students, by carrying out 1 or more of
21 the following activities:

22 (i) Developing educational content for
23 issues relating to comprehensive sex edu-
24 cation that will be incorporated into first-
25 year orientation or core courses.

1 (ii) Developing and employing
2 schoolwide educational programming out-
3 side of class that delivers elements of com-
4 prehensive sex education programs to stu-
5 dents, faculty, and staff.

6 (iii) Creating innovative technology-
7 based approaches to deliver sex education
8 to students, faculty, and staff.

9 (iv) Developing and employing peer-
10 outreach and education programs to gen-
11 erate discussion, educate, and raise aware-
12 ness among students about issues relating
13 to comprehensive sex education.

14 (B) CONTENTS OF SEX EDUCATION PRO-
15 GRAMS.—Each institution of higher education’s
16 program of comprehensive sex education funded
17 under this subsection shall include curricula
18 and program materials that address informa-
19 tion about—

20 (i) safe and responsible sexual behav-
21 ior with respect to the prevention of preg-
22 nancy and sexually transmitted infections,
23 including HIV, including through—

24 (I) abstinence;

1 (II) a reduced number of sexual
2 partners; and

3 (III) the use of condoms and con-
4 traception;

5 (ii) healthy relationships, including
6 the development of healthy attitudes and
7 insights necessary for understanding—

8 (I) relationships between oneself,
9 family, partners, others, and society;
10 and

11 (II) the prevention of sexual
12 abuse, dating violence, bullying, har-
13 assment, and suicide; and

14 (iii) referral services to local health
15 clinics where young people can obtain addi-
16 tional information and services related to
17 sexual and reproductive health, dating vio-
18 lence and sexual assault, and suicide pre-
19 vention.

20 (C) OPTIONAL COMPONENTS OF SEX EDU-
21 CATION.—Each institution of higher education’s
22 program of comprehensive sex education may
23 also include information and skills development
24 relating to—

- 1 (i) how to make responsible decisions
2 about sex and sexuality, including—
- 3 (I) how to avoid, and avoid mak-
4 ing, unwanted verbal, physical, and
5 sexual advances; and
- 6 (II) how alcohol and drug use
7 can affect responsible decisionmaking;
- 8 (ii) healthy life skills, including—
- 9 (I) goal-setting and decision-
10 making;
- 11 (II) interpersonal skills, such as
12 communication, assertiveness, and
13 peer refusal skills;
- 14 (III) critical thinking;
- 15 (IV) self-esteem and self-efficacy;
- 16 and
- 17 (V) stress management;
- 18 (iii) the development of healthy atti-
19 tudes and values about such topics as body
20 image, gender roles and gender identity,
21 racial and ethnic diversity, and sexual ori-
22 entation; and
- 23 (iv) the responsibilities of parenting
24 and the skills necessary to parent well.

1 (6) EVALUATION; REPORT.—The requirements
2 described in section 125B(g) shall also apply to eligi-
3 ble entities receiving a grant under this subsection
4 in the same manner as such requirements apply to
5 eligible entities receiving grants under section 125B.

6 (d) GRANTS FOR PRE-SERVICE AND IN-SERVICE
7 TEACHER TRAINING.—

8 (1) PROGRAM AUTHORIZED.—The Secretary, in
9 coordination with the Director of the Centers for
10 Disease Control and Prevention and the Secretary of
11 Education, shall award grants, on a competitive
12 basis, to eligible entities to enable such eligible enti-
13 ties to carry out the activities described in para-
14 graph (5).

15 (2) DURATION.—Grants awarded under this
16 subsection shall be for a period of 5 years.

17 (3) ELIGIBLE ENTITY.—In this subsection, the
18 term “eligible entity” means—

19 (A) a State educational agency;

20 (B) a local educational agency;

21 (C) a tribe or tribal organization, as de-
22 fined in section 4 of the Indian Self-Determina-
23 tion and Education Assistance Act (25 U.S.C.
24 450b);

25 (D) a State or local department of health;

1 (E) a State or local department of edu-
2 cation;

3 (F) a nonprofit institution of higher edu-
4 cation;

5 (G) a national or statewide nonprofit orga-
6 nization that has as its primary purpose the im-
7 provement of provision of comprehensive sex
8 education through effective teaching of com-
9 prehensive sex education; or

10 (H) a consortium of nonprofit organiza-
11 tions that has as its primary purpose the im-
12 provement of provision of comprehensive sex
13 education through effective teaching of com-
14 prehensive sex education.

15 (4) APPLICATION.—An eligible entity desiring a
16 grant under this subsection shall submit an applica-
17 tion to the Secretary at such time, in such manner,
18 and containing such information as the Secretary
19 may require.

20 (5) AUTHORIZED ACTIVITIES.—

21 (A) REQUIRED ACTIVITY.—Each eligible
22 entity receiving a grant under this subsection
23 shall use grant funds to train targeted faculty
24 and staff, in order to increase effective teaching

1 of comprehensive sex education for elementary
2 school and secondary school students.

3 (B) PERMISSIBLE ACTIVITIES.—Each eligi-
4 ble entity receiving a grant under this sub-
5 section may use grant funds to—

6 (i) strengthen and expand the eligible
7 entity’s relationships with—

8 (I) institutions of higher edu-
9 cation;

10 (II) State educational agencies;

11 (III) local educational agencies;

12 or

13 (IV) other public and private or-
14 ganizations with a commitment to
15 comprehensive sex education and the
16 benefits of comprehensive sex edu-
17 cation;

18 (ii) support and promote research-
19 based training of teachers of comprehen-
20 sive sex education and related disciplines
21 in elementary schools and secondary
22 schools as a means of broadening student
23 knowledge about issues related to human
24 development, relationships, personal skills,

1 sexual behavior, sexual health, and society
2 and culture;

3 (iii) support the dissemination of in-
4 formation on effective practices and re-
5 search findings concerning the teaching of
6 comprehensive sex education;

7 (iv) support research on—

8 (I) effective comprehensive sex
9 education teaching practices; and

10 (II) the development of assess-
11 ment instruments and strategies to
12 document—

13 (aa) student understanding
14 of comprehensive sex education;
15 and

16 (bb) the effects of com-
17 prehensive sex education;

18 (v) convene national conferences on
19 comprehensive sex education, in order to
20 effectively train teachers in the provision of
21 comprehensive sex education; and

22 (vi) develop and disseminate appro-
23 priate research-based materials to foster
24 comprehensive sex education.

1 (C) SUBGRANTS.—Each eligible entity re-
2 ceiving a grant under this subsection may
3 award subgrants to nonprofit organizations,
4 State educational agencies, or local educational
5 agencies to enable such organizations or agen-
6 cies to—

7 (i) train teachers in comprehensive
8 sex education;

9 (ii) support Internet or distance learn-
10 ing related to comprehensive sex education;

11 (iii) promote rigorous academic stand-
12 ards and assessment techniques to guide
13 and measure student performance in com-
14 prehensive sex education;

15 (iv) encourage replication of best
16 practices and model programs to promote
17 comprehensive sex education;

18 (v) develop and disseminate effective,
19 research-based comprehensive sex edu-
20 cation learning materials;

21 (vi) develop academic courses on the
22 pedagogy of sex education at institutions
23 of higher education; or

24 (vii) convene State-based conferences
25 to train teachers in comprehensive sex edu-

1 cation and to identify strategies for im-
2 provement.

3 (e) REPORT TO CONGRESS.—

4 (1) IN GENERAL.—Not later than 1 year after
5 the date of the enactment of this Act, and annually
6 thereafter for a period of 5 years, the Secretary shall
7 prepare and submit to the appropriate committees of
8 Congress a report on the activities to provide adoles-
9 cents and young people with comprehensive sex edu-
10 cation funded under this section.

11 (2) REPORT ELEMENTS.—The report described
12 in paragraph (1) shall include information about—

13 (A) the number of eligible entities and in-
14 stitutions of higher education that are receiving
15 grant funds under subsections (b) and (c);

16 (B) the specific activities supported by
17 grant funds awarded under subsections (b) and
18 (c);

19 (C) the number of adolescents served by
20 grant programs funded under subsection (b);

21 (D) the number of young people served by
22 grant programs funded under subsection (c);
23 and

24 (E) the status of program evaluations de-
25 scribed under subsections (b) and (c).

1 (f) LIMITATION.—No Federal funds provided under
2 this section may be used for health education programs
3 that—

4 (1) deliberately withhold life-saving information
5 about HIV;

6 (2) are medically inaccurate or have been sci-
7 entifically shown to be ineffective;

8 (3) promote gender stereotypes;

9 (4) are insensitive and unresponsive to the
10 needs of sexually active youth or lesbian, gay, bisex-
11 ual, transgender, queer, or questioning youth; or

12 (5) are inconsistent with the ethical imperatives
13 of medicine and public health.

14 (g) DEFINITIONS.—In this section:

15 (1) ESEA DEFINITIONS.—The terms “elemen-
16 tary school”, “local educational agency”, “secondary
17 school”, and “State educational agency” have the
18 meanings given the terms in section 8101 of the Ele-
19 mentary and Secondary Education Act of 1965 (20
20 U.S.C. 7801).

21 (2) AGE AND DEVELOPMENTALLY APPRO-
22 PRIATE.—The term “age and developmentally appro-
23 priate” means suitable for a particular age or age
24 group of children and adolescents, based on devel-

1 oping cognitive, emotional, and behavioral capacity
2 typical for that age or age group.

3 (3) ADOLESCENTS.—The term “adolescents”
4 means individuals who are ages 10 through 19 at
5 the time of commencement of participation in a pro-
6 gram supported under this section.

7 (4) CHARACTERISTICS OF EFFECTIVE PRO-
8 GRAMS.—The term “characteristics of effective pro-
9 grams” means the aspects of evidence-based pro-
10 grams, including development, content, and imple-
11 mentation of such programs, that—

12 (A) have been shown to be effective in
13 terms of increasing knowledge, clarifying values
14 and attitudes, increasing skills, and impacting
15 upon behavior; and

16 (B) are widely recognized by leading med-
17 ical and public health agencies to be effective in
18 changing sexual behaviors that lead to sexually
19 transmitted infections, including HIV, unin-
20 tended pregnancy, and dating violence and sex-
21 ual assault among young people.

22 (5) COMPREHENSIVE SEX EDUCATION.—The
23 term “comprehensive sex education” means a pro-
24 gram that—

1 (A) includes age- and developmentally ap-
2 propriate, culturally and linguistically relevant
3 information on a broad set of topics related to
4 sexuality including human development, rela-
5 tionships, decisionmaking, communication, ab-
6 stinence, contraception, and disease and preg-
7 nancy prevention;

8 (B) provides students with opportunities
9 for developing skills as well as learning informa-
10 tion;

11 (C) is inclusive of lesbian, gay, bisexual,
12 transgender, queer, questioning, and hetero-
13 sexual young people; and

14 (D) aims to—

15 (i) provide scientifically accurate and
16 realistic information about human sexu-
17 ality;

18 (ii) provide opportunities for individ-
19 uals to understand their own, their fami-
20 lies', and their communities' values, atti-
21 tudes, and insights about sexuality;

22 (iii) help individuals develop healthy
23 relationships and interpersonal skills; and

24 (iv) help individuals exercise responsi-
25 bility regarding sexual relationships, which

1 includes addressing abstinence, pressures
2 to become prematurely involved in sexual
3 intercourse, and the use of contraception
4 and other sexual health measures.

5 (6) EVIDENCE-BASED PROGRAM.—The term
6 “evidence-based program” means a sex education
7 program that has been proven through rigorous eval-
8 uation to be effective in changing sexual behavior or
9 incorporates elements of other sex education pro-
10 grams that have been proven to be effective in
11 changing sexual behavior.

12 (7) INSTITUTION OF HIGHER EDUCATION.—The
13 term “institution of higher education” has the
14 meaning given the term in section 101 of the Higher
15 Education Act of 1965 (20 U.S.C. 1001).

16 (8) MEDICALLY ACCURATE AND COMPLETE.—
17 The term “medically accurate and complete”, when
18 used with respect to a sex education program, means
19 that—

20 (A) the information provided through the
21 program is verified or supported by the weight
22 of research conducted in compliance with ac-
23 cepted scientific methods and is published in
24 peer-reviewed journals, where applicable; or

1 (B)(i) the program contains information
2 that leading professional organizations and
3 agencies with relevant expertise in the field rec-
4 ognize as accurate, objective, and complete; and

5 (ii) the program does not withhold infor-
6 mation about the effectiveness and benefits of
7 correct and consistent use of condoms and
8 other contraceptives.

9 (9) SECRETARY.—The term “Secretary” means
10 the Secretary of Health and Human Services.

11 (10) YOUNG PEOPLE.—The term “young peo-
12 ple” means individuals who are ages 10 through 24
13 at the time of commencement of participation in a
14 program supported under this section.

15 (h) FUNDING.—

16 (1) ELIMINATION OF ABSTINENCE-ONLY-UNTIL-
17 MARRIAGE PROGRAM.—Title V of the Social Security
18 Act (42 U.S.C. 701 et seq.) is amended by striking
19 section 510.

20 (2) RESCISSION.—Amounts appropriated for
21 fiscal years 2016 and 2017 under section 510(d) of
22 the Social Security Act (42 U.S.C. 710(d)) (as in ef-
23 fect on the day before the date of enactment of this
24 Act) that are unobligated as of the date of enact-
25 ment of this Act are rescinded.

1 (3) AUTHORIZATION OF APPROPRIATIONS.—

2 There are authorized to be appropriated to carry out
3 this section for fiscal years 2017 through 2021 an
4 amount equal to the funds appropriated for fiscal
5 years 2016 and 2017 under section 510(d) of the
6 Social Security Act (42 U.S.C. 710(d)) (as in effect
7 on the day before the date of enactment of this Act)
8 that are rescinded by paragraph (2).

9 **SEC. 754. REPORT ON IMPACT OF HIV/AIDS IN VULNERABLE**
10 **POPULATIONS.**

11 (a) IN GENERAL.—The Secretary shall submit to the
12 Congress and the President an annual report on the im-
13 pact of HIV/AIDS for racial and ethnic minority commu-
14 nities, women, and youth aged 24 and younger.

15 (b) CONTENTS.—The report under subsection (a)
16 shall include information on the—

17 (1) progress that has been made in reducing
18 the impact of HIV/AIDS in such communities;

19 (2) opportunities that exist to make additional
20 progress in reducing the impact of HIV/AIDS in
21 such communities;

22 (3) challenges that may impede such additional
23 progress; and

1 (4) Federal funding necessary to achieve sub-
2 stantial reductions in HIV/AIDS in racial and ethnic
3 minority communities.

4 **SEC. 755. NATIONAL HIV/AIDS OBSERVANCE DAYS.**

5 (a) NATIONAL OBSERVANCE DAYS.—It is the sense
6 of the Congress that national observance days highlighting
7 the impact of HIV/AIDS on communities of color include
8 the following:

9 (1) National Black HIV/AIDS Awareness Day.

10 (2) National Latino AIDS Awareness Day.

11 (3) National Asian and Pacific Islander HIV/
12 AIDS Awareness Day.

13 (4) National Native American HIV/AIDS
14 Awareness Day.

15 (5) Caribbean-American HIV/AIDS Awareness
16 Day.

17 (6) National Youth HIV/AIDS Awareness Day.

18 (7) National Black Clergy HIV/AIDS Aware-
19 ness Sunday.

20 (b) CALL TO ACTION.—It is the sense of the Con-
21 gress that the President should call on members of com-
22 munities of color—

23 (1) to become involved at the local community
24 level in HIV/AIDS testing, policy, and advocacy;

1 (2) to become aware, engaged, and empowered
2 on the HIV/AIDS epidemic within their commu-
3 nities; and

4 (3) to urge members of their communities to re-
5 duce risk factors, practice safe sex and other preven-
6 tive measures, be tested for HIV/AIDS, and seek
7 care when appropriate.

8 **SEC. 756. REVIEW OF ALL FEDERAL AND STATE LAWS,**
9 **POLICIES, AND REGULATIONS REGARDING**
10 **THE CRIMINAL PROSECUTION OF INDIVID-**
11 **UALS FOR HIV-RELATED OFFENSES.**

12 (a) DEFINITIONS.—

13 (1) HIV AND HIV/AIDS.—The terms “HIV” and
14 “HIV/AIDS” have the meanings given to such terms
15 in section 2689 of the Public Health Service Act (42
16 U.S.C. 300ff–88).

17 (2) STATE.—The term “State” includes the
18 District of Columbia, American Samoa, the Com-
19 monwealth of the Northern Mariana Islands, Guam,
20 Puerto Rico, and the United States Virgin Islands.

21 (b) SENSE OF CONGRESS REGARDING LAWS OR REG-
22 ULATIONS DIRECTED AT PEOPLE LIVING WITH HIV/
23 AIDS.—It is the sense of the Congress that Federal and
24 State laws, policies, and regulations regarding people liv-
25 ing with HIV/AIDS—

1 (1) should not place unique or additional bur-
2 dens on such individuals solely as a result of their
3 HIV status; and

4 (2) should instead demonstrate a public health-
5 oriented, evidence-based, medically accurate, and
6 contemporary understanding of—

7 (A) the multiple factors that lead to HIV
8 transmission;

9 (B) the relative risk of HIV transmission
10 routes;

11 (C) the current health implications of liv-
12 ing with HIV;

13 (D) the associated benefits of treatment
14 and support services for people living with HIV;
15 and

16 (E) the impact of punitive HIV-specific
17 laws and policies on public health, on people liv-
18 ing with or affected by HIV, and on their fami-
19 lies and communities.

20 (c) REVIEW OF ALL FEDERAL AND STATE LAWS,
21 POLICIES, AND REGULATIONS REGARDING THE CRIMINAL
22 PROSECUTION OF INDIVIDUALS FOR HIV-RELATED OF-
23 FENSES.—

24 (1) REVIEW OF FEDERAL AND STATE LAWS.—

1 (A) IN GENERAL.—No later than 90 days
2 after the date of the enactment of this Act, the
3 Attorney General, the Secretary of Health and
4 Human Services, and the Secretary of Defense
5 acting jointly (in this paragraph and paragraph
6 (2) referred to as the “designated officials”) shall
7 initiate a national review of Federal and
8 State laws, policies, regulations, and judicial
9 precedents and decisions regarding criminal and
10 related civil commitment cases involving people
11 living with HIV/AIDS, including in regards to
12 the Uniform Code of Military Justice.

13 (B) CONSULTATION.—In carrying out the
14 review under subparagraph (A), the designated
15 officials shall ensure diverse participation and
16 consultation from each State, including with—

17 (i) State attorneys general (or their
18 representatives);

19 (ii) State public health officials (or
20 their representatives);

21 (iii) State judicial and court system
22 officers, including judges, district attor-
23 neys, prosecutors, defense attorneys, law
24 enforcement, and correctional officers;

1 (iv) members of the United States
2 Armed Forces, including members of other
3 Federal services subject to the Uniform
4 Code of Military Justice;

5 (v) people living with HIV/AIDS, par-
6 ticularly those who have been subject to
7 HIV-related prosecution or who are from
8 communities whose members have been
9 disproportionately subject to HIV-specific
10 arrests and prosecutions;

11 (vi) legal advocacy and HIV/AIDS
12 service organizations that work with people
13 living with HIV/AIDS;

14 (vii) nongovernmental health organi-
15 zations that work on behalf of people living
16 with HIV/AIDS; and

17 (viii) trade organizations or associa-
18 tions representing persons or entities de-
19 scribed in clauses (i) through (vii).

20 (C) RELATION TO OTHER REVIEWS.—In
21 carrying out the review under subparagraph
22 (A), the designated officials may utilize other
23 existing reviews of criminal and related civil
24 commitment cases involving people living with
25 HIV/AIDS, including any such review con-

1 ducted by any Federal or State agency or any
2 public health, legal advocacy, or trade organiza-
3 tion or association if the designated officials de-
4 termine that such reviews were conducted in ac-
5 cordance with the principles set forth in sub-
6 section (b).

7 (2) REPORT.—No later than 180 days after ini-
8 tiating the review required by paragraph (1), the At-
9 torney General shall transmit to the Congress and
10 make publicly available a report containing the re-
11 sults of the review, which includes the following:

12 (A) For each State and for the Uniform
13 Code of Military Justice, a summary of the rel-
14 evant laws, policies, regulations, and judicial
15 precedents and decisions regarding criminal
16 cases involving people living with HIV/AIDS,
17 including, if applicable, the following:

18 (i) A determination of whether such
19 laws, policies, regulations, and judicial
20 precedents and decisions place any unique
21 or additional burdens upon people living
22 with HIV/AIDS.

23 (ii) A determination of whether such
24 laws, policies, regulations, and judicial
25 precedents and decisions demonstrate a

1 public health-oriented, evidence-based,
2 medically accurate, and contemporary un-
3 derstanding of—

4 (I) the multiple factors that lead
5 to HIV transmission;

6 (II) the relative risk of HIV
7 transmission routes;

8 (III) the current health implica-
9 tions of living with HIV;

10 (IV) the associated benefits of
11 treatment and support services for
12 people living with HIV; and

13 (V) the impact of punitive HIV-
14 specific laws and policies on public
15 health, on people living with or af-
16 fected by HIV, and on their families
17 and communities.

18 (iii) An analysis of the public health
19 and legal implications of such laws, poli-
20 cies, regulations, and judicial precedents,
21 including an analysis of the consequences
22 of having a similar penal scheme applied to
23 comparable situations involving other com-
24 municable diseases.

1 (iv) An analysis of the proportionality
2 of punishments imposed under HIV-spe-
3 cific laws, policies, regulations, and judicial
4 precedents, taking into consideration pen-
5 alties attached to violation of State laws
6 against similar degrees of endangerment or
7 harm, such as driving while intoxicated
8 (DWI) or transmission of other commu-
9 nicable diseases, or more serious harms,
10 such as vehicular manslaughter offenses.

11 (B) An analysis of common elements
12 shared among State laws, policies, regulations,
13 and judicial precedents.

14 (C) A set of best practice recommendations
15 directed to State governments, including State
16 attorneys general, public health officials, and
17 judicial officers, in order to ensure that laws,
18 policies, regulations, and judicial precedents re-
19 garding people living with HIV/AIDS are in ac-
20 cordance with the principles set forth in sub-
21 section (b).

22 (D) Recommendations for adjustments to
23 the Uniform Code of Military Justice, as may
24 be necessary, in order to ensure that laws, poli-
25 cies, regulations, and judicial precedents re-

1 garding people living with HIV/AIDS are in ac-
2 cordance with the principles set forth in sub-
3 section (b).

4 (3) GUIDANCE.—Within 90 days of the release
5 of the report required by paragraph (2), the Attor-
6 ney General and the Secretary of Health and
7 Human Services, acting jointly, shall develop and
8 publicly release updated guidance for States based
9 on the set of best practice recommendations required
10 by paragraph (2)(C) in order to assist States dealing
11 with criminal and related civil commitment cases re-
12 garding people living with HIV/AIDS.

13 (4) MONITORING AND EVALUATION SYSTEM.—
14 Within 60 days of the release of the guidance re-
15 quired by paragraph (3), the Attorney General and
16 the Secretary of Health and Human Services, acting
17 jointly, shall establish an integrated monitoring and
18 evaluation system which includes, where appropriate,
19 objective and quantifiable performance goals and in-
20 dicators to measure progress toward statewide im-
21 plementation in each State of the best practice rec-
22 ommendations required in paragraph (2)(C), includ-
23 ing to monitor, track, and evaluate the effectiveness
24 of assistance provided pursuant to subsection (d).

1 (5) ADJUSTMENTS TO FEDERAL LAWS, POLI-
2 CIES, OR REGULATIONS.—Within 90 days of the re-
3 lease of the report required by paragraph (2), the
4 Attorney General, the Secretary of Health and
5 Human Services, and the Secretary of Defense, act-
6 ing jointly, shall develop and transmit to the Presi-
7 dent and the Congress, and make publicly available,
8 such proposals as may be necessary to implement
9 adjustments to Federal laws, policies, or regulations,
10 including to the Uniform Code of Military Justice,
11 based on the recommendations required by para-
12 graph (2)(D), either through Executive order or
13 through changes to statutory law.

14 (6) AUTHORIZATION OF APPROPRIATIONS.—

15 (A) IN GENERAL.—There are authorized to
16 be appropriated such sums as may be necessary
17 for the purpose of carrying out this subsection.
18 Amounts authorized to be appropriated by the
19 preceding sentence are in addition to amounts
20 otherwise authorized to be appropriated for
21 such purpose.

22 (B) AVAILABILITY OF FUNDS.—Amounts
23 appropriated pursuant to the authorization of
24 appropriations in subparagraph (A) are author-
25 ized to remain available until expended.

1 (d) AUTHORIZATION TO PROVIDE GRANTS.—

2 (1) GRANTS BY ATTORNEY GENERAL.—

3 (A) IN GENERAL.—The Attorney General
4 may provide assistance to eligible State and
5 local entities and eligible nongovernmental orga-
6 nizations for the purpose of incorporating the
7 best practice recommendations developed under
8 subsection (c)(2)(C) within relevant State laws,
9 policies, regulations, and judicial decisions re-
10 garding people living with HIV/AIDS.

11 (B) AUTHORIZED ACTIVITIES.—The assist-
12 ance authorized by subparagraph (A) may in-
13 clude—

14 (i) direct technical assistance to eligi-
15 ble State and local entities in order to de-
16 velop, disseminate, or implement State
17 laws, policies, regulations, or judicial deci-
18 sions that conform with the best practice
19 recommendations developed under sub-
20 section (c)(2)(C);

21 (ii) direct technical assistance to eligi-
22 ble nongovernmental organizations in order
23 to provide education and training, includ-
24 ing through classes, conferences, meetings,

1 and other educational activities, to eligible
2 State and local entities; and

3 (iii) subcontracting authority to allow
4 eligible State and local entities and eligible
5 nongovernmental organizations to seek
6 technical assistance from legal and public
7 health experts with a demonstrated under-
8 standing of the principles underlying the
9 best practice recommendations developed
10 under subsection (c)(2)(C).

11 (2) GRANTS BY SECRETARY OF HEALTH AND
12 HUMAN SERVICES.—

13 (A) IN GENERAL.—The Secretary of
14 Health and Human Services, acting through the
15 Director of the Centers for Disease Control and
16 Prevention, may provide assistance to State and
17 local public health departments and eligible
18 nongovernmental organizations for the purpose
19 of supporting eligible State and local entities to
20 incorporate the best practice recommendations
21 developed under subsection (c)(2)(C) within rel-
22 evant State laws, policies, regulations, and judi-
23 cial decisions regarding people living with HIV/
24 AIDS.

1 (B) AUTHORIZED ACTIVITIES.—The assist-
2 ance authorized by subparagraph (A) may in-
3 clude—

4 (i) direct technical assistance to State
5 and local public health departments in
6 order to support the development, dissemi-
7 nation, or implementation of State laws,
8 policies, regulations, or judicial decisions
9 that conform with the set of best practice
10 recommendations developed under sub-
11 section (c)(2)(C);

12 (ii) direct technical assistance to eligi-
13 ble nongovernmental organizations in order
14 to provide education and training, includ-
15 ing through classes, conferences, meetings,
16 and other educational activities, to State
17 and local public health departments; and

18 (iii) subcontracting authority to allow
19 State and local public health departments
20 and eligible nongovernmental organizations
21 to seek technical assistance from legal and
22 public health experts with a demonstrated
23 understanding of the principles underlying
24 the best practice recommendations devel-
25 oped under subsection (c)(2)(C).

1 (3) LIMITATION.—As a condition of receiving
2 assistance through this subsection, eligible State and
3 local entities, State and local public health depart-
4 ments, and eligible nongovernmental organizations
5 shall agree—

6 (A) not to place any unique or additional
7 burdens on people living with HIV/AIDS solely
8 as a result of their HIV status; and

9 (B) that if the entity, department, or orga-
10 nization promulgates any laws, policies, regula-
11 tions, or judicial decisions regarding people liv-
12 ing with HIV/AIDS, such actions shall dem-
13 onstrate a public health-oriented, evidence-
14 based, medically accurate, and contemporary
15 understanding of—

16 (i) the multiple factors that lead to
17 HIV transmission;

18 (ii) the relative risk of HIV trans-
19 mission routes;

20 (iii) the current health implications of
21 living with HIV;

22 (iv) the associated benefits of treat-
23 ment and support services for people living
24 with HIV; and

1 (v) the impact of punitive HIV-spe-
2 cific laws and policies on public health, on
3 people living with or affected by HIV, and
4 on their families and communities.

5 (4) REPORT.—No later than 1 year after the
6 date of the enactment of this Act, and annually
7 thereafter, the Attorney General and the Secretary
8 of Health and Human Services, acting jointly, shall
9 transmit to Congress and make publicly available a
10 report describing, for each State, the impact and ef-
11 fectiveness of the assistance provided through this
12 Act. Each such report shall include—

13 (A) a detailed description of the progress
14 each State has made, if any, in implementing
15 the best practice recommendations developed
16 under subsection (c)(2)(C) as a result of the as-
17 sistance provided under this subsection, and
18 based on the performance goals and indicators
19 established as part of the monitoring and eval-
20 uation system in subsection (c)(4);

21 (B) a brief summary of any outreach ef-
22 forts undertaken during the prior year by the
23 Attorney General and the Secretary of Health
24 and Human Services to encourage States to
25 seek assistance under this subsection in order

1 to implement the best practice recommenda-
2 tions developed under subsection (e)(2)(C);

3 (C) a summary of how assistance provided
4 through this subsection is being utilized by eli-
5 gible State and local entities, State and local
6 public health departments, and eligible non-
7 governmental organizations and, if applicable,
8 any contractors, including with respect to non-
9 governmental organizations, the type of tech-
10 nical assistance provided, and an evaluation of
11 the impact of such assistance on eligible State
12 and local entities; and

13 (D) a summary and description of eligible
14 State and local entities, State and local public
15 health departments, and eligible nongovern-
16 mental organizations receiving assistance
17 through this subsection, including if applicable,
18 a summary and description of any contractors
19 selected to assist in implementing such assist-
20 ance.

21 (5) DEFINITIONS.—For the purposes of this
22 subsection:

23 (A) ELIGIBLE STATE AND LOCAL ENTI-
24 TIES.—The term “eligible State and local enti-
25 ties” means the relevant individuals, offices, or

1 organizations that directly participate in the de-
2 velopment, dissemination, or implementation of
3 State laws, policies, regulations, or judicial deci-
4 sions, including—

5 (i) State governments, including State
6 attorneys general, State departments of
7 justice, and State National Guards, or
8 their equivalents;

9 (ii) State judicial and court systems,
10 including trial courts, appellate courts,
11 State supreme courts and courts of appeal,
12 and State correctional facilities, or their
13 equivalents; and

14 (iii) local governments, including city
15 and county governments, district attorneys,
16 and local law enforcement departments, or
17 their equivalents.

18 (B) STATE AND LOCAL PUBLIC HEALTH
19 DEPARTMENTS.—The term “State and local
20 public health departments” means the fol-
21 lowing:

22 (i) State public health departments, or
23 their equivalents, including the chief officer
24 of such departments and infectious disease

1 and communicable disease specialists with-
2 in such departments.

3 (ii) Local public health departments,
4 or their equivalents, including city and
5 county public health departments, the chief
6 officer of such departments, and infectious
7 disease and communicable disease special-
8 ists within such departments.

9 (iii) Public health departments or offi-
10 cials, or their equivalents, within State or
11 local correctional facilities.

12 (iv) Public health departments or offi-
13 cials, or their equivalents, within State Na-
14 tional Guards.

15 (v) Any other recognized State or
16 local public health organization or entity
17 charged with carrying out official State or
18 local public health duties.

19 (C) ELIGIBLE NONGOVERNMENTAL ORGA-
20 NIZATIONS.—The term “eligible nongovern-
21 mental organizations” means the following:

22 (i) Nongovernmental organizations,
23 including trade organizations or associa-
24 tions that represent—

1 (I) State attorneys general, or
2 their equivalents;

3 (II) State public health officials,
4 or their equivalents;

5 (III) State judicial and court offi-
6 cers, including judges, district attor-
7 neys, prosecutors, defense attorneys,
8 law enforcement, and correctional offi-
9 cers;

10 (IV) State National Guards;

11 (V) people living with HIV/AIDS;

12 (VI) legal advocacy and HIV/
13 AIDS service organizations that work
14 with people living with HIV/AIDS;
15 and

16 (VII) nongovernmental health or-
17 ganizations that work on behalf of
18 people living with HIV/AIDS.

19 (ii) Nongovernmental organizations,
20 including trade organizations or associa-
21 tions that demonstrate a public-health ori-
22 ented, evidence-based, medically accurate,
23 and contemporary understanding of—

24 (I) the multiple factors that lead
25 to HIV transmission;

1 (II) the relative risk of HIV
2 transmission routes;

3 (III) the current health implica-
4 tions of living with HIV;

5 (IV) the associated benefits of
6 treatment and support services for
7 people living with HIV; and

8 (V) the impact of punitive HIV-
9 specific laws and policies on public
10 health, on people living with or af-
11 fected by HIV, and on their families
12 and communities.

13 (6) AUTHORIZATION OF APPROPRIATIONS.—

14 (A) IN GENERAL.—In addition to amounts
15 otherwise made available, there are authorized
16 to be appropriated to the Attorney General and
17 the Secretary of Health and Human Services
18 such sums as may be necessary to carry out
19 this subsection for each of the fiscal years 2017
20 through 2021.

21 (B) AVAILABILITY OF FUNDS.—Amounts
22 appropriated pursuant to the authorizations of
23 appropriations in subparagraph (A) are author-
24 ized to remain available until expended.

1 **SEC. 757. REPEAL OF LIMITATION AGAINST USE OF FUNDS**
2 **FOR EDUCATION OR INFORMATION DE-**
3 **SIGNED TO PROMOTE OR ENCOURAGE, DI-**
4 **RECTLY, HOMOSEXUAL OR HETEROSEXUAL**
5 **ACTIVITY OR INTRAVENOUS SUBSTANCE**
6 **ABUSE.**

7 Section 2500 of the Public Health Service Act (42
8 U.S.C. 300ee) is amended—

9 (1) by striking subsection (c); and

10 (2) by redesignating subsection (d) as sub-
11 section (c).

12 **SEC. 758. EXPANDING SUPPORT FOR CONDOMS IN PRIS-**
13 **ONS.**

14 (a) **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) shall
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 shall 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 (b) SENSE OF CONGRESS REGARDING DISTRIBUTION
4 OF SEXUAL BARRIER PROTECTION DEVICES IN STATE
5 PRISON SYSTEMS.—It is the sense of the Congress that
6 States should allow for the legal distribution of sexual bar-
7 rier protection devices in State correctional facilities to re-
8 duce the prevalence and spread of STIs in those facilities.

9 (c) SURVEY OF AND REPORT ON CORRECTIONAL FA-
10 CILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF
11 STIs.—

12 (1) SURVEY.—The Attorney General, after con-
13 sulting with the Secretary of Health and Human
14 Services, State officials, and community organiza-
15 tions, shall, to the maximum extent practicable, con-
16 duct a survey of all Federal and State correctional
17 facilities, not later than 180 days after the date of
18 enactment of this Act and annually thereafter for 5
19 years, to determine the following:

20 (A) COUNSELING, TREATMENT, AND SUP-
21 PORTIVE SERVICES.—Whether the correctional
22 facility requires incarcerated persons to partici-
23 pate in counseling, treatment, and supportive
24 services related to STIs, or whether it offers
25 such programs to incarcerated persons.

1 (B) ACCESS TO SEXUAL BARRIER PROTEC-
2 TION DEVICES.—Whether incarcerated persons
3 can—

4 (i) possess sexual barrier protection
5 devices;

6 (ii) purchase sexual barrier protection
7 devices;

8 (iii) purchase sexual barrier protection
9 devices at a reduced cost; and

10 (iv) obtain sexual barrier protection
11 devices without cost.

12 (C) INCIDENCE OF SEXUAL VIOLENCE.—
13 The incidence of sexual violence and assault
14 committed by incarcerated persons and by cor-
15 rectional facility staff.

16 (D) PREVENTION EDUCATION OFFERED.—
17 The type of prevention education, information,
18 or training offered to incarcerated persons and
19 correctional facility staff regarding sexual vio-
20 lence and the spread of STIs, including whether
21 such education, information, or training—

22 (i) constitutes comprehensive sexuality
23 education;

24 (ii) is compulsory for new incarcerated
25 persons and for new staff; and

1 (iii) is offered on an ongoing basis.

2 (E) STI TESTING.—Whether the correc-
3 tional facility tests incarcerated persons for
4 STIs or gives them the option to undergo such
5 testing—

6 (i) at intake;

7 (ii) on a regular basis; and

8 (iii) prior to release.

9 (F) STI TEST RESULTS.—The number of
10 incarcerated persons who are tested for STIs
11 and the outcome of such tests at each correc-
12 tional facility, disaggregated to include results
13 for—

14 (i) the type of sexually transmitted in-
15 fection tested for;

16 (ii) the race and/or ethnicity of indi-
17 viduals tested;

18 (iii) the age of individuals tested; and

19 (iv) the gender of individuals tested.

20 (G) PRERELEASE REFERRAL POLICY.—
21 Whether incarcerated persons are informed
22 prior to release about STI-related services or
23 other health services in their communities, in-
24 cluding free and low-cost counseling and treat-
25 ment options.

1 (H) PRERELEASE REFERRALS MADE.—

2 The number of referrals to community-based
3 organizations or public health facilities offering
4 STI-related or other health services provided to
5 incarcerated persons prior to release, and the
6 type of counseling or treatment for which the
7 referral was made.

8 (I) REINSTATEMENT OF MEDICAID BENE-
9 FITS.—Whether the correctional facility assists
10 incarcerated persons that were enrolled in the
11 State Medicaid program prior to their incarcer-
12 ation, in reinstating their enrollment upon re-
13 lease and whether such individuals receive refer-
14 rals as provided by subparagraph (G) to entities
15 that accept the State Medicaid program, includ-
16 ing if applicable—

17 (i) the number of such individuals, in-
18 cluding those diagnosed with the human
19 immunodeficiency virus, that have been re-
20 instated;

21 (ii) a list of obstacles to reinstating
22 enrollment or to making determinations of
23 eligibility for reinstatement, if any; and

24 (iii) the number of individuals denied
25 enrollment.

1 (J) OTHER ACTIONS TAKEN.—Whether the
2 correctional facility has taken any other action,
3 in conjunction with community organizations or
4 otherwise, to reduce the prevalence and spread
5 of STIs in that facility.

6 (2) PRIVACY.—In conducting the survey, the
7 Attorney General shall not request or retain the
8 identity of any person who has sought or been of-
9 fered counseling, treatment, testing, or prevention
10 education information regarding an STI (including
11 information about sexual barrier protection devices),
12 or who has tested positive for an STI.

13 (3) REPORT.—The Attorney General shall
14 transmit to Congress and make publicly available
15 the results of the survey required under paragraph
16 (1), both for the Nation as a whole and
17 disaggregated as to each State and each correctional
18 facility. To the maximum extent possible, the Attor-
19 ney General shall issue the first report no later than
20 1 year after the date of enactment of this Act and
21 shall issue reports annually thereafter for 5 years.

22 (d) STRATEGY.—

23 (1) DIRECTIVE TO ATTORNEY GENERAL.—The
24 Attorney General, in consultation with the Secretary
25 of Health and Human Services, State officials, and

1 community organizations, shall develop and imple-
2 ment a 5-year strategy to reduce the prevalence and
3 spread of STIs in Federal and State correctional fa-
4 cilities. To the maximum extent possible, the strat-
5 egy shall be developed, transmitted to Congress, and
6 made publicly available no later than 180 days after
7 the transmission of the first report required under
8 subsection (c)(3).

9 (2) CONTENTS OF STRATEGY.—The strategy
10 shall include the following:

11 (A) PREVENTION EDUCATION.—A plan for
12 improving prevention education, information,
13 and training offered to incarcerated persons
14 and correctional facility staff, including infor-
15 mation and training on sexual violence and the
16 spread of STIs, and comprehensive sexuality
17 education.

18 (B) SEXUAL BARRIER PROTECTION DEVICE
19 ACCESS.—A plan for expanding access to sexual
20 barrier protection devices in correctional facili-
21 ties.

22 (C) SEXUAL VIOLENCE REDUCTION.—A
23 plan for reducing the incidence of sexual vio-
24 lence among incarcerated persons and correc-
25 tional facility staff, developed in consultation

1 with the National Prison Rape Elimination
2 Commission.

3 (D) COUNSELING AND SUPPORTIVE SERV-
4 ICES.—A plan for expanding access to coun-
5 seling and supportive services related to STIs in
6 correctional facilities.

7 (E) TESTING.—A plan for testing incarcer-
8 ated persons for STIs during intake, during
9 regular health exams, and prior to release, and
10 that—

11 (i) is conducted in accordance with
12 guidelines established by the Centers for
13 Disease Control and Prevention;

14 (ii) includes pretest counseling;

15 (iii) requires that incarcerated persons
16 are notified of their option to decline test-
17 ing at any time;

18 (iv) requires that incarcerated persons
19 are confidentially notified of their test re-
20 sults in a timely manner; and

21 (v) ensures that incarcerated persons
22 testing positive for STIs receive post-test
23 counseling, care, treatment, and supportive
24 services.

1 (F) TREATMENT.—A plan for ensuring
2 that correctional facilities have the necessary
3 medicine and equipment to treat and monitor
4 STIs and for ensuring that incarcerated per-
5 sons living with or testing positive for STIs re-
6 ceive and have access to care and treatment
7 services.

8 (G) STRATEGIES FOR DEMOGRAPHIC
9 GROUPS.—A plan for developing and imple-
10 menting culturally appropriate, sensitive, and
11 specific strategies to reduce the spread of STIs
12 among demographic groups heavily impacted by
13 STIs.

14 (H) LINKAGES WITH COMMUNITIES AND
15 FACILITIES.—A plan for establishing and
16 strengthening linkages to local communities and
17 health facilities that—

18 (i) provide counseling, testing, care,
19 and treatment services;

20 (ii) may receive persons recently re-
21 leased from incarceration who are living
22 with STIs; and

23 (iii) accept payment through the State
24 Medicaid program.

1 (I) ENROLLMENT IN STATE MEDICAID
2 PROGRAMS.—Plans to ensure that incarcerated
3 persons who were—

4 (i) enrolled in their State Medicaid
5 program prior to incarceration in a correc-
6 tional facility are automatically re-enrolled
7 in such program upon their release; and

8 (ii) not enrolled in their State Med-
9 icaid program prior to incarceration, but
10 who are diagnosed with the human im-
11 munodeficiency virus while incarcerated in
12 a correctional facility, are automatically
13 enrolled in such program upon their re-
14 lease.

15 (J) OTHER PLANS.—Any other plans de-
16 veloped by the Attorney General for reducing
17 the spread of STIs or improving the quality of
18 health care in correctional facilities.

19 (K) MONITORING SYSTEM.—A monitoring
20 system that establishes performance goals re-
21 lated to reducing the prevalence and spread of
22 STIs in correctional facilities and which, where
23 feasible, expresses such goals in quantifiable
24 form.

1 (L) MONITORING SYSTEM PERFORMANCE
2 INDICATORS.—Performance indicators that
3 measure or assess the achievement of the per-
4 formance goals described in subparagraph (K).

5 (M) COST ESTIMATE.—A detailed estimate
6 of the funding necessary to implement the
7 strategy at the Federal and State levels for all
8 5 years, including the amount of funds required
9 by community organizations to implement the
10 parts of the strategy in which they take part.

11 (3) REPORT.—The Attorney General shall
12 transmit to Congress and make publicly available an
13 annual progress report regarding the implementation
14 and effectiveness of the strategy described in para-
15 graph (1). The progress report shall include an eval-
16 uation of the implementation of the strategy using
17 the monitoring system and performance indicators
18 provided for in subparagraphs (K) and (L) of para-
19 graph (2).

20 (e) AUTHORIZATION OF APPROPRIATIONS.—

21 (1) IN GENERAL.—There are authorized to be
22 appropriated such sums as may be necessary to
23 carry out this section for each of fiscal years 2017
24 through 2021.

1 (2) AVAILABILITY OF FUNDS.—Amounts made
2 available under paragraph (1) are authorized to re-
3 main available until expended.

4 (f) DEFINITIONS.—For the purposes of this section:

5 (1) COMMUNITY ORGANIZATION.—The term
6 “community organization” means a public health
7 care facility or a nonprofit organization which pro-
8 vides health- or STI-related services according to es-
9 tablished public health standards.

10 (2) COMPREHENSIVE SEXUALITY EDUCATION.—
11 The term “comprehensive sexuality education”
12 means sexuality education that includes information
13 about abstinence and about the proper use and dis-
14 posal of sexual barrier protection devices and which
15 is—

16 (A) evidence-based;

17 (B) medically accurate;

18 (C) age and developmentally appropriate;

19 (D) gender and identity sensitive;

20 (E) culturally and linguistically appro-
21 priate; and

22 (F) structured to promote critical thinking,
23 self-esteem, respect for others, and the develop-
24 ment of healthy attitudes and relationships.

1 (3) CORRECTIONAL FACILITY.—The term “cor-
2 rectional facility” means any prison, penitentiary,
3 adult detention facility, juvenile detention facility,
4 jail, or other facility to which persons may be sent
5 after conviction of a crime or act of juvenile delin-
6 quency within the United States.

7 (4) INCARCERATED PERSON.—The term “incar-
8 cerated person” means any person who is serving a
9 sentence in a correctional facility after conviction of
10 a crime.

11 (5) SEXUALLY TRANSMITTED INFECTION.—The
12 term “sexually transmitted infection” or “STI”
13 means any disease or infection that is commonly
14 transmitted through sexual activity, including HIV/
15 AIDS, gonorrhea, chlamydia, syphilis, genital her-
16 pes, viral hepatitis, and human papillomavirus.

17 (6) SEXUAL BARRIER PROTECTION DEVICE.—
18 The term “sexual barrier protection device” means
19 any FDA-approved physical device which has not
20 been tampered with and which reduces the prob-
21 ability of STI transmission or infection between sex-
22 ual partners, including female condoms, male
23 condoms, and dental dams.

24 (7) STATE.—The term “State” includes the
25 District of Columbia, American Samoa, the Com-

1 monwealth of the Northern Mariana Islands, Guam,
2 Puerto Rico, and the United States Virgin Islands.

3 **SEC. 759. AUTOMATIC REINSTATEMENT OR ENROLLMENT**
4 **IN MEDICAID FOR PEOPLE WHO TEST POSI-**
5 **TIVE FOR HIV BEFORE REENTERING COMMU-**
6 **NITIES.**

7 (a) IN GENERAL.—Section 1902(e) of the Social Se-
8 curity Act (42 U.S.C. 1396a(e)) is amended by adding at
9 the end the following:

10 “(15) ENROLLMENT OF EX-OFFENDERS.—

11 “(A) AUTOMATIC ENROLLMENT OR REIN-
12 STATEMENT.—

13 “(i) IN GENERAL.—The State plan
14 shall provide for the automatic enrollment
15 or reinstatement of enrollment of an eligi-
16 ble individual—

17 “(I) if such individual is sched-
18 uled to be released from a public insti-
19 tution due to the completion of sen-
20 tence, not less than 30 days prior to
21 the scheduled date of the release; and

22 “(II) if such individual is to be
23 released from a public institution on
24 parole or on probation, as soon as
25 possible after the date on which the

1 determination to release such indi-
2 vidual was made, and before the date
3 such individual is released.

4 “(ii) EXCEPTION.—If a State makes a
5 determination that an individual is not eli-
6 gible to be enrolled under the State plan—

7 “(I) on or before the date by
8 which the individual would be enrolled
9 under clause (i), such clause shall not
10 apply to such individual; or

11 “(II) after such date, the State
12 may terminate the enrollment of such
13 individual.

14 “(B) RELATIONSHIP OF ENROLLMENT TO
15 PAYMENT FOR SERVICES.—

16 “(i) IN GENERAL.—Subject to sub-
17 paragraph (A)(ii), an eligible individual
18 who is enrolled, or whose enrollment is re-
19 instated, under subparagraph (A) shall be
20 eligible for medical assistance that is pro-
21 vided after the date that the eligible indi-
22 vidual is released from the public institu-
23 tion.

24 “(ii) RELATIONSHIP TO PAYMENT
25 PROHIBITION FOR INMATES.—No provision

1 of this paragraph may be construed to per-
2 mit payment for care or services for which
3 payment is excluded under the subdivision
4 (A) that follows paragraph (30) of section
5 1905(a).

6 “(C) TREATMENT OF CONTINUOUS ELIGI-
7 BILITY.—

8 “(i) SUSPENSION FOR INMATES.—Any
9 period of continuous eligibility under this
10 title shall be suspended on the date an in-
11 dividual enrolled under this title becomes
12 an inmate of a public institution (except as
13 a patient of a medical institution).

14 “(ii) DETERMINATION OF REMAINING
15 PERIOD.—Notwithstanding any changes to
16 State law related to continuous eligibility
17 during the time that an individual is an in-
18 mate of a public institution (except as a
19 patient of a medical institution), subject to
20 clause (iii), with respect to an eligible indi-
21 vidual who was subject to a suspension
22 under clause (i), on the date that such in-
23 dividual is released from a public institu-
24 tion the suspension of continuous eligibility
25 under such clause shall be lifted for a pe-

1 riod that is equal to the time remaining in
2 the period of continuous eligibility for such
3 individual on the date that such period was
4 suspended under such clause.

5 “(iii) EXCEPTION.—If a State makes
6 a determination that an individual is not
7 eligible to be enrolled under the State
8 plan—

9 “(I) on or before the date that
10 the suspension of continuous eligibility
11 is lifted under clause (ii), such clause
12 shall not apply to such individual; or

13 “(II) after such date, the State
14 may terminate the enrollment of such
15 individual.

16 “(D) AUTOMATIC ENROLLMENT OR REIN-
17 STATEMENT OF ENROLLMENT DEFINED.—For
18 purposes of this paragraph, the term ‘automatic
19 enrollment or reinstatement of enrollment’
20 means that the State determines eligibility for
21 medical assistance under the State plan without
22 a program application from, or on behalf of, the
23 eligible individual, but an individual can only be
24 automatically enrolled in the State Medicaid
25 plan if the individual affirmatively consents to

1 being enrolled through affirmation in writing,
2 by telephone, orally, through electronic signa-
3 ture, or through any other means specified by
4 the Secretary.

5 “(E) ELIGIBLE INDIVIDUAL DEFINED.—

6 For purposes of this paragraph, the term ‘eligi-
7 ble individual’ means an individual who is an
8 inmate of a public institution (except as a pa-
9 tient in a medical institution)—

10 “(i) who was enrolled under the State
11 plan for medical assistance immediately be-
12 fore becoming an inmate of such an insti-
13 tution; or

14 “(ii) is diagnosed with human im-
15 munodeficiency virus.”.

16 (b) SUPPLEMENTAL FUNDING FOR STATE IMPLE-
17 MENTATION OF AUTOMATIC REINSTATEMENT OF MED-
18 ICAID BENEFITS.—

19 (1) IN GENERAL.—Subject to paragraph (6),
20 for each State for which the Secretary of Health and
21 Human Services has approved an application under
22 paragraph (3), the Federal matching payments (in-
23 cluding payments based on the Federal medical as-
24 sistance percentage) made to such State under sec-
25 tion 1903 of the Social Security Act (42 U.S.C.

1 1396b) shall be increased by 5.0 percentage points
2 for payments to the State for the activities per-
3 mitted under paragraph (2) or a period of one year.

4 (2) USE OF FUNDS.—A State may only use in-
5 creased matching payments authorized under para-
6 graph (1)—

7 (A) to strengthen the State’s enrollment
8 and administrative resources for the purpose of
9 improving processes for enrolling (or reinstating
10 the enrollment of) eligible individuals (as such
11 term is defined in subparagraph (E) of para-
12 graph (15) of section 1902(e) of the Social Se-
13 curity Act (as amended by subsection (a))); and

14 (B) for medical assistance (as such term is
15 defined in section 1905(a) of the Social Secu-
16 rity Act) provided to such eligible individuals.

17 (3) APPLICATION AND AGREEMENT.—The Sec-
18 retary may only make payments to a State in the in-
19 creased amount if—

20 (A) the State has amended the State plan
21 under section 1902(e) of the Social Security
22 Act to incorporate the requirements of para-
23 graph (15) of such section (as added by sub-
24 section (a));

1 (B) the State has submitted an application
2 to the Secretary that includes a plan for imple-
3 menting the requirements of section
4 1902(e)(15) of the Social Security Act under
5 the State's amended State plan before the end
6 of the 90-day period beginning on the date that
7 the State receives increased matching payments
8 under paragraph (1);

9 (C) the State's application meets the satis-
10 faction of the Secretary; and

11 (D) the State enters an agreement with
12 the Secretary that states that—

13 (i) the State will only use the in-
14 creased matching funds for the uses per-
15 mitted under paragraph (2); and

16 (ii) at the end of the period under
17 paragraph (1), the State will submit to the
18 Secretary, and make publicly available, a
19 report that contains the information re-
20 quired under paragraph (4).

21 (4) REQUIRED REPORT INFORMATION.—The in-
22 formation that is required in the report under para-
23 graph (3)(D)(ii) includes—

24 (A) the results of an evaluation of the im-
25 pact of the implementation of the requirements

1 of section 1902(e)(15) of the Social Security
2 Act on improving the State's processes for en-
3 rolling of individuals who are released from
4 public institutions into the Medicaid program;

5 (B) the number of individuals who were
6 automatically enrolled (or whose enrollment is
7 reinstated) under such section 1902(e)(15) dur-
8 ing the period under paragraph (1); and

9 (C) any other information that is required
10 by the Secretary.

11 (5) INCREASE IN CAP ON MEDICAID PAYMENTS
12 TO TERRITORIES.—Subject to paragraph (6), the
13 amounts otherwise determined for Puerto Rico, the
14 United States Virgin Islands, Guam, the Northern
15 Mariana Islands, and American Samoa under sub-
16 sections (f) and (g) of section 1108 of the Social Se-
17 curity Act (42 U.S.C. 1308) shall each be increased
18 by the necessary amount to allow for the increase in
19 the Federal matching payments under paragraph
20 (1), but only for the period under such paragraph
21 for such State. In the case of such an increase for
22 a territory, subsection (a)(1) of such section 1108
23 shall be applied without regard to any increase in
24 payment made to the territory under part E of title
25 IV of such Act that is attributable to the increase

1 in Federal medical assistance percentage effected
2 under paragraph (1) for the territory.

3 (6) LIMITATIONS.—

4 (A) TIMING.—With respect to a State, at
5 the end of the period under paragraph (1), no
6 increased matching payments may be made to
7 such State under this subsection.

8 (B) MAINTENANCE OF ELIGIBILITY.—

9 (i) IN GENERAL.—Subject to clause
10 (ii), a State is not eligible for an increase
11 in its Federal matching payments under
12 paragraph (1), or an increase in a cap
13 amount under paragraph (5), if eligibility
14 standards, methodologies, or procedures
15 under its State plan under title XIX of the
16 Social Security Act (including any waiver
17 under such title or under section 1115 of
18 such Act (42 U.S.C. 1315)) are more re-
19 strictive than the eligibility standards,
20 methodologies, or procedures, respectively,
21 under such plan (or waiver) as in effect on
22 the date of enactment of this Act.

23 (ii) STATE REINSTATEMENT OF ELIGI-
24 BILITY PERMITTED.—A State that has re-
25 stricted eligibility standards, methodolo-

1 gies, or procedures under its State plan
2 under title XIX of the Social Security Act
3 (including any waiver under such title or
4 under section 1115 of such Act (42 U.S.C.
5 1315)) after the date of enactment of this
6 Act, is no longer ineligible under subpara-
7 graph (A) beginning with the first calendar
8 quarter in which the State has reinstated
9 eligibility standards, methodologies, or pro-
10 cedures that are no more restrictive than
11 the eligibility standards, methodologies, or
12 procedures, respectively, under such plan
13 (or waiver) as in effect on such date.

14 (C) NO WAIVER AUTHORITY.—The Sec-
15 retary may not waive the application of this
16 subsection under section 1115 of the Social Se-
17 curity Act or otherwise.

18 (D) LIMITATION OF MATCHING PAYMENTS
19 TO 100 PERCENT.—In no case shall an increase
20 in Federal matching payments under this sub-
21 section result in Federal matching payments
22 that exceed 100 percent.

23 (e) EFFECTIVE DATE.—

24 (1) IN GENERAL.—Except as provided in para-
25 graph (2), the amendments made by subsection (a)

1 shall take effect 180 days after the date of the en-
2 actment of this Act and shall apply to services fur-
3 nished on or after such date.

4 (2) RULE FOR CHANGES REQUIRING STATE
5 LEGISLATION.—In the case of a State plan for med-
6 ical assistance under title XIX of the Social Security
7 Act which the Secretary of Health and Human Serv-
8 ices determines requires State legislation (other than
9 legislation appropriating funds) in order for the plan
10 to meet the additional requirement imposed by the
11 amendments made by this section, the State plan
12 shall not be regarded as failing to comply with the
13 requirements of such title solely on the basis of its
14 failure to meet this additional requirement before
15 the first day of the first calendar quarter beginning
16 after the close of the first regular session of the
17 State legislature that begins after the date of the en-
18 actment of this Act. For purposes of the previous
19 sentence, in the case of a State that has a 2-year
20 legislative session, each year of such session shall be
21 deemed to be a separate regular session of the State
22 legislature.

23 **SEC. 760. STOP AIDS IN PRISON.**

24 (a) SHORT TITLE.—This section may be cited as the
25 “Stop AIDS in Prison Act”.

1 (b) IN GENERAL.—The Bureau of Prisons (herein-
2 after in this section referred to as the “Bureau”) shall
3 develop a comprehensive policy to provide HIV testing,
4 treatment, and prevention for inmates within the correc-
5 tional setting and upon reentry.

6 (c) PURPOSE.—The purposes of this policy shall be
7 as follows:

8 (1) To stop the spread of HIV/AIDS among in-
9 mates.

10 (2) To protect prison guards and other per-
11 sonnel from HIV/AIDS infection.

12 (3) To provide comprehensive medical treat-
13 ment to inmates who are living with HIV/AIDS.

14 (4) To promote HIV/AIDS awareness and pre-
15 vention among inmates.

16 (5) To encourage inmates to take personal re-
17 sponsibility for their health.

18 (6) To reduce the risk that inmates will trans-
19 mit HIV/AIDS to other persons in the community
20 following their release from prison.

21 (d) CONSULTATION.—The Bureau shall consult with
22 appropriate officials of the Department of Health and
23 Human Services, the Office of National Drug Control Pol-
24 icy, the Office of National AIDS Policy, and the Centers

1 for Disease Control and Prevention regarding the develop-
2 ment of this policy.

3 (e) TIME LIMIT.—The Bureau shall draft appro-
4 priate regulations to implement this policy not later than
5 1 year after the date of the enactment of this Act.

6 (f) REQUIREMENTS FOR POLICY.—The policy created
7 under subsection (b) shall provide for the following:

8 (1) TESTING AND COUNSELING UPON IN-
9 TAKE.—

10 (A) Health care personnel shall provide
11 routine HIV testing to all inmates as a part of
12 a comprehensive medical examination imme-
13 diately following admission to a facility. (Health
14 care personnel need not provide routine HIV
15 testing to an inmate who is transferred to a fa-
16 cility from another facility if the inmate’s med-
17 ical records are transferred with the inmate and
18 indicate that the inmate has been tested pre-
19 viously.)

20 (B) To all inmates admitted to a facility
21 prior to the effective date of this policy, health
22 care personnel shall provide routine HIV testing
23 within no more than 6 months. HIV testing for
24 these inmates may be performed in conjunction

1 with other health services provided to these in-
2 mates by health care personnel.

3 (C) All HIV tests under this paragraph
4 shall comply with the opt-out provision.

5 (2) PRE-TEST AND POST-TEST COUNSELING.—
6 Health care personnel shall provide confidential pre-
7 test and post-test counseling to all inmates who are
8 tested for HIV. Counseling may be included with
9 other general health counseling provided to inmates
10 by health care personnel.

11 (3) HIV/AIDS PREVENTION EDUCATION.—

12 (A) Health care personnel shall improve
13 HIV/AIDS awareness through frequent edu-
14 cational programs for all inmates. HIV/AIDS
15 educational programs may be provided by com-
16 munity-based organizations, local health depart-
17 ments, and inmate peer educators.

18 (B) HIV/AIDS educational materials shall
19 be made available to all inmates at orientation,
20 at health care clinics, at regular educational
21 programs, and prior to release. Both written
22 and audiovisual materials shall be made avail-
23 able to all inmates.

1 (C)(i) The HIV/AIDS educational pro-
2 grams and materials under this paragraph shall
3 include information on—

4 (I) modes of transmission, including
5 transmission through tattooing, sexual con-
6 tact, and intravenous drug use;

7 (II) prevention methods;

8 (III) treatment; and

9 (IV) disease progression.

10 (ii) The programs and materials shall be
11 culturally sensitive, written or designed for low-
12 literacy levels, available in a variety of lan-
13 guages, and present scientifically accurate in-
14 formation in a clear and understandable man-
15 ner.

16 (4) HIV TESTING UPON REQUEST.—

17 (A) Health care personnel shall allow in-
18 mates to obtain HIV tests upon request once
19 per year or whenever an inmate has a reason to
20 believe the inmate may have been exposed to
21 HIV. Health care personnel shall, both orally
22 and in writing, inform inmates, during orienta-
23 tion and periodically throughout incarceration,
24 of their right to obtain HIV tests.

1 (B) Health care personnel shall encourage
2 inmates to request HIV tests if the inmate is
3 sexually active, has been raped, uses intra-
4 venous drugs, receives a tattoo, or if the inmate
5 is concerned that the inmate may have been ex-
6 posed to HIV/AIDS.

7 (C) An inmate's request for an HIV test
8 shall not be considered an indication that the
9 inmate has put him/herself at risk of infection
10 and/or committed a violation of prison rules.

11 (5) HIV TESTING OF PREGNANT WOMAN.—

12 (A) Health care personnel shall provide
13 routine HIV testing to all inmates who become
14 pregnant.

15 (B) All HIV tests under this paragraph
16 shall comply with the opt-out provision.

17 (6) COMPREHENSIVE TREATMENT.—

18 (A) Health care personnel shall provide all
19 inmates who test positive for HIV—

20 (i) timely, comprehensive medical
21 treatment;

22 (ii) confidential counseling on man-
23 aging their medical condition and pre-
24 venting its transmission to other persons;
25 and

1 (iii) voluntary partner notification
2 services.

3 (B) Health care provided under this para-
4 graph shall be consistent with current Depart-
5 ment of Health and Human Services guidelines
6 and standard medical practice. Health care per-
7 sonnel shall discuss treatment options, the im-
8 portance of adherence to antiretroviral therapy,
9 and the side effects of medications with inmates
10 receiving treatment.

11 (C) Health care personnel and pharmacy
12 personnel shall ensure that the facility for-
13 mulary contains all Food and Drug Administra-
14 tion-approved medications necessary to provide
15 comprehensive treatment for inmates living with
16 HIV/AIDS, and that the facility maintains ade-
17 quate supplies of such medications to meet in-
18 mates' medical needs. Health care personnel
19 and pharmacy personnel shall also develop and
20 implement automatic renewal systems for these
21 medications to prevent interruptions in care.

22 (D) Correctional staff, health care per-
23 sonnel, and pharmacy personnel shall develop
24 and implement distribution procedures to en-

1 sure timely and confidential access to medica-
2 tions.

3 (7) PROTECTION OF CONFIDENTIALITY.—

4 (A) Health care personnel shall develop
5 and implement procedures to ensure the con-
6 fidentiality of inmate tests, diagnoses, and
7 treatment. Health care personnel and correc-
8 tional staff shall receive regular training on the
9 implementation of these procedures. Penalties
10 for violations of inmate confidentiality by health
11 care personnel or correctional staff shall be
12 specified and strictly enforced.

13 (B) HIV testing, counseling, and treat-
14 ment shall be provided in a confidential setting
15 where other routine health services are provided
16 and in a manner that allows the inmate to re-
17 quest and obtain these services as routine med-
18 ical services.

19 (8) TESTING, COUNSELING, AND REFERRAL
20 PRIOR TO REENTRY.—

21 (A) Health care personnel shall provide
22 routine HIV testing to all inmates no more
23 than 3 months prior to their release and re-
24 entry into the community. (Inmates who are al-
25 ready known to be infected need not be tested

1 again.) This requirement may be waived if an
2 inmate's release occurs without sufficient notice
3 to the Bureau to allow health care personnel to
4 perform a routine HIV test and notify the in-
5 mate of the results.

6 (B) All HIV tests under this paragraph
7 shall comply with the opt-out provision.

8 (C) To all inmates who test positive for
9 HIV and all inmates who already are known to
10 have HIV/AIDS, health care personnel shall
11 provide—

12 (i) confidential prerelease counseling
13 on managing their medical condition in the
14 community, accessing appropriate treat-
15 ment and services in the community, and
16 preventing the transmission of their condi-
17 tion to family members and other persons
18 in the community;

19 (ii) referrals to appropriate health
20 care providers and social service agencies
21 in the community that meet the inmate's
22 individual needs, including voluntary part-
23 ner notification services and prevention
24 counseling services for people living with
25 HIV/AIDS; and

1 (iii) a 30-day supply of any medically
2 necessary medications the inmate is cur-
3 rently receiving.

4 (9) OPT-OUT PROVISION.—Inmates shall have
5 the right to refuse routine HIV testing. Inmates
6 shall be informed both orally and in writing of this
7 right. Oral and written disclosure of this right may
8 be included with other general health information
9 and counseling provided to inmates by health care
10 personnel. If an inmate refuses a routine test for
11 HIV, health care personnel shall make a note of the
12 inmate’s refusal in the inmate’s confidential medical
13 records. However, the inmate’s refusal shall not be
14 considered a violation of prison rules or result in dis-
15 ciplinary action. Any reference in this section to the
16 “opt-out provision” shall be deemed a reference to
17 the requirement of this paragraph.

18 (10) EXCLUSION OF TESTS PERFORMED UNDER
19 SECTION 4014(b) FROM THE DEFINITION OF ROU-
20 TINE HIV TESTING.—HIV testing of an inmate
21 under section 4014(b) of title 18, United States
22 Code, is not routine HIV testing for the purposes of
23 the opt-out provision. Health care personnel shall
24 document the reason for testing under section

1 4014(b) of title 18, United States Code, in the in-
2 mate’s confidential medical records.

3 (11) TIMELY NOTIFICATION OF TEST RE-
4 SULTS.—Health care personnel shall provide timely
5 notification to inmates of the results of HIV tests.

6 (g) CHANGES IN EXISTING LAW.—

7 (1) SCREENING IN GENERA.—Section 4014(a)
8 of title 18, United States Code, is amended—

9 (A) by striking “for a period of 6 months
10 or more”;

11 (B) by striking “, as appropriate,”; and

12 (C) by striking “if such individual is deter-
13 mined to be at risk for infection with such virus
14 in accordance with the guidelines issued by the
15 Bureau of Prisons relating to infectious disease
16 management” and inserting “unless the indi-
17 vidual declines. The Attorney General shall also
18 cause such individual to be so tested before re-
19 lease unless the individual declines.”.

20 (2) INADMISSIBILITY OF HIV TEST RESULTS IN
21 CIVIL AND CRIMINAL PROCEEDINGS.—Section
22 4014(d) of title 18, United States Code, is amended
23 by inserting “or under the Stop AIDS in Prison
24 Act” after “under this section”.

1 (3) SCREENING AS PART OF ROUTINE SCREEN-
2 ING.—Section 4014(e) of title 18, United States
3 Code, is amended by adding at the end the fol-
4 lowing: “Such rules shall also provide that the initial
5 test under this section be performed as part of the
6 routine health screening conducted at intake.”.

7 (h) REPORTING REQUIREMENTS.—

8 (1) REPORT ON HEPATITIS, LIVER, AND OTHER
9 DISEASES.—Not later than 1 year after the date of
10 the enactment of this Act, the Bureau shall provide
11 a report to the Congress on Bureau policies and pro-
12 cedures to provide testing, treatment, and prevention
13 education programs for hepatitis, liver failure, and
14 other liver-related diseases transmitted through sex-
15 ual activity, intravenous drug use, or other means.
16 The Bureau shall consult with appropriate officials
17 of the Department of Health and Human Services,
18 the Office of National Drug Control Policy, the Of-
19 fice of National AIDS Policy, and the Centers for
20 Disease Control and Prevention regarding the devel-
21 opment of this report.

22 (2) ANNUAL REPORTS.—

23 (A) GENERALLY.—Not later than 2 years
24 after the date of the enactment of this Act, and
25 then annually thereafter, the Bureau shall re-

1 port to Congress on the incidence among in-
2 mates of diseases transmitted through sexual
3 activity and intravenous drug use.

4 (B) MATTERS PERTAINING TO VARIOUS
5 DISEASES.—Reports under paragraph (1) shall
6 discuss—

7 (i) the incidence among inmates of
8 HIV/AIDS, hepatitis, and other diseases
9 transmitted through sexual activity and in-
10 travenous drug use; and

11 (ii) updates on Bureau testing, treat-
12 ment, and prevention education programs
13 for these diseases.

14 (C) MATTERS PERTAINING TO HIV/AIDS
15 ONLY.—Reports under paragraph (1) shall also
16 include—

17 (i) the number of inmates who tested
18 positive for HIV upon intake;

19 (ii) the number of inmates who tested
20 positive prior to reentry;

21 (iii) the number of inmates who were
22 not tested prior to reentry because they
23 were released without sufficient notice;

24 (iv) the number of inmates who opted-
25 out of taking the test;

1 (v) the number of inmates who were
2 tested under section 4014(b) of title 18,
3 United States Code; and

4 (vi) the number of inmates under
5 treatment for HIV/AIDS.

6 (D) CONSULTATION.—The Bureau shall
7 consult with appropriate officials of the Depart-
8 ment of Health and Human Services, the Office
9 of National Drug Control Policy, the Office of
10 National AIDS Policy, and the Centers for Dis-
11 ease Control and Prevention regarding the de-
12 velopment of reports under paragraph (1).

13 **SEC. 761. SUPPORT DATA SYSTEM REVIEW AND INDICA-**
14 **TORS FOR MONITORING HIV CARE.**

15 The Secretary of Health and Human Services, in col-
16 laboration with the Assistant Secretary for Health, the Di-
17 rector of the Office of HIV/AIDS and Infectious Disease
18 Policy, the Director of the Centers for Disease Control and
19 Prevention, the Administrator of the Substance Abuse and
20 Mental Health Services Administration, the Director of
21 the Department of Housing and Urban Development, the
22 Director of the Office of AIDS Research, the Adminis-
23 trator of the Health Resources and Services Administra-
24 tion, and the Administrator of the Centers for Medicare
25 & Medicaid Services, shall expand and coordinate efforts

1 to align metrics across agencies and modify Federal data
2 systems, to—

3 (1) adopt the Institute of Medicine’s clinical
4 HIV care indicators as the core metrics for moni-
5 toring the quality of HIV care, mental health, sub-
6 stance abuse, and supportive services;

7 (2) better enable assessment of the impact of
8 the National HIV/AIDS Strategy and the Patient
9 Protection and Affordable Care Act on improving
10 HIV/AIDS care and access to supportive services for
11 individuals with HIV;

12 (3) expand the demographic data elements to be
13 captured by Federal data systems relevant to HIV
14 care to permit calculation of the indicators for sub-
15 groups of the population of people with diagnosed
16 HIV infection, including—

17 (A) age;

18 (B) race;

19 (C) ethnicity;

20 (D) sex (assigned at birth);

21 (E) gender identity;

22 (F) sexual orientation;

23 (G) current geographic marker of resi-
24 dence;

25 (H) income or poverty level; and

1 (I) primary means of reimbursement for
2 medical services (including Medicaid, Medicare,
3 the Ryan White HIV/AIDS Program, private
4 insurance, health maintenance organizations,
5 and no coverage); and

6 (4) streamline data collection and systematically
7 review all existing reporting requirements for feder-
8 ally funded HIV/AIDS programs to ensure that only
9 essential data are collected.

10 **SEC. 762. TRANSFER OF FUNDS FOR IMPLEMENTATION OF**
11 **NATIONAL HIV/AIDS STRATEGY.**

12 Title II of the Public Health Service Act (42 U.S.C.
13 202 et seq.) is amended by inserting after section 241 the
14 following:

15 **“SEC. 241A. TRANSFER OF FUNDS FOR IMPLEMENTATION**
16 **OF NATIONAL HIV/AIDS STRATEGY.**

17 “(a) **TRANSFER AUTHORIZATION.**—Of the discre-
18 tionary appropriations made available to the Department
19 of Health and Human Services for any fiscal year for pro-
20 grams and activities that, as determined by the Secretary
21 of Health and Human Services, pertain to HIV/AIDS, the
22 Secretary, in coordination with the Director of the Office
23 of National HIV/AIDS Policy, may transfer up to 1 per-
24 cent of such appropriations to the Office of the Assistant

1 Secretary for Health for implementation of the National
2 HIV/AIDS Strategy.

3 “(b) CONGRESSIONAL NOTIFICATION.—Not less than
4 30 days before making any transfer under this section,
5 the Secretary shall give notice of the transfer to the Con-
6 gress.

7 “(c) DEFINITIONS.—In this section:

8 “(1) The term ‘HIV/AIDS’ has the meaning
9 given to such term in section 2689.

10 “(2) The term ‘National HIV/AIDS Strategy’
11 means the National HIV/AIDS Strategy for the
12 United States issued by the President in July 2010
13 and includes any subsequent revisions to such Strat-
14 egy.”.

15 **SEC. 763. HIV INTEGRATED SERVICES DELIVERY MODEL**
16 **DEMONSTRATION.**

17 (a) IN GENERAL.—Consistent with the National
18 HIV/AIDS Strategy for the United States and in accord-
19 ance with this section, the Secretary of Health and
20 Human Services acting through the Center for Medicare
21 & Medicaid Innovation and in cooperation with CDC,
22 HRSA, SAMHSA, and HUD, shall conduct a 3-year dem-
23 onstration project that is designed to integrate services
24 and funding under the Medicare and Medicaid programs,
25 under HIV-related programs conducted by the CDC, and

1 under the Ryan White HIV/AIDS Program, to reduce new
2 HIV infections, to increase the proportion of people who
3 know their status, to increase access to care, to improve
4 health outcomes, to reduce HIV-related health disparities
5 among Medicaid and Medicare beneficiaries, and to reduce
6 the cost of care provided to HIV positive Medicare and
7 Medicaid beneficiaries.

8 (b) OBJECTIVES.—The objectives of the demonstra-
9 tion are the following:

10 (1) To ensure the early identification of HIV
11 positive beneficiaries to reduce costly HIV-related
12 clinical conditions through HIV screening and rapid
13 linkage to high quality HIV medical care.

14 (2) To reduce new HIV infections among Med-
15 icaid and Medicare beneficiaries through routine
16 HIV testing, prevention services for HIV negative
17 beneficiaries, and intensive “prevention for positive”
18 services for HIV positive beneficiaries.

19 (3) To reduce morbidity, mortality, and high
20 cost inpatient and specialty care among HIV positive
21 beneficiaries by ensuring access to high quality HIV
22 medical care, HIV medications, and support services.

23 (4) To promote HIV treatment adherence and
24 retention in care through intensive case manage-
25 ment, treatment education, and outreach services.

1 (5) To effectively treat behavioral health condi-
2 tions among HIV positive beneficiaries that impair
3 their HIV treatment adherence and lead to sec-
4 ondary HIV infections through services funded
5 under Medicare and Medicaid and programs admin-
6 istered by SAMHSA.

7 (6) To promote independence, treatment adher-
8 ence, and stable housing for HIV positive bene-
9 ficiaries through highly coordinated HIV health,
10 housing, and support services funded by HRSA and
11 HUD.

12 (c) DEMONSTRATION DESIGN.—

13 (1) IN GENERAL.—The Secretary shall design
14 the demonstration to test both—

15 (A) the service delivery model described in
16 paragraph (2); and

17 (B) the payment model described in para-
18 graph (3).

19 (2) SERVICE DELIVERY MODEL.—

20 (A) IN GENERAL.—Under the service deliv-
21 ery model described in this paragraph, the dem-
22 onstration shall test comprehensive HIV test-
23 ing, linkage to care, HIV medical care, and an-
24 cillary services to individuals enrolled under
25 Medicare, Medicaid, or both. The service deliv-

1 ery model will integrate services furnished
2 under Medicare and Medicaid with prevention
3 services funded by CDC for HIV positive bene-
4 ficiaries, intensive case management services
5 funded by HRSA, behavioral services funded by
6 SAMHSA, and housing assistance services
7 funded through HUD.

8 (B) CORE ELEMENTS.—The model under
9 this paragraph shall have the following 8 core
10 elements:

11 (i) HIV testing services that apply the
12 CDC's 2006 recommendations for uni-
13 versal opt-out testing among Medicare and
14 Medicaid beneficiary populations.

15 (ii) Rapid linkage from HIV testing
16 settings to treatment for HIV positive
17 beneficiaries to ensure they are engaged in
18 care in a timely basis.

19 (iii) Access to high quality HIV expe-
20 rienced medical care, laboratory moni-
21 toring, HIV medications, and other re-
22 quired services.

23 (iv) Routine screening and treatment
24 for HIV-related and other chronic condi-
25 tions, including behavioral health.

1 (v) Prevention and treatment edu-
2 cation services, including an adapted Medi-
3 cation Therapy Management (MTM) pro-
4 gram model, to optimize the benefit of
5 HIV therapeutics.

6 (vi) Risk-stratified medical case man-
7 agement.

8 (vii) Provision of preventive care, in-
9 cluding counseling to prevent secondary
10 HIV infection.

11 (viii) Wrap-around support and hous-
12 ing services.

13 (3) PAYMENT MODEL.—Under the payment
14 model described in this paragraph, the demonstra-
15 tion shall test the following:

16 (A) A prepaid capitated payment model
17 that adjusts payment for HIV and behavioral
18 health acuity, to be applied under contracts
19 with managed care organizations with dem-
20 onstrated HIV experience.

21 (B) Use of funds under the Ryan White
22 HIV/AIDS Program to purchase capitated serv-
23 ices from the contracted managed care organi-
24 zations.

1 (C) Provision of additional funds to sup-
2 port services to the extent that Medicaid and
3 Medicare coverage is limited, including for serv-
4 ices such as HIV testing (for Medicaid bene-
5 ficiaries), medical case management, prevention
6 case management, treatment education, case
7 finding, behavioral health services, and housing
8 assistance.

9 (d) BENEFICIARY CRITERIA.—Beneficiaries eligible
10 for participation in the demonstration are the following:

11 (1) MEDICAID FFS BENEFICIARIES.—Fee-for-
12 service Medicaid beneficiaries 18 years of age or
13 older.

14 (2) DUAL ELIGIBLES.—Individuals who are—

15 (A) entitled to medical assistance under
16 Medicaid; and

17 (B) entitled to benefits under part A, and
18 enrolled under part B, of Medicare but are not
19 enrolled under a Medicare Advantage plan
20 under Medicare.

21 (e) ROLES AND RESPONSIBILITIES IN DEMONSTRA-
22 TION.—

23 (1) IN GENERAL.—Consistent with the National
24 HIV/AIDS Strategy for the United States, Federal
25 agencies shall coordinate their funding for the se-

1 lected States or cities covered under the demonstra-
2 tion to provide resources to fund the delivery of serv-
3 ices within the demonstration.

4 (2) HHS.—In carrying out the demonstration,
5 the Secretary shall—

6 (A) design the application process;

7 (B) solicit applications from 5 to 7 State
8 Medicaid agencies to host the demonstration;

9 (C) with respect to the service delivery
10 model described in subsection (c)(2), collaborate
11 with the CDC, HRSA, and the National Insti-
12 tutes of Health to design a minimum service de-
13 livery model that reflects the current standard
14 of care as established by the Public Health
15 Service and CDC guidelines and recommenda-
16 tions; and

17 (D) fund an evaluation of the demonstra-
18 tion to ensure collection of system, provider,
19 and beneficiary-level data to address their rou-
20 tine reporting requirements.

21 The Secretary may carry out the Secretary's author-
22 ity under this paragraph through CMMI.

23 (3) CDC.—The CDC shall collaborate with the
24 Secretary and CDC-funded HIV prevention grantees
25 in the selected States and cities to provide technical

1 assistance to design cost-effective HIV and sexually
2 transmitted infection (STI) screening and testing
3 services for Medicaid and Medicare beneficiaries, in-
4 cluding partner notification services and commu-
5 nicable disease reporting. CDC and CMS shall deter-
6 mine the extent to which testing funds shall be sup-
7 ported jointly or separately by these agencies.

8 (4) HRSA.—HRSA shall allocate funds avail-
9 able through the Special Projects of National Sig-
10 nificance (SPNS) Initiative Program (under subpart
11 I of part F of the Ryan White HIV/AIDS Program)
12 to support wrap-around core and support services
13 not covered under Medicare or Medicaid and shall
14 authorize the use of Ryan White HIV/AIDS Pro-
15 gram funds to purchase services through capitated
16 managed care programs that meet or exceed the
17 services covered by the Ryan White HIV/AIDS Pro-
18 gram at rates that are no greater than current per
19 capita expenditures. HRSA is authorized to use
20 funds under SPNS, and to waive such requirements
21 of SPNS as may be necessary, to carry out the dem-
22 onstration.

23 (5) SAMHSA.—SAMHSA shall allocate funds
24 through the Minority HIV/AIDS Initiative or other

1 programs to support behavioral health services not
2 covered under Medicare or Medicaid.

3 (6) HOPWA.—HUD shall directly allocate
4 funds under the Housing Opportunities for People
5 With AIDS (HOPWA) program to the States or cit-
6 ies participating in the demonstration to provide
7 supportive housing and other housing assistance to
8 beneficiaries who otherwise meet HOPWA eligibility
9 criteria. HUD is authorized to use such HOPWA
10 funds, and to waive such requirements under
11 HOPWA as may be necessary, to carry out the dem-
12 onstration.

13 (7) STATE MEDICAID AGENCIES.—Single State
14 agencies responsible for administration of the Med-
15 icaid program for individuals who are accepted to
16 participate in the demonstration shall—

17 (A) collaborate with CMS to design or re-
18 fine a prepaid capitated payment model, to allo-
19 cate and award contracts with capitated man-
20 aged care plans, to ensure such plans meet
21 State statutory or regulatory requirements, to
22 contract with a coordinating agency to organize
23 and deliver integrated HIV testing, medical
24 care, support, and housing services funded
25 under Medicare and Medicaid, other Federal,

1 State, and local government sponsors, and to
2 coordinate their activities with the State HIV/
3 AIDS program; and

4 (B) identify and contract with a coordi-
5 nating agency to organize the demonstration in
6 the State, to establish a coordinating body rep-
7 resenting State, local, and provider agencies
8 participating in the demonstration, to establish
9 systems of care that integrate HIV prevention,
10 testing, treatment, support, and housing serv-
11 ices, to establish mechanisms to gather evalua-
12 tion data for reporting to CMMI and other par-
13 ticipating Federal agencies, and to establish a
14 quality management program to monitor pro-
15 vider performance in delivering the services pro-
16 vided to participating beneficiaries under the
17 demonstration.

18 (8) MANAGED CARE ORGANIZATIONS.—
19 Capitated managed care organizations participating
20 in the demonstration shall organize and deliver serv-
21 ices as specified by the minimum service delivery
22 model established by CMMI through a network of
23 providers with demonstrated HIV experience, high
24 quality, and sufficient provider capacity.

25 (f) DEFINITIONS.—In this section:

1 (1) CDC.—The term “CDC” means the Direc-
2 tor of the Centers for Disease Control and Preven-
3 tion.

4 (2) CMMI.—The term “CMMI” means the Di-
5 rector of the Center for Medicare & Medicaid Inno-
6 vation.

7 (3) CMS.—The term “CMS” means the Ad-
8 ministrator of the Centers for Medicare & Medicaid
9 Services.

10 (4) DEMONSTRATION.—The term “demonstra-
11 tion” means the demonstration conducted under this
12 section.

13 (5) HRSA.—The term “HRSA” means the Ad-
14 ministrator of the Health Resources and Services
15 Administration.

16 (6) HUD.—The term “HUD” means the Sec-
17 retary of Housing and Urban Development.

18 (7) MEDICARE; MEDICAID.—The terms “Medi-
19 care” and “Medicaid” mean the programs under ti-
20 tles XVIII and XIX, respectively, of the Social Secu-
21 rity Act.

22 (8) NATIONAL HIV/AIDS STRATEGY FOR THE
23 UNITED STATES.—The term “National HIV/AIDS
24 Strategy for the United States” has the meaning

1 given such term under section 241A(b) of the Public
2 Health Service Act.

3 (9) RYAN WHITE HIV/AIDS PROGRAM.—The
4 term “Ryan White HIV/AIDS Program” means the
5 program under title XXVI of the Public Health
6 Service Act.

7 (10) SAMHSA.—The term “SAMHSA” means
8 the Substance Abuse and Mental Health Services
9 Administration.

10 (11) SECRETARY.—The term “Secretary”
11 means the Secretary of Health and Human Services,
12 acting through CMMI.

13 **SEC. 764. REPORT ON THE IMPLEMENTATION OF GOAL 4**
14 **(IMPROVED COORDINATION) OF THE NA-**
15 **TIONAL HIV/AIDS STRATEGY.**

16 (a) REPORT REQUIRED.—The President, in consulta-
17 tion with the heads of all relevant Federal departments
18 and agencies including the Department of Education, the
19 Department of Health and Human Services, the Depart-
20 ment of Housing and Urban Development, the Depart-
21 ment of Justice, the Department of Labor, the Depart-
22 ment of Veteran Affairs, and the Social Security Adminis-
23 tration, shall transmit to the Congress and make publicly
24 available a report on the status of implementation of Goal
25 4 of the National HIV/AIDS Strategy.

1 (b) CONTENTS.—The report required by subsection
2 (a) shall include a description, an analysis, and an evalua-
3 tion of—

4 (1) the extent to which the National HIV/AIDS
5 Strategy has improved coordination of efforts, en-
6 hanced capacity, and strengthened infrastructure in
7 order to maximize the effective delivery of HIV/
8 AIDS prevention, care, and treatment services at the
9 community level, including coordination—

10 (A) within and among Federal agencies
11 and departments;

12 (B) between the Federal Government and
13 State and local governments and health depart-
14 ments;

15 (C) between the Federal Government and
16 nonprofit foundations and civil society organiza-
17 tions, including community- and faith-based or-
18 ganizations focused on addressing the issue of
19 HIV/AIDS; and

20 (D) between the Federal Government and
21 private businesses; and

22 (2) efforts by the Federal Government to edu-
23 cate, involve, and establish and strengthen partner-
24 ships with civil society organizations, including
25 community- and faith-based organizations, in order

1 to implement the National HIV/AIDS Strategy and
2 achieve its goals.

3 (c) DEFINITION.—In this section, the term “National
4 HIV/AIDS Strategy” means the National HIV/AIDS
5 Strategy for the United States issued by the President in
6 July 2010, the revision to such Strategy issued in July
7 2015, and any subsequent revisions to such Strategy.

8 **Subtitle F—Diabetes**

9 **SEC. 771. RESEARCH, TREATMENT, AND EDUCATION.**

10 Subpart 3 of part C of title IV of the Public Health
11 Service Act (42 U.S.C. 285c et seq.) is amended by adding
12 at the end the following new section:

13 **“SEC. 434B. DIABETES IN MINORITY POPULATIONS.**

14 “(a) IN GENERAL.—The Director of NIH shall ex-
15 pand, intensify, and support ongoing research and other
16 activities with respect to prediabetes and diabetes, particu-
17 larly type 2, in minority populations.

18 “(b) RESEARCH.—

19 “(1) DESCRIPTION.—Research under subsection
20 (a) shall include investigation into—

21 “(A) the causes of diabetes, including so-
22 cioeconomic, geographic, clinical, environmental,
23 genetic, and other factors that may contribute
24 to increased rates of diabetes in minority popu-
25 lations; and

1 “(B) the causes of increased incidence of
2 diabetes complications in minority populations,
3 and possible interventions to decrease such inci-
4 dence.

5 “(2) INCLUSION OF MINORITY PARTICIPANTS.—
6 In conducting and supporting research described in
7 subsection (a), the Director of NIH shall seek to in-
8 clude minority participants as study subjects in clin-
9 ical trials.

10 “(c) REPORT; COMPREHENSIVE PLAN.—

11 “(1) IN GENERAL.—The Diabetes Mellitus
12 Interagency Coordinating Committee shall—

13 “(A) prepare and submit to the Congress,
14 not later than 6 months after the date of enact-
15 ment of this section, a report on Federal re-
16 search and public health activities with respect
17 to prediabetes and diabetes in minority popu-
18 lations; and

19 “(B) develop and submit to the Congress,
20 not later than 1 year after the date of enact-
21 ment of this section, an effective and com-
22 prehensive Federal plan (including all appro-
23 priate Federal health programs) to address
24 prediabetes and diabetes in minority popu-
25 lations.

1 “(2) CONTENTS.—The report under paragraph
2 (1)(A) shall at minimum address each of the fol-
3 lowing:

4 “(A) Research on diabetes and prediabetes
5 in minority populations, including such research
6 on—

7 “(i) genetic, behavioral, and environ-
8 mental factors; and

9 “(ii) prevention and complications
10 among individuals within these populations
11 who have already developed diabetes.

12 “(B) Surveillance and data collection on
13 diabetes and prediabetes in minority popu-
14 lations, including with respect to—

15 “(i) efforts to better determine the
16 prevalence of diabetes among Asian-Amer-
17 ican and Pacific Islander subgroups; and

18 “(ii) efforts to coordinate data collec-
19 tion on the American Indian population.

20 “(C) Community-based interventions to ad-
21 dress diabetes and prediabetes targeting minor-
22 ity populations, including—

23 “(i) the evidence base for such inter-
24 ventions;

1 “(ii) the cultural appropriateness of
2 such interventions; and

3 “(iii) efforts to educate the public on
4 the causes and consequences of diabetes.

5 “(D) Education and training programs for
6 health professionals (including community
7 health workers) on the prevention and manage-
8 ment of diabetes and its related complications
9 that is supported by the Health Resources and
10 Services Administration, including such pro-
11 grams supported by—

12 “(i) the National Health Service
13 Corps; or

14 “(ii) the community health centers
15 program under section 330.

16 “(d) EDUCATION.—The Director of NIH shall—

17 “(1) through the National Institute on Minority
18 Health and Health Disparities and the National Di-
19 abetes Education Program—

20 “(A) make grants to programs funded
21 under section 464z-4 (relating to centers of ex-
22 cellence) for the purpose of establishing a men-
23 toring program for health care professionals to
24 be more involved in weight counseling, obesity
25 research, and nutrition; and

1 “(B) provide for the participation of mi-
2 nority health professionals in diabetes-focused
3 research programs; and

4 “(2) make grants for programs to establish a
5 pipeline from high school to professional school that
6 will increase minority representation in diabetes-fo-
7 cused health fields by expanding Minority Access to
8 Research Careers (MARC) program internships and
9 mentoring opportunities for recruitment.

10 “(e) DEFINITIONS.—For purposes of this section:

11 “(1) The ‘Diabetes Mellitus Interagency Coordi-
12 nating Committee’ means the Diabetes Mellitus
13 Interagency Coordinating Committee established
14 under section 429.

15 “(2) The term ‘minority population’ means a
16 racial and ethnic minority group, as defined in sec-
17 tion 1707.”.

18 **SEC. 772. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

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 section:

22 **“SEC. 317U. DIABETES IN MINORITY POPULATIONS.**

23 “(a) RESEARCH AND OTHER ACTIVITIES.—

24 “(1) IN GENERAL.—The Secretary, acting
25 through the Director of the Centers for Disease

1 Control and Prevention, shall conduct and support
2 research and public health activities with respect to
3 diabetes in minority populations.

4 “(2) CERTAIN ACTIVITIES.—Activities under
5 paragraph (1) regarding diabetes in minority popu-
6 lations shall include the following:

7 “(A) Further enhancing the National
8 Health and Nutrition Examination Survey by
9 over-sampling Asian-American, Native Hawai-
10 ian, and Other Pacific Islanders in appropriate
11 geographic areas to better determine the preva-
12 lence of diabetes in such populations as well as
13 to improve the data collection of diabetes pene-
14 tration disaggregated into major ethnic groups
15 within such populations. The Secretary shall en-
16 sure that any such oversampling does not re-
17 duce the oversampling of other minority popu-
18 lations including African-American and Latino
19 populations.

20 “(B) Through the Division of Diabetes
21 Translation—

22 “(i) providing for prevention research
23 to better understand how to influence
24 health care systems changes to improve

1 quality of care being delivered to such pop-
2 ulations;

3 “(ii) carrying out model demonstra-
4 tion projects to design, implement, and
5 evaluate effective diabetes prevention and
6 control interventions for minority popu-
7 lations, including culturally appropriate
8 community-based interventions;

9 “(iii) developing and implementing a
10 strategic plan to reduce diabetes in minor-
11 ity populations through applied research to
12 reduce disparities and culturally and lin-
13 guistically appropriate community-based
14 interventions;

15 “(iv) supporting, through the national
16 diabetes prevention program under section
17 399V–3, diabetes prevention program sites
18 in underserved regions highly impacted by
19 diabetes; and

20 “(v) implementing, through the na-
21 tional diabetes prevention program under
22 section 399V–3, a demonstration program
23 developing new metrics measuring health
24 outcomes related to diabetes that can be
25 stratified by specific minority populations.

1 “(b) EDUCATION.—The Secretary, acting through
2 the Director of the Centers for Disease Control and Pre-
3 vention, shall direct the Division of Diabetes Translation
4 to conduct and support both programs to educate the pub-
5 lie on diabetes in minority populations and programs to
6 educate minority populations about the causes and effects
7 of diabetes.

8 “(c) DIABETES; HEALTH PROMOTION, PREVENTION
9 ACTIVITIES, AND ACCESS.—The Secretary, acting through
10 the Director of the Centers for Disease Control and Pre-
11 vention and the National Diabetes Education Program,
12 shall conduct and support programs to educate specific
13 minority populations through culturally appropriate and
14 linguistically appropriate information campaigns about
15 prevention of, and managing, diabetes.

16 “(d) DEFINITION.—For purposes of this section, the
17 term ‘minority population’ means a racial and ethnic mi-
18 nority group, as defined in section 1707.”.

19 **SEC. 773. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

20 Part P of title III of the Public Health Service Act
21 (42 U.S.C. 280g et seq.), as amended, is further amended
22 by adding at the end the following new section:

1 **“SEC. 399V-7. PROGRAMS TO EDUCATE HEALTH PRO-**
2 **VIDERS ON THE CAUSES AND EFFECTS OF DI-**
3 **ABETES IN MINORITY POPULATIONS.**

4 “(a) IN GENERAL.—The Secretary, acting through
5 the Director of the Health Resources and Services Admin-
6 istration, shall conduct and support programs described
7 in subsection (b) to educate health professionals on the
8 causes and effects of diabetes in minority populations.

9 “(b) PROGRAMS.—Programs described in this sub-
10 section, with respect to education on diabetes in minority
11 populations, shall include the following:

12 “(1) Giving priority, under the primary care
13 training and enhancement program under section
14 747—

15 “(A) to awarding grants to focus on or ad-
16 dress diabetes; and

17 “(B) adding minority populations to the
18 list of vulnerable populations that should be
19 served by such grants.

20 “(2) Providing additional funds for the Health
21 Careers Opportunity Program, Centers for Excel-
22 lence, and the Minority Faculty Fellowship Program
23 to partner with the Office of Minority Health under
24 section 1707 and the National Institutes of Health
25 to strengthen programs for career opportunities fo-

1 cused on diabetes treatment and care within under-
2 served regions highly impacted by diabetes.

3 “(3) Developing a diabetes focus within, and
4 providing additional funds for, the National Health
5 Service Corps Scholarship Program—

6 “(A) to place individuals in areas that are
7 disproportionately affected by diabetes and to
8 provide diabetes treatment and care in such
9 areas; and

10 “(B) to provide such individuals continuing
11 medical education specific to diabetes care.”.

12 **SEC. 774. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

13 Part P of title III of the Public Health Service Act
14 (42 U.S.C. 280g et seq.), as amended, is further amended
15 by adding at the end the following section:

16 **“SEC. 399V-8. RESEARCH, EDUCATION, AND OTHER ACTIVI-**
17 **TIES REGARDING DIABETES IN AMERICAN IN-**
18 **DIAN POPULATIONS.**

19 “In addition to activities under sections 317V-6 and
20 434B, the Secretary, acting through the Indian Health
21 Service and in collaboration with other appropriate Fed-
22 eral agencies, shall—

23 “(1) conduct and support research and other
24 activities with respect to diabetes; and

1 “(2) coordinate the collection of data on clini-
2 cally and culturally appropriate diabetes treatment,
3 care, prevention, and services by health care profes-
4 sionals to the American Indian population.”.

5 **SEC. 775. UPDATED REPORT ON HEALTH DISPARITIES.**

6 The Secretary of Health and Human Services shall
7 seek to enter into an arrangement with the Institute of
8 Medicine under which the Institute will—

9 (1) not later than 1 year after the date of en-
10 actment of this Act, submit to the Congress an up-
11 dated version of the Institute’s 2002 report entitled
12 “Unequal Treatment: Confronting Racial and Ethnic
13 Disparities in Health Care”; and

14 (2) in such updated version, address how racial
15 and ethnic health disparities have changed since the
16 publication of the original report.

17 **Subtitle G—Lung Disease**

18 **SEC. 776. EXPANSION OF THE NATIONAL ASTHMA EDU-**
19 **CATION AND PREVENTION PROGRAM.**

20 (a) FINDINGS.—The Congress finds as follows:

21 (1) The prevalence of asthma has increased
22 since 1980 and affects 25 million Americans.

23 (2) Significant disparities in asthma morbidity
24 and mortality exist for both adults and children par-

1 ticularly for low-income and minority populations,
2 particularly African-Americans and Puerto Ricans.

3 (3) African-American children are twice as like-
4 ly to have asthma as White children.

5 (4) In 2010, almost 4.5 million non-Hispanic
6 African-Americans reported having asthma. African-
7 Americans with asthma are three times as likely to
8 visit the emergency department and twice as likely
9 to get hospitalized as White patients with asthma.

10 (5) Puerto Ricans are 3.4 times as likely to die
11 from asthma compared with all other Hispanic or
12 Latino groups. Overall Hispanic Americans are 30
13 percent more likely to be hospitalized for asthma
14 than non-Hispanic Whites.

15 (6) More than 65 percent of adults with asthma
16 are women.

17 (b) IN GENERAL.—Not later than 2 years after the
18 date of the enactment of this Act, the Secretary of Health
19 and Human Services shall convene a working group com-
20 prised of patient groups, nonprofit organizations, medical
21 societies, and other relevant governmental and nongovern-
22 mental entities, including those that participate in the Na-
23 tional Asthma Education and Prevention Program, to de-
24 velop a report to Congress that—

1 (1) catalogs, with respect to asthma prevention,
2 management, and surveillance—

3 (A) the activities of the Federal Govern-
4 ment, including identifying all Federal pro-
5 grams that carry out asthma-related activities,
6 as well as assessment of the progress of the
7 Federal Government and States, with respect to
8 achieving the goals of the Healthy People 2020
9 initiative; and

10 (B) the activities of other entities that par-
11 ticipate in the program, including nonprofit or-
12 ganizations, patient advocacy groups, and med-
13 ical societies; and

14 (2) makes recommendations for the future di-
15 rection of asthma activities, in consultation with re-
16 searchers from the National Institutes of Health and
17 other member bodies of the National Asthma Edu-
18 cation and Prevention Program who are qualified to
19 review and analyze data and evaluate interventions,
20 including—

21 (A) description of how the Federal Govern-
22 ment may better coordinate and improve its re-
23 sponse to asthma including identifying any bar-
24 riers that may exist;

1 (B) description of how the Federal Govern-
2 ment may continue, expand, and improve its
3 private-public partnerships with respect to asth-
4 ma including identifying any barriers that may
5 exist;

6 (C) identification of steps that may be
7 taken to reduce the—

8 (i) morbidity, mortality, and overall
9 prevalence of asthma;

10 (ii) financial burden of asthma on so-
11 ciety;

12 (iii) burden of asthma on dispropor-
13 tionately affected areas, particularly those
14 in medically underserved populations (as
15 defined in section 330(b)(3) of the Public
16 Health Service Act (42 U.S.C.
17 254b(b)(3))); and

18 (iv) burden of asthma as a chronic
19 disease;

20 (D) identification of programs and policies
21 that have achieved the steps described in sub-
22 paragraph (C), and steps that may be taken to
23 expand such programs and policies to benefit
24 larger populations; and

1 (E) recommendations for future research
2 and interventions.

3 (c) REPORT TO CONGRESS.—At the end of the 5-year
4 period following the submission of the report under sub-
5 section (a), the National Asthma Education and Preven-
6 tion Program shall evaluate the analyses and rec-
7 ommendations under such report and determine whether
8 a new report to the Congress is necessary, and make ap-
9 propriate recommendations to the Congress.

10 **SEC. 777. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**
11 **FOR DISEASE CONTROL AND PREVENTION.**

12 Section 317I of the Public Health Service Act (42
13 U.S.C. 247b–10) is amended to read as follows:

14 **“SEC. 317I. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**
15 **FOR DISEASE CONTROL AND PREVENTION.**

16 “(a) PROGRAM FOR PROVIDING INFORMATION AND
17 EDUCATION TO THE PUBLIC.—The Secretary, acting
18 through the Director of the Centers for Disease Control
19 and Prevention, shall collaborate with State and local
20 health departments to conduct activities, including the
21 provision of information and education to the public re-
22 garding asthma including—

23 “(1) deterring the harmful consequences of un-
24 controlled asthma; and

1 “(2) disseminating health education and infor-
2 mation regarding prevention of asthma episodes and
3 strategies for managing asthma.

4 “(b) DEVELOPMENT OF STATE ASTHMA PLANS.—
5 The Secretary, acting through the Director of the Centers
6 for Disease Control and Prevention, shall collaborate with
7 State and local health departments to develop State plans
8 incorporating public health responses to reduce the burden
9 of asthma, particularly regarding disproportionately af-
10 fected populations.

11 “(c) COMPILATION OF DATA.—The Secretary, acting
12 through the Director of the Centers for Disease Control
13 and Prevention, shall, in cooperation with State and local
14 public health officials—

15 “(1) conduct asthma surveillance activities to
16 collect data on the prevalence and severity of asth-
17 ma, the effectiveness of public health asthma inter-
18 ventions, and the quality of asthma management, in-
19 cluding—

20 “(A) collection of household data on the
21 local burden of asthma;

22 “(B) surveillance of health care facilities;
23 and

24 “(C) collection of data not containing indi-
25 vidually identifiable information from electronic

1 health records or other electronic communica-
2 tions;

3 “(2) compile and annually publish data regard-
4 ing the prevalence and incidence of childhood asth-
5 ma, the child mortality rate, and the number of hos-
6 pital admissions and emergency department visits by
7 children associated with asthma nationally and in
8 each State and at the county level by age, sex, race,
9 and ethnicity, as well as lifetime and current preva-
10 lence; and

11 “(3) compile and annually publish data regard-
12 ing the prevalence and incidence of adult asthma,
13 the adult mortality rate, and the number of hospital
14 admissions and emergency department visits by
15 adults associated with asthma nationally and in each
16 State and at the county level by age, sex, race, eth-
17 nicity, industry, and occupation, as well as lifetime
18 and current prevalence.

19 “(d) COORDINATION OF DATA COLLECTION.—The
20 Director of the Centers for Disease Control and Preven-
21 tion, in conjunction with State and local health depart-
22 ments, shall coordinate data collection activities under
23 subsection (c)(2) so as to maximize comparability of re-
24 sults.

1 “(e) COLLABORATION.—The Centers for Disease
2 Control and Prevention are encouraged to collaborate with
3 national, State, and local nonprofit organizations to pro-
4 vide information and education about asthma, and to
5 strengthen such collaborations when possible.

6 “(f) ADDITIONAL FUNDING.—In addition to any
7 other authorization of appropriations that is available to
8 the Centers for Disease Control and Prevention for the
9 purpose of carrying out this section, there are authorized
10 to be appropriated to such Centers such sums as may be
11 necessary for each of fiscal years 2017 through 2021 for
12 the purpose of carrying out this section.”.

13 **SEC. 778. INFLUENZA AND PNEUMONIA VACCINATION CAM-**
14 **PAIGN.**

15 (a) IN GENERAL.—The Secretary of Health and
16 Human Services shall—

17 (1) enhance the annual campaign by the De-
18 partment of Health and Human Services to increase
19 the number of people vaccinated each year for influ-
20 enza and pneumonia; and

21 (2) include in such campaign the use of written
22 educational materials, public service announcements,
23 physician education, and any other means which the
24 Secretary deems effective.

1 (b) MATERIALS AND ANNOUNCEMENTS.—In carrying
2 out the annual campaign described in subsection (a), the
3 Secretary of Health and Human Services shall ensure
4 that—

5 (1) educational materials and public service an-
6 nouncements are readily and widely available in
7 communities experiencing disparities in the incidence
8 and mortality rates of influenza and pneumonia; and

9 (2) the campaign uses targeted, culturally ap-
10 propriate messages and messengers to reach under-
11 served communities.

12 (c) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this section
14 such sums as may be necessary for each of fiscal years
15 2017 through 2021.

16 **SEC. 779. CHRONIC OBSTRUCTIVE PULMONARY DISEASE**
17 **ACTION PLAN.**

18 (a) FINDINGS.—The Congress finds as follows:

19 (1) Chronic obstructive pulmonary disease
20 (“COPD”) refers to chronic bronchitis and emphy-
21 sema, incurable diseases that make it difficult to ex-
22 hale all the air from one’s lungs, and that can cause
23 persistent coughing, shortness of breath, and spu-
24 tum.

1 (2) COPD exacerbations—episodes of acute dif-
2 ficulty breathing and moderate to severe fatigue—
3 are dangerous, and their treatment often requires
4 hospitalization.

5 (3) While smoking is the primary risk factor for
6 COPD, other risk factors include air pollution, occu-
7 pational exposures, heredity, a history of childhood
8 respiratory infections, and socioeconomic status.

9 (4) Over 13.5 million United States adults are
10 estimated to have COPD.

11 (5) COPD is the third leading cause of death
12 in America, claiming over 134,000 lives in 2010.

13 (6) Since 2000, deaths for women with COPD
14 have exceed deaths in men.

15 (7) Although African-Americans have a lower
16 prevalence of COPD in the United States, research-
17 ers have shown that African-Americans may be
18 underdiagnosed. Furthermore, research has shown
19 that African-Americans develop COPD with less cu-
20 mulative smoke exposure and at a younger age.

21 (b) IN GENERAL.—The Director of the Centers for
22 Disease Control and Prevention shall conduct, support,
23 and expand public health strategies, prevention, diagnosis,
24 surveillance, and public and professional awareness activi-
25 ties regarding chronic obstructive pulmonary disease.

1 (c) NATIONAL ACTION PLAN.—

2 (1) DEVELOPMENT.—Not later than 2 years
3 after the date of the enactment of this Act, the Di-
4 rector of the National Heart, Lung, and Blood Insti-
5 tute, in consultation with the Director of the Centers
6 for Disease Control and Prevention, shall develop a
7 national action plan to address chronic obstructive
8 pulmonary disease in the United States with partici-
9 pation from patients, caregivers, health profes-
10 sionals, patient advocacy organizations, researchers,
11 providers, public health professionals, and other
12 stakeholders.

13 (2) CONTENTS.—At a minimum, such plan
14 shall include recommendations for—

15 (A) public health interventions for the pur-
16 pose of implementation of the national plan;

17 (B) biomedical, health services, and public
18 health research on chronic obstructive pul-
19 monary disease; and

20 (C) inclusion of chronic obstructive pul-
21 monary disease in the health data collections of
22 all Federal agencies.

23 (3) CONSIDERATION.—In developing such plan,
24 the Director of the National Heart, Lung, and Blood
25 Institute shall consider the recommendations and

1 findings of the Institute of Medicine in the report
2 entitled “A Nationwide Framework for Surveillance
3 of Cardiovascular and Chronic Lung Diseases” (July
4 22, 2011).

5 (d) CHRONIC DISEASE PREVENTION PROGRAMS.—
6 The Director of the National Heart, Lung, and Blood In-
7 stitute shall carry out the following:

8 (1) Conduct public education and awareness ac-
9 tivities with patient and professional organizations
10 to stimulate earlier diagnosis and improve patient
11 outcomes from treatment of chronic obstructive pul-
12 monary disease. To the extent known and relevant,
13 such public education and awareness activities shall
14 reflect differences in chronic obstructive pulmonary
15 disease by cause (tobacco, environmental, occupa-
16 tional, biological, and genetic) and include a focus
17 on outreach to undiagnosed and, as appropriate, mi-
18 nority populations.

19 (2) Supplement and expand upon the activities
20 of the National Heart, Lung, and Blood Institute by
21 making grants to nonprofit organizations, State and
22 local jurisdictions, and Indian tribes for the purpose
23 of reducing the burden of chronic obstructive pul-
24 monary disease, especially in disproportionately im-

1 pacted communities, through public health interven-
2 tions and related activities.

3 (3) Coordinate with the Centers for Disease
4 Control and Prevention, the Indian Health Service,
5 the Health Resources and Services Administration,
6 and the Department of Veterans Affairs to develop
7 pilot programs to demonstrate best practices for the
8 diagnosis and management of chronic obstructive
9 pulmonary disease.

10 (4) Develop improved techniques and identify
11 best practices, in coordination with the Secretary of
12 Veterans Affairs, for assisting chronic obstructive
13 pulmonary disease patients to successfully stop
14 smoking, including identification of subpopulations
15 with different needs. Initiatives under this para-
16 graph may include research to determine whether
17 successful smoking cessation strategies are different
18 for chronic obstructive pulmonary disease patients
19 compared to such strategies for patients with other
20 chronic diseases.

21 (e) ENVIRONMENTAL AND OCCUPATIONAL HEALTH
22 PROGRAMS.—The Director of the Centers for Disease
23 Control and Prevention shall—

24 (1) support research into the environmental and
25 occupational causes and biological mechanisms that

1 contribute to chronic obstructive pulmonary disease;
2 and

3 (2) develop and disseminate public health inter-
4 ventions that will lessen the impact of environmental
5 and occupational causes of chronic obstructive pul-
6 monary disease.

7 (f) DATA COLLECTION.—Not later than 180 days
8 after the enactment of this Act, the Director of the Na-
9 tional Heart, Lung, and Blood Institute and the Director
10 of the Centers for Disease Control and Prevention, acting
11 jointly, shall assess the depth and quality of information
12 on chronic obstructive pulmonary disease that is collected
13 in surveys and population studies conducted by the Cen-
14 ters for Disease Control and Prevention, including wheth-
15 er there are additional opportunities for information to be
16 collected in the National Health and Nutrition Examina-
17 tion Survey, the National Health Interview Survey, and
18 the Behavioral Risk Factors Surveillance System surveys.
19 The Director of the National Heart, Lung, and Blood In-
20 stitute shall include the results of such assessment in the
21 national action plan under subsection (b).

22 (g) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to carry out this section
24 such sums as may be necessary for each of fiscal years
25 2017 through 2021.

1 **Subtitle H—Osteoarthritis and** 2 **Musculoskeletal Diseases**

3 **SEC. 781. FINDINGS.**

4 The Congress finds as follows:

5 (1) Eighty percent of African-American women
6 and nearly 74 percent of Hispanic men are either
7 overweight or obese, speeding the onset and progres-
8 sion of arthritis.

9 (2) Arthritis affects 46 million Americans, and
10 that number will rise to 67 million by the year 2030.

11 (3) Twenty-seven million Americans suffer from
12 osteoarthritis, the most common form of arthritis,
13 making it the leading cause of disability in the
14 United States. Osteoarthritis is sometimes referred
15 to as degenerative joint disease.

16 (4) Obesity accelerates the onset of arthritis: 70
17 percent of obese adults with mild osteoarthritis of
18 the knee at age 60 will develop advanced end-stage
19 disease by age 80. In contrast, just 43 percent of
20 non-obese adults will have end-stage disease over the
21 same time period.

22 (5) Arthritis affects one in five Americans, and
23 is the single greatest cause of chronic pain and dis-
24 ability in the United States.

1 (6) Women, African-Americans, and Hispanics
2 have more severe arthritis and functional limitations.
3 These same individuals are more likely to be obese,
4 diabetic, and have higher incidence of heart dis-
5 ease—medical conditions that can be improved with
6 physical activity. Instead of moving; however, these
7 groups have an inactivity rate of 40 to 50 percent,
8 which continues to increase.

9 (7) Arthritis costs \$128 billion a year, including
10 \$81 billion in direct costs (medical) and \$47 billion
11 in indirect costs (lost earnings). Each year, \$309 bil-
12 lion in direct and indirect costs is lost due to dis-
13 parities in osteoarthritis and musculoskeletal dis-
14 eases.

15 (8) Obesity and other chronic health conditions
16 exacerbate the debilitating impact of arthritis, lead-
17 ing to inactivity, loss of independence, and a per-
18 petual cycle of comorbid chronic conditions.

19 (9) Sixty-one percent of arthritis sufferers are
20 women, and women represent 64 percent of an esti-
21 mated 43 million annual visits to physicians' offices
22 and outpatient clinics where arthritis was the pri-
23 mary diagnosis. Women also represented 60 percent
24 of approximately 1 million hospitalizations that oc-

1 curred in 2003 for which arthritis was the primary
2 diagnosis.

3 (10) Women ages 65 and older have up to 2½
4 times more disabilities than men of the same age.
5 Higher rates of obesity and arthritis among this
6 group explained up to 48 percent of the gender gap
7 in disability, above all other common chronic health
8 conditions.

9 (11) The primary indication for total knee
10 arthroplasty (TKA), also known as knee replace-
11 ment, is relief of significant, disabling pain caused
12 by severe arthritis.

13 (12) Knee replacement is surgery for people
14 with severe knee damage. Knee replacement can re-
15 lieve pain and allow you to be more active. When
16 you have a total knee replacement, the surgeon re-
17 moves damaged cartilage and bone from the surface
18 of your knee joint and replaces them with a man-
19 made surface of metal and plastic. In a partial knee
20 replacement, the surgeon only replaces one part of
21 your knee joint.

22 (13) Total hip replacement, also called total hip
23 arthroplasty (THA), is used if your hip pain inter-
24 feres with daily activities and more-conservative

1 treatments have not helped. Arthritis damage is the
2 most common reason to need hip replacement.

3 (14) The odds of a family practice physician
4 recommending TKA to a male patient with moderate
5 arthritis are twice that of a female patient, while the
6 odds of an orthopaedic surgeon recommending TKA
7 to a male patient with moderate arthritis are 22
8 times that of a female patient.

9 (15) African-Americans with doctor-diagnosed
10 arthritis have a higher prevalence of severe pain at-
11 tributable to arthritis, compared with Whites (34.0
12 percent versus 22.6 percent). African-Americans,
13 compared to Whites, report a higher proportion of
14 work limitations (39.5 percent versus 28.0 percent)
15 and a higher prevalence of arthritis-attributable
16 work limitation (6.6 percent versus 4.6 percent).

17 (16) Hispanics are 50 percent more likely than
18 non-Hispanic Whites to report needing assistance
19 with at least one instrumental activity of daily living
20 and to have difficulty walking.

21 (17) African-Americans and Hispanics were 1.3
22 times more likely to have activity limitation, 1.6
23 times more likely to have work limitations, and 1.9
24 times more likely to have severe joint pain than
25 Whites.

1 (18) In 2003, the Institute of Medicine reported
2 that the rates of TKA and THA among African-
3 American and Hispanic patients are significantly
4 lower than for Whites—even for those with equitable
5 health care coverage such as through Medicare or
6 the Department of Veterans Affairs.

7 (19) According to the Centers for Disease Con-
8 trol and Prevention, in 2000, African-American
9 Medicare enrollees were 37 percent less likely than
10 White Medicare enrollees to undergo total knee re-
11 placements. In 2006, the disparity increased to 39
12 percent.

13 (20) Even after adjusting for insurance and
14 health access, Hispanics and African-Americans are
15 almost 50 percent less likely to undergo total knee
16 replacement than Whites.

17 **SEC. 782. OSTEOARTHRITIS AND OTHER MUSCULO-**
18 **SKELETAL HEALTH-RELATED ACTIVITIES OF**
19 **THE CENTERS FOR DISEASE CONTROL AND**
20 **PREVENTION.**

21 (a) EDUCATION AND AWARENESS ACTIVITIES.—The
22 Secretary of Health and Human Services, acting through
23 the Director of the Centers for Disease Control and Pre-
24 vention, shall direct the National Center for Chronic Dis-
25 ease Prevention and Health Promotion to conduct and ex-

1 pand the Health Community Program and Arthritis Pro-
2 gram to educate the public on—

3 (1) the causes of, preventive health actions for,
4 and effects of arthritis and other musculoskeletal
5 conditions in minority patient populations; and

6 (2) the effects of such conditions on other
7 comorbidities including obesity, hypertension, and
8 cardiovascular disease.

9 (b) PROGRAMS ON ARTHRITIS AND MUSCULO-
10 SKELETAL CONDITIONS.—Education and awareness pro-
11 grams of the Centers for Disease Control and Prevention
12 on arthritis and other musculoskeletal conditions in minor-
13 ity communities shall—

14 (1) be culturally and linguistically appropriate
15 to minority patients, targeting musculoskeletal
16 health promotion and prevention programs of each
17 major ethnic group, including—

18 (A) Native Americans and Alaska Natives;

19 (B) Asian-Americans;

20 (C) African-Americans/Blacks;

21 (D) Hispanic/Latino-Americans; and

22 (E) Native Hawaiians and Pacific Island-
23 ers; and

24 (2) include public awareness campaigns directed
25 toward these patient populations that emphasize the

1 importance of musculoskeletal health, physical activ-
2 ity, diet and healthy lifestyle, and weight reduction
3 for overweight and obese patients.

4 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
5 out this section, there are authorized to be appropriated
6 such sums as necessary for fiscal year 2017 and each sub-
7 sequent fiscal year.

8 **SEC. 783. GRANTS FOR COMPREHENSIVE OSTEOARTHRITIS**
9 **AND MUSCULOSKELETAL DISEASE HEALTH**
10 **EDUCATION WITHIN HEALTH PROFESSIONS**
11 **SCHOOLS.**

12 (a) PROGRAM AUTHORIZED.—The Secretary of
13 Health and Human Services (in this section referred to
14 as the “Secretary”), in coordination with the Secretary of
15 Education, shall award grants, on a competitive basis, to
16 academic health science centers, health professions
17 schools, and other institutions of higher education to en-
18 able such institutions to provide people with comprehen-
19 sive education on arthritis and musculoskeletal health,
20 particularly—

- 21 (1) obesity related musculoskeletal diseases;
22 (2) arthritis and osteoarthritis;
23 (3) arthritis and musculoskeletal health dispari-
24 ties; and

1 (4) the relationship between arthritis and mus-
2 culoskeletal diseases and metabolic activity, psycho-
3 logical health, and co-morbidities such as diabetes,
4 cardiovascular disease, and hypertension.

5 (b) DURATION.—Grants awarded under this section
6 shall be for a period of 5 years.

7 (c) APPLICATIONS.—An academic health science cen-
8 ter, health professions school, or other institution of high-
9 er education seeking a grant under this section shall sub-
10 mit an application to the Secretary at such time, in such
11 manner, and containing such information as the Secretary
12 may require.

13 (d) PRIORITY.—In awarding grants under this sec-
14 tion, the Secretary shall give priority to an institution of
15 higher education that—

16 (1) has an enrollment of needy students, as de-
17 fined in section 318(b) of the Higher Education Act
18 of 1965 (20 U.S.C. 1059e(b));

19 (2) is a Hispanic-serving institution, as defined
20 in section 502(a) of such Act (20 U.S.C. 1101a(a));

21 (3) is a Tribal College or University, as defined
22 in section 316(b) of such Act (20 U.S.C. 1059c(b));

23 (4) is an Alaska Native-serving institution, as
24 defined in section 317(b) of such Act (20 U.S.C.
25 1059d(b));

1 (5) is a Native Hawaiian-serving institution, as
2 defined in section 317(b) of such Act (20 U.S.C.
3 1059d(b));

4 (6) is a Predominately Black Institution, as de-
5 fined in section 318(b) of such Act (20 U.S.C.
6 1059e(b));

7 (7) is a Native American-serving, nontribal in-
8 stitution, as defined in section 319(b) of such Act
9 (20 U.S.C. 1059f(b));

10 (8) is an Asian American and Native American
11 Pacific Islander-serving institution, as defined in
12 section 320(b) of such Act (20 U.S.C. 1059g(b)); or

13 (9) is a minority institution, as defined in sec-
14 tion 365 of such Act (20 U.S.C. 1067k), with an en-
15 rollment of needy students, as defined in section 312
16 of such Act (20 U.S.C. 1058).

17 (e) USES OF FUNDS.—An institution of higher edu-
18 cation receiving a grant under this section may use grant
19 funds to integrate issues relating to comprehensive arthri-
20 tis and musculoskeletal health into the academic or sup-
21 port sectors of the institution in order to reach a large
22 number of students, by carrying out 1 or more of the fol-
23 lowing activities:

24 (1) Developing educational content for issues
25 relating to comprehensive arthritis and musculo-

1 skeletal health education that will be incorporated
2 into first-year orientation or core courses.

3 (2) Creating innovative technology-based ap-
4 proaches to deliver arthritis and musculoskeletal
5 health education to students, faculty, and staff.

6 (3) Developing and employing peer-outreach
7 and education programs to generate discussion, edu-
8 cate, and raise awareness among students about
9 issues relating to arthritis and musculoskeletal
10 health disorders, and their relationship to diabetes,
11 hypertension, cardiovascular disease, psychological
12 health, and other co-morbid conditions.

13 (f) REPORT TO CONGRESS.—

14 (1) IN GENERAL.—Not later than 1 year after
15 the date of the enactment of this Act, and annually
16 thereafter for a period of 5 years, the Secretary shall
17 prepare and submit to the appropriate committees of
18 Congress a report on the activities to provide health
19 professions students with comprehensive arthritis
20 and musculoskeletal health education funded under
21 this section.

22 (2) REPORT ELEMENTS.—The report described
23 in paragraph (1) shall include information about—

24 (A) the number of entities that are receiv-
25 ing grant funds;

1 (B) the specific activities supported by
2 grant funds;

3 (C) the number of students served by
4 grant programs; and

5 (D) the status of program evaluations.

6 **Subtitle I—Sleep and Circadian**
7 **Rhythm Disorders**

8 **SEC. 791. SHORT TITLE; FINDINGS.**

9 (a) **SHORT TITLE.**—This subtitle may be cited as the
10 “Sleep and Circadian Rhythm Disorders Health Dispari-
11 ties Act”.

12 (b) **FINDINGS.**—The Congress finds the following:

13 (1) Decrements in sleep health such as sleep
14 apnea, insufficient sleep time, and insomnia, affect
15 50–70 million United States adults. Twelve to eight-
16 een million United States adults have sleep apnea, a
17 chronic disorder characterized by one or more
18 pauses in breathing which can last from a few sec-
19 onds to minutes. They may occur 30 times or more
20 an hour, disrupting sleep and resulting in excessive
21 daytime sleepiness and loss in productivity.

22 (2) Seventy percent of high school students are
23 not getting enough sleep on school nights, while 33
24 percent of Americans get fewer than 7 hours of sleep

1 per night and roughly 6,000 fatal motor vehicle
2 crashes are caused by drowsy drivers.

3 (3) Insufficient sleep and insomnia are more
4 prevalent in women. Women who are pregnant and
5 have sleep apnea are at an increased risk of cardio-
6 vascular complications during pregnancy. The im-
7 pact of disparities in sleep health is associated with
8 a growing number of health problems, including the
9 following:

10 (A) Hypertension.

11 (B) Cancer.

12 (C) Stroke.

13 (D) Cardiac arrhythmia.

14 (E) Chronic heart failure and heart dis-
15 ease.

16 (F) Diabetes.

17 (G) Cognitive functioning and behavior.

18 (H) Depression and bipolar disorder.

19 (I) Substance abuse.

20 (4) A “sleep disparity” exists in that poor sleep
21 quality is strongly associated with poverty and race.
22 Factors such as employment, education, and health
23 status, amongst others, significantly mediated this
24 effect only in poor subjects, suggesting a differential

1 vulnerability to these factors in poor relative to non-
2 poor individuals in the context of sleep quality.

3 (5) African-Americans sleep worse than Cauca-
4 sian Americans. African-Americans take longer to
5 fall asleep, report poorer sleep quality, have more
6 light and less deep sleep, and nap more often and
7 longer.

8 (6) African-Americans and individuals in lower
9 socioeconomic status groups may be at an increased
10 risk for sleep disturbances and associated health
11 consequences.

12 (7) Among young African-Americans, the likeli-
13 hood of having sleep disordered breathing and exhib-
14 iting risk factors for poor sleep is twice that in
15 young Caucasians. Frequent snoring is more com-
16 mon among African-American and Hispanic women
17 and Hispanic men compared to non-Hispanic Cauca-
18 sians, independent of other factors including obesity.

19 (8) African-Americans with sleep disordered
20 breathing develop symptoms at a younger age than
21 Caucasians but appear less likely to be diagnosed
22 and treated in a timely manner. This delay may at
23 least in part be due to reduced access to care.

24 (9) Sleep loss contributes to increased risk for
25 chronic conditions such as obesity, diabetes, and hy-

1 pertension, all of which have increased prevalence in
2 underserved, underrepresented minorities. Racial
3 and ethnic disparities related to obesity may also
4 contribute to disparities in health outcomes related
5 to sleep disordered breathing.

6 (10) Non-Caucasian adults report an insomnia
7 rate of 12.9 percent compared to only 6.6 percent
8 for Caucasians.

9 (11) African-American women have a higher in-
10 cidence of insomnia than African-American men,
11 perhaps related in part to higher risk for chronic
12 persisting symptoms.

13 **SEC. 792. SLEEP AND CIRCADIAN RHYTHM DISORDERS RE-**
14 **SEARCH ACTIVITIES OF THE NATIONAL IN-**
15 **STITUTES OF HEALTH.**

16 (a) IN GENERAL.—The Director of the National In-
17 stitutes of Health, acting through the Director of the Na-
18 tional Heart, Lung, and Blood Institute, shall—

19 (1) continue to expand research activities ad-
20 dressing sleep health disparities; and

21 (2) continue implementation of the “NIH Sleep
22 Disorders Research Plan” across all institutes and
23 centers of the National Institutes of Health to im-
24 prove treatment and prevention of sleep health dis-
25 parities.

1 (b) REQUIRED RESEARCH ACTIVITIES.—In con-
2 ducting or supporting research relating to sleep and circa-
3 dian rhythm, the Director of the National Heart, Lung,
4 and Blood Institute shall—

5 (1) advance epidemiology and clinical research
6 to achieve a more complete understanding of dispari-
7 ties in domains of sleep health and across population
8 subgroups for which cardiovascular and metabolic
9 health disparities exist, including—

10 (A) prevalence and severity of sleep apnea;

11 (B) habitual sleep duration;

12 (C) sleep timing and regularity; and

13 (D) insomnia;

14 (2) develop study designs and analytical ap-
15 proaches to explain and predict multilevel and life-
16 course determinants of sleep health and to elucidate
17 the sleep-related causes of cardiovascular and meta-
18 bolic health disparities across the age spectrum, in-
19 cluding such determinants and causes that are—

20 (A) environmental;

21 (B) biological or genetic;

22 (C) psychosocial;

23 (D) societal;

24 (E) political; or

25 (F) economic;

1 (3) determine the contribution of sleep impair-
2 ments such as sleep apnea, insufficient sleep dura-
3 tion, irregular sleep schedules, and insomnia to un-
4 explained disparities in cardiovascular and metabolic
5 risk and disease outcomes;

6 (4) develop study designs, data sampling and
7 collection tools, and analytical approaches to opti-
8 mize understanding of mediating and moderating
9 factors, and feedback mechanisms coupling sleep to
10 cardiovascular and metabolic health disparities;

11 (5) advance research to understand cultural
12 and linguistic barriers (on the person, provider, or
13 system level) to access to care, medical diagnosis,
14 and treatment of sleep disorders in diverse popu-
15 lation groups;

16 (6) develop and test multilevel interventions (in-
17 cluding sleep health education in diverse commu-
18 nities) to reduce disparities in sleep health that will
19 impact ability to improve disparities in cardio-
20 vascular and metabolic risk or disease;

21 (7) create opportunities to integrate sleep and
22 health disparity science by strategically utilizing re-
23 sources (existing or anticipated cohorts), exchanging
24 scientific data and ideas (cross-over into scientific

1 meetings), and develop multidisciplinary investi-
2 gator-initiated grant applications; and

3 (8) enhance the diversity and foster career de-
4 velopment of young investigators involved in sleep
5 and health disparities science.

6 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
7 out this section, there are authorized to be appropriated
8 such sums as may be necessary for fiscal year 2017 and
9 each subsequent fiscal year.

10 **SEC. 793. SLEEP AND CIRCADIAN RHYTHM HEALTH DIS-**
11 **PARITIES-RELATED ACTIVITIES OF THE CEN-**
12 **TERS FOR DISEASE CONTROL AND PREVEN-**
13 **TION.**

14 (a) IN GENERAL.—The Director of the Centers for
15 Disease Control and Prevention shall conduct, support,
16 and expand public health strategies and prevention, diag-
17 nosis, surveillance, and public and professional awareness
18 activities regarding sleep and circadian rhythm disorders.

19 (b) FINDINGS.—The Congress finds as follows:

20 (1) Sleep disorders and sleep deficiency unre-
21 lated to a primary sleep disorder are underdiagnosed
22 and are increasingly detrimental to health status.

23 (2) The consequences to society include addi-
24 tional diseases, motor vehicle accidents, decreased
25 longevity, elevated direct medical costs, and indirect

1 costs related to work absenteeism and property dam-
2 age.

3 (c) REQUIRED SURVEILLANCE AND EDUCATION
4 AWARENESS ACTIVITIES.—In conducting or supporting
5 research relating to sleep and circadian rhythm disorders
6 surveillance and education awareness activities, the Direc-
7 tor of the Centers for Disease Control and Prevention
8 shall—

9 (1) ensure that such activities are culturally
10 and linguistically appropriate to minority patients,
11 targeting sleep and circadian rhythm health pro-
12 motion and prevention programs of each major eth-
13 nic group, including—

14 (A) Native Americans and Alaska Natives;

15 (B) Asian-Americans;

16 (C) African-Americans/Blacks;

17 (D) Hispanic/Latino-Americans; and

18 (E) Native Hawaiians and Pacific Island-
19 ers;

20 (2) collect and compile national and State sur-
21 veillance data on sleep disorders health disparities;

22 (3) continue to develop and implement new
23 sleep questions in public health surveillance systems
24 to increase public awareness of sleep health and
25 sleep disorders and their impact on health;

1 (4) publish monthly reports highlighting geo-
2 graphic, racial, and ethnic disparities in sleep health,
3 as well as relationships between insufficient sleep
4 and chronic disease, health risk behaviors, and other
5 outcomes as determined necessary by the Director;
6 and

7 (5) include public awareness campaigns that in-
8 form patient populations from major ethnic groups
9 about the prevalence of sleep and circadian rhythm
10 disorders and emphasize the importance of sleep
11 health.

12 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
13 out this section, there are authorized to be appropriated
14 such sums as may be necessary for fiscal year 2017 and
15 each subsequent fiscal year.

16 **SEC. 794. GRANTS FOR COMPREHENSIVE SLEEP AND CIR-**
17 **CADIAN HEALTH EDUCATION WITHIN**
18 **HEALTH PROFESSIONS SCHOOLS.**

19 (a) PROGRAM AUTHORIZED.—The Secretary of
20 Health and Human Services (in this section referred to
21 as the “Secretary”), in coordination with the Secretary of
22 Education, shall award grants, on a competitive basis, to
23 academic health science centers, health professions
24 schools, and other institutions of higher education to en-
25 able such institutions to provide people with comprehen-

1 sive education on sleep and circadian health, particu-
2 larly—

3 (1) poor sleep health;

4 (2) sleep disorders;

5 (3) sleep health disparities; and

6 (4) the relationship between sleep and circadian
7 health on metabolic activity, neurological activity, co-
8 morbidities, and other diseases.

9 (b) DURATION.—Grants awarded under this section
10 shall be for a period of 5 years.

11 (c) APPLICATIONS.—Any academic health science
12 center, health professions school, or other institutions of
13 higher education seeking a grant under this section shall
14 submit an application to the Secretary at such time, in
15 such manner, and containing such information as the Sec-
16 retary may require.

17 (d) PRIORITY.—In awarding grants under this sec-
18 tion, the Secretary shall give priority to an institution
19 that—

20 (1) has an enrollment of needy students, as de-
21 fined in section 318(b) of the Higher Education Act
22 of 1965 (20 U.S.C. 1059e(b));

23 (2) is a Hispanic-serving institution, as defined
24 in section 502(a) of such Act (20 U.S.C. 1101a(a));

1 (3) is a Tribal College or University, as defined
2 in section 316(b) of such Act (20 U.S.C. 1059c(b));

3 (4) is an Alaska Native-serving institution, as
4 defined in section 317(b) of such Act (20 U.S.C.
5 1059d(b));

6 (5) is a Native Hawaiian-serving institution, as
7 defined in section 317(b) of such Act (20 U.S.C.
8 1059d(b));

9 (6) is a Predominately Black Institution, as de-
10 fined in section 318(b) of such Act (20 U.S.C.
11 1059e(b));

12 (7) is a Native American-serving, nontribal in-
13 stitution, as defined in section 319(b) of such Act
14 (20 U.S.C. 1059f(b));

15 (8) is an Asian American and Native American
16 Pacific Islander-serving institution, as defined in
17 section 320(b) of such Act (20 U.S.C. 1059g(b)); or

18 (9) is a minority institution, as defined in sec-
19 tion 365 of such Act (20 U.S.C. 1067k), with an en-
20 rollment of needy students, as defined in section 312
21 of such Act (20 U.S.C. 1058).

22 (e) USES OF FUNDS.—An institution of higher edu-
23 cation receiving a grant under this section may use grant
24 funds to integrate issues relating to comprehensive sleep
25 and circadian health into the academic or support sectors

1 of the institution in order to reach a large number of stu-
2 dents, by carrying out 1 or more of the following activities:

3 (1) Developing educational content for issues
4 relating to comprehensive sleep and circadian health
5 education that will be incorporated into first-year
6 orientation or core courses.

7 (2) Creating innovative technology-based ap-
8 proaches to deliver sleep health education to stu-
9 dents, faculty, and staff.

10 (3) Developing and employing peer-outreach
11 and education programs to generate discussion, edu-
12 cate, and raise awareness among students about
13 issues relating to poor quality sleep, sleep and circa-
14 dian disorders, and the role sleep health plays in
15 other diseases and co-morbidities.

16 (f) REPORT TO CONGRESS.—

17 (1) IN GENERAL.—Not later than 1 year after
18 the date of the enactment of this Act, and annually
19 thereafter for a period of 5 years, the Secretary shall
20 prepare and submit to the appropriate committees of
21 Congress a report on the activities to provide health
22 professions students with comprehensive sleep and
23 circadian health education funded under this section.

24 (2) REPORT ELEMENTS.—The report described
25 in paragraph (1) shall include information about—

1 (A) the number of eligible entities and in-
2 stitutions of higher education that are receiving
3 grant funds;

4 (B) the specific activities supported by
5 grant funds;

6 (C) the number of students served by
7 grant programs; and

8 (D) the status of program evaluations.

9 **SEC. 795. REPORT ON IMPACT OF SLEEP AND CIRCADIAN**
10 **HEALTH DISORDERS IN VULNERABLE & RA-**
11 **CIAL/ETHNIC POPULATIONS.**

12 (a) IN GENERAL.—Not later than 1 year after the
13 date of enactment of this Act, the Secretary of Health and
14 Human Services shall submit to the Congress and the
15 President a report on the impact of sleep and circadian
16 health disorders for racial and ethnic minority commu-
17 nities and other vulnerable populations.

18 (b) CONTENTS.—The report under subsection (a)
19 shall include information on the—

20 (1) progress that has been made in reducing
21 the impact of sleep and circadian health disorders in
22 such communities and populations;

23 (2) opportunities that exist to make additional
24 progress in reducing the impact of sleep and circa-

1 dian health disorders in such communities and popu-
2 lations;

3 (3) challenges that may impede such additional
4 progress; and

5 (4) Federal funding necessary to achieve sub-
6 stantial reductions in sleep and circadian health dis-
7 orders in racial and ethnic minority communities.

8 **TITLE VIII—HEALTH**
9 **INFORMATION TECHNOLOGY**

10 **SEC. 800. DEFINITIONS.**

11 In this title:

12 (1) The term “certified EHR technology” has
13 the meaning given to that term in section 3000 of
14 the Public Health Service Act (42 U.S.C. 300jj).

15 (2) The term “EHR” means an electronic
16 health record.

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 ulations served by such providers, with the popu-
2 lations stratified by disparity variables.

3 (b) NATIONAL CENTER FOR HEALTH STATISTICS.—

4 As soon as practicable after the date of enactment of this
5 Act, the Director of the National Center for Health Statis-
6 tics shall provide to Congress a more detailed analysis of
7 the data presented in the Data Brief 79 published by such
8 Center in November 2011 (entitled “Electronic Health
9 Record Systems and Intent to Apply for Meaningful Use
10 Incentives Among Office-Based Physician Practices”).

11 (c) INSTITUTE OF MEDICINE.—The Secretary of
12 Health and Human Services may enter into an agreement
13 with the Institute of Medicine of the National Academies
14 that provides such Institute will—

15 (1) evaluate the impact of health information
16 technology in racial and ethnic minority commu-
17 nities; and

18 (2) publish a report regarding such evaluation.

19 (d) CENTERS FOR MEDICARE & MEDICAID SERV-
20 ICES.—

21 (1) IN GENERAL.—As part of the process of
22 collecting information, with respect to a provider, at
23 registration and attestation for purposes of the
24 Medicare and Medicaid Electronic Health Records
25 Incentive Programs, the Secretary of Health and

1 Human Services shall collect the race and ethnicity
2 of such provider.

3 (2) MEDICARE AND MEDICAID ELECTRONIC
4 HEALTH RECORDS INCENTIVE PROGRAMS DE-
5 FINED.—For purposes of paragraph (1), the term
6 “Medicare and Medicaid Electronic Health Records
7 Incentive Programs” means the incentive programs
8 under section 1814(l)(3), subsections (a)(7) and (o)
9 of section 1848, subsections (l) and (m) of section
10 1853, subsections (b)(3)(B)(ix)(I) and (n) of section
11 1886, and subsections (a)(3)(F) and (t) of section
12 1903 of the Social Security Act (42 U.S.C.
13 1395f(l)(3), 1395w-4, 1395w-23, 1395ww, and
14 1396b).

15 (e) NATIONAL COORDINATOR’S ASSESSMENT OF IM-
16 PACT OF HIT.—Section 3001(e)(6)(C) of the Public
17 Health Service Act (42 U.S.C. 300jj-11(e)(6)(C)) is
18 amended—

19 (1) in the heading by inserting “, RACIAL AND
20 ETHNIC MINORITY COMMUNITIES,” after “HEALTH
21 DISPARITIES”;

22 (2) by inserting “, in communities with a high
23 proportion of individuals from racial and ethnic mi-
24 nority groups (as defined in section 1707(g)), in-

1 cluding people with disabilities in these groups,”
2 after “communities with health disparities”; and

3 (3) by adding at the end the following new sen-
4 tence: “In any publication under the previous sen-
5 tence, the National Coordinator shall include best
6 practices for encouraging partnerships between the
7 Federal Government, States, and private entities to
8 expand outreach for and the adoption of certified
9 EHR technology in communities with a high propor-
10 tion of individuals from racial and ethnic minority
11 groups (as so defined), while also maintaining the
12 accessibility requirements of section 508 of the Re-
13 habilitation Act to encourage patient involvement in
14 their own health care. The National Coordinator
15 shall—

16 “(i) not later than 6 months after the
17 submission to the Congress of the report
18 required by section 832 of the Health Eq-
19 uity and Accountability Act of 2016, estab-
20 lish criteria for evaluating the impact of
21 health information technology on commu-
22 nities with a high proportion of individuals
23 from racial and ethnic minority groups (as
24 so defined) taking into account the find-
25 ings in such report; and

1 “(ii) not later than 12 months after
2 the submission to the Congress of such re-
3 ports, conduct and publish the results of
4 an evaluation of such impact.”.

5 **Subtitle B—Modifications To**
6 **Achieve Parity in Existing Pro-**
7 **grams**

8 **SEC. 811. EXTENDING FUNDING TO STRENGTHEN THE**
9 **HEALTH IT INFRASTRUCTURE IN RACIAL**
10 **AND ETHNIC MINORITY COMMUNITIES.**

11 Section 3011 of the Public Health Service Act (42
12 U.S.C. 300jj–31) is amended—

13 (1) in subsection (a), by adding at the end the
14 following new paragraph:

15 “(8) Activities described in the previous para-
16 graphs of this subsection with respect to commu-
17 nities with a high proportion of individuals from ra-
18 cial and ethnic minority groups (as defined in sec-
19 tion 1707(g)).”; and

20 (2) by adding at the end the following new sub-
21 section:

22 “(e) ANNUAL REPORT ON EXPENDITURES.—The
23 National Coordinator shall report annually to the Con-
24 gress on activities and expenditures under this section.”.

1 **SEC. 812. PRIORITIZING REGIONAL EXTENSION CENTER AS-**
2 **SISTANCE TO RACIAL AND ETHNIC MINORITY**
3 **GROUPS.**

4 (a) **IN GENERAL.**—Section 3012(c)(4)(C) of the Pub-
5 lic Health Service Act (42 U.S.C. 300jj–32(e)(4)(C)) is
6 amended by inserting “or individuals from racial and eth-
7 nic minority groups (as defined in section 1707(g))” after
8 “medically underserved individuals”.

9 (b) **BIENNIAL EVALUATION.**—Section 3012(c)(8) of
10 the Public Health Service Act (42 U.S.C. 300jj–32(e)(8))
11 is amended—

12 (1) by inserting: “Each evaluation panel shall
13 include at least one consumer advocate from a racial
14 and ethnic minority community served by the center
15 involved, at least one patient or family caregiver,
16 and at least one representative of a minority-serving
17 institution.” after “and of Federal officials.”; and

18 (2) by inserting “and shall determine the de-
19 gree to which such center provides outreach and as-
20 sistance to providers predominantly serving racial
21 and ethnic minority groups (as defined in section
22 1707(g))” after “specified in paragraph (3)”.

1 **SEC. 813. EXTENDING COMPETITIVE GRANTS FOR THE DE-**
2 **VELOPMENT OF LOAN PROGRAMS TO FACILI-**
3 **TATE ADOPTION OF CERTIFIED EHR TECH-**
4 **NOLOGY BY PROVIDERS SERVING RACIAL**
5 **AND ETHNIC MINORITY GROUPS.**

6 Section 3014(e) of the Public Health Service Act (42
7 U.S.C. 300jj–34(e)) is amended—

8 (1) in paragraph (3), by striking at the end
9 “or”;

10 (2) in paragraph (4), by striking the period at
11 the end and inserting “; or”; and

12 (3) by adding at the end the following new
13 paragraph:

14 “(5) carry out any of the activities described in
15 a previous paragraph of this subsection with respect
16 to communities with a high proportion of individuals
17 from racial and ethnic minority groups (as defined
18 in section 1707(g)).”.

19 **SEC. 814. AUTHORIZATION OF APPROPRIATIONS.**

20 Section 3018 of the Public Health Service Act (42
21 U.S.C. 300jj–38) is amended by striking “fiscal years
22 2009 through 2013” and inserting “fiscal years 2017
23 through 2021”.

1 **Subtitle C—Additional Research**
2 **and Studies**

3 **SEC. 831. DATA COLLECTION AND ASSESSMENTS CON-**
4 **DUCTED IN COORDINATION WITH MINORITY-**
5 **SERVING INSTITUTIONS.**

6 Section 3001(c)(6) of the Public Health Service Act
7 (42 U.S.C. 300jj–11(c)(6)) is amended by adding at the
8 end the following new subparagraph:

9 “(F) DATA COLLECTION AND ASSESS-
10 MENTS CONDUCTED IN COORDINATION WITH
11 MINORITY-SERVING INSTITUTIONS.—

12 “(i) IN GENERAL.—In carrying out
13 subparagraph (C) with respect to commu-
14 nities with a high proportion of individuals
15 from racial and ethnic minority groups (as
16 defined in section 1707(g)), the National
17 Coordinator shall, to the greatest extent
18 possible, coordinate with an entity de-
19 scribed in clause (ii).

20 “(ii) MINORITY-SERVING INSTITU-
21 TIONS.—For purposes of clause (i), an en-
22 tity described in this clause is a historically
23 Black college or university, a Hispanic-
24 serving institution, a tribal college or uni-
25 versity, or an Asian-American-, Native

1 American-, and Pacific Islander-serving in-
2 stitution with an accredited public health,
3 health policy, or health services research
4 program.”.

5 **SEC. 832. STUDY OF HEALTH INFORMATION TECHNOLOGY**
6 **IN MEDICALLY UNDERSERVED COMMU-**
7 **NITIES.**

8 (a) IN GENERAL.—Not later than 24 months after
9 the date of enactment of this Act, the Secretary of Health
10 and Human Services shall—

11 (1) enter into an agreement with the Institute
12 of Medicine of the National Academies (or, if the In-
13 stitute of Medicine declines, another appropriate
14 public or nonprofit private entity) to conduct a study
15 on the development, implementation, and effective-
16 ness of health information technology within medi-
17 cally underserved areas (as described in subsection
18 (c)); and

19 (2) submit a report to Congress describing the
20 results of such study, including any recommenda-
21 tions for legislative or administrative action.

22 (b) STUDY.—The study described in subsection
23 (a)(1) shall—

1 (1) identify barriers to successful implementa-
2 tion of health information technology in medically
3 underserved areas;

4 (2) examine the impact of health information
5 technology on providing quality care and reducing
6 the cost of care to individuals in such areas, includ-
7 ing the impact of such technology on improved
8 health outcomes for individuals, including which
9 technology worked for which population and how it
10 improved health outcomes for that population;

11 (3) examine the impact of health information
12 technology on improving health-care-related deci-
13 sions by both patients and providers in such areas;

14 (4) identify specific best practices for using
15 health information technology to foster the con-
16 sistent provision of physical accessibility and reason-
17 able policy accommodations in health care to individ-
18 uals with disabilities in such areas;

19 (5) assess the feasibility and costs associated
20 with the use of health information technology in
21 such areas;

22 (6) evaluate whether the adoption and use of
23 qualified electronic health records (as described in
24 section 3000(13) of the Public Health Service Act
25 (42 U.S.C. 300jj(13)) is effective in reducing health

1 disparities, including analysis of clinical quality
2 measures reported by Medicare and Medicaid pro-
3 viders pursuant to programs to encourage the adop-
4 tion and use of certified EHR technology;

5 (7) identify providers in medically underserved
6 areas that are not electing to adopt and use elec-
7 tronic health records and determine what barriers
8 are preventing those providers from adopting and
9 using such records; and

10 (8) examine urban and rural community health
11 systems and determine the impact that health infor-
12 mation technology may have on the capacity of pri-
13 mary health providers in those systems.

14 (c) **MEDICALLY UNDERSERVED AREA.**—The term
15 “medically underserved area” means—

16 (1) a population that has been designated as a
17 medically underserved population under section
18 330(b)(3) of the Public Health Service Act (42
19 U.S.C. 254b(b)(3));

20 (2) an area that has been designated as a
21 health professional shortage area under section 332
22 of the Public Health Service Act (42 U.S.C. 254e);

23 (3) an area or population that has been des-
24 ignated as a medically underserved community under

1 section 799B(6) of the Public Health Service Act
2 (42 U.S.C. 295p(6)); or

3 (4) an area or population that—

4 (A) is not described in paragraphs (1)
5 through (3) of this subsection;

6 (B) experiences significant barriers to ac-
7 cessing quality health services; and

8 (C) has a high prevalence of diseases or
9 conditions described in title VII of this Act,
10 with such diseases or conditions having a dis-
11 proportionate impact on racial and ethnic mi-
12 nority groups (as defined in section 1707(g) of
13 the Public Health Service Act (42 U.S.C. 300u-
14 6(g))) or a subgroup of people with disabilities
15 who have specific functional impairments.

16 **Subtitle D—Closing Gaps in**
17 **Funding To Adopt Certified EHRs**

18 **SEC. 841. EXTENDING MEDICAID EHR INCENTIVE PAY-**
19 **MENTS TO REHABILITATION FACILITIES,**
20 **LONG-TERM CARE FACILITIES, AND HOME**
21 **HEALTH AGENCIES.**

22 Section 1903(t)(2)(B) of the Social Security Act (42
23 U.S.C. 1396b(t)(2)(B)) is amended—

24 (1) in clause (i), by striking “, or” and insert-
25 ing a semicolon;

1 (2) in clause (ii), by striking the period at the
2 end and inserting a semicolon; and

3 (3) by inserting after clause (ii) the following
4 new clauses:

5 “(iii) a rehabilitation facility (as defined in sec-
6 tion 1886(j)(1)) that furnishes acute or subacute re-
7 habilitation services;

8 “(iv) a long-term care hospital (as defined in
9 section 1886(d)(1)(B)(iv)(I)); or

10 “(v) a home health agency (as defined in sec-
11 tion 1861(o)).”.

12 **SEC. 842. EXTENDING PHYSICIAN ASSISTANT ELIGIBILITY**
13 **FOR MEDICAID ELECTRONIC HEALTH**
14 **RECORD INCENTIVE PAYMENTS.**

15 (a) IN GENERAL.—Section 1903(t)(3)(B)(v) of the
16 Social Security Act (42 U.S.C. 1396b(t)(3)(B)(v)) is
17 amended to read as follows:

18 “(v) physician assistant, in the case that
19 the assistant is a primary care provider, includ-
20 ing an assistant who practices in a rural health
21 clinic that is led by a physician assistant or
22 practices in a federally qualified health center
23 that is so led.”.

24 (b) EFFECTIVE DATE.—The amendment made by
25 subsection (a) shall apply with respect to amounts ex-

1 pended under section 1903(a)(3)(F) of the Social Security
2 Act (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters be-
3 ginning on or after the date of the enactment of this Act.

4 **TITLE IX—ACCOUNTABILITY**
5 **AND EVALUATION**

6 **SEC. 901. PROHIBITION ON DISCRIMINATION IN FEDERAL**
7 **ASSISTED HEALTH CARE SERVICES AND RE-**
8 **SEARCH PROGRAMS ON THE BASIS OF SEX,**
9 **RACE, COLOR, NATIONAL ORIGIN, MARITAL**
10 **STATUS, FAMILIAL STATUS, SEXUAL ORI-**
11 **ENTATION, GENDER IDENTITY, OR DIS-**
12 **ABILITY STATUS.**

13 (a) **IN GENERAL.**—No person in the United States
14 shall, on the basis of sex, race, color, national origin, mar-
15 ital status, familial status, sexual orientation, gender iden-
16 tity, or disability status, be excluded from participation
17 in, be denied the benefits of, or be subjected to discrimina-
18 tion under any health program or activity, including any
19 health research program or activity, receiving Federal fi-
20 nancial assistance.

21 (b) **DEFINITION.**—In this section, the term “familial
22 status” means, with respect to one or more individuals—
23 (1) being domiciled with any individual related
24 by blood or affinity whose close association with the
25 individual is the equivalent of a family relationship;

1 (2) being in the process of securing legal cus-
2 tody of any individual; or

3 (3) being pregnant.

4 **SEC. 902. TREATMENT OF MEDICARE PAYMENTS UNDER**
5 **TITLE VI OF THE CIVIL RIGHTS ACT OF 1964.**

6 A payment to a provider of services, physician, or
7 other supplier under part B, C, or D of title XVIII of
8 the Social Security Act shall be deemed a grant, and not
9 a contract of insurance or guaranty, for the purposes of
10 title VI of the Civil Rights Act of 1964.

11 **SEC. 903. ACCOUNTABILITY AND TRANSPARENCY WITHIN**
12 **THE DEPARTMENT OF HEALTH AND HUMAN**
13 **SERVICES.**

14 Title XXXIV of the Public Health Service Act, as
15 amended by titles I, II, and III of this Act, is further
16 amended by inserting after subtitle B the following:

17 **“Subtitle C—Strengthening**
18 **Accountability**

19 **“SEC. 3441. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.**

20 “(a) IN GENERAL.—The Secretary shall establish
21 within the Office for Civil Rights an Office of Health Dis-
22 parities, which shall be headed by a director to be ap-
23 pointed by the Secretary.

24 “(b) PURPOSE.—The Office of Health Disparities
25 shall ensure that the health programs, activities, and oper-

1 ations of health entities which receive Federal financial as-
2 sistance are in compliance with title VI of the Civil Rights
3 Act, which prohibits discrimination on the basis of race,
4 color, or national origin. The activities of the Office shall
5 include the following:

6 “(1) The development and implementation of
7 an action plan to address racial and ethnic health
8 care disparities, which shall address concerns relat-
9 ing to the Office for Civil Rights as released by the
10 United States Commission on Civil Rights in the re-
11 port entitled ‘Health Care Challenge: Acknowledging
12 Disparity, Confronting Discrimination, and Ensuring
13 Equity’ (September 1999) in conjunction with
14 the reports by the Institute of Medicine entitled ‘Un-
15 equal Treatment: Confronting Racial and Ethnic
16 Disparities in Health Care’, ‘Crossing the Quality
17 Chasm: A New Health System for the 21st Cen-
18 tury’, ‘In the Nation’s Compelling Interest: Ensuring
19 Diversity in the Health Care Workforce’, ‘The
20 National Partnership for Action to End Health Dis-
21 parities’, and ‘The Health of Lesbian, Gay, Bisexual,
22 and Transgender People’, and other related reports
23 by the Institute of Medicine. This plan shall be pub-
24 licly disclosed for review and comment and the final

1 plan shall address any comments or concerns that
2 are received by the Office.

3 “(2) Investigative and enforcement actions
4 against intentional discrimination and policies and
5 practices that have a disparate impact on minorities.

6 “(3) The review of racial, ethnic, gender iden-
7 tity, sexual orientation, sex, disability status, socio-
8 economic status, and primary language health data
9 collected by Federal health agencies to assess health
10 care disparities related to intentional discrimination
11 and policies and practices that have a disparate im-
12 pact on minorities.

13 “(4) Outreach and education activities relating
14 to compliance with title VI of the Civil Rights Act.

15 “(5) The provision of technical assistance for
16 health entities to facilitate compliance with title VI
17 of the Civil Rights Act.

18 “(6) Coordination and oversight of activities of
19 the civil rights compliance offices established under
20 section 3442.

21 “(7) Ensuring—

22 “(A) at a minimum, compliance with the
23 1997 Office of Management and Budget Stand-
24 ards for Maintaining, Collecting, and Pre-

1 senting Federal Data on Race and Ethnicity;
2 and

3 “(B) consideration of available data and
4 language standards such as—

5 “(i) the standards for collecting and
6 reporting data under section 3101; and

7 “(ii) the National Standards on Cul-
8 turally and Linguistically Appropriate
9 Services of the Office of Minority Health
10 within the Department of Health and
11 Human Services.

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 “(F) civil rights; and

1 “(G) social, behavioral, and economic de-
2 terminants of health.

3 “(d) REPORT.—Not later than December 31, 2017,
4 and annually thereafter, the Secretary, in collaboration
5 with the Director of the Office for Civil Rights and the
6 Deputy Assistant Secretary for Minority Health, shall
7 submit a report to the Committee on Health, Education,
8 Labor, and Pensions of the Senate and the Committee on
9 Energy and Commerce of the House of Representatives
10 that includes—

11 “(1) the number of cases filed, broken down by
12 category;

13 “(2) the number of cases investigated and
14 closed by the office;

15 “(3) the outcomes of cases investigated;

16 “(4) the staffing levels of the office including
17 staff credentials;

18 “(5) the number of other lingering and emerg-
19 ing cases in which civil rights inequities can be dem-
20 onstrated; and

21 “(6) the number of cases remaining open and
22 an explanation for their open status.

23 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
24 are authorized to be appropriated to carry out this section

1 “(1) The establishment of compliance and pro-
2 gram participation standards for recipients of Fed-
3 eral financial assistance under each program admin-
4 istered by an agency within the Department of
5 Health and Human Services including the establish-
6 ment of disparity reduction standards to encompass
7 disparities in health and health care related to race,
8 national origin, language, ethnicity, sex, age, dis-
9 ability, sexual orientation, and gender identity.

10 “(2) The development and implementation of
11 program-specific guidelines that interpret and apply
12 Department of Health and Human Services guid-
13 ance under title VI of the Civil Rights Act of 1964
14 and section 1557 of the Patient Protection and Af-
15 fordable Care Act to each Federal health program
16 administered by the agency.

17 “(3) The development of a disparity-reduction
18 impact analysis methodology that shall be applied to
19 every rule issued by the agency and published as
20 part of the formal rulemaking process under sections
21 555, 556, and 557 of title 5, United States Code.

22 “(4) Oversight of data collection, analysis, and
23 publication requirements for all recipients of Federal
24 financial assistance under each Federal health pro-
25 gram administered by the agency; compliance with,

1 at a minimum, the 1997 Office of Management and
2 Budget Standards for Maintaining, Collecting, and
3 Presenting Federal Data on Race and Ethnicity; and
4 consideration of available data and language stand-
5 ards such as—

6 “(A) the standards for collecting and re-
7 porting data under section 3101; and

8 “(B) the National Standards on Culturally
9 and Linguistically Appropriate Services of the
10 Office of Minority Health within the Depart-
11 ment of Health and Human Services.

12 “(5) The conduct of publicly available studies
13 regarding discrimination within Federal health pro-
14 grams administered by the agency as well as dis-
15 parity reduction initiatives by recipients of Federal
16 financial assistance under Federal health programs.

17 “(6) Annual reports to the Committee on
18 Health, Education, Labor, and Pensions and the
19 Committee on Finance of the Senate and the Com-
20 mittee on Energy and Commerce and the Committee
21 on Ways and Means of the House of Representatives
22 on the progress in reducing disparities in health and
23 health care through the Federal programs adminis-
24 tered by the agency.

1 “(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS
2 IN THE DEPARTMENT OF JUSTICE.—

3 “(1) DEPARTMENT OF HEALTH AND HUMAN
4 SERVICES.—The Office for Civil Rights in the De-
5 partment of Health and Human Services shall pro-
6 vide standard-setting and compliance review inves-
7 tigation support services to the Civil Rights Compli-
8 ance Office for each agency.

9 “(2) DEPARTMENT OF JUSTICE.—The Office
10 for Civil Rights in the Department of Justice shall
11 continue to maintain the power to institute formal
12 proceedings when an agency Office for Civil Rights
13 determines that a recipient of Federal financial as-
14 sistance is not in compliance with the disparity re-
15 duction standards of the agency.

16 “(e) DEFINITION.—In this section, the term ‘Federal
17 health programs’ mean programs—

18 “(1) under the Social Security Act (42 U.S.C.
19 301 et seq.) that pay for health care and services;
20 and

21 “(2) under this Act that provide Federal finan-
22 cial assistance for health care, biomedical research,
23 health services research, and programs designed to
24 improve the public’s health, including health service
25 programs.”.

1 **SEC. 904. UNITED STATES COMMISSION ON CIVIL RIGHTS.**

2 (a) COORDINATION WITHIN DEPARTMENT OF JUSTICE OF ACTIVITIES REGARDING HEALTH DISPARITIES.—Section 3(a) of the Civil Rights Commission Act
3
4
5 of 1983 (42 U.S.C. 1975a(a)) is amended—

6 (1) in paragraph (1), by striking “and” at the
7 end;

8 (2) in paragraph (2), by striking the period at
9 the end and inserting “; and”; and

10 (3) by adding at the end the following:

11 “(3) shall, with respect to activities carried out
12 in health care and correctional facilities toward the
13 goal of eliminating health disparities between the
14 general population and members of racial or ethnic
15 minority groups, coordinate such activities of—

16 “(A) the Office for Civil Rights within the
17 Department of Justice;

18 “(B) the Office of Justice Programs within
19 the Department of Justice;

20 “(C) the Office for Civil Rights within the
21 Department of Health and Human Services;
22 and

23 “(D) the Office of Minority Health within
24 the Department of Health and Human Services
25 (headed by the Deputy Assistant Secretary for
26 Minority Health).”.

1 (b) AUTHORIZATION OF APPROPRIATIONS.—Section
2 5 of the Civil Rights Commission Act of 1983 (42 U.S.C.
3 1975c) is amended by striking the first sentence and in-
4 serting the following: “For the purpose of carrying out
5 this Act, there are authorized to be appropriated
6 \$30,000,000 for fiscal year 2017, and such sums as may
7 be necessary for each of the fiscal years 2018 through
8 2022.”.

9 **SEC. 905. SENSE OF CONGRESS CONCERNING FULL FUND-**
10 **ING OF ACTIVITIES TO ELIMINATE RACIAL**
11 **AND ETHNIC HEALTH DISPARITIES.**

12 (a) FINDINGS.—Congress makes the following find-
13 ings:

14 (1) The health status of the American populace
15 is declining and the United States currently ranks
16 below most industrialized nations in health status
17 measured by longevity, sickness, and mortality.

18 (2) Racial and ethnic minority populations tend
19 have the poorest health status and face substantial
20 cultural, social, and economic barriers to obtaining
21 quality health care.

22 (3) Lesbian, gay, bisexual, transgender, queer,
23 and questioning (LGBTQ) populations experience
24 significant personal and structural barriers to ob-
25 taining high-quality health care.

1 (4) Efforts to improve minority health have
2 been limited by inadequate resources (funding, staff-
3 ing, and stewardship) and lack of accountability.

4 (b) SENSE OF CONGRESS.—It is the sense of Con-
5 gress that—

6 (1) funding should be doubled by fiscal year
7 2018 for the National Institute for Minority Health
8 Disparities, the Office of Civil Rights in the Depart-
9 ment of Health and Human Services, the National
10 Institute of Nursing Research, and the Office of Mi-
11 nority Health;

12 (2) adequate funding by fiscal year 2018, and
13 subsequent funding increases, should be provided for
14 health and human service professions training pro-
15 grams, the Racial and Ethnic Approaches to Com-
16 munity Health (REACH) Initiative at the Centers
17 for Disease Control and Prevention, the Minority
18 HIV/AIDS Initiative, and the Excellence Centers to
19 Eliminate Ethnic/Racial Disparities (EXCEED)
20 Program at the Agency for Healthcare Research and
21 Quality;

22 (3) funding should be fully restored to the Ra-
23 cial and Ethnic Approaches to Community Health
24 (REACH) Initiative at the Centers for Disease Con-
25 trol and Prevention, which has been a successful

1 program at the community health level, and efforts
2 should continue to place a strong emphasis on build-
3 ing community capacity to secure financial resources
4 and technical assistance to eliminate health dispari-
5 ties;

6 (4) adequate funding for fiscal year 2018 and
7 increased funding for future years should be pro-
8 vided for the REACH Initiative’s United States Risk
9 Factor Survey to ensure adequate data collection to
10 track health disparities, and there should be appro-
11 priate avenues provided to disseminate findings to
12 the general public;

13 (5) 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 2018; and

18 (6) 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 on January 1, 2006, and ending De-
8 cember 31, 2015.

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 2022, the Comptroller General of the United States
18 shall submit to Congress a report that identifies—

19 (1) the racial and ethnic diversity of commu-
20 nity-based organizations that applied for Federal en-
21 rollment funding provided pursuant to the provisions
22 of (and amendments made by) the Patient Protec-
23 tion and Affordable Care Act;

24 (2) the percentage of such organizations that
25 were awarded such funding; and

1 (3) the impact of such community-based organi-
2 zations' enrollment efforts on the insurance status of
3 their communities.

4 (d) ANNUAL REPORT ON ACTIVITIES OF NATIONAL
5 INSTITUTE ON MINORITY HEALTH AND HEALTH DIS-
6 PARITIES.—The Director of the National Institute on Mi-
7 nority Health and Health Disparities shall prepare an an-
8 nual report on the activities carried out or to be carried
9 out by the Institute, and shall submit each such report
10 to the Committee on Health, Education, Labor, and Pen-
11 sions of the Senate, the Committee on Energy and Com-
12 merce of the House of Representatives, the Secretary of
13 Health and Human Services, and the Director of the Na-
14 tional Institutes of Health. With respect to the fiscal year
15 involved, the report shall—

16 (1) describe and evaluate the progress made in
17 health disparities research conducted or supported
18 by institutes and centers of the National Institutes
19 of Health;

20 (2) summarize and analyze expenditures made
21 for activities with respect to health disparities re-
22 search conducted or supported by the National Insti-
23 tutes of Health;

1 (3) include a separate statement applying the
2 requirements of paragraphs (1) and (2) specifically
3 to minority health disparities research; and

4 (4) contain such recommendations as the Direc-
5 tor of the Institute considers appropriate.

6 **TITLE X—ADDRESSING SOCIAL**
7 **DETERMINANTS AND IM-**
8 **PROVING ENVIRONMENTAL**
9 **JUSTICE**

10 **SEC. 1001. DEFINITIONS.**

11 (a) DETERMINANTS OF HEALTH.—The term “deter-
12 minants of health”—

13 (1) refers to the range of personal, social, eco-
14 nomic, and environmental factors that influence
15 health status; and

16 (2) includes social determinants of health
17 (which are sometimes referred to as “social and eco-
18 nomic determinants of health” or “socioeconomic de-
19 terminants of health”), environmental determinants
20 of health, and personal determinants of health.

21 (b) ENVIRONMENTAL DETERMINANTS OF
22 HEALTH.—The term “environmental determinants of
23 health” refers to the broad physical, psychological, social,
24 and aesthetic environment.

1 (c) PERSONAL DETERMINANTS OF HEALTH.—The
2 term “personal determinants of health” refers to an indi-
3 vidual’s behavior, biology, and genetics.

4 (d) SOCIAL DETERMINANTS OF HEALTH.—The term
5 “social determinants of health” refers to a subset of deter-
6 minants of the health of individuals and environments
7 (such as communities, neighborhoods, and societies) that
8 describe people’s social identity, describe the social and
9 economic resources to which people have access, and de-
10 scribe the conditions in which people work, live, and play.

11 **SEC. 1002. FINDINGS.**

12 The Congress finds as follows:

13 (1) There are more opportunities to improve
14 health for everyone when we understand that health
15 starts, first, not in a medical setting, but in our
16 families, in our schools and workplaces, in our
17 neighborhoods, and in the air we breathe and water
18 we drink.

19 (2) The social determinants of health are the
20 largest predictors of health outcomes.

21 (3) Healthy People 2020 identifies health and
22 health care quality as a function of not only access
23 to health care, but also the social determinants of
24 health, categorized into the following: neighborhoods
25 and the built environment; social and community

1 context; education; and economic stability. The fol-
2 lowing examples illustrate the nexus between the un-
3 equal distribution of the social determinants of
4 health and health disparities:

5 (A) The built environment influences resi-
6 dents' level of physical activity. Neighborhoods
7 with high levels of poverty are significantly less
8 likely to have places where children can be
9 physically active, such as parks, green spaces,
10 and bike paths and lanes. Neighborhoods and
11 communities can provide opportunities for phys-
12 ical activity and support active lifestyles
13 through accessible and safe parks and open
14 spaces and through land use policy, zoning, and
15 healthy community design.

16 (B) Emotional and physical health and
17 well-being are directly impacted by perceived
18 levels of safety, such as unlit streets at night.
19 Community members have expressed that safety
20 is not only a barrier to accessing programs and
21 services that increase quality of life but they
22 are also not able to access physical activity in
23 their community through the built environment.

24 (C) In many workplace environments, toxic
25 chemicals have lasting detrimental effects on

1 employees' health. The hazardous compounds
2 found in most nail salon products affect the
3 respiratory system, reproductive system, and
4 central nervous system, and also cause kidney
5 and liver damage. Recognizing the importance
6 of addressing occupational hazards as a matter
7 of public health, especially for Asian-American
8 women who constitute 40 percent of nail salon
9 technicians—with Vietnamese-American women
10 accounting for 37 percent of this—the White
11 House Initiative on Asian American Pacific Is-
12 landers has created an interagency working
13 group to coordinate efforts by the Environ-
14 mental Protection Agency, Occupational and
15 Safety Health Administration, Food and Drug
16 Administration, and other Federal agencies to
17 create programming, draft regulations, and con-
18 duct more outreach on educating workers on
19 health and safety issues.

20 (D) Historical and institutional discrimina-
21 tion against certain racial groups in the United
22 States has shaped the way in which social and
23 economic resources and exposure to health pro-
24 moting environments are distributed. Income,
25 education, occupation, neighborhood conditions,

1 schools, workplaces, the use of and health and
2 social services, and experiences with the crimi-
3 nal justice system are all highly patterned by
4 race, with racial minorities (compared to
5 Whites) experiencing more that is health harm-
6 ing. Finding ways to uncouple the link between
7 race and access to resources and healthy envi-
8 ronments is a principal means of reducing
9 health disparities. Additionally, the anticipation
10 of racism itself causes higher psychological and
11 cardiovascular stress levels that are linked to
12 poor health outcomes. Remedying discrimina-
13 tory practices at the individual and systemic
14 levels will likely reduce health disparities caused
15 by this unequal distribution of stress.

16 (E) Poor health among Native Americans
17 has largely been driven by post-colonial oppres-
18 sion and historical trauma. The expropriation of
19 native lands and territories to the American
20 state had severe consequences on Native Amer-
21 ican health. This resulted in the deprivation of
22 traditional food sources—and nutrients—for
23 Native Americans and also the destruction of
24 traditional economies and community organiza-
25 tion. Today, Native Americans have twice the

1 rate of diabetes than non-Hispanic Whites. Rec-
2 ognition of the origins of the diabetes as having
3 a social and community context, rather than
4 just individual responsibility and genetic pre-
5 disposition, will shape better policy to provide
6 food security.

7 (F) In the context of prisons, overcrowding
8 has led to the deterioration of the physical and
9 mental health of individuals after they leave
10 prison. In particular, the mass incarceration of
11 African-American males as a result of unequal
12 contact with and treatment in the criminal jus-
13 tice system has contributed to an overburdening
14 of certain infectious diseases within the African-
15 American community. As a social institution,
16 incarceration amplifies existing adverse health
17 conditions by concentrating diseases and harm
18 health behaviors such as tobacco use, drug use,
19 and violence.

20 (G) Educational attainment is the strong-
21 est predictor of adult mortality. It is a basic
22 component of socioeconomic status by shaping
23 earning potential to access resources that pro-
24 mote health. People with more education are
25 less likely to report that they are in poor health,

1 and are also less likely to have diabetes and
2 other chronic diseases.

3 (H) Similarly, reading ability is a strong
4 predictor of adult health status and is often
5 correlated with other child health issues, such
6 as developmental problems, vision and hearing
7 impairments, and frequent school absence due
8 to illness.

9 (I) Individuals with lower levels of edu-
10 cational attainment are much more likely to re-
11 port to be current smokers. In 2011, smoking
12 prevalence was 45.3 percent among adults with
13 a GED diploma, 34.6 percent with nine to 11
14 years of education, and 23.8 percent with a
15 high school diploma, while dropping signifi-
16 cantly to 9.3 percent among adults with an un-
17 dergraduate college degree and 5.0 percent with
18 a postgraduate college degree.

19 (J) Social class differences account for a
20 large part of health disparities. For example,
21 children living in poverty experience poorer
22 housing conditions, increased exposure to in-
23 door allergens and toxins (such as pesticides,
24 lead, mercury, radon, air pollution, and carcino-
25 gens), and more psychological stress. These ex-

1 periences culminate in worse adult health as
2 compared with children with higher socio-
3 economic status. Specifically, children living in
4 socioeconomic neighborhoods have higher rates
5 of asthma due to higher rates of psychological
6 stress resulting from higher rates of violence.

7 (K) Lesbian, gay, bisexual, transgender,
8 queer, and questioning (LGBTQ) individuals
9 face health disparities linked to societal stigma,
10 discrimination, and denial of their civil and
11 human rights. Discrimination against LGBTQ
12 individuals has been associated with high rates
13 of psychiatric disorders, substance abuse, and
14 suicide. Experiences of violence and victimiza-
15 tion are frequent for LGBTQ individuals, and
16 have long-lasting effects on the individual and
17 the community. Personal, family, and social ac-
18 ceptance of sexual orientation and gender iden-
19 tity affects the mental health and personal safe-
20 ty of LGBTQ individuals.

21 (4) Laws and regulations that improve opportu-
22 nities to live in safe neighborhoods, with more social
23 cohesion, attain higher education, sustain stable em-
24 ployment, and bridge class differences help foster
25 the health and safety of individuals.

1 (5) The global public health community has
2 reached consensus through the Rio Political Declara-
3 tion of Social Determinants of Health that
4 “[c]ollaboration in coordinated and intersectoral pol-
5 icy actions has proven to be effective. Health in All
6 Policies, together with intersectoral cooperation and
7 action, is one promising approach to enhance ac-
8 countability in other sectors of health, as well as the
9 promotion of health equity and more inclusive and
10 productive societies.”

11 **SEC. 1003. HEALTH IMPACT ASSESSMENTS.**

12 (a) FINDINGS.—Congress makes the following find-
13 ings:

14 (1) Health Impact Assessment is a tool to help
15 planners, health officials, decisionmakers, and the
16 public make more informed decisions about the po-
17 tential health effects of proposed plans, policies, pro-
18 grams, and projects in order to maximize health
19 benefits and minimize harms.

20 (2) Health Impact Assessments can be done at
21 a fraction of the cost and time typically required for
22 other planning and permitting reviews.

23 (3) Health Impact Assessments can build com-
24 munity support and reduce opposition to a project or
25 policy, thereby facilitating economic growth by aid-

1 ing the development of consensus regarding new de-
2 velopment proposals.

3 (4) Health Impact Assessments facilitate col-
4 laboration across sectors.

5 (b) PURPOSES.—It is the purpose of this section to—

6 (1) provide more information about the poten-
7 tial human health effects of policy decisions and the
8 distribution of those effects;

9 (2) improve how health is considered in plan-
10 ning and decisionmaking processes; and

11 (3) build stronger, healthier communities
12 through the use of Health Impact Assessment.

13 (c) HEALTH IMPACT ASSESSMENTS.—Part P of title
14 III of the Public Health Service Act (42 U.S.C. 280g et
15 seq.), as amended, is further amended by adding at the
16 end the following:

17 “**SEC. 399V-9. HEALTH IMPACT ASSESSMENTS.**

18 “(a) DEFINITIONS.—In this section and section
19 399V-10:

20 “(1) ADMINISTRATOR.—The term ‘Adminis-
21 trator’ means the Administrator of the Environ-
22 mental Protection Agency.

23 “(2) BUILT ENVIRONMENT.—The term ‘built
24 environment’ means the components of the environ-
25 ment, and the location of these components in a geo-

1 graphically defined space, that are created or modi-
2 fied by individuals to form the physical and social
3 characteristics of a community or enhance quality of
4 human life, including—

5 “(A) homes, schools, and places of work
6 and worship;

7 “(B) parks, recreation areas, and green-
8 ways;

9 “(C) transportation systems;

10 “(D) business, industry, and agriculture;

11 and

12 “(E) land-use plans, projects, and policies
13 that impact the physical or social characteris-
14 tics of a community, including access to services
15 and amenities.

16 “(3) DIRECTOR.—The term ‘Director’ means
17 the Director of the Centers for Disease Control and
18 Prevention.

19 “(4) ELIGIBLE ENTITY.—The term ‘eligible en-
20 tity’ means a unit of State or tribal government the
21 jurisdiction of which includes individuals or popu-
22 lations the health of which are, or will be, affected
23 by an activity or a proposed activity.

24 “(5) ELIGIBLE INSTITUTION.—The term ‘eligi-
25 ble institution’ means a public agency or private

1 nonprofit institution that submits to the Secretary,
2 in consultation with the Administrator, an applica-
3 tion for a grant authorized under such section at
4 such time, in such manner, and containing such
5 agreements, assurances, and information as the Sec-
6 retary and Administrator may require.

7 “(6) HEALTH IMPACT ASSESSMENT.—The term
8 ‘Health Impact Assessment’ means a systematic
9 process that uses an array of data sources and ana-
10 lytic methods and considers input from stakeholders
11 to determine the potential effects of a proposed pol-
12 icy, plan, program, or project on the health of a pop-
13 ulation and the distribution of those effects within
14 the population. Such term includes identifying and
15 recommending appropriate actions on monitoring
16 and maximizing potential benefits and minimizing
17 the potential harms.

18 “(7) HEALTH DISPARITIES.—The term ‘health
19 disparities’ are a particular type of health dif-
20 ferences that are closely linked with social, economic,
21 and/or environmental disadvantage. Health dispari-
22 ties adversely affect groups of people who have sys-
23 tematically experienced greater obstacles to health
24 based on their racial or ethnic group; religion; socio-
25 economic status; gender; age; mental health; cog-

1 nitive, sensory, or physical disability; sexual orienta-
2 tion or gender identity; geographic location; or other
3 characteristics historically linked to discrimination
4 or exclusion.

5 “(8) PROPOSED ACTIVITY.—The term ‘proposed
6 activity’ means a proposed policy, program, plan, or
7 project currently under consideration by a local,
8 State, tribal, or Federal agency or government.

9 “(b) ESTABLISHMENT.—The Secretary, acting
10 through the Director and in collaboration with the Admin-
11 istrator, shall carry out the following:

12 “(1) Establish a program at the National Cen-
13 ter for Environmental Health at the Centers for Dis-
14 ease Control and Prevention focused on advancing
15 the field of Health Impact Assessment. In devel-
16 oping and implementing the program, the Director
17 of the National Center for Environmental Health
18 shall consult with the Director of the National Cen-
19 ter for Chronic Disease Prevention and Health Pro-
20 motion as well as relevant offices within the Depart-
21 ment of Housing and Urban Development, the De-
22 partment of Transportation, and the Department of
23 Agriculture. The program shall include—

24 “(A) collecting and disseminating best
25 practices;

1 “(B) administering capacity building
2 grants to States to support grantees in initi-
3 ating Health Impact Assessments, in accord-
4 ance with subsection (d);

5 “(C) providing technical assistance;

6 “(D) developing training tools and pro-
7 viding training on conducting Health Impact
8 Assessment and the implementation of built en-
9 vironment and health indicators;

10 “(E) making information available, as ap-
11 propriate, regarding the existence of other com-
12 munity healthy living tools, checklists, and indi-
13 ces that help connect public health to other sec-
14 tors, and tools to help examine the effect of the
15 indoor built environment and building codes on
16 population health;

17 “(F) conducting research and evaluations
18 of Health Impact Assessments; and

19 “(G) awarding competitive extramural re-
20 search grants.

21 “(2) In accordance with subsection (c), develop
22 guidance and guidelines to conduct Health Impact
23 Assessments.

1 “(3) In accordance with subsection (d), estab-
2 lish a grant program to allow States to fund eligible
3 entities to conduct Health Impact Assessments.

4 “(c) GUIDANCE.—The Director, in consultation with
5 the Director of the National Center for Environmental
6 Health and, the Director of the National Center for
7 Chronic Disease Prevention and Health Promotion, and
8 relevant offices within the Department of Housing and
9 Urban Development, the Department of Transportation,
10 and the Department of Agriculture, shall—

11 “(1) develop guidance for conducting Health
12 Impact Assessment, including—

13 “(A) background on national and inter-
14 national efforts to bridge urban planning and
15 public health institutions and disciplines, in-
16 cluding a review of Health Impact Assessment
17 best practices internationally;

18 “(B) evidence-based direct and indirect
19 pathways that link land-use planning, transpor-
20 tation, and housing policy and objectives to
21 human health outcomes;

22 “(C) data resources and quantitative and
23 qualitative forecasting methods to evaluate both
24 the status of health determinants and health ef-

1 fects, including identification of existing pro-
2 grams that can disseminate these resources;

3 “(D) best practices for inclusive public in-
4 volvement in conducting Health Impact Assess-
5 ments; and

6 “(E) technical assistance for other agen-
7 cies seeking to develop their own guidelines and
8 procedures for Health Impact Assessment;

9 “(2) in developing the guidance, consider avail-
10 able international Health Impact Assessment guid-
11 ance, North American Health Impact Assessment
12 Practice Standards, and recommendations from the
13 National Academy of Science; and

14 “(3) not later than 1 year after the date of en-
15 actment of this section, publish the guidance.

16 “(d) GRANT PROGRAM.—The Secretary, acting
17 through the Director and in collaboration with the Admin-
18 istrator, shall establish a program under which the Sec-
19 retary shall award grants to States to fund eligible entities
20 for capacity building or to prepare Health Impact Assess-
21 ments, and shall ensure that States receiving a grant
22 under this subsection further support training and tech-
23 nical assistance for grantees under the program by fund-
24 ing and overseeing appropriate local, State, tribal, Fed-
25 eral, university, or nonprofit Health Impact Assessment

1 experts to provide technical assistance. Such assessments
2 shall—

3 “(1) ensure that appropriate health factors are
4 taken into consideration as early as practicable dur-
5 ing the planning, review, or decisionmaking proc-
6 esses;

7 “(2) assess the effect on the health of individ-
8 uals and populations of proposed policies, projects,
9 or plans that result in modifications to the built en-
10 vironment; and

11 “(3) assess the distribution of health effects
12 across various factors, such as race, income, eth-
13 nicity, age, disability status, gender, and geography.

14 “(e) APPLICATIONS.—

15 “(1) IN GENERAL.—To be eligible to receive a
16 grant under this section, an eligible entity shall sub-
17 mit to the Secretary an application in accordance
18 with this subsection, at such time, in such manner,
19 and containing such additional information as the
20 Secretary may require.

21 “(2) INCLUSION.—An application under this
22 subsection shall include a list of proposed activities
23 that require or would benefit from conducting a
24 Health Impact Assessment within six months of
25 awarding funds. The list should be accompanied by

1 supporting documentation, including letters of sup-
2 port, from potential conductors of Health Impact
3 Assessments for the listed proposed activities. Each
4 application should also include an assessment by the
5 eligible entity of the health of the population of its
6 jurisdiction and describe potential adverse or positive
7 effects on health that the proposed activities may
8 create.

9 “(3) PREFERENCE.—Preference in awarding
10 funds under this section may be given to eligible en-
11 tities that demonstrate the potential to significantly
12 improve population health or lower health care costs
13 as a result of potential Health Impact Assessment
14 work.

15 “(f) USE OF FUNDS.—

16 “(1) IN GENERAL.—An eligible entity shall use
17 amounts provided under a grant under this section
18 to conduct Health Impact Assessment capacity
19 building or to conduct or fund subgrantees to con-
20 duct a Health Impact Assessment for a proposed ac-
21 tivity in accordance with this subsection.

22 “(2) PURPOSES.—The purposes of a Health
23 Impact Assessment under this subsection are—

24 “(A) to facilitate the involvement of tribal,
25 State, and local public health officials in com-

1 community planning, transportation, housing, and
2 land use decisions and other decisions affecting
3 the built environment to identify any potential
4 health concern or health benefit relating to an
5 activity or proposed activity;

6 “(B) to provide for an investigation of any
7 health-related issue of concern raised in a plan-
8 ning process, an environmental impact assess-
9 ment process, or policy appraisal relating to a
10 proposed activity;

11 “(C) to describe and compare alternatives
12 (including no-action alternatives) to a proposed
13 activity to provide clarification with respect to
14 the potential health outcomes associated with
15 the proposed activity and, where appropriate, to
16 the related benefit-cost or cost-effectiveness of
17 the proposed activity and alternatives;

18 “(D) to contribute, when applicable, to the
19 findings of a planning process, policy appraisal,
20 or an environmental impact statement with re-
21 spect to the terms and conditions of imple-
22 menting a proposed activity or related mitiga-
23 tion recommendations, as necessary;

24 “(E) to ensure that the disproportionate
25 distribution of negative impacts among vulner-

1 able populations is minimized as much as possible;
2

3 “(F) to engage affected community members and ensure adequate opportunity for public
4 comment on all stages of the Health Impact Assessment; and
5

6 “(G) where appropriate, to consult with
7 local and county health departments and appropriate organizations, including planning, transportation, and housing organizations and providing them with information and tools regarding how to conduct and integrate Health Impact Assessment into their work.
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13

14 “(3) ELIGIBLE ACTIVITIES.—

15 “(A) IN GENERAL.—Eligible entities funded under this subsection shall conduct an evaluation of any proposed activity to determine whether it will have a significant adverse or positive effect on the health of the affected population in the jurisdiction of the eligible entity, based on the criteria described in subparagraph
16
17
18
19
20
21
22 (B).

23 “(B) CRITERIA.—The criteria described in
24 this subparagraph include, as applicable to the
25 proposed activity, the following:

1 “(i) Any substantial adverse effect or
2 significant health benefit on health out-
3 comes or factors known to influence health,
4 including the following:

5 “(I) Physical activity.

6 “(II) Injury.

7 “(III) Mental health.

8 “(IV) Accessibility to health-pro-
9 moting goods and services.

10 “(V) Respiratory health.

11 “(VI) Chronic disease.

12 “(VII) Nutrition.

13 “(VIII) Land use changes that
14 promote local, sustainable food
15 sources.

16 “(IX) Infectious disease.

17 “(X) Health disparities.

18 “(XI) Existing air quality,
19 ground or surface water quality or
20 quantity, or noise levels; and

21 “(ii) Other factors that may be con-
22 sidered, including—

23 “(I) the potential for a proposed
24 activity to result in systems failure

1 that leads to a public health emer-
2 gency;

3 “(II) the probability that the pro-
4 posed activity will result in a signifi-
5 cant increase in tourism, economic de-
6 velopment, or employment in the ju-
7 risdiction of the eligible entity;

8 “(III) any other significant po-
9 tential hazard or enhancement to
10 human health, as determined by the
11 eligible entity; or

12 “(IV) whether the evaluation of a
13 proposed activity would duplicate an-
14 other analysis or study being under-
15 taken in conjunction with the pro-
16 posed activity.

17 “(C) FACTORS FOR CONSIDERATION.—In
18 evaluating a proposed activity under subpara-
19 graph (A), an eligible entity may take into con-
20 sideration any reasonable, direct, indirect, or
21 cumulative effect that can be clearly related to
22 potential health effects and that is related to
23 the proposed activity, including the effect of
24 any action that is—

1 “(i) included in the long-range plan
2 relating to the proposed activity;

3 “(ii) likely to be carried out in coordi-
4 nation with the proposed activity;

5 “(iii) dependent on the occurrence of
6 the proposed activity; or

7 “(iv) likely to have a disproportionate
8 impact on high-risk or vulnerable popu-
9 lations.

10 “(4) REQUIREMENTS.—A Health Impact As-
11 sessment prepared with funds awarded under this
12 subsection shall incorporate the following, after con-
13 ducting the screening phase (identifying projects or
14 policies for which a Health Impact Assessment
15 would be valuable and feasible) through the applica-
16 tion process:

17 “(A) SCOPING.—Identifying which health
18 effects to consider and the research methods to
19 be utilized.

20 “(B) ASSESSING RISKS AND BENEFITS.—
21 Assessing the baseline health status and factors
22 known to influence the health status in the af-
23 fected community, which may include aggreg-
24 ating and synthesizing existing health assess-
25 ment evidence and data from the community.

1 “(C) DEVELOPING RECOMMENDATIONS.—
2 Suggesting changes to proposals to promote
3 positive or mitigate adverse health effects.

4 “(D) REPORTING.—Synthesizing the as-
5 sessment and recommendations and commu-
6 nicating the results to decisionmakers.

7 “(E) MONITORING AND EVALUATING.—
8 Tracking the decision and implementation effect
9 on health determinants and health status.

10 “(5) PLAN.—An eligible entity that is awarded
11 a grant under this section shall develop and imple-
12 ment a plan, to be approved by the Director, for
13 meaningful and inclusive stakeholder involvement in
14 all phases of the Health Impact Assessment. Stake-
15 holders may include community-based organizations,
16 youth-serving organizations, planners, public health
17 experts, State and local public health departments
18 and officials, health care experts or officials, housing
19 experts or officials, and transportation experts or of-
20 ficials.

21 “(6) SUBMISSION OF FINDINGS.—An eligible
22 entity that is awarded a grant under this section
23 shall submit the findings of any funded Health Im-
24 pact Assessment activities to the Secretary and
25 make these findings publicly available.

1 “(7) ASSESSMENT OF IMPACTS.—An eligible en-
2 tity that is awarded a grant under this section shall
3 ensure the assessment of the distribution of health
4 impacts (related to the proposed activity) across
5 race, ethnicity, income, age, gender, disability status,
6 and geography.

7 “(8) CONDUCT OF ASSESSMENT.—To the great-
8 est extent feasible, a Health Impact Assessment
9 shall be conducted under this section in a manner
10 that respects the needs and timing of the decision-
11 making process it evaluates.

12 “(9) METHODOLOGY.—In preparing a Health
13 Impact Assessment under this subsection, an eligible
14 entity or partner shall follow the guidance published
15 under subsection (c).

16 “(g) HEALTH IMPACT ASSESSMENT DATABASE.—
17 The Secretary, acting through the Director and in collabo-
18 ration with the Administrator, shall establish, maintain,
19 and make publicly available a Health Impact Assessment
20 database, including—

21 “(1) a catalog of Health Impact Assessments
22 received under this section;

23 “(2) an inventory of tools used by eligible enti-
24 ties to conduct Health Impact Assessments; and

1 “(3) guidance for eligible entities with respect
2 to the selection of appropriate tools described in
3 paragraph (2).

4 “(h) EVALUATION OF GRANTEE ACTIVITIES.—The
5 Secretary shall award competitive grants to Prevention
6 Research Centers, or nonprofit organizations or academic
7 institutions with expertise in Health Impact Assessments
8 to—

9 “(1) assist grantees with the provision of train-
10 ing and technical assistance in the conducting of
11 Health Impact Assessments;

12 “(2) evaluate the activities carried out with
13 grants under subsection (d); and

14 “(3) assist the Secretary in disseminating evi-
15 dence, best practices, and lessons learned from
16 grantees.

17 “(i) REPORT TO CONGRESS.—Not later than 1 year
18 after the date of enactment of this section, the Secretary
19 shall submit to Congress a report concerning the evalua-
20 tion of the programs under this section, including rec-
21 ommendations as to how lessons learned from such pro-
22 grams can be incorporated into future guidance docu-
23 ments developed and provided by the Secretary and other
24 Federal agencies, as appropriate.

1 “(j) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 such sums as may be necessary.

4 **“SEC. 399V-10. ADDITIONAL RESEARCH ON THE RELATION-**
5 **SHIP BETWEEN THE BUILT ENVIRONMENT**
6 **AND HEALTH OUTCOMES.**

7 “(a) RESEARCH GRANT PROGRAM.—

8 “(1) GRANTS.—The Secretary, in collaboration
9 with the Administrator, shall award grants to eligi-
10 ble institutions to conduct and coordinate research
11 on the built environment and its influence on human
12 health. Factors that influence health that may be
13 considered include—

14 “(A) levels of physical activity;

15 “(B) consumption of nutritional foods;

16 “(C) rates of crime;

17 “(D) air, water, and soil quality;

18 “(E) risk or rate of injury;

19 “(F) accessibility to health-promoting
20 goods and services;

21 “(G) chronic disease rates;

22 “(H) community design;

23 “(I) housing; and

24 “(J) other indicators as determined appro-
25 priate by the Secretary.

1 “(2) RESEARCH.—The Secretary, in consulta-
2 tion with the Administrator, shall support research
3 under this section that—

4 “(A) investigates and defines links between
5 the built environment and human health and
6 identifies causal relationships;

7 “(B) examines—

8 “(i) the scope and intensity of the im-
9 pact that the built environment (including
10 the various characteristics of the built en-
11 vironment) has on the human health; or

12 “(ii) the distribution of such impacts
13 by—

14 “(I) location; and

15 “(II) population subgroup;

16 “(C) is used to develop—

17 “(i) measures and indicators to ad-
18 dress health impacts and the connection of
19 health to the built environment;

20 “(ii) efforts to link the measures to
21 transportation, land use, and health data-
22 bases; and

23 “(iii) efforts to enhance the collection
24 of built environment surveillance data;

1 “(D) distinguishes carefully between per-
2 sonal attitudes and choices and external influ-
3 ences on behavior to determine how much the
4 association between the built environment and
5 the health of residents, versus the lifestyle pref-
6 erences of the people that choose to live in the
7 neighborhood, reflects the physical characteris-
8 tics of the neighborhood; and

9 “(E)(i) identifies or develops effective
10 intervention strategies focusing on enhance-
11 ments to the built environment that promote in-
12 creased use physical activity, access to nutri-
13 tious foods, or other health-promoting activities
14 by residents; and

15 “(ii) in developing the intervention strate-
16 gies under clause (i), ensures that the interven-
17 tion strategies will reach out to high-risk or vul-
18 nerable populations, including low-income urban
19 and rural communities and aging populations,
20 in addition to the general population.

21 “(3) SURVEYS.—The Secretary may use funds
22 appropriated under this section to support the ex-
23 pansion of national surveys and data tracking sys-
24 tems to provide more detailed information about the

1 connection between the built environment and
2 health.

3 “(4) PRIORITY.—In providing assistance under
4 the grant program under this section, the Secretary
5 and the Administrator shall give priority to research
6 that incorporates—

7 “(A) interdisciplinary approaches; or

8 “(B) the expertise of the public health,
9 physical activity, urban planning, land use, and
10 transportation research communities in the
11 United States and abroad.

12 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated such sums as may be
14 necessary to carry out this section. Not to exceed 20 per-
15 cent of amounts appropriated for each fiscal year under
16 this subsection may be used for the research component
17 of the program under this section.”.

18 **SEC. 1004. IMPLEMENTATION OF RECOMMENDATIONS BY**
19 **ENVIRONMENTAL PROTECTION AGENCY.**

20 (a) INSPECTOR GENERAL RECOMMENDATIONS.—The
21 Administrator of the Environmental Protection Agency
22 shall, as promptly as practicable, carry out each of the
23 following recommendations of the Inspector General of the
24 Agency as set forth in Report No. 2006–P–00034 entitled

1 “EPA needs to conduct environmental justice reviews of
2 its programs, policies and activities”:

3 (1) The recommendation that the Agency’s pro-
4 gram and regional offices identify which programs,
5 policies, and activities need environmental justice re-
6 views and require these offices to establish a plan to
7 complete the necessary reviews.

8 (2) The recommendation that the Administrator
9 of the Agency ensure that these reviews determine
10 whether the programs, policies, and activities may
11 have a disproportionately high and adverse health or
12 environmental impact on minority and low-income
13 populations.

14 (3) The recommendation that each program
15 and regional office develop specific environmental
16 justice review guidance for conducting environmental
17 justice reviews.

18 (4) The recommendation that the Administrator
19 designate a responsible office to compile results of
20 environmental justice reviews and recommend appro-
21 priate actions.

22 (b) GAO RECOMMENDATIONS.—In developing rules
23 under laws administered by the Environmental Protection
24 Agency, the Administrator of the Agency shall, as prompt-
25 ly as practicable, carry out each of the following rec-

1 ommendations of the Comptroller General of the United
2 States as set forth in GAO Report numbered GAO–05–
3 289 entitled “EPA Should Devote More Attention to En-
4 vironmental Justice when Developing Clean Air Rules”:

5 (1) The recommendation that the Administrator
6 ensure that workgroups involved in developing a rule
7 devote attention to environmental justice while draft-
8 ing and finalizing the rule.

9 (2) The recommendation that the Administrator
10 enhance the ability of such workgroups to identify
11 potential environmental justice issues through such
12 steps as providing workgroup members with guid-
13 ance and training to help them identify potential en-
14 vironmental justice problems and involving environ-
15 mental justice coordinators in the workgroups when
16 appropriate.

17 (3) The recommendation that the Administrator
18 improve assessments of potential environmental jus-
19 tice impacts in economic reviews by identifying the
20 data and developing the modeling techniques needed
21 to assess such impacts.

22 (4) The recommendation that the Administrator
23 direct appropriate Agency officers and employees to
24 respond fully when feasible to public comments on
25 environmental justice, including improving the Agen-

1 cy’s explanation of the basis for its conclusions, to-
2 gether with supporting data.

3 (c) 2004 INSPECTOR GENERAL REPORT.—The Ad-
4 ministrator of the Environmental Protection Agency shall,
5 as promptly as practicable, carry out each of the following
6 recommendations of the Inspector General of the Agency
7 as set forth in the report entitled “EPA Needs to Consist-
8 ently Implement the Intent of the Executive Order on En-
9 vironmental Justice” (Report No. 2004–P–00007):

10 (1) The recommendation that the Agency clear-
11 ly define the mission of the Office of Environmental
12 Justice (OEJ) and provide Agency staff with an un-
13 derstanding of the roles and responsibilities of the
14 Office.

15 (2) The recommendation that the Agency estab-
16 lish (through issuing guidance or a policy statement
17 from the Administrator) specific timeframes for the
18 development of definitions, goals, and measurements
19 regarding environmental justice and provide the re-
20 gions and program offices a standard and consistent
21 definition for a minority and low-income community,
22 with instructions on how the Agency will implement
23 and put into operation environmental justice in the
24 Agency’s daily activities.

1 (3) The recommendation that the Agency en-
2 sure the comprehensive training program currently
3 under development includes standard and consistent
4 definitions of the key environmental justice concepts
5 (such as “low-income”, “minority”, and “dispropor-
6 tionately impacted”) and instructions for implemen-
7 tation of those concepts.

8 The Administrator shall submit an initial report to Con-
9 gress within 6 months after the enactment of this Act re-
10 garding the Administrator’s strategy for implementing the
11 recommendations referred to in paragraphs (1), (2), and
12 (3). Thereafter, the Administrator shall provide semi-
13 annual reports to Congress regarding the Administrator’s
14 progress in implementing such recommendations and
15 modifying the Administrator’s emergency management
16 procedures to incorporate environmental justice in the
17 Agency’s Incident Command Structure (in accordance
18 with the December 18, 2006, letter from the Deputy Ad-
19 ministrator to the Acting Inspector General of the Agen-
20 cy).

21 (d) FEDERAL ACTION PLAN FOR SAVING LIVES,
22 PROTECTING PEOPLE AND THEIR FAMILIES FROM
23 RADON.—

24 (1) IN GENERAL.—Because radon is a naturally
25 occurring radioactive gas that is recognized as the

1 leading cause of lung cancer among nonsmokers and
2 is a particular environmental threat for low-income
3 and minority individuals because of the lack of infor-
4 mation about radon levels in their own homes, the
5 Administrator of the Environmental Protection
6 Agency shall within 6 months after the date of the
7 enactment of this Act, implement the action plan en-
8 titled “Protecting People and Families from Radon:
9 A Federal Action Plan for Saving Lives” (June 20,
10 2011), working with the Secretary of Health and
11 Human Services acting through the Director of the
12 Centers for Disease Control and Prevention, and
13 with the other Federal agencies mentioned in and as
14 set forth in the action plan.

15 (2) SPECIFIC STEPS.—In carrying out para-
16 graph (1), the Administrator shall take steps to
17 achieve each of the following:

18 (A) The recommendation that the
19 workgroup comprised of the Federal agencies
20 participating in the development of the action
21 plan referred to in paragraph (1) implement
22 specific steps within the current authority and
23 activities of each Federal agency to reduce ex-
24 posure to radon.

1 (B) The recommendation that such
2 workgroup meet on the 1-year anniversary of
3 the plan to assess and recognize achievements
4 of the plan.

5 (3) REPORT.—The Administrator shall report
6 to the Congress on the 1-year assessment of the
7 plan’s implementation, including the challenges re-
8 maining and the progress in reducing radon expo-
9 sure particularly to low-income and minority fami-
10 lies.

11 **SEC. 1005. GRANT PROGRAM TO CONDUCT ENVIRON-**
12 **MENTAL HEALTH IMPROVEMENT ACTIVITIES**
13 **AND TO IMPROVE SOCIAL DETERMINANTS OF**
14 **HEALTH.**

15 (a) DEFINITIONS.—In this section:

16 (1) DIRECTOR.—The term “Director” means
17 the Director of the Centers for Disease Control and
18 Prevention, acting in collaboration with the Adminis-
19 trator of the Environmental Protection Agency and
20 the Director of the National Institute of Environ-
21 mental Health Sciences.

22 (2) ELIGIBLE ENTITY.—The term “eligible enti-
23 ty” means a State or local community that—

24 (A) bears a disproportionate burden of ex-
25 posure to environmental health hazards;

1 (B) bears a disproportionate burden of ex-
2 posure to unhealthy living conditions, low
3 standard housing conditions, low socioeconomic
4 status, poor nutrition, less opportunity for edu-
5 cational attainment, disproportionate unemploy-
6 ment rates, or lower literacy levels;

7 (C) has established a coalition—

8 (i) with not less than 1 community-
9 based organization or demonstration pro-
10 gram; and

11 (ii) with not less than 1—

12 (I) public health entity;

13 (II) health care provider organi-
14 zation;

15 (III) academic institution, includ-
16 ing any minority-serving institution
17 (including a Hispanic-serving institu-
18 tion, a historically Black college or
19 university, and a tribal college or uni-
20 versity); or

21 (IV) child-serving institution;

22 (D) ensures planned activities and funding
23 streams are coordinated to improve community
24 health; and

1 (E) submits an application in accordance
2 with subsection (c).

3 (b) ESTABLISHMENT.—The Director shall establish a
4 grant program under which eligible entities shall receive
5 grants to conduct environmental health improvement ac-
6 tivities and to improve social determinants of health.

7 (c) APPLICATION.—To receive a grant under this sec-
8 tion, an eligible entity shall submit an application to the
9 Director at such time, in such manner, and accompanied
10 by such information as the Director may require.

11 (d) COOPERATIVE AGREEMENTS.—An eligible entity
12 may use a grant under this section—

13 (1) to promote environmental health;

14 (2) to address environmental health disparities
15 among all populations, including children; and

16 (3) to address racial and ethnic disparities in
17 social determinants of health.

18 (e) AMOUNT OF COOPERATIVE AGREEMENT.—

19 (1) IN GENERAL.—The Director shall award
20 grants to eligible entities at the 3 different funding
21 levels described in this subsection.

22 (2) LEVEL 1 COOPERATIVE AGREEMENTS.—

23 (A) IN GENERAL.—An eligible entity
24 awarded a grant under this paragraph shall use

1 the funds to identify environmental health prob-
2 lems and solutions by—

3 (i) establishing a planning and
4 prioritizing council in accordance with sub-
5 paragraph (B); and

6 (ii) conducting an environmental
7 health assessment in accordance with sub-
8 paragraph (C).

9 (B) PLANNING AND PRIORITIZING COUN-
10 CIL.—

11 (i) IN GENERAL.—A prioritizing and
12 planning council established under sub-
13 paragraph (A)(i) (referred to in this para-
14 graph as a “PPC”) shall assist the envi-
15 ronmental health assessment process and
16 environmental health promotion activities
17 of the eligible entity.

18 (ii) MEMBERSHIP.—Membership of a
19 PPC shall consist of representatives from
20 various organizations within public health,
21 planning, development, and environmental
22 services and shall include stakeholders
23 from vulnerable groups such as children,
24 the elderly, disabled, and minority ethnic

1 groups that are often not actively involved
2 in democratic or decisionmaking processes.

3 (iii) DUTIES.—A PPC shall—

4 (I) identify key stakeholders and
5 engage and coordinate potential part-
6 ners in the planning process;

7 (II) establish a formal advisory
8 group to plan for the establishment of
9 services;

10 (III) conduct an in-depth review
11 of the nature and extent of the need
12 for an environmental health assess-
13 ment, including a local epidemiological
14 profile, an evaluation of the service
15 provider capacity of the community,
16 and a profile of any target popu-
17 lations; and

18 (IV) define the components of
19 care and form essential programmatic
20 linkages with related providers in the
21 community.

22 (C) ENVIRONMENTAL HEALTH ASSESS-
23 MENT.—

1 (i) IN GENERAL.—A PPC shall carry
2 out an environmental health assessment to
3 identify environmental health concerns.

4 (ii) ASSESSMENT PROCESS.—The
5 PPC shall—

6 (I) define the goals of the assess-
7 ment;

8 (II) generate the environmental
9 health issue list;

10 (III) analyze issues with a sys-
11 tems framework;

12 (IV) develop appropriate commu-
13 nity environmental health indicators;

14 (V) rank the environmental
15 health issues;

16 (VI) set priorities for action;

17 (VII) develop an action plan;

18 (VIII) implement the plan; and

19 (IX) evaluate progress and plan-
20 ning for the future.

21 (D) EVALUATION.—Each eligible entity
22 that receives a grant under this paragraph shall
23 evaluate, report, and disseminate program find-
24 ings and outcomes.

1 (E) TECHNICAL ASSISTANCE.—The Direc-
2 tor may provide such technical and other non-
3 financial assistance to eligible entities as the
4 Director determines to be necessary.

5 (3) LEVEL 2 COOPERATIVE AGREEMENTS.—

6 (A) ELIGIBILITY.—

7 (i) IN GENERAL.—The Director shall
8 award grants under this paragraph to eli-
9 gible entities that have already—

10 (I) established broad-based col-
11 laborative partnerships; and

12 (II) completed environmental as-
13 sessments.

14 (ii) NO LEVEL 1 REQUIREMENT.—To
15 be eligible to receive a grant under this
16 paragraph, an eligible entity is not re-
17 quired to have successfully completed a
18 Level 1 Cooperative Agreement (as de-
19 scribed in paragraph (2)).

20 (B) USE OF GRANT FUNDS.—An eligible
21 entity awarded a grant under this paragraph
22 shall use the funds to further activities to carry
23 out environmental health improvement activi-
24 ties, including—

1 (i) addressing community environ-
2 mental health priorities in accordance with
3 paragraph (2)(C)(ii), including—

4 (I) geography;

5 (II) the built environment;

6 (III) air quality;

7 (IV) water quality;

8 (V) land use;

9 (VI) solid waste;

10 (VII) housing;

11 (VIII) crime;

12 (IX) socioeconomic status;

13 (X) ethnicity, social construct
14 and language preference;

15 (XI) educational attainment;

16 (XII) employment;

17 (XIII) food safety;

18 (XIV) nutrition;

19 (XV) health care services; and

20 (XVI) injuries;

21 (ii) building partnerships between
22 planning, public health, and other sectors,
23 including child-serving institutions, to ad-
24 dress how the built environment impacts
25 food availability and access and physical

1 activity to promote healthy behaviors and
2 lifestyles and reduce overweight and obe-
3 sity, musculoskeletal diseases, respiratory
4 conditions, dental, oral and mental health
5 conditions, poverty, and related co-
6 morbidities;

7 (iii) establishing programs to ad-
8 dress—

9 (I) how environmental and social
10 conditions of work and living choices
11 influence physical activity and dietary
12 intake; or

13 (II) how those conditions influ-
14 ence the concerns and needs of people
15 who have impaired mobility and use
16 assistance devices, including wheel-
17 chairs, lower limb prostheses, and hip,
18 knee, and other joint replacements;
19 and

20 (iv) convening intervention and dem-
21 onstration programs that examine the role
22 of the social environment in connection
23 with the physical and chemical environ-
24 ment in—

1 (I) determining access to nutri-
2 tional food; and

3 (II) improving physical activity to
4 reduce overweight, obesity, and co-
5 morbidities and increase quality of
6 life.

7 (4) LEVEL 3 COOPERATIVE AGREEMENTS.—

8 (A) IN GENERAL.—An eligible entity
9 awarded a grant under this paragraph shall use
10 the funds to identify and address racial and
11 ethnic disparities in social determinants of
12 health by creating demonstration programs that
13 assess the feasibility of establishing a federally
14 funded comprehensive program and describe
15 key outcomes that address racial and ethnic dis-
16 parities in social determinants of health.

17 (B) PROGRAM DESIGN.—

18 (i) EVALUATION.—No later than 1
19 year after enactment of this Act, the Di-
20 rector shall evaluate the best practices of
21 existing programs from the private, public,
22 community based, and academically sup-
23 ported initiatives focused on reducing dis-
24 parities in the social determinants of
25 health for racial and ethnic populations.

1 (ii) DEMONSTRATION PROJECTS.—

2 Not later than two years after the date of
3 enactment of this Act, the Director shall
4 implement at least ten demonstration
5 projects including at least one project for
6 each major racial and ethnic minority
7 group, each of which is unique to the cul-
8 tural and linguistic needs of each of the
9 following groups:

10 (I) Native Americans and Alaska
11 Natives.

12 (II) Asian-Americans.

13 (III) African-Americans/Blacks.

14 (IV) Hispanic/Latino-Americans.

15 (V) Native Hawaiians and Pacific
16 Islanders.

17 (iii) REPORT TO CONGRESS.—No later
18 than 2 years after the implementation of
19 the initial demonstration projects, the Di-
20 rector shall submit to Congress a report
21 which includes—

22 (I) a description of each dem-
23 onstration project and design;

1 (II) an evaluation of the cost ef-
2 fectiveness of each project's preven-
3 tion and treatment efforts;

4 (III) an evaluation of the cultural
5 and linguistic appropriateness of each
6 project by racial and ethnic group;
7 and

8 (IV) an evaluation of the bene-
9 ficiary's health status improvement
10 under the demonstration project.

11 (iv) ANY OTHER INFORMATION
12 DEEMED APPROPRIATE BY THE DIREC-
13 TOR.—The Director shall require any other
14 information deemed appropriate to be
15 shared by or developed by eligible entities
16 awarded a grant under this paragraph, in-
17 cluding the following:

18 (I) Developing models and evalu-
19 ating methods that improve the cul-
20 tural and linguistically appropriate
21 services provided through the Centers
22 for Disease Control and Prevention to
23 target individuals impacted by health
24 disparities based on their race, eth-
25 nicity, and gender.

1 (II) Promoting the collaboration
2 between primary and specialty care
3 health care providers and patients, to
4 ensure patients impacted by health
5 disparities based on race, ethnicity,
6 and gender are receiving comprehen-
7 sive and organized treatment and
8 care.

9 (III) Educating health care pro-
10 fessionals on the causes and effects of
11 disparities in the social determinants
12 of health as it relates to minority and
13 racial and ethnic communities and the
14 need for culturally and linguistically
15 appropriate care in the prevention and
16 treatment of high-impact diseases.

17 (IV) Encouraging collaboration
18 among community and patient-based
19 organizations which work to address
20 disparities in the social determinants
21 of health as it relates to high-impact
22 diseases in minority and racial and
23 ethnic populations.

1 (f) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this sec-
3 tion—

4 (1) \$25,000,000 for fiscal year 2017; and

5 (2) such sums as may be necessary for fiscal
6 years 2018 through 2020.

7 **SEC. 1006. ADDITIONAL RESEARCH ON THE RELATIONSHIP**
8 **BETWEEN THE BUILT ENVIRONMENT AND**
9 **THE HEALTH OF COMMUNITY RESIDENTS.**

10 (a) DEFINITION OF ELIGIBLE INSTITUTION.—In this
11 section, the term “eligible institution” means a public or
12 private nonprofit institution that submits to the Secretary
13 of Health and Human Services (in this section referred
14 to as the “Secretary”) and the Administrator of the Envi-
15 ronmental Protection Agency (in this section referred to
16 as the “Administrator”) an application for a grant under
17 the grant program authorized under subsection (b)(2) at
18 such time, in such manner, and containing such agree-
19 ments, assurances, and information as the Secretary and
20 Administrator may require.

21 (b) RESEARCH GRANT PROGRAM.—

22 (1) DEFINITION OF HEALTH.—In this section,
23 the term “health” includes—

24 (A) levels of physical activity;

- 1 (B) degree of mobility due to factors such
2 as musculoskeletal diseases, arthritis, and obe-
3 sity;
- 4 (C) consumption of nutritional foods;
- 5 (D) rates of crime;
- 6 (E) air, water, and soil quality;
- 7 (F) risk of injury;
- 8 (G) accessibility to health care services;
- 9 (H) levels of educational attainment; and
- 10 (I) other indicators as determined appro-
11 priate by the Secretary.

12 (2) GRANTS.—The Secretary, in collaboration
13 with the Administrator, shall provide grants to eligi-
14 ble institutions to conduct and coordinate research
15 on the built environment and its influence on indi-
16 vidual and population-based health.

17 (3) RESEARCH.—The Secretary shall support
18 research that—

19 (A) investigates and defines the causal
20 links between all aspects of the built environ-
21 ment and the health of residents;

22 (B) examines—

23 (i) the extent of the impact of the
24 built environment (including the various

1 characteristics of the built environment) on
2 the health of residents;

3 (ii) the variance in the health of resi-
4 dents by—

5 (I) location (such as inner cities,
6 inner suburbs, and outer suburbs);
7 and

8 (II) population subgroup (includ-
9 ing children, the elderly, the disadvan-
10 tagged); or

11 (iii) the importance of the built envi-
12 ronment to the total health of residents,
13 which is the primary variable of interest
14 from a public health perspective;

15 (C) is used to develop—

16 (i) measures to address health and the
17 connection of health to the built environ-
18 ment; and

19 (ii) efforts to link the measures to
20 travel and health databases; and

21 (D) distinguishes carefully between per-
22 sonal attitudes and choices and external influ-
23 ences on observed behavior to determine how
24 much an observed association between the built
25 environment and the health of residents, versus

1 the lifestyle preferences of the people that
2 choose to live in the neighborhood, reflects the
3 physical characteristics of the neighborhood;
4 and

5 (E)(i) identifies or develops effective inter-
6 vention strategies to promote better health
7 among residents with a focus on behavioral
8 interventions and enhancements of the built en-
9 vironment that promote increased use by resi-
10 dents; and

11 (ii) in developing the intervention strate-
12 gies under clause (i), ensures that the interven-
13 tion strategies will reach out to high-risk popu-
14 lations, including racial and ethnic minorities,
15 low-income urban and rural communities, and
16 children.

17 (4) PRIORITY.—In providing assistance under
18 the grant program authorized under paragraph (2),
19 the Secretary and the Administrator shall give pri-
20 ority to research that incorporates—

21 (A) minority-serving institutions as grant-
22 ees;

23 (B) interdisciplinary approaches; or

24 (C) the expertise of the public health,
25 physical activity, nutrition and health care (in-

1 including child health), urban planning, and
2 transportation research communities in the
3 United States and abroad.

4 **SEC. 1007. ENVIRONMENT AND PUBLIC HEALTH RESTORA-**
5 **TION.**

6 (a) FINDINGS.—

7 (1) GENERAL FINDINGS.—The Congress finds
8 as follows:

9 (A) As human beings, we share our envi-
10 ronment with a wide variety of habitats and
11 ecosystems that nurture and sustain a diversity
12 of species.

13 (B) The abundance of natural resources in
14 our environment forms the basis for our econ-
15 omy and has greatly contributed to human de-
16 velopment throughout history.

17 (C) The accelerated pace of human devel-
18 opment over the last several hundred years has
19 significantly impacted our natural environment
20 and its resources, the health and diversity of
21 plant and animal wildlife, the availability of
22 critical habitats, the quality of our air and our
23 water, and our global climate.

24 (D) The intervention of the Federal Gov-
25 ernment is necessary to minimize and mitigate

1 human impact on the environment for the ben-
2 efit of public health, to maintain air quality and
3 water quality, to sustain the diversity of plants
4 and animals, to combat global climate change,
5 and to protect the environment.

6 (E) Laws and regulations in the United
7 States have been created and promulgated to
8 minimize and mitigate human impact on the en-
9 vironment for the benefit of public health, to
10 maintain air quality and water quality, to sus-
11 tain wildlife, and to protect the environment.

12 (F) Such laws include the Antiquities Act
13 of 1906 (16 U.S.C. 431 et seq.) initiated by
14 President Theodore Roosevelt to create the na-
15 tional park system, the National Environmental
16 Policy Act of 1969 (42 U.S.C. 4321 et seq.),
17 the Clean Air Act (42 U.S.C. 7401 et seq.), the
18 Federal Water Pollution Control Act (33 U.S.C.
19 1251 et seq.), the Comprehensive Environ-
20 mental Response, Compensation, and Liability
21 Act of 1980 (Public Law 96–510), the Endan-
22 gered Species Act of 1973 (Public Law 93–
23 205), and the National Forest Management Act
24 of 1976 (Public Law 94–588).

1 (G) Attempts to repeal or weaken key envi-
2 ronmental safeguards pose dangers to the pub-
3 lic health, air quality, water quality, wildlife,
4 and the environment.

5 (2) FINDINGS ON CHANGES AND PROPOSED
6 CHANGES IN LAW.—The Congress finds that, since
7 2001, the following changes and proposed changes
8 to existing law or regulations have negatively im-
9 pacted or will negatively impact the environment and
10 public health:

11 (A) CLEAN WATER.—

12 (i) On May 9, 2002, the Environ-
13 mental Protection Agency (EPA) and the
14 Army Corps of Engineers put forth a final
15 rule that reconciled regulations imple-
16 menting section 404 of the Federal Water
17 Pollution Control Act by redefining the
18 term “fill material” and amending the def-
19 inition of the term “discharge of fill mate-
20 rial”, reversing a 25-year-old regulation.
21 The new rule fails to restrict the dumping
22 of hardrock mining waste, construction de-
23 bris, and other industrial wastes into riv-
24 ers, streams, lakes, and wetlands. The rule
25 further allows destructive mountaintop re-

1 moval coal mining companies to dump
2 waste into streams and lakes, polluting the
3 surrounding natural habitat and poisoning
4 plants and animals that depend on those
5 water sources.

6 (ii) On February 12, 2003, the Envi-
7 ronmental Protection Agency published the
8 rule “National Pollutant Discharge Elim-
9 ination System Permit Regulation and Ef-
10 fluent Limitation Guidelines and Stand-
11 ards for Concentrated Animal Feeding Op-
12 erations”, new livestock waste regulations
13 that aimed to control factory farm pollu-
14 tion but which would severely undermine
15 existing protections under the Federal
16 Water Pollution Control Act. This regula-
17 tion allows large-scale animal factories to
18 foul the Nation’s waters with animal
19 waste, allows livestock owners to draft
20 their own pollution-management plans and
21 avoid ground water monitoring, legalizes
22 the discharge of contaminated runoff water
23 rich in nitrogen, phosphorus, bacteria, and
24 metals, and ensures that large factory
25 farms are not held liable for the environ-

1 mental damage they cause. In a 2005 Fed-
2 eral court decision (“Waterkeeper Alliance,
3 et al. v. Environmental Protection Agen-
4 cy”, 399 F.3d 486 (2nd Cir. 2005)), major
5 parts of the rule were upheld, others va-
6 cated, and still others remanded back to
7 the EPA. On November 20, 2008, the En-
8 vironmental Protection Agency published a
9 revised final rule which undermines envi-
10 ronmental protection provisions by remov-
11 ing mandatory permitting requirements
12 and allowing large animal farms to self-
13 certify the absence of pollutant discharge
14 activity.

15 (iii) On March 19, 2003, the Environ-
16 mental Protection Agency published a new
17 rule regarding the Total Maximum Daily
18 Load program of the Federal Water Pollu-
19 tion Control Act that regulates the max-
20 imum amount of a particular pollutant
21 that can be present in a body of water and
22 still meet water quality standards. The new
23 rule withdrew the existing regulation put
24 forth on July 13, 2000, and halted mo-
25 mentum in cleaning up polluted waterways

1 throughout the Nation. By abandoning the
2 existing rule, the Environmental Protection
3 Agency is undermining the effectiveness of
4 cleanup plans and is allowing States to
5 avoid cleaning polluted waters entirely by
6 dropping them from their cleanup lists.
7 Waterways play a crucial role in the lives
8 of the people of the United States and are
9 critical to the livelihood of fish and wildlife.
10 The result of dropping the July 2000 rule
11 is that the restoration of polluted rivers,
12 shorelines, and lakes will be delayed, harm-
13 ing more fish and wildlife and worsening
14 the quality of drinking water.

15 (iv) On December 2, 2008, the Envi-
16 ronmental Protection Agency and the
17 Army Corps of Engineers jointly issued a
18 guidance document in the form of a legal
19 memorandum, titled “Clean Water Act Ju-
20 risdiction Following the U.S. Supreme
21 Court’s Decision in *Rapanos v. United*
22 *States & Carabell v. United States*”. This
23 new guidance dictates enforcement actions
24 under the Federal Water Pollution Control
25 Act and calls for a complicated “case-by-

1 case” analysis to determine jurisdiction for
2 waterways that do not flow all year. Such
3 actions endanger small streams and wet-
4 lands that serve as important habitats for
5 aquatic life, which play a fundamental role
6 in safeguarding sources of clean drinking
7 water and mitigate the risks and effects of
8 floods and droughts. Further, the defini-
9 tion provided therein for “waters of the
10 United States” is applicable to the Federal
11 Water Pollution Control Act as a whole,
12 potentially affecting programs that control
13 industrial pollution and sewage levels, pre-
14 vent oil spills, and set water quality stand-
15 ards for all waters in the United States
16 protected under the Federal Water Pollu-
17 tion Control Act.

18 (B) FORESTS AND LAND MANAGEMENT.—

19 (i) On December 3, 2003, the Presi-
20 dent signed into law the Healthy Forests
21 Restoration Act of 2003 (Public Law 108–
22 148; 16 U.S.C. 6501 et seq.). Although the
23 law attempts to reduce the risk of cata-
24 strophic forest fires, it provides a boon to
25 timber companies by accelerating the ag-

1 gressive thinning of backcountry forests
2 that are far from at-risk communities. The
3 law allows for increased logging of large,
4 fire-resistant trees that are not in close
5 proximity of homes and communities; it
6 undermines critical protections for endan-
7 gered species by exempting Federal land
8 management agencies from consulting with
9 the United States Fish and Wildlife Serv-
10 ice before approving any action that could
11 harm endangered plants or wildlife; and it
12 limits public participation by reducing the
13 number of environmental project reviews.

14 (ii) On April 21, 2008, the Depart-
15 ment of Agriculture issued a Final Plan-
16 ning Rule and Record of Decision for Na-
17 tional Forest System Land Management
18 Planning. Similar to rules enacted by the
19 Administration on January 5, 2005, later
20 remanded back to the agency in Federal
21 district court for violating the National
22 Environmental Policy Act of 1969, the En-
23 dangered Species Act of 1973, and the Ad-
24 ministrative Procedure Act (“Citizens for
25 Better Forestry v. United States Depart-

1 ment of Agriculture”, 481 F. Supp. 2d
2 1059 (N.D. Cal. 2007)), this revised rule
3 eliminates strict forest planning standards
4 established in 1982, and opens millions of
5 acres of public lands to damaging and
6 invasive logging, mining, and drilling oper-
7 ations. These regulations would reverse
8 more than 20 years of protection for wild-
9 life and national forests by removing the
10 overall goal of ensuring ecological sustain-
11 ability in managing the national forest sys-
12 tem, weakening the National Forest Man-
13 agement Act of 1976, and effectively end-
14 ing the review of forest management plans
15 under the National Environmental Policy
16 Act of 1969.

17 (iii) On September 20, 2006, the Dis-
18 trict Court for the Northern District of
19 California vacated the Protection of Inven-
20 toried Roadless Areas rule, enacted on May
21 13, 2005, which gave State Governors 18
22 months to petition the Federal Government
23 to either restore the previous rule for their
24 States, or submit a new management and
25 development plan for national forest areas

1 inventoried under the rule. Despite the
2 enjoinment of the Administration's 2005
3 rule, and the subsequent restoration of the
4 original Roadless Area Conservation Rule,
5 the United States Forest Service has con-
6 tinued to allow States to petition for a spe-
7 cial rule under the authority of the Admin-
8 istrative Procedure Act, publishing a final
9 special rule for Idaho on October 16, 2008.
10 As a result, 58.5 million acres of wild na-
11 tional forests are still vulnerable to log-
12 ging, road building, and other develop-
13 ments that may fragment natural habitats
14 and negatively impact fish and wildlife.

15 (iv) On November 17, 2008, the De-
16 partment of the Interior's Bureau of Land
17 Management (BLM) signed the Record of
18 Decision (ROD) amending 12 resource
19 management plans in Colorado, Utah, and
20 Wyoming, opening 2,000,000 acres of pub-
21 lic lands to commercial tar sands and oil
22 shale exploration and development. On No-
23 vember 18, 2008, the BLM published a
24 final rule for Oil Shale Management set-
25 ting the policies and procedures for a com-

1 merchial leasing program for the manage-
2 ment of federally owned oil shale in those
3 three States. Previously barred by a con-
4 gressional moratorium on the commercial
5 leasing regulations for oil shale until Sep-
6 tember 30, 2008, the development of oil
7 shale on public lands poses a serious threat
8 to land conservation, endangered and
9 threatened species, and critical habitat.
10 Domestic shale oil production allowed by
11 these regulations is highly water and en-
12 ergy intensive, the impacts of which will in-
13 tensify existing water scarcity in the arid
14 Western Region and potentially degrade
15 air and water quality for surrounding pop-
16 ulations.

17 (C) SCIENTIFIC REVIEW.—On December
18 16, 2008, the United States Fish and Wildlife
19 Service of the Department of the Interior and
20 the National Oceanic and Atmospheric Admin-
21 istration of the Department of Commerce joint-
22 ly issued a new rule amending regulations gov-
23 erning interagency cooperation under section 7
24 of the Endangered Species Act of 1973 (ESA).
25 This rule undermines the intention of the ESA

1 to protect species and the ecosystems upon
2 which they depend by allowing Federal agencies
3 to carry out, permit, or fund an action without
4 proper environmental review and expert third-
5 party consultation from Federal wildlife ex-
6 perts. Under this new rule, Federal agencies
7 can unilaterally circumvent the formal review
8 process, eliminating longstanding and scientif-
9 ically grounded safeguards that serve to protect
10 the biodiversity of our Nation's ecosystems and
11 avert harm to thousands of endangered and
12 threatened species.

13 (b) STATEMENT OF POLICY.—It is the policy of the
14 United States Government to work in conjunction with
15 States, territories, tribal governments, international orga-
16 nizations, and foreign governments in order to act as a
17 steward of the environment for the benefit of public
18 health, to maintain air quality and water quality, to sus-
19 tain the diversity of plant and animal species, to combat
20 global climate change, and to protect the environment for
21 future generations to enjoy.

22 (c) STUDY AND REPORT ON PUBLIC HEALTH OR EN-
23 VIRONMENTAL IMPACT OF REVISED RULES, REGULA-
24 TIONS, LAWS, OR PROPOSED LAWS.—

1 (1) STUDY.—Not later than 30 days after the
2 date of enactment of this Act, the President shall
3 enter into an arrangement under which the National
4 Academy of Sciences will conduct a study to deter-
5 mine the impact on public health, air quality, water
6 quality, wildlife, and the environment of the fol-
7 lowing regulations, laws, and proposed laws:

8 (A) CLEAN WATER.—

9 (i) Final revisions to the Federal
10 Water Pollution Control Act regulatory
11 definitions of “fill material” and “dis-
12 charge of fill material”, finalized and pub-
13 lished in the Federal Register on May 9,
14 2002 (67 Fed. Reg. 31129), amending
15 part 232 of title 40, Code of Federal Regu-
16 lations.

17 (ii) Revised National Pollutant Dis-
18 charge Elimination System Permit Regula-
19 tion and Effluent Limitation Guidelines
20 and Standards for Concentrated Animal
21 Feeding Operations in response to the
22 “Waterkeeper Alliance, et al. v. Environ-
23 mental Protection Agency” decision, final-
24 ized and published in the Federal Register
25 on November 20, 2008 (73 Fed. Reg.

1 225), amending parts 9, 122, and 412 of
2 title 40, Code of Federal Regulations.

3 (iii) A March 19, 2003, rule published
4 in the Federal Register (68 Fed. Reg.
5 13608) withdrawing a July 13, 2000, rule
6 revising the Total Maximum Daily Load
7 program of the Federal Water Pollution
8 Control Act (65 Fed. Reg. 43586), amend-
9 ing parts 9, 122, 123, 124, and 130 of
10 title 40, Code of Federal Regulations.

11 (iv) Official Guidance Document,
12 “Clean Water Act Jurisdiction Following
13 the United States Supreme Court’s Deci-
14 sion in *Rapanos v. United States &*
15 *Carabell v. United States*”, issued on De-
16 cember 2, 2008, relating to jurisdiction
17 under section 404 of the Federal Water
18 Pollution Control Act.

19 (B) FORESTS AND LAND MANAGEMENT.—

20 (i) Healthy Forests Restoration Act of
21 2003, signed into law on December 3,
22 2003 (Public Law 108–148; 16 U.S.C.
23 6501 et seq.).

24 (ii) National Forest System Land
25 Management Planning Rule, finalized and

1 published in the Federal Register on April
2 21, 2008 (73 Fed. Reg. 21468), replacing
3 the 2005 final rule (70 Fed. Reg. 1022,
4 Jan. 5, 2005), as amended March 3, 2006
5 (71 Fed. Reg. 10837), and the 2000 final
6 rule adopted on November 9, 2000 (65
7 Fed. Reg. 67514), as amended on Sep-
8 tember 29, 2004 (69 Fed. Reg. 58055),
9 amending title 36, Code of Federal Regula-
10 tions, part 219.

11 (iii) The application of the Adminis-
12 trative Procedure Act (5 U.S.C. 551 to
13 559, 701 to 706, et seq.), such that States
14 may petition for a special rule for the
15 roadless areas in all or part of said State.

16 (iv) Record of Decision, “Oil Shale
17 and Tar Sands Resources Resource Man-
18 agement Plan Amendments”, issued on
19 November 17, 2008, along with the Final
20 Rule, Oil Shale Management-General, pub-
21 lished in the Federal Register on Novem-
22 ber 18, 2008 (73 Fed. Reg. 223), amend-
23 ing title 43, Code of Federal Regulations,
24 parts 3900, 3910, 3920, and 3930.

1 (C) SCIENTIFIC REVIEW.—Final Rule,
2 Interagency Cooperation Under the Endangered
3 Species Act, published in the Federal Register
4 on December 16, 2008, amending title 50, Code
5 of Federal Regulations, part 402.

6 (2) METHOD.—In conducting the study under
7 paragraph (1), the National Academy of Sciences
8 may utilize and compare existing scientific studies
9 regarding the regulations, laws, and proposed laws
10 listed in paragraph (1).

11 (3) REPORT.—Under the arrangement entered
12 into under paragraph (1), not later than 270 days
13 after the date on which such arrangement is entered
14 into, the National Academy of Sciences shall make
15 publicly available and shall submit to the Congress
16 and to the head of each department and agency of
17 the Federal Government that issued, implements, or
18 would implement a regulation, law, or proposed law
19 listed in paragraph (1), a report containing—

20 (A) a description of the impact of all such
21 regulations, laws, and proposed laws on public
22 health, air quality, water quality, wildlife, and
23 the environment, compared to the impact of
24 preexisting regulations, or laws in effect, includ-
25 ing—

1 (i) any negative impacts to air quality
2 or water quality;

3 (ii) any negative impacts to wildlife;

4 (iii) any delays in hazardous waste
5 cleanup that are projected to be hazardous
6 to public health; and

7 (iv) any other negative impact on pub-
8 lic health or the environment; and

9 (B) any recommendations that the Na-
10 tional Academy of Sciences considers appro-
11 priate to maintain, restore, or improve in whole
12 or in part protections for public health, air
13 quality, water quality, wildlife, and the environ-
14 ment for each of the regulations, laws, and pro-
15 posed laws listed in paragraph (1), which may
16 include recommendations for the adoption of
17 any regulation or law in place or proposed prior
18 to January 1, 2001.

19 (d) DEPARTMENT AND AGENCY REVISION OF EXIST-
20 ING RULES, REGULATIONS, OR LAWS.—Not later than
21 180 days after the date on which the report is submitted
22 pursuant to subsection (c)(3), the head of each depart-
23 ment and agency that has issued or implemented a regula-
24 tion or law listed in subsection (c)(1) shall submit to the
25 Congress a plan describing the steps such department or

1 such agency will take, or has taken, to restore or improve
2 protections for public health and the environment in whole
3 or in part that were in existence prior to the issuance of
4 such regulation or law.

5 **SEC. 1008. GAO REPORT ON HEALTH EFFECTS OF DEEP-**
6 **WATER HORIZON OIL RIG EXPLOSION IN THE**
7 **GULF COAST.**

8 (a) STUDY.—The Comptroller General of the United
9 States shall conduct a study on the type and scope of
10 health care services administered through the Department
11 of Health and Human Services addressing the provision
12 of health care to racial and ethnic minorities (whether
13 residents, cleanup workers, or volunteers) affected by the
14 explosion of the mobile offshore drilling unit Deepwater
15 Horizon that occurred on April 20, 2010.

16 (b) SPECIFIC COMPONENTS; REPORTING.—In car-
17 rying out subsection (a), the Comptroller General shall—

18 (1) assess the type, size, and scope of programs
19 administered by the Department of Health and
20 Human Services that focus on provision of health
21 care to communities in the Gulf Coast;

22 (2) identify the merits and disadvantages asso-
23 ciated with each the programs;

24 (3) perform an analysis of the costs and bene-
25 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.

○