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(Original Signature of Member)

116TH CONGRESS
2ND SESSION

# H. R. _____

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

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IN THE HOUSE OF REPRESENTATIVES

Mr. GARCÍA of Illinois introduced the following bill; which was referred to the Committee on _____

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# A BILL

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

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Health Equity and Accountability Act of 2020''.

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

The table of contents of this Act is as follows:

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

TITLE I—DATA COLLECTION AND REPORTING

Sec. 101. Amendment to the Public Health Service Act.
Sec. 102. Elimination of prerequisite of direct appropriations for data collection and analysis.
Sec. 103. Collection of data for the Medicare program.
Sec. 104. Revision of HIPAA claims standards.
Sec. 105. National Center for Health Statistics.
Sec. 106. Disparities data collected by the Federal Government.
Sec. 107. Data collection and analysis grants to minority-serving institutions.
Sec. 108. Standards for measuring sexual orientation, gender identity, and socioeconomic status in collection of health data.
Sec. 109. Safety and effectiveness of drugs with respect to racial and ethnic background.
Sec. 110. Improving health data regarding Native Hawaiians and other Pacific Islanders.
Sec. 111. Clarification of simplified administrative reporting requirement.

TITLE II—CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH AND HEALTH CARE

Sec. 201. Definitions; findings.
Sec. 202. Improving access to services for individuals with limited-English proficiency.
Sec. 203. Ensuring standards for culturally and linguistically appropriate services in health care.
Sec. 204. Culturally and linguistically appropriate health care in the Public Health Service Act.
Sec. 205. Pilot program for improvement and development of State medical interpreting services.
Sec. 206. Training tomorrow's doctors for culturally and linguistically appropriate care: graduate medical education.
Sec. 207. Federal reimbursement for culturally and linguistically appropriate services under the Medicare, Medicaid, and State Children's Health Insurance Programs.
Sec. 208. Increasing understanding of and improving health literacy.
Sec. 209. Requirements for health programs or activities receiving Federal funds.
Sec. 210. Report on Federal efforts to provide culturally and linguistically appropriate health care services.
Sec. 211. English for speakers of other languages.
Sec. 212. Implementation.
Sec. 213. Language access services.
Sec. 214. Medically underserved populations.

TITLE III—HEALTH WORKFORCE DIVERSITY

Sec. 301. Amendment to the Public Health Service Act.
Sec. 302. Hispanic-serving institutions, historically black colleges and universities, Asian American and Native American Pacific Islander-serving institutions, Tribal colleges, regional community-based organizations, and national minority medical associations.
Sec. 303. Loan repayment program of Centers for Disease Control and Prevention.
Sec. 304. Cooperative agreements for online degree programs at schools of public health and schools of allied health.
Sec. 305. Sense of Congress on the mission of the National Health Care Workforce Commission.

Sec. 306. Scholarship and fellowship programs.
Sec. 307. McNair Postbaccalaureate Achievement Program.
Sec. 308. Rules for determination of full-time equivalent residents for cost-reporting periods.
Sec. 309. Developing and implementing strategies for local health equity.
Sec. 310. Loan forgiveness for mental and behavioral health social workers.
Sec. 311. Health Professions Workforce Fund.
Sec. 312. Findings; sense of Congress relating to graduate medical education.
Sec. 313. Career support for skilled, internationally-educated health professionals.
Sec. 314. Study and report on strategies for increasing diversity.
Sec. 315. Conrad State 30 and physician retention.

TITLE IV—IMPROVING HEALTH CARE ACCESS AND QUALITY

Subtitle A—Improvement of Coverage

Sec. 401. Repeal of requirement for documentation evidencing citizenship or nationality under the Medicaid program.
Sec. 402. Removing citizenship and immigration barriers to access to affordable health care under ACA.
Sec. 403. Study on the uninsured.
Sec. 404. Medicaid in the territories.
Sec. 405. Extension of Medicare secondary payer.
Sec. 406. Indian defined in title I of the Patient Protection and Affordable Care Act.
Sec. 407. Removing Medicare barrier to health care.
Sec. 408. 100 percent FMAP for medical assistance provided by urban Indian health centers.
Sec. 409. 100 percent FMAP for medical assistance provided to a Native Hawaiian through a federally qualified health center or a Native Hawaiian health care system under the Medicaid program.
Sec. 410. Medicaid coverage for citizens of freely associated states.
Sec. 411. At-risk youth medicaid protection.

Subtitle B—Expansion of Access

Sec. 412. Amendment to the public health service act.
Sec. 413. Protecting sensitive locations.
Sec. 414. Grants for racial and ethnic approaches to community health.
Sec. 415. Border health grants.
Sec. 416. Critical access hospital improvements.
Sec. 417. Establishment of Rural Community Hospital (RCH) Program.
Sec. 418. Medicare remote monitoring pilot projects.
Sec. 419. Rural health quality advisory commission and demonstration projects.
Sec. 420. Rural health care services.
Sec. 421. Community health center collaborative access expansion.
Sec. 422. Facilitating the provision of telehealth services across State lines.
Sec. 423. Scoring of preventive health savings.
Sec. 424. Sense of Congress on Maintenance of Effort Provisions Regarding Children's Health.
Sec. 425. Protection of the HHS Offices of Minority Health.
Sec. 426. Office of Minority Health in Veterans Health Administration of Department of Veterans Affairs.
Sec. 427. Study of DSH payments to ensure hospital access for low-income patients.

Sec. 428. Assistant Secretary of the Indian Health Service.
Sec. 429. Reauthorization of the Native Hawaiian Health Care Improvement Act.
Sec. 430. Availability of non-English language speaking providers.
Sec. 431. Access to essential community providers.
Sec. 432. Provider network adequacy in communities of color.
Sec. 433. Improving access to dental care.
Sec. 434. Providing for a special enrollment period for pregnant individuals.
Sec. 435. Coverage of maternity care for dependent children.
Sec. 436. Federal employee health benefit plans.
Sec. 437. Continuation of medicaid income eligibility standard for pregnant individuals and infants.

Subtitle C—Advancing Health Equity Through Payment and Delivery Reform

Sec. 441. Sense of Congress.
Sec. 442. Centers for Medicare & Medicaid Services reporting and value based programs.
Sec. 443. Development and testing of disparity reducing delivery and payment models.
Sec. 444. Diversity in Centers for Medicare and Medicaid consultation.
Sec. 445. Supporting safety net and community-based providers to compete in value-based payment systems.

Subtitle D—Health Empowerment Zones

Sec. 451. Short title.
Sec. 452. Findings.
Sec. 453. Designation of health empowerment zones.
Sec. 454. Assistance to those seeking designation.
Sec. 455. Benefits of designation.
Sec. 456. Definition of Secretary.
Sec. 457. Authorization of appropriations.

TITLE V—IMPROVING HEALTH OUTCOMES FOR WOMEN, CHILDREN, AND FAMILIES

Subtitle A—In General

Sec. 501. Grants to promote health for underserved communities.
Sec. 502. Removing barriers to health care and nutrition assistance for children, pregnant persons, and lawfully present individuals.
Sec. 503. Repeal of denial of benefits.
Sec. 504. Birth defects prevention, risk reduction, and awareness.
Sec. 505. MOMMA'S Act.
Sec. 506. Rural maternal and obstetric modernization of services.
Sec. 507. Decreasing the risk factors for sudden unexpected infant death and sudden unexplained death in childhood.
Sec. 508. Reducing unintended teenage pregnancies.
Sec. 509. Gestational diabetes.
Sec. 510. Emergency contraception education and information programs.
Sec. 511. Comprehensive sex education programs.
Sec. 512. Compassionate assistance for rape emergencies.
Sec. 513. Access to birth control duties of pharmacies to ensure provision of FDA-approved contraception.
Sec. 514. Additional focus area for the Office on Women's Health.

Sec. 515. Interagency coordinating committee on the promotion of optimal maternity outcomes.
Sec. 516. Consumer education campaign.
Sec. 517. Bibliographic database of systematic reviews for care of childbearing individuals and newborns.
Sec. 518. Expansion of CDC prevention research centers program to include centers on optimal maternity outcomes.
Sec. 519. Expanding models allowed to be tested by Center for Medicare & Medicaid Innovation to include maternity care models.
Sec. 520. Development of interprofessional maternity care educational models and tools.
Sec. 521. Including services furnished by certain students, interns, and residents supervised by certified nurse midwives within inpatient hospital services under Medicare.
Sec. 522. Grants to professional organizations to increase diversity in maternal, reproductive, and sexual health professionals.
Sec. 523. Interagency update to the quality family planning guidelines.
Sec. 524. Dissemination of the quality family planning guidelines.

Subtitle B—Pregnancy Screening

Sec. 531. Pregnancy intention screening initiative demonstration program.

TITLE VI—MENTAL HEALTH

Sec. 601. Mental health findings.
Sec. 602. Coverage of marriage and family therapist services, mental health counselor services, and substance abuse counselor services under part B of the Medicare program.
Sec. 603. Integrated Health Care Demonstration Program.
Sec. 604. Addressing racial and ethnic mental health disparities research gaps.
Sec. 605. Health professions competencies to address racial and ethnic mental health disparities.
Sec. 606. Geoaccess study.
Sec. 607. Asian American, Native Hawaiian, Pacific Islander, and Hispanic and Latino behavioral and mental health outreach and education strategies.
Sec. 608. Mental health in schools.
Sec. 609. Building an effective workforce in mental health.
Sec. 610. Mental health at the border.

TITLE VII—ADDRESSING HIGH IMPACT MINORITY DISEASES

Subtitle A—Cancer

Sec. 701. Lung cancer mortality reduction.
Sec. 702. Expanding prostate cancer research, outreach, screening, testing, access, and treatment effectiveness.
Sec. 703. Prostate research, imaging, and men's education (PRIME).
Sec. 704. Prostate cancer detection research and education.
Sec. 705. National prostate cancer council.
Sec. 706. Improved Medicaid coverage for certain breast and cervical cancer patients in the territories.
Sec. 707. Cancer prevention and treatment demonstration for ethnic and racial minorities.
Sec. 708. Reducing cancer disparities within Medicare.
Sec. 709. Cancer clinical trials.

Subtitle B—Viral Hepatitis and Liver Cancer Control and Prevention

Sec. 711. Viral hepatitis and liver cancer control and prevention.

Subtitle C—Acquired Bone Marrow Failure Diseases

Sec. 721. Acquired bone marrow failure diseases.

Subtitle D—Cardiovascular Disease, Chronic Disease, Obesity, and Other Disease Issues

Sec. 731. Guidelines for disease screening for minority patients.
Sec. 732. CDC Wisewoman Screening Program.
Sec. 733. Report on cardiovascular care for women and minorities.
Sec. 734. Coverage of comprehensive tobacco cessation services in Medicaid and private health insurance.
Sec. 735. Clinical research funding for oral health.
Sec. 736. Participation by Medicaid beneficiaries in approved clinical trials.
Sec. 737. Guide on evidence-based strategies for public health department obesity prevention programs.

Subtitle E—HIV/AIDS

Sec. 741. Statement of policy.
Sec. 742. Findings.
Sec. 743. Additional funding for AIDS drug assistance program treatments.
Sec. 744. Enhancing the national HIV surveillance system.
Sec. 745. Evidence-based strategies for improving linkage to and retention in appropriate care.
Sec. 746. Improving entry into and retention in care and antiretroviral adherence for persons with HIV.
Sec. 747. Services to reduce HIV/AIDS in racial and ethnic minority communities.
Sec. 748. Minority AIDS initiative.
Sec. 749. Health care professionals treating individuals with HIV.
Sec. 750. HIV/AIDS provider loan repayment program.
Sec. 751. Dental education loan repayment program.
Sec. 752. Reducing new HIV infections among injecting drug users.
Sec. 753. Report on impact of HIV/AIDS in vulnerable populations.
Sec. 754. National HIV/AIDS observance days.
Sec. 755. Review of all Federal and State laws, policies, and regulations regarding the criminal prosecution of individuals for HIV-related offenses.
Sec. 756. Expanding support for condoms in prisons.
Sec. 757. Automatic reinstatement or enrollment in Medicaid for people who test positive for HIV before reentering communities.
Sec. 758. Stop HIV in prison.
Sec. 759. Support data system review and indicators for monitoring HIV care.
Sec. 760. Transfer of funds for implementation of ending the HIV epidemic: a plan for America.

Subtitle F—Diabetes

Sec. 771. Research, treatment, and education.
Sec. 772. Research, education, and other activities.
Sec. 773. Research, education, and other activities.
Sec. 774. Research, education, and other activities.

Sec. 775. Updated report on health disparities.

Subtitle G—Lung Disease

Sec. 776. Expansion of the National Asthma Education and Prevention Program.
Sec. 777. Asthma-related activities of the Centers for Disease Control and Prevention.
Sec. 778. Influenza and pneumonia vaccination campaign.
Sec. 779. Chronic obstructive pulmonary disease action plan.

Subtitle H—Tuberculosis

Sec. 781. Elimination of all forms of tuberculosis.
Sec. 782. Additional funding for States in combating and eliminating tuberculosis.
Sec. 783. Strengthening clinical research funding for tuberculosis.

Subtitle I—Osteoarthritis and Musculoskeletal Diseases

Sec. 785. Findings.
Sec. 786. Osteoarthritis and other musculoskeletal health-related activities of the Centers for Disease Control and Prevention.
Sec. 787. Grants for comprehensive osteoarthritis and musculoskeletal disease health education within health professions schools.

Subtitle J—Sleep and Circadian Rhythm Disorders

Sec. 791. Short title; findings.
Sec. 792. Sleep and circadian rhythm disorders research activities of the National Institutes of Health.
Sec. 793. Sleep and circadian rhythm health disparities-related activities of the Centers for Disease Control and Prevention.
Sec. 794. Grants for comprehensive sleep and circadian health education within health professions schools.
Sec. 795. Report on impact of sleep and circadian health disorders in vulnerable and racial/ethnic populations.

Subtitle K—Kidney Disease Research, Surveillance, Prevention, and Treatment

Sec. 797. Kidney disease, research, surveillance, prevention, and treatment.
Sec. 798. Kidney disease research in minority populations.
Sec. 799. Kidney disease action plan.
Sec. 799A. Home dialysis and increasing end-stage renal disease treatment modalities in minority communities action plan.
Sec. 799B. Increasing kidney transplants in minority communities.
Sec. 799C. Environmental and occupational health programs.
Sec. 799D. Understanding the treatment patterns associated with providing care and treatment of kidney failure in minority populations.
Sec. 799E. Improving access in underserved areas.

TITLE VIII—HEALTH INFORMATION TECHNOLOGY

Sec. 800. Definitions.

Subtitle A—Reducing Health Disparities Through Health IT

Sec. 801. HRSA assistance to health centers for promotion of Health IT.
Sec. 802. Assessment of impact of Health IT on racial and ethnic minority communities; outreach and adoption of Health IT in such communities.
Sec. 803. Nondiscrimination and health equity in health information technology.
Sec. 804. Language access in health information technology.

Subtitle B—Modifications To Achieve Parity in Existing Programs

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

Subtitle C—Additional Research and Studies

Sec. 821. Data collection and assessments conducted in coordination with minority-serving institutions.
Sec. 822. Study of health information technology in medically underserved communities.
Sec. 823. Assessment of use and misuse of de-identified health data.

Subtitle D— Closing Gaps in Funding To Adopt Certified EHRs

Sec. 831. Extending Medicaid EHR incentive payments to rehabilitation facilities, long-term care facilities, and home health agencies.
Sec. 832. Extending physician assistant eligibility for Medicaid electronic health record incentive payments.

TITLE IX—ACCOUNTABILITY AND EVALUATION

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

TITLE X—ADDRESSING SOCIAL DETERMINANTS AND IMPROVING ENVIRONMENTAL JUSTICE

Subtitle A—In General

Sec. 1001. Definitions.
Sec. 1002. Findings.
Sec. 1003. Health impact assessments.

Sec. 1004. Implementation of recommendations by Environmental Protection Agency.
Sec. 1005. Grant program to conduct environmental health improvement activities and to improve social determinants of health.
Sec. 1006. Additional research on the relationship between the built environment and the health of community residents.
Sec. 1007. Environment and public health restoration.
Sec. 1008. GAO report on health effects of Deepwater Horizon oil rig explosion in the Gulf Coast.
Sec. 1009. Establish an interagency counsel and grant programs on social determinants of health.
Sec. 1010. Correcting hurtful and alienating names in government expression (CHANGE).

Subtitle B—Gun Violence

Sec. 1011. Findings.
Sec. 1012. Reaffirming research authority of the Centers for Disease Control and Prevention.
Sec. 1013. National violent death reporting system.
Sec. 1014. Report on effects of gun violence on public health.
Sec. 1015. Report on effects of gun violence on mental health in minority communities.

**SEC. 3. FINDINGS.**

The Congress finds as follows:

(1) The population of racial and ethnic minorities is expected to increase over the next few decades, yet racial and ethnic minorities have the poorest health status and face substantial cultural, social, and economic barriers to obtaining quality health care.

(2) Health disparities are a function of not only access to health care, but also the social determinants of health—including the environment, the physical structure of communities, nutrition and food options, educational attainment, employment, race, ethnicity, sex, geography, language preference, immigrant or citizenship status, sexual orientation,

gender identity, socioeconomic status, or disability status—that directly and indirectly affect the health, health care, and wellness of individuals and communities.

(3) Over the next few decades, the United States will face a shortage of health care providers and allied health workers.

(4) All efforts to reduce health disparities and barriers to quality health services require better and more consistent data, and better and more consistent collection of and access to data, and better and more consistent collection of and access to data.

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

(6) Racial and ethnic minorities and underserved populations must be included early and equitably in health reform innovations.

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

(8) In 2011, the Department of Health and Human Services developed the HHS Action Plan to Reduce Racial and Ethnic Health Disparities and the National Stakeholder Strategy for Achieving Health Equity, which are 2 strategic plans that represent the first coordinated roadmap in the United States to reducing health disparities. These comprehensive plans, along with the National Prevention Strategy issued by the National Prevention Council of the Department of Health and Human Services, Healthy People 2030, and the National Quality Strategy of the Agency for Healthcare Research and Quality, as well as critical resources such as the 2012 National Healthcare Quality and Disparities Reports, will work to increase the number of people in the United States who are healthy at every stage of life.

(9) The Secretary of Health and Human Services has also reviewed and advanced updated clinical guidelines and developed other strategic planning documents to combat health disparities with a high impact on minority populations and to provide high-quality family planning services. Such guidelines and documents include the National HIV/AIDS Strategy, the Action Plan for the Prevention, Care, and Treat-

ment of Viral Hepatitis, and recommendations of the Centers for Disease Control and Prevention and the Office of Population Affairs.

(10) The Patient Protection and Affordable Care Act (Public Law 111–148), as amended by the Health Care and Education Reconciliation Act (Public Law 111–152), represents the biggest advancement for minority health in the 40 years immediately preceding the enactment of this Act.

(11) The Health Information Technology for Educational and Clinical Health Act of 2009, part of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), provides that the nationwide health information exchange infrastructure be developed and used to reduce health disparities, among other purposes.

# TITLE I—DATA COLLECTION AND REPORTING

## SEC. 101. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

(a) PURPOSE.—It is the purpose of the amendment made by this section to promote data collection, analysis, and reporting by race, ethnicity, sex, primary language, sexual orientation, disability status, gender identity, age,

and socioeconomic status among federally supported health programs.

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

# "Subtitle C—Strengthening Data Collection, Improving Data Analysis, and Expanding Data Reporting

**"SEC. 3431. HEALTH DISPARITY DATA.**

''(a) REQUIREMENTS.—

''(1) IN GENERAL.—Each health-related program shall—

''(A) require the collection, by the agency or program involved, of data on the race, ethnicity, sex, primary language, sexual orientation, disability status, gender identity, age, and socioeconomic status of each applicant for and recipient of health-related assistance under such program, including—

''(i) using, at a minimum, standards for data collection on race, ethnicity, sex, primary language, sexual orientation, gender identity, age, socioeconomic status, and

disability status as each are developed under section 3101;

''(ii) collecting data for additional population groups if such groups can be aggregated into the race and ethnicity categories outlined by standards developed under section 3101;

''(iii) using, where practicable, the standards developed by the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (formerly known as the 'Institute of Medicine') in the 2009 publication, entitled 'Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement'; and

''(iv) where practicable, collecting such data through self-reporting;

''(B) with respect to the collection of the data described in subparagraph (A), for applicants and recipients who are minors, require communication assistance in speech or writing, and for applicants and recipients who are otherwise legally incapacitated, require that—

"(i) such data be collected from the parent or legal guardian of such an applicant or recipient; and

"(ii) the primary language of the parent or legal guardian of such an applicant or recipient be collected;

"(C) systematically analyze such data using the smallest appropriate units of analysis feasible to detect racial and ethnic disparities, as well as disparities along the lines of primary language, sex, disability status, sexual orientation, gender identity, age, and socioeconomic status in health and health care, and report the results of such analysis to the Secretary, the Director of the Office for Civil Rights, each agency listed in section 3101(c)(1), the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives;

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

"(E) ensure that the provision of assistance to an applicant or recipient of assistance

is not denied or otherwise adversely affected because of the failure of the applicant or recipient to provide race, ethnicity, primary language, sex, sexual orientation, disability status, gender identity, age, and socioeconomic status data.

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

''(A) permit the use of information collected under this subsection in a manner that would adversely affect any individual providing any such information; or

''(B) diminish any requirements, including such requirements in effect on or after the date of enactment of this section, on health care providers to collect data.

''(3) NO COMPELLED DISCLOSURE OF DATA.—This title does not authorize any health care provider, Federal official, or other entity to compel the disclosure of any data collected under this title. The disclosure of any such data by an individual pursuant to this title shall be strictly voluntary.

''(b) PROTECTION OF DATA.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant to subsection (a) are protected—

''(1) under the same privacy protections as the Secretary applies to other health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 relating to the privacy of individually identifiable health information and other protections; and

''(2) from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary.

''(c) NATIONAL PLAN OF THE DATA COUNCIL.—The Secretary shall develop and implement a national plan to ensure the collection of data in a culturally and linguistically appropriate manner, to improve the collection, analysis, and reporting of racial, ethnic, sex, primary language, sexual orientation, disability status, gender identity, age, and socioeconomic status data at the Federal, State, territorial, Tribal, and local levels, including data to be collected under subsection (a), and to ensure that data collection activities carried out under this section are in compliance with standards developed under section 3101. The Data Council of the Department of Health and Human Services, in consultation with the National Com-

mittee on Vital Health Statistics, the Office of Minority Health, Office on Women's Health, and other appropriate public and private entities, shall make recommendations to the Secretary concerning the development, implementation, and revision of the national plan. Such plan shall include recommendations on how to—

''(1) implement subsection (a) while minimizing the cost and administrative burdens of data collection and reporting;

''(2) expand knowledge among Federal agencies, States, territories, Indian Tribes, counties, municipalities, health providers, health plans, and the general public that data collection, analysis, and reporting by race, ethnicity, sex, primary language, sexual orientation, gender identity, age, socioeconomic status, and disability status is legal and necessary to assure equity and nondiscrimination in the quality of health care services;

''(3) ensure that future patient record systems follow Federal standards promulgated under the Health Information Technology for Economic and Clinical Health Act for the collection and meaningful use of electronic health data on race, ethnicity, sex, primary language, sexual orientation, gender identity, age, socioeconomic status, and disability status;

''(4) improve health and health care data collection and analysis for more population groups if such groups can be aggregated into the minimum race and ethnicity categories, including exploring the feasibility of enhancing collection efforts in States, counties, and municipalities for racial and ethnic groups that comprise a significant proportion of the population of the State, county, or municipality;

''(5) provide researchers with greater access to racial, ethnic, primary language, sex, sexual orientation, gender identity, age, socioeconomic status data, and disability status data, subject to all applicable privacy and confidentiality requirements, including HIPAA privacy and security law as defined in section 3009; and

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

''(d) COMPLIANCE WITH STANDARDS.—Data collected under subsection (a) shall be obtained, maintained, and presented (including for reporting purposes) in accordance with standards developed under section 3101.

''(e) ANALYSIS OF HEALTH DISPARITY DATA.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and in coordination with the Assistant Secretary for Planning and Evaluation, the

Administrator of the Centers for Medicare & Medicaid Services, the Director of the National Center for Health Statistics, and the Director of the National Institutes of Health, shall provide technical assistance to agencies of the Department of Health and Human Services in meeting Federal standards for health disparity data collection and for analysis of racial, ethnic, and other disparities in health and health care in programs conducted or supported by such agencies by—

''(1) identifying appropriate quality assurance mechanisms to monitor for health disparities;

''(2) specifying the clinical, diagnostic, or therapeutic measures which should be monitored;

''(3) developing new quality measures relating to racial and ethnic disparities and their overlap with other disparity factors in health and health care;

''(4) identifying the level at which data analysis should be conducted; and

''(5) sharing data with external organizations for research and quality improvement purposes.

''(f) DEFINITIONS.—In this section—

''(1) the term 'health-related program' means a program that is operated by the Secretary, or that receives funding or reimbursement, in whole or in

part, either directly or indirectly from the Secretary—

''(A) for activities under the Social Security Act for health care services; or

''(B) for providing federal financial assistance for health care, biomedical research, or health services research or for otherwise improving the health of the public;

''(2) the term 'primary language data' includes spoken and written primary language data; and

''(3) the term 'primary language data collection activities' includes identifying, collecting, storing, tracking, and analyzing primary language data and information on the methods used to meet the language access needs of individuals with limited-English proficiency.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

**''SEC. 3432. ESTABLISHING GRANTS FOR DATA COLLECTION IMPROVEMENT ACTIVITIES.**

''(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and in consultation with the Deputy Assistant

Secretary for Minority Health, the Director of the National Institutes of Health, the Assistant Secretary for Planning and Evaluation, and the Director of the National Center for Health Statistics, shall establish a technical assistance program under which the Secretary provides grants to eligible entities to assist such entities in complying with section 3431.

''(b) TYPES OF ASSISTANCE.—A grant provided under this section may be used to—

''(1) enhance or upgrade computer technology that will facilitate collection, analysis, and reporting of racial, ethnic, primary language, sexual orientation, sex, gender identity, socioeconomic status, and disability status data;

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

''(3) develop mechanisms for submitting collected data subject to any applicable privacy and confidentiality regulations; and

''(4) develop educational programs to inform health plans, health providers, health-related agencies, and the general public that data collection and

reporting by race, ethnicity, primary language, sexual orientation, sex, gender identity, disability status, and socioeconomic status are legal and essential for eliminating health and health care disparities.

''(c) ELIGIBLE ENTITY.—To be eligible for grants under this section, an entity shall be a State, territory, Indian Tribe, municipality, county, health provider, health care organization, or health plan making a demonstrated effort to bring data collections into compliance with section 3431.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

**''SEC. 3433. OVERSAMPLING OF UNDERREPRESENTED GROUPS IN FEDERAL HEALTH SURVEYS.**

''(a) NATIONAL STRATEGY.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the National Center for Health Statistics of the Centers for Disease Control and Prevention, and other agencies within the Department of Health and Human Services as the Secretary determines appropriate, shall develop and implement an ongoing and sustainable national strategy for oversampling underrepresented populations

within the categories of race, ethnicity, sex, primary language, sexual orientation, disability status, gender identity, and socioeconomic status as determined appropriate by the Secretary in Federal health surveys and program data collections. Such national strategy shall include a strategy for oversampling of Asian Americans, Native Hawaiians, and Pacific Islanders.

''(2) CONSULTATION.—In developing and implementing a national strategy, as described in paragraph (1), not later than 180 days after the date of the enactment of this section, the Secretary shall—

''(A) consult with representatives of community groups, nonprofit organizations, nongovernmental organizations, and government agencies working with underrepresented populations;

''(B) solicit the participation of representatives from other Federal departments and agencies, including subagencies of the Department of Health and Human Services; and

''(C) consult on, and use as models, the 2014 National Health Interview Survey oversample of Native Hawaiian and Pacific Islander populations and the 2017 Behavioral Risk Fac-

tor Surveillance System oversample of American Indian and Alaska Native communities.

''(b) PROGRESS REPORT.—Not later than 2 years after the date of the enactment of this section, the Secretary shall submit to the Congress a progress report, which shall include the national strategy described in subsection (a)(1).

''(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2021 through 2025.''.

**SEC. 102. ELIMINATION OF PREREQUISITE OF DIRECT APPROPRIATIONS FOR DATA COLLECTION AND ANALYSIS.**

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

(1) by striking subsection (h); and

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

**SEC. 103. COLLECTION OF DATA FOR THE MEDICARE PROGRAM.**

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

''COLLECTION OF DATA FOR THE MEDICARE PROGRAM

''SEC. 1150C.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—The Commissioner of Social Security, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall collect data on the race, ethnicity, sex, primary language, sexual orientation, gender identity, socioeconomic status, and disability status of all applicants for Social Security benefits under title II or Medicare benefits under title XVIII.

''(2) DATA COLLECTION STANDARDS.—In collecting data under paragraph (1), the Commissioner of Social Security shall at least use the standards for data collection developed under section 3101 of the Public Health Service Act or the standards developed by the Office of Management and Budget, whichever is more disaggregated. In the event there are no standards for the demographic groups listed under paragraph (1), the Commissioner shall consult with stakeholder groups representing the various identities as well as with the Office of Minority Health within the Centers for Medicare & Medicaid Services to develop appropriate standards.

''(3) DATA FOR ADDITIONAL POPULATION GROUPS.—Where practicable, the information collected by the Commissioner of Social Security under

paragraph (1) shall include data for additional population groups if such groups can be aggregated into the race and ethnicity categories outlined by the data collection standards described in paragraph (2).

''(4) COLLECTION OF DATA FOR MINORS AND LEGALLY INCAPACITATED INDIVIDUALS.—With respect to the collection of the data described in paragraph (1) of applicants who are under 18 years of age or otherwise legally incapacitated, the Commissioner of Social Security shall require that—

''(A) such data be collected from the parent or legal guardian of such an applicant; and

''(B) the primary language of the parent or legal guardian of such an applicant or recipient be used in collecting the data.

''(5) QUALITY OF DATA.—The Commissioner of Social Security shall periodically review the quality and completeness of the data collected under paragraph (1) and make adjustments as necessary to improve both.

''(6) TRANSMISSION OF DATA.—Upon enrollment in Medicare benefits under title XVIII, the Commissioner of Social Security shall transmit an individual's demographic data as collected under

paragraph (1) to the Centers for Medicare and Medicaid Services.

''(7) ANALYSIS AND REPORTING OF DATA.—With respect to data transmitted under paragraph (5), the Administrator of the Centers for Medicare and Medicaid Services, in consultation with the Commissioner of Social Security shall—

''(A) require that such data be uniformly analyzed and that such analysis be reported at least annually to Congress;

''(B) incorporate such data in other analysis and reporting on health disparities as appropriate;

''(C) make such data available to researchers, under the protections outlined in paragraph (7);

''(D) provide opportunities to individuals enrolled in Medicare to submit updated data; and

''(E) ensure that the provision of assistance or benefits to an applicant is not denied or otherwise adversely affected because of the failure of the applicant to provide any of the data collected under paragraph (1).

''(8) PROTECTION OF DATA.—The Commissioner of Social Security shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant to subsection (a) is protected—

''(A) under the same privacy protections as the Secretary applies to health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (relating to the privacy of individually identifiable health information and other protections); and

''(B) from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary.

''(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit the use of information collected under this section in a manner that would adversely affect any individual providing any such information.

''(c) TECHNICAL ASSISTANCE.—The Secretary may, either directly or by grant or contract, provide technical

assistance to enable any entity to comply with the requirements of this section or with regulations implementing this section.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $500 million for 2020 and $100 million for each fiscal year thereafter.''.

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

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

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

(2) in consultation with the Office of the National Coordinator for Health Information Technology, the designation of the appropriate racial,

ethnic, primary language, disability, sex, and other code sets as required for claims and enrollment data.

(b) DISSEMINATION.—The Secretary of Health and Human Services shall disseminate the new standards developed under subsection (a) to all entities that are subject to the regulations described in such subsection and provide technical assistance with respect to the collection of the data involved.

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

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

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

(1) in paragraph (1), by striking ''2003'' and inserting ''2022'';

(2) in paragraph (2), in the first sentence, by striking ''2003'' and inserting ''2022''; and

(3) in paragraph (3), by striking ''2002'' and inserting ''2022''.

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

(a) REPOSITORY OF GOVERNMENT DATA.—The Secretary of Health and Human Services, in coordination with the departments, agencies, or offices described in subsection (b), shall establish a centralized electronic repository of Government data on factors related to the health and well-being of the population of the United States.

(b) COLLECTION; SUBMISSION.—Not later than 180 days after the date of the enactment of this Act, and January 31 of each year thereafter, each department, agency, and office of the Federal Government that has collected data on race, ethnicity, sex, primary language, sexual orientation, disability status, gender identity, age, or socioeconomic status during the preceding calendar year shall submit such data to the repository of Government data established under subsection (a).

(c) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—Not later than April 30, 2021, and April 30 of each year thereafter, the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation, the Assistant Secretary for Health, the Director of the Agency for Healthcare Research and Quality, the Director of the National Center for Health Statistics, the Administrator of the Centers for Medicare & Medicaid

Services, the Director of the National Institute on Minority Health and Health Disparities, and the Deputy Assistant Secretary for Minority Health, shall—

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

(2) ensure that these datasets are publicly identified on the repository established under subsection (a) as ''disparities'' data; and

(3) submit a report to the Congress on the availability and use of such data by public stakeholders.

**SEC. 107. DATA COLLECTION AND ANALYSIS GRANTS TO MINORITY-SERVING INSTITUTIONS.**

(a) AUTHORITY.—The Secretary of Health and Human Services, acting through the Director of the National Institute on Minority Health and Health Disparities and the Deputy Assistant Secretary for Minority Health, shall award grants to eligible entities to access and analyze racial and ethnic data on disparities in health and health care, and where possible other data on disparities in health

and health care, to monitor and report on progress to reduce and eliminate disparities in health and health care.

(b) ELIGIBLE ENTITY.—In this section, the term ''eligible entity'' means an entity that has an accredited public health, health policy, or health services research program and is any of the following:

(1) A part B institution, as defined in section 322 of the Higher Education Act of 1965 (20 U.S.C. 1061).

(2) A Hispanic-serving institution, as defined in section 502 of such Act (20 U.S.C. 1101a).

(3) A Tribal College or University, as defined in section 316 of such Act (20 U.S.C. 1059c).

(4) An Asian American and Native American Pacific Islander-serving institution, as defined in section 371(c) of such Act (20 U.S.C. 1067q(c)).

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2021 through 2025.

**SEC. 108. STANDARDS FOR MEASURING SEXUAL ORIENTATION, GENDER IDENTITY, AND SOCIOECONOMIC STATUS IN COLLECTION OF HEALTH DATA.**

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

(1) in paragraph (1)(A), by inserting ''sexual orientation, gender identity, socioeconomic status,'' before ''and disability status'';

(2) in paragraph (1)(C), by inserting ''sexual orientation, gender identity, socioeconomic status,'' before ''and disability status''; and

(3) in paragraph (2)(B), by inserting ''sexual orientation, gender identity, socioeconomic status,'' before ''and disability status''.

**SEC. 109. SAFETY AND EFFECTIVENESS OF DRUGS WITH RESPECT TO RACIAL AND ETHNIC BACKGROUND.**

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

**''SEC. 505G. SAFETY AND EFFECTIVENESS OF DRUGS WITH RESPECT TO RACIAL AND ETHNIC BACKGROUND.**

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

ethnic background as to the safety or effectiveness of a drug or biological product, then—

''(1)(A) in the case of a drug, the investigations required under section 505(b)(1)(A) shall include adequate and well-controlled investigations of the disparity; or

''(B) in the case of a biological product, the evidence required under section 351(a) of the Public Health Service Act for approval of a biologics license application for the biological product shall include adequate and well-controlled investigations of the disparity; and

''(2) if the investigations described in subparagraph (A) or (B) of paragraph (1) confirm that there is such a disparity, the labeling of the drug or biological product shall include appropriate information about the disparity.

''(b) POSTMARKET STUDIES.—

''(1) IN GENERAL.—If there is evidence that there may be a disparity on the basis of racial or ethnic background as to the safety or effectiveness of a drug for which there is an approved application under section 505 of this Act or of a biological product for which there is an approved license under section 351 of the Public Health Service Act, the Sec-

retary may by order require the holder of the approved application or license to conduct, by a date specified by the Secretary, postmarket studies to investigate the disparity.

''(2) LABELING.—If the Secretary determines that the postmarket studies confirm that there is a disparity described in paragraph (1), the labeling of the drug or biological product shall include appropriate information about the disparity.

''(3) STUDY DESIGN.—The Secretary may, in an order under paragraph (1), specify all aspects of the design of the postmarket studies required under such paragraph for a drug or biological product, including the number of studies and study participants, and the other demographic characteristics of the study participants.

''(4) MODIFICATIONS OF STUDY DESIGN.—The Secretary may, by order and as necessary, modify any aspect of the design of a postmarket study required in an order under paragraph (1) after issuing such order.

''(5) STUDY RESULTS.—The results from a study required under paragraph (1) shall be submitted to the Secretary as a supplement to the drug application or biologics license application.

''(c) APPLICATIONS UNDER SECTION 505(j).—

''(1) IN GENERAL.—A drug for which an application has been submitted or approved under section 505(j) shall not be considered ineligible for approval under that section or misbranded under section 502 on the basis that the labeling of the drug omits information relating to a disparity on the basis of racial or ethnic background as to the safety or effectiveness of the drug, whether derived from investigations or studies required under this section or derived from other sources, when the omitted information is protected by patent or by exclusivity under section 505(j)(5)(F).

''(2) LABELING.—Notwithstanding paragraph (1), the Secretary may require that the labeling of a drug approved under section 505(j) that omits information relating to a disparity on the basis of racial or ethnic background as to the safety or effectiveness of the drug include a statement of any appropriate contraindications, warnings, or precautions related to the disparity that the Secretary considers necessary.

''(d) DEFINITION.—The term 'evidence that there may be a disparity on the basis of racial or ethnic back-

ground as to the safety or effectiveness', with respect to a drug or biological product, includes—

''(1) evidence that there is a disparity on the basis of racial or ethnic background as to safety or effectiveness of a drug or biological product in the same chemical class as the drug or biological product;

''(2) evidence that there is a disparity on the basis of racial or ethnic background in the way the drug or biological product is metabolized; and

''(3) other evidence as the Secretary may determine appropriate.''.

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

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

(c) DRUG FEES.—Section 736(a)(1)(A)(ii) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379h(a)(1)(A)(ii)) is amended by inserting after ''are not required'' the following: '', including postmarket studies required under section 505G''.

**SEC. 110. IMPROVING HEALTH DATA REGARDING NATIVE HAWAIIANS AND OTHER PACIFIC ISLANDERS.**

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 317U the following:

**"SEC. 317V. NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER HEALTH DATA.**

''(a) DEFINITIONS.—In this section:

''(1) COMMUNITY GROUP.—The term 'community group' means a group of NHOPI who are organized at the community level, and may include a church group, social service group, national advocacy organization, or cultural group.

''(2) NONPROFIT, NONGOVERNMENTAL ORGANIZATION.—The term 'nonprofit, nongovernmental organization' means a group of NHOPI with a demonstrated history of addressing NHOPI issues, including a NHOPI coalition.

''(3) DESIGNATED ORGANIZATION.—The term 'designated organization' means an entity established to represent NHOPI populations and which has statutory responsibilities to provide, or has community support for providing, health care.

''(4) GOVERNMENT REPRESENTATIVES OF NHOPI POPULATIONS.—The term 'government representatives of NHOPI populations' means rep-

resentatives from Hawaii, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, the Republic of Palau, and the Republic of the Marshall Islands.

''(5) NATIVE HAWAIIANS AND OTHER PACIFIC ISLANDERS (NHOPI).—The term 'Native Hawaiians and Other Pacific Islanders' or 'NHOPI' means people having origins in any of the original peoples of American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, Hawaii, the Republic of the Marshall Islands, the Republic of Palau, or any other Pacific Island.

''(6) INSULAR AREA.—The term 'insular area' means Guam, the Commonwealth of Northern Mariana Islands, American Samoa, the United States Virgin Islands, the Federated States of Micronesia, the Republic of Palau, or the Republic of the Marshall Islands.

''(b) NATIONAL STRATEGY.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the National Center for Health Statistics (referred to in this section as 'NCHS') of the Centers for Disease Control and

Prevention, and other agencies within the Department of Health and Human Services as the Secretary determines appropriate, shall develop and implement an ongoing and sustainable national strategy for identifying and evaluating the health status and health care needs of NHOPI populations living in the continental United States, Hawaii, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, the Republic of Palau, and the Republic of the Marshall Islands.

''(2) CONSULTATION.—In developing and implementing a national strategy, as described in paragraph (1), not later than 180 days after the date of enactment of the Health Equity and Accountability Act of 2020, the Secretary—

''(A) shall consult with representatives of community groups, designated organizations, and nonprofit, nongovernmental organizations and with government representatives of NHOPI populations; and

''(B) may solicit the participation of representatives from other Federal departments.

''(c) PRELIMINARY HEALTH SURVEY.—

''(1) IN GENERAL.—The Secretary, acting through the Director of NCHS, shall conduct a preliminary health survey in order to identify the major areas and regions in the continental United States, Hawaii, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, the Republic of Palau, and the Republic of the Marshall Islands in which NHOPI people reside.

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

''(A) useful in determining health status and health care needs; or

''(B) required for developing or implementing a national strategy.

''(3) METHODOLOGY.—Methodology for the health survey described in paragraph (1), including plans for designing questions, implementation, sampling, and analysis, shall be developed in consultation with community groups, designated organizations, nonprofit, nongovernmental organizations, and government representatives of NHOPI populations, as determined by the Secretary.

''(4) TIMEFRAME.—The survey required under this subsection shall be completed not later than 18 months after the date of enactment of the Health Equity and Accountability Act of 2020.

''(d) PROGRESS REPORT.—Not later than 2 years after the date of enactment of the Health Equity and Accountability Act of 2020, the Secretary shall submit to Congress a progress report, which shall include the national strategy described in subsection (b)(1).

''(e) STUDY AND REPORT BY THE HEALTH AND MEDICINE DIVISION.—

''(1) IN GENERAL.—The Secretary shall enter into an agreement with the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine to conduct a study, with input from stakeholders in insular areas, on each of the following:

''(A) The standards and definitions of health care applied to health care systems in insular areas and the appropriateness of such standards and definitions.

''(B) The status and performance of health care systems in insular areas, evaluated based upon standards and definitions, as the Secretary determines appropriate.

''(C) The effectiveness of donor aid in addressing health care needs and priorities in insular areas.

''(D) The progress toward implementation of recommendations of the Committee on Health Care Services in the United States—Associated Pacific Basin that are set forth in the 1998 report entitled 'Pacific Partnerships for Health: Charting a New Course'.

''(2) REPORT.—An agreement described in paragraph (1) shall require the Health and Medicine Division to submit to the Secretary and to Congress, not later than 2 years after the date of the enactment of the Health Equity and Accountability Act of 2020, a report containing a description of the results of the study conducted under paragraph (1), including the conclusions and recommendations of the Health and Medicine Division for each of the items described in subparagraphs (A) through (D) of such paragraph.

''(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2021 through 2025.''.

**SEC. 111. CLARIFICATION OF SIMPLIFIED ADMINISTRATIVE REPORTING REQUIREMENT.**

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

''(5) SIMPLIFIED ADMINISTRATIVE REPORTING REQUIREMENT.—With respect to any obligation of a State agency to comply with the notification requirement under paragraph (2) of section 421(e) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1631(e)), notwithstanding the requirement to include in that notification the names of the sponsor and the sponsored alien involved, the State agency shall be considered to have complied with the notification requirement if the State agency submits to the Attorney General a report that includes the aggregate number of exceptions granted by the State agency under paragraph (1) of that section.''.

# TITLE II—CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH AND HEALTH CARE

**SEC. 201. DEFINITIONS; FINDINGS.**

(a) DEFINITIONS.—In this title, the definitions in section 3400 of the Public Health Service Act, as added by section 204, shall apply.

(b) FINDINGS.—Congress finds the following:

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

(2) Research indicates that the lack of appropriate language services creates language barriers that result in increased risk of misdiagnosis, ineffective treatment plans, and poor health outcomes for individuals with limited-English proficiency and individuals with communication disabilities such as cognitive, hearing, vision, or print impairments.

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

(4) The responsibility to fund language services in the provision of health care and health-care-related services to individuals with limited-English proficiency and individuals with communication disabilities such as cognitive hearing, vision, or print impairments is a societal one that cannot fairly be placed solely upon the health care, public health, or social services community.

(5) Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) prohibits discrimination based on the grounds of race, color, or national origin by any entity receiving Federal financial assistance. In order to avoid discrimination on the grounds of national origin, all programs or activities administered by the Federal Government must take adequate steps to ensure that their policies and procedures do not deny or have the effect of denying individuals with limited-English proficiency with equal access to benefits and services for which such persons qualify.

(6) Both the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.) and the Rehabilitation Act of 1973 (29 U.S.C. 701 et seq.) prohibit discrimination on the basis of disability and require the provision of appropriate auxiliary aids and services necessary to ensure effective communication with individuals with disabilities. The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the method of communication used by the individual; the nature, length, and complexity of the communication involved; and the context in which the communication is taking place. A public accommodation should consult with individuals with disabilities whenever pos-

sible to determine what type of auxiliary aid is needed to ensure effective communication. The public accommodation should use the person's preferred method of communication whenever possible, unless it would be an undue burden to the public accommodation and an alternative would provide an equally effective means of communication. The ultimate decision as to what measures to take rests with the public accommodation, provided that the method chosen results in effective communication.

(7) Section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116) builds on Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) and the Rehabilitation Act of 1973 (29 U.S.C. 701 et seq.), prohibits discrimination on the basis of race, color, national origin, disability, sex, and age, requires the provision of language services to ensure effective communication with individuals with limited English proficiency, and requires the provision of appropriate auxiliary aids and services necessary to ensure effective communication with individuals with disabilities.

(8) Linguistic diversity in the health care and health-care-related services workforce is important

for providing all patients the environment most conducive to positive health outcomes.

(9) All members of the health care and health-care-related services community should continue to educate their staff and constituents about limited-English-proficient and disability communication issues and help them identify resources to improve access to quality care for individuals with limited-English proficiency and individuals with communication disabilities such as cognitive, hearing, vision, or print impairments.

(10) Access to English as a second language, foreign language, and sign language interpreters, translated and alternative format documents, readers, and other auxiliary aids and services, are essential to ensure effective communication and eliminate the language barriers that impede access to health care.

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

**SEC. 202. IMPROVING ACCESS TO SERVICES FOR INDIVIDUALS WITH LIMITED-ENGLISH PROFICIENCY.**

(a) PURPOSE.—Consistent with the goals provided in Executive Order 13166 (42 U.S.C. 2000d–1 note; relating

to improving access to services for persons with limited-English proficiency), it is the purpose of this section—

(1) to improve Federal agency performance regarding access to federally conducted and federally assisted programs and activities for individuals with limited-English proficiency;

(2) to require each Federal agency to examine the services it provides and develop and implement a system by which individuals with limited-English proficiency can obtain culturally competence services and meaningful access to those services consistent with, and without substantially burdening, the fundamental mission of the agency;

(3) to require each Federal agency to ensure that recipients of Federal financial assistance provide culturally competence services and meaningful access to applicants and beneficiaries that are individuals with limited-English proficiency;

(4) to ensure that recipients of Federal financial assistance take reasonable steps, consistent with the guidelines set forth in the ''Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (67 Fed. Reg. 41455 (June 18, 2002))'', to ensure cul-

turally and linguistically appropriate access to their programs and activities by individuals with limited-English proficiency; and

(5) to ensure compliance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) and section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116) as published in the Federal Register on May 18, 2016, that health care providers and organizations do not discriminate in the provision of services.

(b) FEDERALLY CONDUCTED PROGRAMS AND ACTIVITIES.—

(1) IN GENERAL.—Not later than 120 days after the date of enactment of this Act, each Federal agency providing financial assistance to, or administering, a health program or activity described in section 203(a) shall prepare a plan or update their current plan to improve culturally and linguistically appropriate access to such program or activity with respect to individuals with limited-English proficiency. Not later than 1 year after the date of enactment of this title, each such Federal agency shall ensure that such plan is fully implemented.

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

(A) the steps the agency will take to ensure that individuals with limited-English proficiency have access to each health program or activity supported or administered by the agency;

(B) the policies and procedures for identifying, assessing, and meeting the culturally and linguistically appropriate language needs of its beneficiaries that are individuals with limited-English proficiency served by such program or activity;

(C) the steps the agency will take for such program or activity to be culturally and linguistically appropriate by providing a range of language assistance options, notice to individuals with limited-English proficiency of the right to competent language services, periodic training of staff, monitoring and quality assessment of the language services and, in appropriate circumstances, the translation of written materials;

(D) the steps the agency will take for such program or activity to provide reasonable accommodations necessary for individuals with limited English proficiency and communication

disabilities to understand communications from the agency;

(E) the steps the agency will take to ensure that applications, forms, and other relevant documents for such program or activity are competently translated into the primary language of a client that is an individual with limited-English proficiency where such materials are needed to improve access of such client to such program or activity;

(F) the resources the agency will provide to improve cultural and linguistic appropriateness to assist recipients of Federal funds to improve access to health care related programs and activities for individuals with limited-English proficiency;

(G) the resources the agency will provide to ensure that competent language assistance is provided to patients that are individuals with limited-English proficiency by interpreters or trained bilingual staff; and

(H) the resources the agency will provide to ensure that family, particularly minor children, and friends are not used to provide interpretation services, except as permitted under

regulations implementing section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116) as published in the Federal Register on May 18, 2016.

(3) SUBMISSION OF PLAN TO DOJ.—Each agency that is required to prepare a plan under paragraph (1) shall send a copy of such plan to the Attorney General, which shall serve as the central repository of all such plans.

**SEC. 203. ENSURING STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE.**

(a) APPLICABILITY.—This section shall apply to any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or any program or activity that is administered by an executive agency or any entity established under title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18001 et seq.) (or amendments made thereby).

(b) STANDARDS.—Each program or activity described in subsection (a)—

(1) shall implement strategies to recruit, retain, and promote individuals at all levels to maintain a diverse staff and leadership that can provide cul-

turally and linguistically appropriate health care to patient populations of the service area of the program or activity;

(2) shall educate and train governance, leadership, and workforce at all levels and across all disciplines of the program or activity in culturally and linguistically appropriate policies and practices on an ongoing basis at least yearly;

(3) shall offer and provide language assistance, including trained and competent bilingual staff and interpreter services, to individuals with limited-English proficiency or who have other communication needs, at no cost to the individual at all points of contact, and during all hours of operation, to facilitate timely access to health care services and health-care-related services;

(4) shall for each language group consisting of individuals with limited-English proficiency that constitutes 5 percent or 500 individuals, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered in the service area of the program or activity, make available at a fifth grade reading level—

(A) easily understood patient-related materials, including print and multimedia materials, in the language of such language group;

(B) information or notices about termination of benefits in such language;

(C) signage; and

(D) any other documents or types of documents designated by the Secretary;

(5) shall develop and implement clear goals, policies, operational plans, and management, accountability, and oversight mechanisms to provide culturally and linguistically appropriate services and infuse them throughout the planning and operations of the program or activity;

(6) shall conduct initial and ongoing organizational assessments of culturally and linguistically appropriate services-related activities and integrate valid linguistic, competence-related National Standards for Culturally and Linguistically Appropriate Services (CLAS) measures into the internal audits, performance improvement programs, patient satisfaction assessments, continuous quality improvement activities, and outcomes-based evaluations of the program or activity and develop ways to standardize

the assessments, and such assessments must occur at least yearly;

(7) shall ensure that, consistent with the privacy protections provided for under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320–2 note), data on an individual required to be collected pursuant to section 3101, including the individual's alternative format preferences and policy modification needs, are—

(A) collected in health records;

(B) integrated into the management information systems of the program or activity; and

(C) periodically updated;

(8) shall maintain a current demographic, cultural, and epidemiological profile of the community, conduct regular assessments of community health assets and needs, and use the results of such assessments to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area of the program or activity;

(9) shall develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient involvement in designing,

implementing, and evaluating policies and practices to ensure culturally and linguistically appropriate service-related activities;

(10) shall ensure that conflict and grievance resolution processes are culturally and linguistically appropriate and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients;

(11) shall regularly make available to the public information about their progress and successful innovations in implementing the standards under this section and provide public notice in their communities about the availability of this information; and

(12) shall, if requested, regularly make available to the head of each Federal entity from which Federal funds are provided, information about the progress and successful innovations of the program or activity in implementing the standards under this section as required by the head of such entity.

(c) COMMENTS ACCEPTED THROUGH NOTICE AND COMMENT RULEMAKING.—An agency carrying out a program described in subsection (a) shall ensure that comments with respect to such program that are accepted through notice and comment rulemaking be accepted in all languages, may not require such comments to be sub-

mitted only in English, and must ensure these comments are considered equally as comments submitted in English during the agency's review of comments submitted.

**SEC. 204. CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE IN THE PUBLIC HEALTH SERVICE ACT.**

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

# "TITLE XXXIV—CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE

**"SEC. 3400. DEFINITIONS.**

''(a) IN GENERAL.—In this title:

''(1) BILINGUAL.—The term 'bilingual', with respect to an individual, means a person who has sufficient degree of proficiency in 2 languages.

''(2) CULTURAL.—The term 'cultural' means relating to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups, including lesbian, gay, bisexual, transgender, queer, and questioning individuals, and individuals with physical and mental disabilities.

''(3) CULTURALLY AND LINGUISTICALLY APPROPRIATE.—The term 'culturally and linguistically appropriate' means being respectful of and responsive to the cultural and linguistic needs of all individuals.

''(4) EFFECTIVE COMMUNICATION.—The term 'effective communication' means an exchange of information between the provider of health care or health-care-related services and the recipient of such services who is limited in English proficiency, or has a communication impairment such as a hearing, vision, speaking, or learning impairment, that enables access to, understanding of, and benefit from health care or health-care-related services, and full participation in the development of their treatment plan.

''(5) GRIEVANCE RESOLUTION PROCESS.—The term 'grievance resolution process' means all aspects of dispute resolution including filing complaints, grievance and appeal procedures, and court action.

''(6) HEALTH CARE GROUP.—The term 'health care group' means a group of physicians organized, at least in part, for the purposes of providing physician services under the Medicaid program under title XIX of the Social Security Act, the State Children's Health Insurance Program under title XXI of such

Act, or the Medicare program under title XVIII of such Act and may include a hospital and any other individual or entity furnishing services covered under any such program that is affiliated with the health care group.

''(7) HEALTH CARE SERVICES.—The term 'health care services' means services that address physical as well as mental health conditions in all care settings.

''(8) HEALTH-CARE-RELATED SERVICES.—The term 'health-care-related services' means human or social services programs or activities that provide access, referrals, or links to health care.

''(9) HEALTH EDUCATOR.—The term 'health educator' includes a professional with a baccalaureate degree who is responsible for designing, implementing, and evaluating individual and population health promotion and chronic disease prevention programs.

''(10) INDIAN; INDIAN TRIBE.—The terms 'Indian' and 'Indian Tribe' have the meanings given such terms in section 4 of the Indian Self-Determination and Education Assistance Act.

''(11) INDIVIDUAL WITH A DISABILITY.—The term 'individual with a disability' means any indi-

vidual who has a disability as defined for the purpose of section 504 of the Rehabilitation Act of 1973.

''(12) INDIVIDUAL WITH LIMITED-ENGLISH PROFICIENCY.—The term 'individual with limited-English proficiency' means an individual whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.

''(13) INTEGRATED HEALTH CARE DELIVERY SYSTEM.—The term 'integrated health care delivery system' means an interdisciplinary system that brings together providers from the primary health, mental health, substance use disorder, and related disciplines to improve the health outcomes of an individual. Such providers may include hospitals, health, mental health, or substance use disorder clinics and providers, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation centers, and employed, independent, or contracted physicians.

''(14) INTERPRETING; INTERPRETATION.—The terms 'interpreting' and 'interpretation' mean the transmission of a spoken, written, or signed message

from one language or format into another, faithfully, accurately, and objectively.

''(15) LANGUAGE ACCESS.—The term 'language access' means the provision of language services to an individual with limited-English proficiency or an individual with communication disabilities designed to enhance that individual's access to, understanding of, or benefit from health care services or health-care-related services.

''(16) LANGUAGE ASSISTANCE SERVICES.—The term 'language assistance services' includes—

''(A) oral language assistance, including interpretation in non-English languages provided in-person or remotely by a qualified interpreter for an individual with limited-English proficiency, and the use of qualified bilingual or multilingual staff to communicate directly with individuals with limited-English proficiency;

''(B) written translation, performed by a qualified and competent translator, of written content in paper or electronic form into languages other than English; and

''(C) taglines.

''(17) MINORITY.—

"(A) IN GENERAL.—The terms 'minority' and 'minorities' refer to individuals from a minority group.

"(B) POPULATIONS.—The term 'minority', with respect to populations, refers to racial and ethnic minority groups, members of sexual and gender minority groups, and individuals with a disability.

"(18) MINORITY GROUP.—The term 'minority group' has the meaning given the term 'racial and ethnic minority group'.

"(19) ONSITE INTERPRETATION.—The term 'onsite interpretation' means a method of interpreting or interpretation for which the interpreter is in the physical presence of the provider of health care services or health-care-related services and the recipient of such services who is limited in English proficiency or has a communication impairment such as an impairment in hearing, vision, or learning.

"(20) QUALIFIED INDIVIDUAL WITH A DISABILITY.—The term 'qualified individual with a disability' means, with respect to a health program or activity, an individual with a disability who, with or without reasonable modifications to policies, practices, or procedures, the removal of architectural,

communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of aids, benefits, or services offered or provided by the health program or activity.

''(21) QUALIFIED INTERPRETER FOR AN INDIVIDUAL WITH A DISABILITY.—The term ' qualified interpreter for an individual with a disability', for an individual with a disability—

''(A) means an interpreter who by means of a remote interpreting service or an in-side appearance;

''(i) adheres to generally accepted interpreter ethics principles, including client confidentiality; and

''(ii) is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology; and

''(B) may include sign language interpreters, oral transliterators (individuals who represent or spell in the characters of another alphabet), and cued language transliterators

(individuals who represent or spell by using a small number of handshapes).

''(22) QUALIFIED INTERPRETER FOR AN INDIVIDUAL WITH LIMITED-ENGLISH PROFICIENCY.—The term 'qualified interpreter for an individual with limited-English proficiency' means an interpreter who via a remote interpreting service or an on-site appearance—

''(A) adheres to generally accepted interpreter ethics principles, including client confidentiality;

''(B) has demonstrated proficiency in speaking and understanding both spoken English and one or more other spoken languages; and

''(C) is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such languages and English, using any necessary specialized vocabulary, terminology, and phraseology.

''(23) QUALIFIED TRANSLATOR.—The term 'qualified translator' means a translator who—

''(A) adheres to generally accepted translator ethics principles, including client confidentiality;

"(B) has demonstrated proficiency in writing and understanding both written English and one or more other written non-English languages; and

"(C) is able to translate effectively, accurately, and impartially to and from such languages and English, using any necessary specialized vocabulary, terminology, and phraseology.

"(24) RACIAL AND ETHNIC MINORITY GROUP.—The term 'racial and ethnic minority group' means Indians and Alaska Natives, African Americans (including Caribbean Blacks, Africans, and other Blacks), Asian Americans, Hispanics (including Latinos), and Native Hawaiians and other Pacific Islanders.

"(25) SEXUAL AND GENDER MINORITY GROUP.—The term 'sexual and gender minority group' encompasses lesbian, gay, bisexual, and transgender populations, as well as those whose sexual orientation, gender identity and expression, or reproductive development varies from traditional, societal, cultural, or physiological norms.

"(26) SIGHT TRANSLATION.—The term 'sight translation' means the transmission of a written

message in one language into a spoken or signed message in another language, or an alternative format in English or another language.

''(27) STATE.—Notwithstanding section 2, the term 'State' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

''(28) TELEPHONIC INTERPRETATION.—The term 'telephonic interpretation' (also known as 'over the phone interpretation' or 'OPI') means, with respect to interpretation for an individual with limited-English proficiency, a method of interpretation in which the interpreter is not in the physical presence of the provider of health care services or health-care-related services and such individual receiving such services, but the interpreter is connected via telephone.

''(29) TRANSLATION.—The term 'translation' means the transmission of a written message in one language into a written or signed message in another language, and includes translation into another language or alternative format, such as large print font, Braille, audio recording, or CD.

''(30) VIDEO REMOTE INTERPRETING SERVICES.—The term 'video remote interpreting services' means the provision, in health care services or health-care-related services, through a qualified interpreter for an individual with limited-English proficiency, of video remote interpreting services that are—

''(A) in real-time, full-motion video, and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; and

''(B) in a sharply delineated image that is large enough to display.

''(31) VITAL DOCUMENT.—The term 'vital document' includes applications for government programs that provide health care services, medical or financial consent forms, financial assistance documents, letters containing important information regarding patient instructions (such as prescriptions, referrals to other providers, and discharge plans) and participation in a program (such as a Medicaid managed care program), notices pertaining to the reduction, denial, or termination of services or bene-

fits, notices of the right to appeal such actions, and notices advising individuals with limited-English proficiency with communication disabilities of the availability of free language services, alternative formats, and other outreach materials.

''(b) REFERENCE.—In any reference in this title to a regulatory provision applicable to a 'handicapped individual', the term 'handicapped individual' in such provision shall have the same meaning as the term 'individual with a disability' as defined in subsection (a).

## "Subtitle A—Resources and Innovation for Culturally and Linguistically Appropriate Health Care

### "SEC. 3401. ROBERT T. MATSUI CENTER FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE.

''(a) ESTABLISHMENT.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish and support a center to be known as the 'Robert T. Matsui Center for Culturally and Linguistically Appropriate Health Care' (referred to in this section as the 'Center') to carry out each of the following activities:

''(1) INTERPRETATION SERVICES.—The Center shall provide resources via the internet to identify

and link health care providers to competent interpreter and translation services.

''(2) TRANSLATION OF WRITTEN MATERIAL.—

''(A) VITAL DOCUMENTS.—The Center shall provide, directly or through contract, vital documents from competent translation services for providers of health care services and health-care-related services at no cost to such providers. Such documents may be submitted by covered entities (as defined in section 92.4 of title 42, Code of Federal Regulations, as in effect on May 16, 2016) for translation into non-English languages or alternative formats at a fifth-grade reading level. Such translation services shall be provided in a timely and reasonable manner. The quality of such translation services shall be monitored and reported publicly.

''(B) FORMS.—For each form developed or revised by the Secretary that will be used by individuals with limited-English proficiency in health care or health-care-related settings, the Center shall translate the form, at a minimum, into the top 15 non-English languages in the United States according to the most recent data

from the American Community Survey or its replacement. The translation shall be completed within 45 calendar days of the Secretary receiving final approval of the form from the Office of Management and Budget. The Center shall post all translated forms on its website so that other entities may use the same translations.

''(3) TOLL-FREE CUSTOMER SERVICE TELEPHONE NUMBER.—The Center shall provide, through a toll-free number, a customer service line for individuals with limited-English proficiency—

''(A) to obtain information about federally conducted or funded health programs, including the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of such Act, and the State Children's Health Insurance Program under title XXI of such Act, marketplace coverage available pursuant to title XXVII of this Act and the Patient Protection and Affordable Care Act, and other sources of free or reduced care including federally qualified health centers, title X clinics, and public health departments;

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

"(C) to learn how to access language services.

"(4) HEALTH INFORMATION CLEARINGHOUSE.—

"(A) IN GENERAL.—The Center shall develop and maintain an information clearinghouse to facilitate the provision of language services by providers of health care services and health-care-related services to reduce medical errors, improve medical outcomes, improve cultural competence, reduce health care costs caused by miscommunication with individuals with limited-English proficiency, and reduce or eliminate the duplication of efforts to translate materials. The clearinghouse shall include the information described in subparagraphs (B) through (F) and make such information available on the internet and in print.

"(B) DOCUMENT TEMPLATES.—The Center shall collect and evaluate for accuracy, develop, and make available templates for standard documents that are necessary for patients

and consumers to access and make educated decisions about their health care, including templates for each of the following:

"(i) Administrative and legal documents, including—

"(I) intake forms;

"(II) forms related to the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of such Act, and the State Children's Health Insurance Program under title XXI of such Act, including eligibility information for such programs;

"(III) forms informing patients of the compliance and consent requirements pursuant to the regulations under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320–2 note); and

"(IV) documents concerning informed consent, advanced directives, and waivers of rights.

''(ii) Clinical information, such as how to take medications, how to prevent transmission of a contagious disease, and other prevention and treatment instructions.

''(iii) Public health, patient education, and outreach materials, such as immunization notices, health warnings, or screening notices.

''(iv) Additional health or health-care-related materials as determined appropriate by the Director of the Center.

''(C) STRUCTURE OF FORMS.—In operating the clearinghouse, the Center shall—

''(i) ensure that the documents posted in English and non-English languages are culturally and linguistically appropriate;

''(ii) allow public review of the documents before dissemination in order to ensure that the documents are understandable and culturally and linguistically appropriate for the target populations;

''(iii) allow health care providers to customize the documents for their use;

''(iv) facilitate access to these documents;

''(v) provide technical assistance with respect to the access and use of such information; and

''(vi) carry out any other activities the Secretary determines to be useful to fulfill the purposes of the clearinghouse.

''(D) LANGUAGE ASSISTANCE PROGRAMS.—The Center shall provide for the collection and dissemination of information on current examples of language assistance programs and strategies to improve language services for individuals with limited-English proficiency, including case studies using de-identified patient information, program summaries, and program evaluations.

''(E) CULTURALLY AND LINGUISTICALLY APPROPRIATE MATERIALS.—The Center shall provide information relating to culturally and linguistically appropriate health care for minority populations residing in the United States to all health care providers and health-care-related services at no cost. Such information shall include—

''(i) tenets of culturally and linguistically appropriate care;

''(ii) culturally and linguistically appropriate self-assessment tools;

''(iii) culturally and linguistically appropriate training tools;

''(iv) strategic plans to increase cultural and linguistic appropriateness in different types of providers of health care services and health-care-related services, including regional collaborations among health care organizations; and

''(v) culturally and linguistically appropriate information for educators, practitioners, and researchers.

''(F) TRANSLATION GLOSSARIES.—The Center shall—

''(i) develop and publish on its website translation glossaries that provide standardized translations of commonly used terms and phrases utilized in documents translated by the Center; and

''(ii) make these glossaries available—

''(I) free of charge;

''(II) in the 15 languages in which the Center translates materials; and

"(III) in alternative formats in accordance with the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.).

"(G) INFORMATION ABOUT PROGRESS.—The Center shall regularly collect and make publicly available information about the progress of entities receiving grants under section 3402 regarding successful innovations in implementing the obligations under this subsection and provide public notice in the entities' communities about the availability of this information.

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

"(c) AVAILABILITY OF LANGUAGE ACCESS.—The Director shall collaborate with the Deputy Assistant Secretary for Minority Health, the Administrator of the Centers for Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration to notify health care providers and health care organizations about the availability of language access services by the Center.

''(d) EDUCATION.—The Secretary, directly or through contract, shall undertake a national education campaign to inform providers, individuals with limited-English proficiency, individuals with hearing or vision impairments, health professionals, graduate schools, and community health centers about—

''(1) Federal and State laws and guidelines governing access to language services;

''(2) the value of using trained and competent interpreters and the risks associated with using family members, friends, minors, and untrained bilingual staff;

''(3) funding sources for developing and implementing language services; and

''(4) promising practices to effectively provide language services.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $5,000,000 for each of fiscal years 2021 through 2025.

**''SEC. 3402. INNOVATIONS IN CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE GRANTS.**

''(a) IN GENERAL.—

''(1) GRANTS.—The Secretary, acting through the Director of the Agency for Healthcare Research

and Quality, shall award grants to eligible entities to enable such entities to design, implement, and evaluate innovative, cost-effective programs to improve culturally and linguistically appropriate access to health care services for individuals with limited-English proficiency.

''(2) COORDINATION.—The Director of the Agency for Healthcare Research and Quality shall coordinate with, and ensure the participation of, other agencies including the Health Resources and Services Administration, the National Institute on Minority Health and Health Disparities at the National Institutes of Health, and the Office of Minority Health, regarding the design and evaluation of the grants program.

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

''(1) be—

''(A) a city, county, Indian Tribe, State, or subdivision thereof;

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

''(C) a community health, mental health, or substance use disorder center or clinic;

''(D) a solo or group physician practice;

''(E) an integrated health care delivery system;

''(F) a public hospital;

''(G) a health care group, university, or college; or

''(H) any other entity designated by the Secretary; and

''(2) prepare and submit to the Secretary an application, at such time, in such manner, and containing such additional information as the Secretary may reasonably require.

''(c) USE OF FUNDS.—An entity shall use funds received through a grant under this section to—

''(1) develop, implement, and evaluate models of providing competent interpretation services through onsite interpretation, telephonic interpretation, or video remote interpreting services;

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

''(3) develop and maintain a needs assessment that identifies the current demographic, cultural, and epidemiological profile of the community to accurately plan for and implement language services needed in the service area of the entity;

''(4) develop a strategic plan to implement language services;

''(5) develop participatory, collaborative partnerships with communities encompassing the patient populations of individuals with limited-English proficiency served by the grant to gain input in designing and implementing language services;

''(6) develop and implement grievance resolution processes that are culturally and linguistically appropriate and capable of identifying, preventing, and resolving complaints by individuals with limited-English proficiency;

''(7) develop short-term medical and mental health interpretation training courses and incentives for bilingual health care staff who are asked to provide interpretation services in the workplace;

''(8) develop formal training programs, including continued professional development and education programs as well as supervision, for individuals interested in becoming dedicated health care in-

terpreters and culturally and linguistically appropriate providers;

''(9) provide staff language training instruction, which shall include information on the practical limitations of such instruction for nonnative speakers;

''(10) develop policies that address compensation in salary for staff who receive training to become either a staff interpreter or bilingual provider;

''(11) develop other language assistance services as determined appropriate by the Secretary;

''(12) develop, implement, and evaluate models of improving cultural competence, including cultural competence programs for community health workers; and

''(13) ensure that, consistent with the privacy protections provided for under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 and any applicable State privacy laws, data on the individual patient or recipient's race, ethnicity, and primary language are collected (and periodically updated) in health records and integrated into the organization's information management systems or any similar system used to store and retrieve data.

''(d) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to entities that primarily engage in providing direct care and that have developed partnerships with community organizations or with agencies with experience in improving language access.

''(e) EVALUATION.—

''(1) BY GRANTEES.—An entity that receives a grant under this section shall submit to the Secretary an evaluation that describes, in the manner and to the extent required by the Secretary, the activities carried out with funds received under the grant, and how such activities improved access to health care services and health-care-related services and the quality of health care for individuals with limited-English proficiency. Such evaluation shall be collected and disseminated through the Robert T. Matsui Center for Culturally and Linguistically Appropriate Health Care established under section 3401. The Director of the Agency for Healthcare Research and Quality shall notify grantees of the availability of technical assistance for the evaluation and provide such assistance upon request.

''(2) BY SECRETARY.—The Director of the Agency for Healthcare Research and Quality shall evaluate or arrange with other individuals or organi-

zations to evaluate projects funded under this section.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $5,000,000 for each of fiscal years 2021 through 2025.

**"SEC. 3403. RESEARCH ON CULTURAL AND LANGUAGE COMPETENCE.**

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

''(b) ELIGIBILITY.—The Director of the Agency for Healthcare Research and Quality may conduct the research described in subsection (a) or enter into contracts with other individuals or organizations to conduct such research.

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

''(1) To identify the barriers to mental and behavioral services that are faced by individuals with limited-English proficiency.

''(2) To identify health care providers' and health administrators' attitudes, knowledge, and awareness of the barriers to quality health care serv-

ices that are faced by individuals with limited-English proficiency.

''(3) To identify optimal approaches for delivering language access.

''(4) To identify best practices for data collection, including—

''(A) the collection by providers of health care services and health-care-related services of data on the race, ethnicity, and primary language of recipients of such services, taking into account existing research conducted by the Government or private sector;

''(B) the development and implementation of data collection and reporting systems; and

''(C) effective privacy safeguards for collected data.

''(5) To develop a minimum data collection set for primary language.

''(6) To evaluate the most effective ways in which the Secretary can create or coordinate, and subsidize or otherwise fund, telephonic interpretation services for health care providers, taking into consideration, among other factors, the flexibility necessary for such a system to accommodate variations in—

''(A) provider type;

''(B) languages needed and their frequency of use;

''(C) type of encounter;

''(D) time of encounter, including regular business hours and after hours; and

''(E) location of encounter.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $5,000,000 for each of fiscal years 2021 through 2025.''.

**SEC. 205. PILOT PROGRAM FOR IMPROVEMENT AND DEVELOPMENT OF STATE MEDICAL INTERPRETING SERVICES.**

(a) GRANTS AUTHORIZED.—The Secretary of Health and Human Services shall award 1 grant in accordance with this section to each of 3 States (to be selected by the Secretary) to assist each such State in designing, implementing, and evaluating a statewide program to provide onsite interpreter services under the State Medicaid plan.

(b) GRANT PERIOD.—A grant awarded under this section is authorized for the period of 3 fiscal years beginning on October 1, 2021, and ending on September 30, 2024.

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

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

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

(3) that has a high growth rate of the population of individuals with limited-English proficiency, as determined by the Secretary; and

(4) that has a population of qualified LEP enrollees that is linguistically diverse, requiring interpreter services in at least 200 non-English languages.

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

(1) ensure that all health care providers in the State participating in the State Medicaid plan have access to onsite interpreter services, for the purpose of enabling effective communication between such providers and qualified LEP enrollees during the furnishing of items and services and administrative interactions;

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

(A) a statewide health care information technology system that is designed to achieve efficiencies and economies of scale with respect to onsite interpreter services provided to health

care providers in the State participating in the State Medicaid plan; and

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

(i) procuring and scheduling interpreter services for qualified LEP enrollees;

(ii) procuring and scheduling interpreter services for individuals with limited-English proficiency seeking to enroll in the State Medicaid plan;

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

(iv) consulting regularly with organizations representing consumers, interpreters, and health care providers; and

(3) develop mechanisms to establish, improve, and strengthen the competency of the medical interpretation workforce that serves qualified LEP enrollees in the State, including a national certification process that is valid, credible, and vendor-neutral.

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

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

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

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

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

(C) collect information that accurately tracks the language services requested by consumers as compared to the language services provided by health care providers in the State participating in the State Medicaid plan.

(3) A description of how the program will be evaluated, including a proposal for collaboration with organizations representing interpreters, consumers, and individuals with limited-English proficiency.

(f) DEFINITIONS.—In this section:

(1) QUALIFIED LEP ENROLLEE.—The term ''qualified LEP enrollee'' means an individual—

(A) who is limited-English proficient; and

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

(2) STATE.—The term ''State'' has the meaning given the term in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)), for purposes of title XIX of such Act (42 U.S.C. 1396 et seq.).

(3) STATE MEDICAID PLAN.—The term ''State Medicaid plan'' means a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) or a waiver of such a plan.

(4) UNITED STATES.—The term ''United States'' has the meaning given the term in section 1101(a)(2) of the Social Security Act (42 U.S.C. 1301(a)(2)), for purposes of title XIX of such Act (42 U.S.C. 1396 et seq.).

(g) CONTINUATION PAST DEMONSTRATION.—Any state receiving a grant under this section must agree to directly pay for language services in Medicaid for all Medicaid providers by the end of the grant period.

(h) FUNDING.—

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

(2) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to the authorization in paragraph

(1) are authorized to remain available without fiscal year limitation.

(3) INCREASED FEDERAL FINANCIAL PARTICIPATION.—Section 1903(a)(2)(E) of the Social Security Act (42 U.S.C. 1396b(a)(2)(E)) is amended by inserting ''(or, in the case of a State that was awarded a grant under section 203 of the Health Equity and Accountability Act of 2020, 100 percent for each quarter occurring during the grant period specified in subsection (b) of such section)'' after ''75 percent''.

(i) LIMITATION.—No Federal funds awarded under this section may be used to provide interpreter services from a location outside the United States.

**SEC. 206. TRAINING TOMORROW'S DOCTORS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE: GRADUATE MEDICAL EDUCATION.**

(a) DIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(h)(4) of the Social Security Act (42 U.S.C. 1395ww(h)(4)) is amended by adding at the end the following new subparagraph:

''(L) TREATMENT OF CULTURALLY AND LINGUISTICALLY APPROPRIATE TRAINING.—In determining a hospital's number of full-time

equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program for education and training in culturally and linguistically appropriate service delivery, which shall include all diverse populations including people with disabilities and the Lesbian, gay, bisexual, transgender, queer, questioning, questioning and intersex (LGBTQIA) community, shall be counted toward the determination of full-time equivalency.''.

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

(1) by redesignating the clause (x) added by section 5505(b) of the Patient Protection and Affordable Care Act as clause (xi); and

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

''(xii) The provisions of subparagraph (L) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.''.

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

**SEC. 207. FEDERAL REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES UNDER THE MEDICARE, MEDICAID, AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS.**

(a) LANGUAGE ACCESS GRANTS FOR MEDICARE PROVIDERS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services, acting through the Centers for Medicare & Medicaid Services and in consultation with the Center for Medicare and Medicaid Innovation (as referred to in section 1115A of the Social Security Act (42 U.S.C. 1315a)), shall establish a demonstration program under which the Secretary shall award grants to eligible Medicare service providers to improve communication between such providers and Medicare beneficiaries who are limited English proficient, including

beneficiaries who live in diverse and underserved communities.

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

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

(D) GRANT PERIOD.—Except as provided under paragraph (2)(D), each grant awarded under this subsection shall be for a 3-year period.

(2) ELIGIBILITY REQUIREMENTS.—To be eligible for a grant under this subsection, an entity must meet the following requirements:

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

(i) a provider of services under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.);

(ii) a provider of services under part B of such title (42 U.S.C. 1395j et seq.);

(iii) a Medicare Advantage organization offering a Medicare Advantage plan under part C of such title (42 U.S.C. 1395w–21 et seq.); or

(iv) a PDP sponsor offering a prescription drug plan under part D of such title (42 U.S.C. 1395w–101 et seq.).

(B) UNDERSERVED COMMUNITIES.—The entity must serve a community that, with respect to necessary language services for improving access and utilization of health care among English learners, is disproportionally underserved.

(C) APPLICATION.—The entity must prepare and submit to the Secretary an application, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

(D) REPORTING.—In the case of a grantee that received a grant under this subsection in a previous year, such grantee is only eligible for continued payments under a grant under this subsection if the grantee met the reporting requirements under paragraph (9) for such year. If a grantee fails to meet the requirement of

such paragraph for the first year of a grant, the Secretary may terminate the grant and solicit applications from new grantees to participate in the demonstration program.

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

(A) at least 6 grants to providers of services described in paragraph (2)(A)(i);

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

(C) at least 6 grants to organizations described in paragraph (2)(A)(iii); and

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

(4) CONSIDERATIONS IN AWARDING GRANTS.—

(A) VARIATION IN GRANTEES.—In awarding grants under this subsection, the Secretary shall select grantees to ensure the following:

(i) The grantees provide many different types of language services.

(ii) The grantees serve Medicare beneficiaries who speak different languages, and who, as a population, have differing needs for language services.

(iii) The grantees serve Medicare beneficiaries in both urban and rural settings.

(iv) The grantees serve Medicare beneficiaries in at least two geographic regions, as defined by the Secretary.

(v) The grantees serve Medicare beneficiaries in at least two large metropolitan statistical areas with racial, ethnic, sexual, gender, disability, and economically diverse populations.

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

(i) a community organization; or

(ii) a consortia of community organizations, State agencies, and local agencies, that has experience in providing language services.

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

(A) IN GENERAL.—Subject to subparagraph (E), a grantee may only use grant funds

received under this subsection to pay for the provision of competent language services to Medicare beneficiaries who are English learners.

(B) COMPETENT LANGUAGE SERVICES DEFINED.—For purposes of this subsection, the term ''competent language services'' means—

(i) interpreter and translation services that—

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

(aa) if the grantee operates in a State that has statewide health care interpreter standards, meet the State standards currently in effect; or

(bb) if the grantee operates in a State that does not have statewide health care interpreter standards, utilizes competent interpreters who follow the National Council on Interpreting in Health Care's Code of Ethics and Standards of Practice and comply with the requirements of sec-

tion 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116) as published in the Federal Register on May 18, 2016; and

(II) that, in the case of interpreter services, are provided through—

(aa) onsite interpretation;

(bb) telephonic interpretation; or

(cc) video interpretation; and

(ii) the direct provision of health care or health-care-related services by a competent bilingual health care provider.

(C) EXCEPTIONS.—The requirements of subparagraph (B)(i)(I) do not apply, with respect to interpreter and translation services and a grantee—

(i) in the case of a Medicare beneficiary who is an English learner if—

(I) such beneficiary has been informed, in the beneficiary's primary language, of the availability of free in-

terpreter and translation services and the beneficiary instead requests that a family member, friend, or other person provide such services; and

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

(ii) in the case of a medical emergency where the delay directly associated with obtaining a competent interpreter or translation services would jeopardize the health of the patient.

Clause (ii) shall not be construed to exempt emergency rooms or similar entities that regularly provide health care services in medical emergencies to patients who are English learners from any applicable legal or regulatory requirements related to providing competent interpreter and translation services without undue delay.

(D) MEDICARE ADVANTAGE ORGANIZATIONS AND PDP SPONSORS.—If a grantee is a Medicare Advantage organization offering a Medicare Advantage plan under part C of title XVIII of the Social Security Act (42 U.S.C.

1395w–21 et seq.) or a PDP sponsor offering a prescription drug plan under part D of such title (42 U.S.C. 1395w–101 et seq.), such entity must provide at least 50 percent of the grant funds that the entity receives under this subsection directly to the entity's network providers (including all health providers and pharmacists) for the purpose of providing support for such providers to provide competent language services to Medicare beneficiaries who are English learners.

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

(6) DETERMINATION OF AMOUNT OF GRANT PAYMENTS.—

(A) IN GENERAL.—Payments to grantees under this subsection shall be calculated based on the estimated numbers of Medicare beneficiaries who are English learners in a grantee's service area utilizing—

(i) data on the numbers of English learners who speak English less than ''very well'' from the most recently available data from the Bureau of the Census or other State-based study the Secretary determines likely to yield accurate data regarding the number of such individuals in such service area; or

(ii) data provided by the grantee, if the grantee routinely collects data on the primary language of the Medicare beneficiaries that the grantee serves and the Secretary determines that the data is accurate and shows a greater number of English learners than would be estimated using the data under clause (i).

(B) DISCRETION OF SECRETARY.—Subject to subparagraph (C), the amount of payment made to a grantee under this subsection may be modified annually at the discretion of the Secretary, based on changes in the data under subparagraph (A) with respect to the service area of a grantee for the year.

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

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

(7) ASSURANCES.—Grantees under this subsection shall, as a condition of receiving a grant under this subsection—

(A) ensure that clinical and support staff receive appropriate ongoing education and training in linguistically appropriate service delivery;

(B) ensure the linguistic competence of bilingual providers;

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

(D) notify Medicare beneficiaries of their right to receive language services in their primary language;

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

(F) ensure that—

(i) primary language data are collected for recipients of language services

and such data are consistent with standards developed under title XXXIV of the Public Health Service Act, as added by section 202 of this Act, to the extent such standards are available upon the initiation of the demonstration program; and

(ii) consistent with the privacy protections provided under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), if the recipient of language services is a minor or is incapacitated, primary language data are collected on the parent or legal guardian of such recipient.

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

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

(A) The number of Medicare beneficiaries to whom competent language services are provided.

(B) The primary languages of those Medicare beneficiaries.

(C) The types of language services provided to such beneficiaries.

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

(E) The types of interpretation services provided to such beneficiaries, and the approximate length of time such service is provided to such beneficiaries.

(F) The costs of providing competent language services.

(G) An account of the training or accreditation of bilingual staff, interpreters, and translators providing services funded by the grant under this subsection.

(10) EVALUATION AND REPORT TO CONGRESS.—Not later than 1 year after the completion of a 3-year grant under this subsection, the Secretary shall conduct an evaluation of the demonstra-

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

(A) An analysis of the patient outcomes and the costs of furnishing care to the Medicare beneficiaries who are English learners participating in the project as compared to such outcomes and costs for such Medicare beneficiaries not participating, based on the data provided under paragraph (9) and any other information available to the Secretary.

(B) The effect of delivering language services on—

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

(ii) the efficiency and cost effectiveness of health care delivery;

(iii) patient satisfaction;

(iv) health outcomes; and

(v) the provision of culturally appropriate services provided to such beneficiaries.

(C) The extent to which bilingual staff, interpreters, and translators providing services under such demonstration were trained or accredited and the nature of accreditation or

training needed by type of provider, service, or other category as determined by the Secretary to ensure the provision of high-quality interpretation, translation, or other language services to Medicare beneficiaries if such services are expanded pursuant to section 1115A(c) of the Social Security Act (42 U.S.C. 1315a(c)).

(D) Recommendations, if any, regarding the extension of such project to the entire Medicare Program, subject to the provisions of such section 1115A(c).

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

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

(b) LANGUAGE ASSISTANCE SERVICES UNDER THE MEDICARE PROGRAM.—

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

(A) in subsection (aa)(1)—

(i) in subparagraph (B), by striking ''and'' at the end;

(ii) by adding ''and'' at the end of subparagraph (C); and

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

''(D) language assistance services as defined in subsection (jjj)(1),''; and

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

''Language Assistance Services and Related Terms

''(kkk)(1) The term 'language assistance services' means 'language access' or 'language assistance services' (as those terms are defined in section 3400 of the Public Health Service Act) furnished by a 'qualified interpreter for an individual with limited-English proficiency' or a 'qualified translator' (as those terms are defined in such section 3400) to an 'individual with limited English pro-

ficiency' (as defined in such section 3400) or an 'English learner' (as defined in paragraph (2)).

''(2) The term 'English learner' has the meaning given that term in section 8101(20) of the Elementary and Secondary Education Act of 1965, except that subparagraphs (A), (B), and (D) of such section shall not apply.''.

(2) COVERAGE.—Section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)) is amended—

(A) by striking ''and'' at the end of subparagraph (I);

(B) by striking the period at the end of subparagraph (J) and inserting ''; and''; and

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

''(K) language assistance services (as defined in section 1861(jjj)(1)).''.

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

(A) by striking ''and'' at the end of paragraph (8);

(B) by striking the period at the end of paragraph (9) and inserting ''; and''; and

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

''(10) in the case of language assistance services (as defined in section 1861(jjj)(1)), 100 percent of the reasonable charges for such services, as determined in consultation with the Medicare Payment Advisory Commission.''.

(4) WAIVER OF BUDGET NEUTRALITY.—For the 3-year period beginning on the date of enactment of this section, the budget neutrality provision of section 1848(c)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(ii)) shall not apply with respect to language assistance services (as defined in section 1861(kkk)(1) of such Act).

(c) MEDICARE PARTS C AND D.—

(1) IN GENERAL.—Medicare Advantage plans under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) and prescription drug plans under part D of such title (42 U.S.C. 1395q–101) shall comply with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) and section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116) to provide effective language services to enrollees of such plans.

(2) MEDICARE ADVANTAGE PLANS AND PRESCRIPTION DRUG PLANS REPORTING REQUIREMENT.—Section 1857(e) of the Social Security Act

(42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

''(5) REPORTING REQUIREMENTS RELATING TO EFFECTIVE LANGUAGE SERVICES.—A contract under this part shall require a Medicare Advantage organization (and, through application of section 1860D–12(b)(3)(D), a contract under section 1860D–12 shall require a PDP sponsor) to annually submit (for each year of the contract) a report that contains information on the internal policies and procedures of the organization (or sponsor) related to recruitment and retention efforts directed to workforce diversity and linguistically and culturally appropriate provision of services in each of the following contexts:

''(A) The collection of data in a manner that meets the requirements of title I of the Health Equity and Accountability Act of 2020, regarding the enrollee population.

''(B) Education of staff and contractors who have routine contact with enrollees regarding the various needs of the diverse enrollee population.

''(C) Evaluation of the language services programs and services offered by the organiza-

tion (or sponsor) with respect to the enrollee population, such as through analysis of complaints or satisfaction survey results.

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

''(E) The periodic provision of educational information to plan enrollees on the language services and programs offered by the organization (or sponsor).''.

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

(1) PAYMENTS TO STATES.—Section 1903(a)(2)(E) of the Social Security Act (42 U.S.C. 1396b(a)(2)(E)), as amended by section 203(g)(3), is further amended by—

(A) striking ''75'' and inserting ''95'';

(B) striking ''translation or interpretation services'' and inserting ''language assistance services''; and

(C) striking ''children of families'' and inserting ''individuals''.

(2) STATE PLAN REQUIREMENTS.—Section 1902(a)(10)(A) of the Social Security Act (42

U.S.C. 1396a(a)(10)(A)) is amended by striking ''and (29)'' and inserting ''(29), and (30)''.

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

(A) in paragraph (29), by striking ''and'' at the end;

(B) by redesignating paragraph (30) as paragraph (31); and

(C) by inserting after paragraph (29) the following new paragraph:

''(30) language assistance services, as such term is defined in section 1861(kkk)(1), provided in a timely manner to individuals with limited-English proficiency as defined in section 3400 of the Public Health Service Act; and''.

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

(A) by striking ''or'' at the end of subparagraph (D);

(B) by striking ''; and'' at the end of subparagraph (E) and inserting '', or''; and

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

''(F) language assistance services described in section 1905(a)(29); and''.

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

(A) in subsection (a), in the matter before paragraph (1), by striking ''and (7)'' and inserting ''(7), and (10)''; and

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

''(10) LANGUAGE ASSISTANCE SERVICES.—The child health assistance provided to a targeted low-income child shall include coverage of language assistance services, as such term is defined in section 1861(jjj)(1), provided in a timely manner to individuals with limited-English proficiency (as defined in section 3400 of the Public Health Service Act).''; and

(C) in subsection (e)(2)—

(i) in the heading, by striking ''PREVENTIVE'' and inserting ''CERTAIN''; and

(ii) by inserting ''or subsection (c)(10)'' after ''subsection (c)(1)(D)''.

(6) DEFINITION OF CHILD HEALTH ASSISTANCE.—Section 2110(a)(27) of the Social Security

Act (42 U.S.C. 1397jj(a)(27)) is amended by striking ''translation'' and inserting ''language assistance services as described in section 2103(c)(10)''.

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

(A) the primary language of individuals receiving child health assistance under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.); and

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

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

(A) in subsection (a)(1), by striking ''75'' and inserting ''90''; and

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

(e) FUNDING LANGUAGE ASSISTANCE SERVICES FURNISHED BY PROVIDERS OF HEALTH CARE AND HEALTH-CARE-RELATED SERVICES THAT SERVE HIGH RATES OF UNINSURED LEP INDIVIDUALS.—

(1) PAYMENT OF COSTS.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall make payments (on a quarterly basis) directly to eligible entities to support the provision of language assistance services to English learners in an amount equal to an eligible entity's eligible costs for providing such services for the quarter.

(B) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services such sums as may be necessary for each of fiscal years 2021 through 2025.

(C) RELATION TO MEDICAID DSH.—Payments under this subsection shall not offset or reduce payments under section 1923 of the Social Security Act (42 U.S.C. 1396r–4), nor shall payments under such section be consid-

ered when determining uncompensated costs associated with the provision of language assistance services for the purposes of this section.

(2) METHODOLOGY FOR PAYMENT OF CLAIMS.—

(A) IN GENERAL.—The Secretary shall establish a methodology to determine the average per person cost of language assistance services.

(B) DIFFERENT ENTITIES.—In establishing such methodology, the Secretary may establish different methodologies for different types of eligible entities.

(C) NO INDIVIDUAL CLAIMS.—The Secretary may not require eligible entities to submit individual claims for language assistance services for individual patients as a requirement for payment under this subsection.

(3) DATA COLLECTION INSTRUMENT.—For purposes of this subsection, the Secretary shall create a standard data collection instrument that is consistent with any existing reporting requirements by the Secretary or relevant accrediting organizations regarding the number of individuals to whom language access are provided.

(4) GUIDELINES.—Not later than 6 months after the date of enactment of this Act, the Secretary shall establish and distribute guidelines concerning the implementation of this subsection.

(5) REPORTING REQUIREMENTS.—

(A) REPORT TO SECRETARY.—Entities receiving payment under this subsection shall provide the Secretary with a quarterly report on how the entity used such funds. Such report shall contain aggregate (and may not contain individualized) data collected using the instrument under paragraph (3) and shall otherwise be in a form and manner determined by the Secretary.

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

(6) DEFINITIONS.—In this subsection:

(A) ELIGIBLE COSTS.—The term ''eligible costs'' means, with respect to an eligible entity that provides language assistance services to English learners, the product of—

(i) the average per person cost of language assistance services, determined according to the methodology devised under paragraph (2); and

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

(B) ELIGIBLE ENTITY.—The term ''eligible entity'' means an entity that—

(i) is a Medicaid provider that is—

(I) a physician;

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

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

(ii) not later than 6 months after the date of the enactment of this Act, provides language assistance services to not less than 8 percent of the entity's total number of patients; and

(iii) prepares and submits an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary may require, to ascertain the entity's eligibility for funding under this subsection.

(C) ENGLISH LEARNER.—The term ''English learner'' has the meaning given such term in section 8101(20) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801(20)), except that subparagraphs (A), (B), and (D) of such section shall not apply.

(D) LANGUAGE ASSISTANCE SERVICES.—The term ''language assistance services'' has the meaning given such term in section 1861(kkk)(1) of the Social Security Act, as added by subsection (b).

(f) APPLICATION OF CIVIL RIGHTS ACT OF 1964, SECTION 1557 OF THE AFFORDABLE CARE ACT, AND

OTHER LAWS.—Nothing in this section shall be construed to limit otherwise existing obligations of recipients of Federal financial assistance under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), section 1557 of the Affordable Care Act, or other laws that protect the civil rights of individuals.

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided and subject to paragraph (2), the amendments made by this section shall take effect on January 1, 2021.

(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature

that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

**SEC. 208. INCREASING UNDERSTANDING OF AND IMPROVING HEALTH LITERACY.**

(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality with respect to grants under subsection (c)(1) and through the Administrator of the Health Resources and Services Administration with respect to grants under subsection (c)(2), in consultation with the Director of the National Institute on Minority Health and Health Disparities and the Deputy Assistant Secretary for Minority Health, shall award grants to eligible entities to improve health care for patient populations that have low functional health literacy.

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

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

(2) prepare and submit to the Secretary an application at such time, in such manner, and con-

taining such information as the Secretary may reasonably require.

(c) USE OF FUNDS.—

(1) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.—A grant awarded under subsection (a) through the Director of the Agency for Healthcare Research and Quality shall be used—

(A) to define and increase the understanding of health literacy;

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

(C) to clarify which aspects of health literacy have an effect on health outcomes; and

(D) for any other activity determined appropriate by the Director.

(2) HEALTH RESOURCES AND SERVICES ADMINISTRATION.—A grant awarded under subsection (a) through the Administrator of the Health Resources and Services Administration shall be used to conduct demonstration projects for interventions for patients with low health literacy that may include—

(A) the development of new disease management programs for patients with low health literacy;

(B) the tailoring of disease management programs addressing mental, physical, oral, and behavioral health conditions for patients with low health literacy;

(C) the translation of written health materials for patients with low health literacy;

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

(E) the conduct of educational campaigns for patients and providers about low health literacy;

(F) the conduct of educational campaigns concerning health directed specifically at patients with mental disabilities, including those with cognitive and intellectual disabilities, designed to reduce the incidence of low health literacy among these populations, which shall have instructional materials in the plain language standards promulgated under the Plain Writing Act of 2010 (5 U.S.C. 301 note) for Federal agencies; and

(G) other activities determined appropriate by the Administrator.

(d) DEFINITIONS.—In this section, the term ''low health literacy'' means the inability of an individual to ob-

tain, process, and understand basic health information and services needed to make appropriate health decisions.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2021 through 2025.

**SEC. 209. REQUIREMENTS FOR HEALTH PROGRAMS OR ACTIVITIES RECEIVING FEDERAL FUNDS.**

(a) COVERED ENTITY; COVERED PROGRAM OR ACTIVITY.—In this section—

(1) The term ''covered entity'' has the meaning given such term in section 92.4 of title 42, Code of Federal Regulations, as in effect on May 16, 2016; and

(2) The term ''covered program or activity'' has the meaning given such term in section 92.4 of title 42, Code of Federal Regulations, as in effect on May 16, 2016.

(b) REQUIREMENTS.—A covered entity, in order to ensure the right of individuals with limited English proficiency to receive access to high-quality health care through the covered program or activity, shall—

(1) ensure that appropriate clinical and support staff receive ongoing education and training in culturally and linguistically appropriate service delivery;

(2) offer and provide appropriate language assistance services at no additional charge to each patient that is an individual with limited-English proficiency at all points of contact, in a timely manner during all hours of operation;

(3) notify patients of their right to receive language services in their primary language; and

(4) utilize only qualified interpreters for an individual with limited-English proficiency or qualified translators, except as provided in subsection (c).

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

(1) When a patient requests the use of family, friends, or other persons untrained in interpretation or translation if each of the following conditions are met:

(A) The interpreter requested by the patient is over the age of 18.

(B) The covered entity informs the patient in the primary language of the patient that he or she has the option of having the entity provide to the patient an interpreter and translation services without charge.

(C) The covered entity informs the patient that the entity may not require an individual

with a limited-English proficiency to use a family member or friend as an interpreter.

(D) The covered entity evaluates whether the person the patient wishes to use as an interpreter is competent. If the covered entity has reason to believe that such person is not competent as an interpreter, the entity provides its own interpreter to protect the covered entity from liability if the patient's interpreter is later found not competent.

(E) If the covered entity has reason to believe that there is a conflict of interest between the interpreter and patient, the covered entity may not use the patient's interpreter.

(F) The covered entity has the patient sign a waiver, witnessed by at least 1 individual not related to the patient, that includes the information stated in subparagraphs (A) through (E) and is translated into the patient's primary language.

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

(d) RULE OF CONSTRUCTION.—Subsection (c)(2) shall not be construed to mean that emergency rooms or similar entities that regularly provide health care services in medical emergencies are exempt from legal or regulatory requirements related to competent interpreter services.

**SEC. 210. REPORT ON FEDERAL EFFORTS TO PROVIDE CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE SERVICES.**

(a) REPORT.—Not later than 1 year after the date of enactment of this Act and annually thereafter, the Secretary of Health and Human Services shall enter into a contract with the National Academy of Medicine for the preparation and publication of a report that describes Federal efforts to ensure that all individuals with limited-English proficiency have meaningful access to health care services and health-care-related services that are culturally and linguistically appropriate. Such report shall include—

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

(2) a description and analysis of best practices, model programs, guidelines, and other effective strategies for providing access to culturally and linguistically appropriate health care services;

(3) recommendations on the development and implementation of policies and practices by providers of health care services and health-care-related services for individuals with limited-English proficiency, including people with cognitive, hearing, vision, or print impairments;

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

(5) a description of the effect of providing language services on quality of health care and access to care; and

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

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

**SEC. 211. ENGLISH FOR SPEAKERS OF OTHER LANGUAGES.**

(a) GRANTS AUTHORIZED.—The Secretary of Education is authorized to provide grants to eligible entities for the provision of English as a second language (in this section referred to ''ESL'') instruction and shall determine, after consultation with appropriate stakeholders, the

mechanism for administering and distributing such grants.

(b) ELIGIBLE ENTITY DEFINED.—In this section, the term ''eligible entity'' means a State or community-based organization that employs and serves minority populations.

(c) APPLICATION.—An eligible entity may apply for a grant under this section by submitting such information as the Secretary of Education may require and in such form and manner as the Secretary may require.

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

(1) develop and implement a plan for assuring the availability of ESL instruction that effectively integrates information about the nature of the United States health care system, how to access care, and any special language skills that may be required for individuals to access and regularly negotiate the system effectively;

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

(3) maintain current ESL instruction efforts by using funds available under this section to supple-

ment rather than supplant any funds expended for ESL instruction in the State as of January 1, 2020.

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

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

(2) collect data from State and local governments to identify the unmet needs of English language learners for appropriate ESL instruction, including—

(A) the preferred written and spoken language of such English language learners;

(B) the extent of waiting lists for ESL instruction, including how many programs maintain waiting lists and, for programs that do not have waiting lists, the reasons why not;

(C) the availability of programs to geographically isolated communities;

(D) the impact of course enrollment policies, including open enrollment, on the availability of ESL instruction;

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

(F) the effectiveness of the instruction in meeting the needs of individuals receiving instruction and those needing instruction;

(G) as assessment of the need for programs that integrate job training and ESL instruction, to assist individuals to obtain better jobs; and

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

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

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

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Education $250,000,000 for each of fiscal years 2021 through 2024 to carry out this section.

**SEC. 212. IMPLEMENTATION.**

(a) GENERAL PROVISIONS.—

(1) IMMUNITY.—A State shall not be immune under the 11th Amendment to the Constitution of the United States from suit in Federal court for a violation of this title (including an amendment made by this title).

(2) REMEDIES.—In a suit against a State for a violation of this title (including an amendment made by this title), remedies (including remedies both at law and in equity) are available for such a violation to the same extent as such remedies are available for such a violation in a suit against any public or private entity other than a State.

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

**SEC. 213. LANGUAGE ACCESS SERVICES.**

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

''(K) Language access services, including oral interpretation and written translations.''.

(b) EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.—

(1) IN GENERAL.—Section 36B(c)(2)(C) of the Internal Revenue Code of 1986 is amended by redesignating clauses (iii) and (iv) as clauses (iv) and (v), respectively, and by inserting after clause (ii) the following new clause:

''(iii) COVERAGE MUST INCLUDE LANGUAGE ACCESS AND SERVICES.—Except as provided in clause (iv), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan does not provide coverage for language access services, including oral interpretation and written translations.''.

(2) CONFORMING AMENDMENTS.—

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

(B) Section 36B(c)(2)(C)(iv) of such Code, as redesignated by this subsection, is amended

by striking ''(i) and (ii)'' and inserting ''(i), (ii), and (iii)''.

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

(1) by striking ''and'' at the end of subparagraph (C);

(2) by striking the period at the end of subparagraph (D) and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(E) reduce health disparities through the provision of language access services, including oral interpretation and written translations.''.

(d) REGULATIONS REGARDING INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW PROCESSES FOR HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services shall amend the regulations in section 54.9815–2719(e) of title 26, Code of Federal Regulations, section 2590.715–2719(e) of title 29, Code of Federal Regulations, and section 147.136(e) of title 45, Code of Federal Regulations, respectively, to require group health plans and health in-

surance issuers offering group or individual health insurance coverage to which such sections apply—

(1) to provide oral interpretation services without any threshold requirements;

(2) to provide in the English versions of all notices a statement prominently displayed in not less than 15 non-English languages clearly indicating how to access the language services provided by the plan or issuer; and

(3) with respect to the requirements for providing relevant notices in a culturally and linguistically appropriate manner in the applicable non-English languages, to apply a threshold that 5 percent of the population, or not less than 500 individuals, in the county is literate only in the same non-English language in order for the language to be considered an applicable non-English language.

(e) DATA COLLECTION AND REPORTING.—The Secretary of Health and Human Services shall—

(1) amend the single streamlined application form developed pursuant to section 1413 of the Patient Protection and Affordable Care Act (42 U.S.C. 18083) to collect the preferred spoken and written language for each household member applying for coverage under a qualified health plan through an

Exchange under title I of such Act (42 U.S.C. 18001 et seq.);

(2) require navigators, certified application counselors, and other individuals assisting with enrollment to collect and report requests for language assistance; and

(3) require the toll-free telephone hotlines established pursuant to section 1311(d)(4)(B) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(d)(4)(B)) to submit an annual report documenting the number of language assistance requests, the types of languages requested, the range and average wait time for a consumer to speak with an interpreter, and any steps the hotline, and any entity contracting with the Secretary to provide language services, have taken to actively address some of the consumer complaints.

(f) EFFECTIVE DATE.—The amendments made by this section shall not apply to plans beginning prior to the date of the enactment of this Act.

**SEC. 214. MEDICALLY UNDERSERVED POPULATIONS.**

Section 330(a) of the Public Health Service Act (42 U.S.C. 254b(a)) is amended is by adding at the end the following new paragraph:

''(3) MEDICALLY UNDERSERVED.—The term 'medically underserved', with respect to a population, means—

''(A) the population of an urban or rural area designated by the Secretary as—

''(i) an area with a shortage of personal health services; or

''(ii) a population group having a shortage of such services; or

''(B) a population of individuals, not confined to a particular urban or rural area, who are designated by the Secretary as having a shortage of personal health services due to a specific demographic trait.''.

# TITLE III—HEALTH WORKFORCE DIVERSITY

## SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title XXXIV of the Public Health Service Act, as added by section 204, is amended by adding at the end the following:

# "Subtitle B—Diversifying the Health Care Workplace

**"SEC. 3411. NATIONAL WORKING GROUP ON WORKFORCE DIVERSITY.**

''(a) IN GENERAL.—The Secretary, acting through the Bureau of Health Workforce of the Health Resources and Services Administration, shall award a grant to an entity determined appropriate by the Secretary for the establishment of a national working group on workforce diversity.

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

''(1) The grantee shall ensure that the group has representatives of each of the following:

''(A) The Health Resources and Services Administration.

''(B) The Department of Health and Human Services Data Council.

''(C) The Office of Minority Health of the Department of Health and Human Services.

''(D) The Substance Abuse and Mental Health Services Administration.

''(E) The Bureau of Labor Statistics of the Department of Labor.

''(F) The National Institute on Minority Health and Health Disparities.

''(G) The Agency for Healthcare Research and Quality.

''(H) The Institute of Medicine Study Committee for the 2004 workforce diversity report.

''(I) The Indian Health Service.

''(J) The Department of Education.

''(K) Minority-serving academic institutions.

''(L) Consumer organizations.

''(M) Health professional associations, including those that represent underrepresented minority populations.

''(N) Researchers in the area of health workforce.

''(O) Health workforce accreditation entities.

''(P) Private (including nonprofit) foundations that have sponsored workforce diversity initiatives.

''(Q) Local and State health departments.

''(R) Representatives of community members to be included on admissions committees

for health profession schools pursuant to subsection (c)(9).

''(S) National community-based organizations that serve as a national intermediary to their urban affiliate members and have demonstrated capacity to train health care professionals.

''(T) The Veterans Health Administration.

''(U) Other entities determined appropriate by the Secretary.

''(2) The grantee shall ensure that, in addition to the representatives under paragraph (1), the working group has not less than 5 health professions students representing various health profession fields and levels of training.

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

''(1) Review public and private health workforce diversity initiatives.

''(2) Identify successful health workforce diversity programs and practices.

''(3) Examine challenges relating to the development and implementation of health workforce diversity initiatives.

''(4) Draft a national strategic work plan for health workforce diversity, including recommendations for public and private sector initiatives.

''(5) Develop a framework and methods for the evaluation of current and future health workforce diversity initiatives.

''(6) Develop recommended standards for workforce diversity that could be applicable to all health professions programs and programs funded under this Act.

''(7) Develop guidelines to train health professionals to care for a diverse population.

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

''(9) Develop a strategy for the inclusion of community members on admissions committees for health profession schools.

''(10) Help with monitoring and implementation of standards for diversity, equity, and inclusion.

''(11) Other activities determined appropriate by the Secretary.

''(d) ANNUAL REPORT.—Not later than 1 year after the establishment of the working group under subsection (a), and annually thereafter, the working group shall pre-

pare and make available to the general public for comment, an annual report on the activities of the working group. Such report shall include the recommendations of the working group for improving health workforce diversity.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

**"SEC. 3412. TECHNICAL CLEARINGHOUSE FOR HEALTH WORKFORCE DIVERSITY.**

''(a) IN GENERAL.—The Secretary, acting through the Deputy Assistant Secretary for Minority Health, and in collaboration with the Bureau of Health Workforce within the Health Resources and Services Administration and the National Institute on Minority Health and Health Disparities, shall establish a technical clearinghouse on health workforce diversity within the Office of Minority Health and coordinate current and future clearinghouses related to health workforce diversity.

''(b) INFORMATION AND SERVICES.—The clearinghouse established under subsection (a) shall offer the following information and services:

''(1) Information on the importance of health workforce diversity.

''(2) Statistical information relating to underrepresented minority representation in health and allied health professions and occupations.

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

''(4) Admissions policies that promote health workforce diversity and are in compliance with Federal and State laws.

''(5) Retainment policies that promote completion of health profession degrees for underserved populations.

''(6) Lists of scholarship, loan repayment, and loan cancellation grants as well as fellowship information for underserved populations for health professions schools.

''(7) Foundation and other large organizational initiatives relating to health workforce diversity.

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

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section

such sums as may be necessary for each of fiscal years 2021 through 2025.

**"SEC. 3413. SUPPORT FOR INSTITUTIONS COMMITTED TO WORKFORCE DIVERSITY, EQUITY, AND INCLUSION.**

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

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

"(1) be an educational institution or entity that historically produces or trains meaningful numbers of underrepresented minority health professionals, including—

"(A) part B institutions, as defined in section 322 of the Higher Education Act of 1965;

"(B) Hispanic-serving health professions schools;

"(C) Hispanic-serving institutions, as defined in section 502 of such Act;

"(D) Tribal colleges or universities, as defined in section 316 of such Act;

''(E) Asian American and Native American Pacific Islander-serving institutions, as defined in section 371(c) of such Act;

''(F) institutions that have programs to recruit and retain underrepresented minority health professionals, in which a significant number of the enrolled participants are underrepresented minorities;

''(G) health professional associations, which may include underrepresented minority health professional associations; and

''(H) institutions, including national and regional community-based organizations with demonstrated commitment to a diversified workforce—

''(i) located in communities with predominantly underrepresented minority populations;

''(ii) with whom partnerships have been formed for the purpose of increasing workforce diversity; and

''(iii) in which at least 20 percent of the enrolled participants are underrepresented minorities; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—Amounts received under a grant under subsection (a) shall be used to expand existing workforce diversity programs, implement new workforce diversity programs, or evaluate existing or new workforce diversity programs, including with respect to mental health care professions. Such programs shall enhance diversity by considering minority status as part of an individualized consideration of qualifications. Possible activities may include—

''(1) educational outreach programs relating to opportunities in the health professions;

''(2) scholarship, fellowship, grant, loan repayment, and loan cancellation programs;

''(3) postbaccalaureate programs;

''(4) academic enrichment programs, particularly targeting those who would not be competitive for health professions schools;

''(5) supporting workforce diversity in kindergarten through 12th grade and other health pipeline programs;

''(6) mentoring programs;

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

''(8) community partnership development for purposes relating to workforce diversity; or

''(9) leadership training.

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

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2021 through 2025.

**''SEC. 3414. CAREER DEVELOPMENT FOR SCIENTISTS AND RESEARCHERS.**

''(a) IN GENERAL.—The Secretary, acting through the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, the Commissioner of Food and Drugs, the Director of the Agency for Healthcare Research and Quality, and the Administrator of the Health Resources and Services Administration, shall award grants that expand existing opportunities for scientists and researchers and promote the inclu-

sion of underrepresented minorities in the health professions.

''(b) RESEARCH FUNDING.—The head of each agency listed in subsection (a) shall establish or expand existing programs to provide research funding to scientists and researchers in training. Under such programs, the head of each such entity shall give priority in allocating research funding to support health research in traditionally underserved communities, including underrepresented minority communities, and research classified as community or participatory.

''(c) DATA COLLECTION.—The head of each agency listed in subsection (a) shall collect data on the number (expressed as an absolute number and a percentage) of underrepresented minority and nonminority applicants who receive and are denied agency funding at every stage of review. Such data shall be reported annually to the Secretary and the appropriate committees of Congress.

''(d) STUDENT LOAN REIMBURSEMENT.—The Secretary shall establish a student loan reimbursement program to provide student loan reimbursement assistance to researchers who focus on racial and ethnic disparities in health. The Secretary shall promulgate regulations to define the scope and procedures for the program under this subsection.

''(e) STUDENT LOAN CANCELLATION.—The Secretary shall establish a student loan cancellation program to provide student loan cancellation assistance to researchers who focus on racial and ethnic disparities in health. Students participating in the program shall make a minimum 5-year commitment to work at an accredited health profession school. The Secretary shall promulgate additional regulations to define the scope and procedures for the program under this subsection.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2021 through 2025.

**"SEC. 3415. CAREER SUPPORT FOR NONRESEARCH HEALTH PROFESSIONALS.**

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, the Assistant Secretary for Mental Health and Substance Use, the Administrator of the Health Resources and Services Administration, and the Administrator of the Centers for Medicare & Medicaid Services, shall establish a program to award grants to eligible individuals for career support in nonresearch-related health and wellness professions.

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

''(1) be a student in a health professions school, a graduate of such a school who is working in a health profession, an individual working in a health or wellness profession (including mental and behavioral health), or a faculty member of such a school; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

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

''(1) support the individual's health activities or projects that involve underserved communities, including racial and ethnic minority communities;

''(2) support health-related career advancement activities;

''(3) to pay, or as reimbursement for payments of, student loans or training or credentialing costs for individuals who are health professionals and are focused on health issues affecting underserved communities, including racial and ethnic minority communities; and

''(4) to establish and promote leadership training programs to decrease health disparities and to increase cultural competence with the goal of increasing diversity in leadership positions.

''(d) DEFINITION.—In this section, the term 'career in nonresearch-related health and wellness professions' means employment or intended employment in the field of public health, health policy, health management, health administration, medicine, nursing, pharmacy, psychology, social work, psychiatry, other mental and behavioral health, allied health, community health, social work, or other fields determined appropriate by the Secretary, other than in a position that involves research.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

**"SEC. 3416. RESEARCH ON THE EFFECT OF WORKFORCE DIVERSITY ON QUALITY.**

''(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, in collaboration with the Deputy Assistant Secretary for Minority Health and the Director of the National Institute on Minority Health and Health Disparities, shall award grants to eligible enti-

ties to expand research on the link between health workforce diversity and quality health care.

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

''(1) be a clinical, public health, or health services research entity or other entity determined appropriate by the Director; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—Amounts received under a grant awarded under subsection (a) shall be used to support research that investigates the effect of health workforce diversity on—

''(1) language access;

''(2) cultural competence;

''(3) patient satisfaction;

''(4) timeliness of care;

''(5) safety of care;

''(6) effectiveness of care;

''(7) efficiency of care;

''(8) patient outcomes;

''(9) community engagement;

''(10) resource allocation;

''(11) organizational structure;

''(12) compliance of care; or

''(13) other topics determined appropriate by the Director.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director shall give individualized consideration to all relevant aspects of the applicant's background. Consideration of prior research experience involving the health of underserved communities shall be such a factor.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

**''SEC. 3417. HEALTH DISPARITIES EDUCATION PROGRAM.**

''(a) ESTABLISHMENT.—The Secretary, acting through the Office of Minority Health, in collaboration with the National Institute on Minority Health and Health Disparities, the Office for Civil Rights, the Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services, the Health Resources and Services Administration, and other appropriate public and private entities, shall establish and coordinate a health and health care disparities education program to support, develop, and implement educational initiatives and outreach strategies that inform health care professionals and the public

about the existence of and methods to reduce racial and ethnic disparities in health and health care.

''(b) ACTIVITIES.—The Secretary, through the education program established under subsection (a), shall, through the use of public awareness and outreach campaigns targeting the general public and the medical community at large—

''(1) disseminate scientific evidence for the existence and extent of racial and ethnic disparities in health care, including disparities that are not otherwise attributable to known factors such as access to care, patient preferences, or appropriateness of intervention, as described in the 2002 Institute of Medicine Report entitled 'Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care', as well as the impact of disparities related to age, disability status, socioeconomic status, sex, gender identity, and sexual orientation on racial and ethnic minorities;

''(2) disseminate new research findings to health care providers and patients to assist them in understanding, reducing, and eliminating health and health care disparities;

''(3) disseminate information about the impact of linguistic and cultural barriers on health care

quality and the obligation of health providers who receive Federal financial assistance to ensure that individuals with limited-English proficiency have access to language access services;

''(4) disseminate information about the importance and legality of racial, ethnic, disability status, socioeconomic status, sex, gender identity, and sexual orientation, and primary language data collection, analysis, and reporting;

''(5) design and implement specific educational initiatives to health care providers relating to health and health care disparities;

''(6) assess the impact of the programs established under this section in raising awareness of health and health care disparities and providing information on available resources; and

''(7) design and implement specific educational initiatives to educate the health care workforce relating to unconscious bias.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.''.

**SEC. 302. HISPANIC-SERVING INSTITUTIONS, HISTORICALLY BLACK COLLEGES AND UNIVERSITIES, ASIAN AMERICAN AND NATIVE AMERICAN PACIFIC ISLANDER-SERVING INSTITUTIONS, TRIBAL COLLEGES, REGIONAL COMMUNITY-BASED ORGANIZATIONS, AND NATIONAL MINORITY MEDICAL ASSOCIATIONS.**

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

**"SEC. 742. HISPANIC-SERVING INSTITUTIONS, HISTORICALLY BLACK COLLEGES AND UNIVERSITIES, ASIAN AMERICAN AND NATIVE AMERICAN PACIFIC ISLANDER-SERVING INSTITUTIONS, AND TRIBAL COLLEGES.**

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Secretary of Education, shall award grants to Hispanic-serving institutions, historically black colleges and universities, Asian American and Native American Pacific Islander-serving institutions, Tribal Colleges or Universities, regional community-based organizations, and national minority medical associations, for counseling, mentoring and providing information on financial assistance to prepare underrepresented minority individuals to enroll in and graduate

from health professional schools and to increase services for underrepresented minority students including—

''(1) mentoring with underrepresented health professionals; and

''(2) providing financial assistance information for continued education and applications to health professional schools.

''(b) DEFINITIONS.—In this section:

''(1) ASIAN AMERICAN AND NATIVE AMERICAN PACIFIC ISLANDER-SERVING INSTITUTION.—The term 'Asian American and Native American Pacific Islander-serving institution' has the meaning given such term in section 320(b) of the Higher Education Act of 1965.

''(2) HISPANIC SERVING INSTITUTION.—The term 'hispanic-serving institution' means an entity that—

''(A) is a school or program for which there is a definition under 799B;

''(B) has an enrollment of full-time equivalent students that is made up of at least 9 percent Hispanic students;

''(C) has been effective in carrying out programs to recruit Hispanic individuals to enroll in and graduate from the school;

''(D) has been effective in recruiting and retaining Hispanic faculty members;

''(E) has a significant number of graduates who are providing health services to medically underserved populations or to individuals in health professional shortage areas; and

''(F) is a Hispanic Center of Excellence in Health Professions Education designated under section 736(d)(2) of the Public Health Service Act (42 U.S.C. 293(d)(2)).

''(3) HISTORICALLY BLACK COLLEGES AND UNIVERSITY.—The term 'historically black college and university' has the meaning given the term 'part B institution' as defined in section 322 of the Higher Education Act of 1965.

''(4) TRIBAL COLLEGE OR UNIVERSITY.—The term 'Tribal College or University' has the meaning given such term in section 316(b) of the Higher Education Act of 1965.

''(c) CERTAIN LOAN REPAYMENT PROGRAMS.—In carrying out the National Health Service Corps Loan Repayment Program established under subpart III of part D of title III and the loan repayment program under section 317F, the Secretary shall ensure, notwithstanding such subpart or section, that loan repayments of not less

than $50,000 per year per person are awarded for repayment of loans incurred for enrollment or participation of underrepresented minority individuals in health professional schools and other health programs described in this section.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2026.''.

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

Section 317F(c)(1) of the Public Health Service Act (42 U.S.C. 247b–7(c)(1)) is amended—

(1) by striking ''and'' after ''1994,''; and

(2) by inserting before the period at the end the following: '', $750,000 for fiscal year 2020, and such sums as may be necessary for each of the fiscal years 2021 through 2025''.

**SEC. 304. COOPERATIVE AGREEMENTS FOR ONLINE DEGREE PROGRAMS AT SCHOOLS OF PUBLIC HEALTH AND SCHOOLS OF ALLIED HEALTH.**

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

**"SEC. 743. COOPERATIVE AGREEMENTS FOR ONLINE DEGREE PROGRAMS.**

''(a) COOPERATIVE AGREEMENTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, in consultation with the Director of the Centers for Disease Control and Prevention, the Director of the Agency for Healthcare Research and Quality, and the Deputy Assistant Secretary for Minority Health, shall enter into cooperative agreements with schools of public health and schools of allied health to design and implement online degree programs.

''(b) PRIORITY.—In entering into cooperative agreements under this section, the Secretary shall give priority to any school of public health or school of allied health that has an established track record of serving medically underserved communities.

''(c) REQUIREMENTS.—As a condition of entering into a cooperative agreement with the Secretary under this section, a school of public health or school of allied health shall agree to design and implement an online degree program that meets the following restrictions:

''(1) Enrollment of individuals who have obtained a secondary school diploma or its recognized equivalent.

''(2) Maintaining a significant enrollment of underrepresented minority or disadvantaged students.

''(3) Achieving a high completion rate of enrolled underrepresented minority or disadvantaged students.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

''(e) PERIOD OF GRANTS.—The period during which payments are made under a grant awarded may not exceed 3 years.''.

**SEC. 305. SENSE OF CONGRESS ON THE MISSION OF THE NATIONAL HEALTH CARE WORKFORCE COMMISSION.**

It is the sense of Congress that the National Health Care Workforce Commission established by section 5101 of the Patient Protection and Affordable Care Act (42 U.S.C. 294q) should, in carrying out its assigned duties under that section, give attention to the needs of racial and ethnic minorities, individuals with lower socioeconomic status, individuals with mental, developmental, and physical disabilities, lesbian, gay, bisexual, transgender, queer, and questioning populations, and indi-

viduals who are members of multiple minority or special population groups.

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

Subtitle B of title XXXIV of the Public Health Service Act, as added by section 301, is further amended by inserting after section 3417 the following:

**"SEC. 3418. DAVID SATCHER PUBLIC HEALTH AND HEALTH SERVICES CORPS.**

''(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Administrator of the Health Resources and Services Administration and the Deputy Assistant Secretary for Minority Health, shall award grants to eligible entities to increase awareness among secondary and postsecondary students of career opportunities in the health professions.

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

''(1) be a clinical, public health, or health services organization, community-based or nonprofit entity, or other entity determined appropriate by the Director of the Centers for Disease Control and Prevention;

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

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

''(4) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

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

''(1) Medicine.

''(2) Nursing.

''(3) Public health.

''(4) Pharmacy.

''(5) Health administration and management.

''(6) Health policy.

''(7) Psychology.

''(8) Dentistry.

''(9) International health.

''(10) Social work.

''(11) Allied health.

''(12) Psychiatry.

''(13) Hospice care.

''(14) Community health, patient navigation, and peer support.

''(15) Other professions determined appropriate by the Director of the Centers for Disease Control and Prevention.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director of the Centers for Disease Control and Prevention shall give priority to those entities that—

''(1) serve a high proportion of individuals from disadvantaged backgrounds;

''(2) have experience in health disparity elimination programs;

''(3) facilitate the entry of disadvantaged individuals into institutions of higher education; and

''(4) provide counseling or other services designed to assist disadvantaged individuals in successfully completing their education at the postsecondary level.

''(e) STIPENDS.—

''(1) IN GENERAL.—Subject to paragraph (2), an entity receiving a grant under this section may use the funds made available through such grant to award stipends for educational and living expenses to students participating in the internship supported by the grant.

''(2) LIMITATIONS.—A stipend awarded under paragraph (1) to an individual—

''(A) may not be provided for a period that exceeds 6 months; and

''(B) may not exceed $20 per day for an individual (notwithstanding any other provision of law regarding the amount of a stipend).

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2026.

**"SEC. 3419. LOUIS STOKES PUBLIC HEALTH SCHOLARS PROGRAM.**

''(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Deputy Assistant Secretary for Minority Health, shall award scholarships to eligible individuals under subsection (b) who seek a career in public health.

''(b) ELIGIBILITY.—To be eligible to receive a scholarship under subsection (a), an individual shall—

''(1) have interest, knowledge, or skill in public health research or public health practice, or other health professions as determined appropriate by the Director of the Centers for Disease Control and Prevention;

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

''(3) demonstrate promise for becoming a leader in public health;

''(4) secure admission to a 4-year institution of higher education; and

''(5) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—Amounts received under an award under subsection (a) shall be used to support opportunities for students to become public health professionals.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director shall give priority to those students that—

''(1) are from disadvantaged backgrounds;

''(2) have secured admissions to a minority-serving institution; and

''(3) have identified a health professional as a mentor at their school or institution and an academic advisor to assist in the completion of their baccalaureate degree.

''(e) SCHOLARSHIPS.—The Secretary may approve payment of scholarships under this section for such individuals for any period of education in student under-

graduate tenure, except that such a scholarship may not be provided to an individual for more than 4 years, and such a scholarship may not exceed $10,000 per academic year for an individual (notwithstanding any other provision of law regarding the amount of a scholarship).

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

**''SEC. 3420. PATSY MINK HEALTH AND GENDER RESEARCH FELLOWSHIP PROGRAM.**

''(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Deputy Assistant Secretary for Minority Health, the Assistant Secretary for Mental Health and Substance Use, and the Director of the Indian Health Services, shall award research fellowships to eligible individuals under subsection (b) to conduct research that will examine gender and health disparities and to pursue a career in the health professions.

''(b) ELIGIBILITY.—To be eligible to receive a fellowship under subsection (a), an individual shall—

''(1) have experience in health research or public health practice;

''(2) reside in a health professional shortage area as designated by the Secretary under section 332;

''(3) have expressed an interest in the health professions;

''(4) demonstrate promise for becoming a leader in the field of women's health;

''(5) secure admission to a health professions school or graduate program with an emphasis in gender studies; and

''(6) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—A fellowship awarded under subsection (a) to an eligible individual shall be used to support an opportunity for the individual to become a researcher and advance the research base on the intersection between gender and health.

''(d) PRIORITY.—In awarding fellowships under subsection (a), the Director of the Centers for Disease Control and Prevention shall give priority to those applicants that—

''(1) are from disadvantaged backgrounds; and

''(2) have identified a mentor and academic advisor who will assist in the completion of their grad-

uate or professional degree and have secured a research assistant position with a researcher working in the area of gender and health.

''(e) FELLOWSHIPS.—The Director of the Centers for Disease Control and Prevention may approve fellowships for individuals under this section for any period of education in the student's graduate or health profession tenure, except that such a fellowship may not be provided to an individual for more than 3 years, and such a fellowship may not exceed $18,000 per academic year for an individual (notwithstanding any other provision of law regarding the amount of a fellowship).

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

**''SEC. 3421. PAUL DAVID WELLSTONE INTERNATIONAL HEALTH FELLOWSHIP PROGRAM.**

''(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, in collaboration with the Deputy Assistant Secretary for Minority Health, shall award research fellowships to eligible individuals under subsection (b) to advance their understanding of international health.

''(b) ELIGIBILITY.—To be eligible to receive a fellowship under subsection (a), an individual shall—

''(1) have educational experience in the field of international health;

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

''(3) demonstrate promise for becoming a leader in the field of international health;

''(4) be a college senior or recent graduate of a 4-year institution of higher education; and

''(5) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—A fellowship awarded under subsection (a) to an eligible individual shall be used to support an opportunity for the individual to become a health professional and to advance the knowledge of the individual about international issues relating to health care access and quality.

''(d) PRIORITY.—In awarding fellowships under subsection (a), the Director shall give priority to eligible individuals that—

''(1) are from a disadvantaged background; and

''(2) have identified a mentor at a health professions school or institution, an academic advisor to

assist in the completion of their graduate or professional degree, and an advisor from an international health non-governmental organization, private volunteer organization, or other international institution or program that focuses on increasing health care access and quality for residents in developing countries.

''(e) FELLOWSHIPS.—A fellowship awarded under this section may not—

''(1) be provided to an eligible individual for more than a period of 6 months;

''(2) be awarded to a graduate of a 4-year institution of higher education that has not been enrolled in such institution for more than 1 year; and

''(3) exceed $4,000 per academic year (notwithstanding any other provision of law regarding the amount of a fellowship).

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2021 through 2025.

**''SEC. 3422. EDWARD R. ROYBAL HEALTH SCHOLAR PROGRAM.**

''(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, the Director of the Cen-

ters for Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration, in collaboration with the Deputy Assistant Secretary for Minority Health, shall award grants to eligible entities to expose entering graduate students to the health professions.

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

''(1) be a clinical, public health, or health services organization, community-based, academic, or nonprofit entity, or other entity determined appropriate by the Director of the Agency for Healthcare Research and Quality;

''(2) serve in a health professional shortage area as designated by the Secretary under section 332;

''(3) work with students obtaining a degree in the health professions; and

''(4) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—Amounts received under a grant awarded under subsection (a) shall be used to support opportunities that expose students to non-research-based health professions, including—

''(1) public health policy;

''(2) health care and pharmaceutical policy;

''(3) health care administration and management;

''(4) health economics; and

''(5) other professions determined appropriate by the Director of the Agency for Healthcare Research and Quality, the Director of the Centers for Medicare & Medicaid Services, or the Administrator of the Health Resources and Services Administration.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director of the Agency for Healthcare Research and Quality, the Director of the Centers for Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration, in collaboration with the Deputy Assistant for Secretary for Minority Health, shall give priority to those entities that—

''(1) have experience with health disparity elimination programs;

''(2) facilitate training in the fields described in subsection (c); and

''(3) provide counseling or other services designed to assist students in successfully completing their education at the postsecondary level.

''(e) STIPENDS.—

''(1) IN GENERAL.—Subject to paragraph (2), an entity receiving a grant under this section may use the funds made available through such grant to award stipends for educational and living expenses to students participating in the opportunities supported by the grant.

''(2) LIMITATIONS.—A stipend awarded under paragraph (1) to an individual—

''(A) may not be provided for a period that exceeds 2 months; and

''(B) may not exceed $100 per day (notwithstanding any other provision of law regarding the amount of a stipend).

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

**''SEC. 3423. LEADERSHIP FELLOWSHIP PROGRAMS.**

''(a) IN GENERAL.—The Secretary shall award grants to national minority medical or health professional associations to develop leadership fellowship programs for underrepresented health professionals in order to—

''(1) assist such professionals in becoming future leaders in public health and health care delivery institutions; and

''(2) increase diversity in decision-making positions that can improve the health of underserved communities.

''(b) USE OF FUNDS.—A leadership fellowship program supported under this section shall—

''(1) focus on training mid-career physicians and health care executives who have documented leadership experience and a commitment to public health services in underserved communities; and

''(2) support Federal public health policy and budget programs, and priorities that impact health equity, through activities such as didactic lectures and leader site visits.

''(c) PERIOD OF GRANTS.—The period during which payments are made under a grant awarded under subsection (a) may not exceed 3 years.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2026.''.

**SEC. 307. MCNAIR POSTBACCALAUREATE ACHIEVEMENT PROGRAM.**

Section 402E of the Higher Education Act of 1965 (20 U.S.C. 1070a–15) is amended by striking subsection (g) and inserting the following:

''(g) COLLABORATION IN HEALTH PROFESSION DIVERSITY TRAINING PROGRAMS.—The Secretary shall coordinate with the Secretary of Health and Human Services to ensure that there is collaboration between the goals of the program under this section and programs of the Health Resources and Services Administration that promote health workforce diversity. The Secretary of Education shall take such measures as may be necessary to encourage students participating in projects assisted under this section to consider health profession careers.

''(h) FUNDING.—From amounts appropriated pursuant to the authority of section 402A(g), the Secretary shall, to the extent practicable, allocate funds for projects authorized by this section in an amount which is not less than $31,000,000 for each of the fiscal years 2021 though 2026.''.

**SEC. 308. RULES FOR DETERMINATION OF FULL-TIME EQUIVALENT RESIDENTS FOR COST-REPORTING PERIODS.**

(a) DGME DETERMINATIONS.—Section 1886(h)(4) of the Social Security Act (42 U.S.C. 1395ww(h)(4)), as amended by section 204(a), is amended—

(1) in subparagraph (E), by striking ''Subject to subparagraphs (J) and (K), such rules'' and inserting ''Subject to subparagraphs (J), (K), and (M), such rules'';

(2) in subparagraph (J), by striking ''Such rules'' and inserting ''Subject to subparagraph (M), such rules'';

(3) in subparagraph (K), by striking ''In determining'' and inserting ''Subject to subparagraph (M), in determining''; and

(4) by adding at the end the following new subparagraph:

''(M) TREATMENT OF CERTAIN RESIDENTS AND INTERNS.—For purposes of cost-reporting periods beginning on or after October 1, 2021, in determining the hospital's number of full-time equivalent residents for purposes of this paragraph, all the time spent by an intern or resident in an approved medical residency training program shall be counted toward the deter-

mination of full-time equivalency if the hospital—

''(i) is recognized as a subsection (d) hospital;

''(ii) is recognized as a subsection (d) Puerto Rico hospital;

''(iii) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

''(iv) is a provider-based hospital outpatient department.''.

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B)(xi) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(xi)), as redesignated by section 204(b), is amended—

(1) in subclause (II), by striking ''In determining'' and inserting ''Subject to subclause (IV), in determining'';

(2) in subclause (III), by striking ''In determining'' and inserting ''Subject to subclause (IV), in determining''; and

(3) by inserting after subclause (III) the following new subclause:

''(IV) For purposes of cost-reporting periods beginning on or after October 1, 2021, the

provisions of subparagraph (M) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.''.

**SEC. 309. DEVELOPING AND IMPLEMENTING STRATEGIES FOR LOCAL HEALTH EQUITY.**

(a) GRANTS.—The Secretary of Health and Human Services, acting jointly with the Secretary of Education and the Secretary of Labor, shall make grants to institutions of higher education for the purposes of—

(1) in accordance with subsection (b), developing capacity—

(A) to build an evidence base for successful strategies for increasing local health equity; and

(B) to serve as national models of driving local health equity;

(2) in accordance with subsection (c), developing a strategic partnership with the community in which the institution is located; and

(3) collecting data on, and periodically evaluating, the effectiveness of the institution's programs funded through this section to enable the institution to adapt accordingly for maximum efficiency and success.

(b) DEVELOPING CAPACITY FOR INCREASING LOCAL HEALTH EQUITY.—As a condition on receipt of a grant under subsection (a), an institution of higher education shall agree to use the grant to build an evidence base for successful strategies for increasing local health equity, and to serve as a national model of driving local health equity, by supporting—

(1) resources to strengthen institutional metrics and capacity to execute institution-wide health workforce goals that can serve as models for increasing health equity in communities across the United States;

(2) collaborations among a cohort of institutions in implementing systemic change, partnership development, and programmatic efforts supportive of health equity goals across disciplines and populations; and

(3) enhanced or newly developed data systems and research infrastructure capable of informing current and future workforce efforts and building a foundation for a broader research agenda targeting urban health disparities.

(c) STRATEGIC PARTNERSHIPS.—As a condition on receipt of a grant under subsection (a), an institution of higher education shall agree to use the grant to develop

a strategic partnership with the community in which the institution is located for the purposes of—

(1) strengthening connections between the institution and the community—

(A) to improve evaluation of and address the community's health and health workforce needs; and

(B) to engage the community in health workforce development;

(2) developing, enhancing, or accelerating innovative undergraduate and graduate programs in the biomedical sciences and health professions; and

(3) strengthening pipeline programs in the biomedical sciences and health professions, including by developing partnerships between institutions of higher education and elementary schools and secondary schools to recruit the next generation of health professionals earlier in the pipeline to a health care career.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2026.

**SEC. 310. LOAN FORGIVENESS FOR MENTAL AND BEHAVIORAL HEALTH SOCIAL WORKERS.**

Section 455 of the Higher Education Act of 1965 (20 U.S.C. 1087e) is amended by adding at the end the following:

''(r) REPAYMENT PLAN FOR MENTAL AND BEHAVIORAL HEALTH SOCIAL WORKERS.—

''(1) IN GENERAL.—The Secretary shall cancel the balance of interest and principal due, in accordance with paragraph (2), on any eligible Federal Direct Loan not in default for a borrower who—

''(A) has made 120 monthly payments on the eligible Federal Direct Loan after October 1, 2020, pursuant to any one or a combination of the following—

''(i) payments under an income-based repayment plan under section 493C;

''(ii) payments under a standard repayment plan under subsection (d)(1)(A), based on a 10-year repayment period;

''(iii) monthly payments under a repayment plan under subsection (d)(1) or (g) of not less than the monthly amount calculated under subsection (d)(1)(A), based on a 10-year repayment period; or

''(iv) payments under an income contingent repayment plan under subsection (d)(1)(D); and

''(B)(i) is employed as a mental health or behavioral health social worker, as defined by the Secretary by regulation, at the time of such forgiveness; and

''(ii) has been employed as such a mental health or behavioral health social worker during the period in which the borrower makes each of the 120 payments as described in subparagraph (A).

''(2) LOAN CANCELLATION AMOUNT.—After the conclusion of the employment period described in paragraph (1), the Secretary shall cancel the obligation to repay the balance of principal and interest due as of the time of such cancellation, on the eligible Federal Direct Loans made to the borrower under this part.

''(3) INELIGIBILITY FOR DOUBLE BENEFITS.—No borrower may, for the same employment as a mental health or behavioral health social worker, receive a reduction of loan obligations under both this subsection and subsection (m), 428J, 428K, 428L, or 460.

''(4) DEFINITION OF ELIGIBLE FEDERAL DIRECT LOAN.—In this subsection, the term 'eligible Federal Direct Loan' means a Federal Direct Stafford Loan, Federal Direct PLUS Loan, Federal Direct Unsubsidized Stafford Loan, or a Federal Direct Consolidation Loan.''.

**SEC. 311. HEALTH PROFESSIONS WORKFORCE FUND.**

(a) ESTABLISHMENT.—There is established in the Health Resources and Services Administration of the Department of Health and Human Services a Health Professions Workforce Fund to provide for expanded and sustained national investment in the health professions and nursing workforce development programs under title VII and title VIII of the Public Health Service Act (42 U.S.C. 292 et seq; 42 U.S.C. 296 et seq).

(b) FUNDING.—

(1) IN GENERAL.—There is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, to the Health Professions Workforce Fund—

(A) $355,000,000 for fiscal year 2021;

(B) $375,000,000 for fiscal year 2022;

(C) $392,000,000 for fiscal year 2023;

(D) $412,000,000 for fiscal year 2024;

(E) $432,000,000 for fiscal year 2025;

(F) $454,000,000 for fiscal year 2026;

(G) $476,000,000 for fiscal year 2027;

(H) $500,000,000 for fiscal year 2028;

(I) $525,000,000 for fiscal year 2029; and

(J) $552,000,000 for fiscal year 2030.

(2) HEALTH PROFESSIONS EDUCATION PROGRAMS.—For the purpose of carrying out health professions education programs authorized under title VII of the Public Health Service Act, in addition to any other amounts authorized to be appropriated for such purpose, there is authorized to be appropriated out of any monies in the Health Professions Workforce Fund, the following:

(A) $240,000,000 for fiscal year 2021.

(B) $253,000,000 for fiscal year 2022.

(C) $265,000,000 for fiscal year 2023.

(D) $278,000,000 for fiscal year 2024.

(E) $292,000,000 for fiscal year 2025.

(F) $307,000,000 for fiscal year 2026.

(G) $322,000,000 for fiscal year 2027.

(H) $338,000,000 for fiscal year 2028.

(I) $355,000,000 for fiscal year 2029.

(J) $373,000,000 for fiscal year 2030.

(3) NURSING WORKFORCE DEVELOPMENT PROGRAMS.—For the purpose of carrying out nursing

workforce development programs authorized under Title VIII of the Public Health Service Act, in addition to any other amounts authorized to be appropriated for such purpose, there is authorized to be appropriated out of any monies in the Health Professions Workforce Fund, the following:

(A) $115,000,000 for fiscal year 2021.

(B) $122,000,000 for fiscal year 2022.

(C) $127,000,000 for fiscal year 2023.

(D) $134,000,000 for fiscal year 2024.

(E) $140,000,000 for fiscal year 2025.

(F) $147,000,000 for fiscal year 2026.

(G) $154,000,000 for fiscal year 2027.

(H) $162,000,000 for fiscal year 2028.

(I) $170,000,000 for fiscal year 2029.

(J) $179,000,000 for fiscal year 2030.

**SEC. 312. FINDINGS; SENSE OF CONGRESS RELATING TO GRADUATE MEDICAL EDUCATION.**

(a) FINDINGS.—Congress finds the following:

(1) Projections by the Association of American Medical Colleges and other expert entities, such as the Health Resources and Services Administration, have indicated a nationwide shortage of up to 121,900 physicians, split evenly between primary care and specialists, by 2032.

(2) Primarily due to the growing and aging population, over the next decade, physician demand is expected to grow up to 17 percent.

(3) The United States Census Bureau estimates that the United States population will grow from 321 million in 2015 to 347 million in 2025. Further, the number of Medicare beneficiaries is estimated to increase from 47,800,000 in 2015 to approximately 66,000,000 in 2025.

(4) Approximately 36 percent of practicing physicians are over the age of 55 and are likely to retire within the next decade.

(5) A nationwide physician shortage will result in many people in the United States waiting longer and traveling farther for health care; seeking non-emergent care in emergency departments; and delaying treatment until their health care needs become more serious, complex, and costly.

(6) Changing demographics (such as an aging population), new health care delivery models (such as medical homes), and other factors (such as disaster preparedness) are contributing to a shortage of both generalist and specialist physicians.

(7) These shortages will have the most severe impact on vulnerable and underserved populations,

including racial and ethnic minorities and the approximately 20 percent of people in the United States who live in rural or inner-city locations designated as health professional shortage areas.

(8) The health care utilization equity model of the Association of American Medical Colleges estimates that if racial and ethnic minorities and individuals from rural areas utilized health care in a similar way to their Caucasian counterparts living in metropolitan areas, the physician shortage would require an additional 96,000 physicians.

(9) To address the physician shortage in rural and medically underserved areas, medical education and training need to be accessible to underrepresented minorities (African American, Hispanic, Native American, and Native Hawaiian), and need to increase pathway programs for underrepresented minorities who make up less than 12 percent as well as for international medical graduates who make up 25 percent of graduate medical education. Immigration pathways like student, exchange-visitor, and employment visas, and programs like the National Interest Waiver and Conrad 30 J–1 Visa Waiver, help improve health access across the United States.

(10) United States medical school enrollment will grow by 30 percent from 2018 to 2019 to help reduce the shortage of quality physicians in the United States.

(11) An increase in United States medical school graduates must be accompanied by an increase of 4,000 graduate medical education training positions each year.

(12) Graduate medical education programs and teaching hospitals provide venues in which the next generation of physicians learns to work collaboratively with other physicians and health professionals, adopt more efficient care delivery models (such as care coordination and medical homes), incorporate health information technology and electronic health records in every aspect of their work, apply new methods of assuring quality and safety, and participate in groundbreaking clinical and public health research.

(13) The Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (having more beneficiaries than any other health care program), supports its ''fair share'' of the costs associated with graduate medical education.

(14) In general, the level of support of graduate medical education by the Medicare program has been capped since 1997 and has not been increased to support the expansion of graduate medical education programs needed to avert the projected physician shortage or to accommodate the increase in United States medical school graduates.

(b) SENSE OF CONGRESS.—It is the sense of Congress that eliminating the limit of the number of residency positions that receive some level of Medicare support under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)), also referred to as the Medical graduate medical education cap, is critical to—

(1) ensuring an appropriate supply of physicians to meet the health care needs in the United States;

(2) facilitating equitable access for all who seek health care; and

(3) mitigating disparities in health and health care.

**SEC. 313. CAREER SUPPORT FOR SKILLED, INTERNATIONALLY-EDUCATED HEALTH PROFESSIONALS.**

(a) FINDINGS.—Congress finds the following:

(1) According to the Association of Schools and Programs of Public Health, projections indicate a

nationwide shortage of up to 250,000 public health workers needed by 2020.

(2) Similar trends are projected for other health professions indicating shortages across disciplines, including within the fields of nursing (500,000 by 2025), dentistry (15,000 by 2025), pharmacy (38,000 by 2030), mental and behavioral health, primary care (46,000 by 2025), and community and allied health.

(3) A nationwide health workforce shortage will result in serious health threats and more severe and costly health care needs, due to, in part, a delayed response to food-borne outbreaks, emerging infectious diseases, natural disasters, fewer cancer screenings, and delayed treatment.

(4) Vulnerable and underserved populations and health professional shortage areas will be most severely impacted by the health workforce shortage.

(5) According to the Migration Policy Institute, more than 2,000,000 college-educated immigrants in the United States today are unemployed or underemployed in low- or semi-skilled jobs that fail to draw on their education and expertise.

(6) Approximately 2 out of every 5 internationally educated immigrants are unemployed or underemployed.

(7) According to the Drexel University Center for Labor Markets and Policy, underemployment for internationally educated immigrant women is 28 percent higher than for their male counterparts.

(8) According to the Drexel University Center for Labor Markets and Policy, the mean annual earnings of underemployed immigrants were $32,000, or 43 percent less than United States born college graduates employed in the college labor market.

(9) According to Upwardly Global and the Welcome Back Initiative, with proper guidance and support, underemployed skilled immigrants typically increase their income by 215 percent to 900 percent.

(10) According to the Brookings Institution and the Partnership for a New American Economy, immigrants working in the health workforce are, on average, better educated than United States-born workers in the health workforce.

(b) GRANTS TO ELIGIBLE ENTITIES.—

(1) AUTHORITY TO PROVIDE GRANTS.—The Secretary of Health and Human Services, acting

through the Bureau of Health Workforce within the Health Resources and Services Administration, the National Institute on Minority Health and Health Disparities, or the Office of Minority Health (in this section referred to as the ''Secretary''), may award grants to eligible entities to carry out activities described in subsection (c).

(2) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall—

(A) be a clinical, public health, or health services organization, a community-based or nonprofit entity, an academic institution, a faith-based organization, a State, county, or local government, an area health education center, or another entity determined appropriate by the Secretary; and

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) AUTHORIZED ACTIVITIES.—A grant awarded under this section shall be used—

(1) to provide services to assist unemployed and underemployed skilled immigrants, residing in the United States, who have legal, permanent work authorization and who are internationally educated

health professionals, enter into the health workforce of the United States with employment matching their health professional skills and education, and advance in employment to positions that better match their health professional education and expertise;

(2) to provide training opportunities to reduce barriers to entry and advancement in the health workforce for skilled, internationally educated immigrants;

(3) to educate employers regarding the abilities and capacities of internationally educated health professionals;

(4) to assist in the evaluation of foreign credentials;

(5) to support preceptorships for international medical graduates in hospital primary care training; and

(6) to facilitate access to contextualized and accelerated courses on English as a second language.

**SEC. 314. STUDY AND REPORT ON STRATEGIES FOR INCREASING DIVERSITY.**

(a) STUDY.—The Comptroller General of the United States shall conduct a study on strategies for increasing the diversity of the health professional workforce. Such

study shall include an analysis of strategies for increasing the number of health professionals from rural, lower income, and underrepresented minority communities, including which strategies are most effective for achieving such goal.

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

**SEC. 315. CONRAD STATE 30 AND PHYSICIAN RETENTION.**

(a) CONRAD STATE 30 PROGRAM EXTENSION.—Section 220(c) of the Immigration and Nationality Technical Corrections Act of 1994 (Public Law 103–416; 8 U.S.C. 1182 note) is amended by striking ''September 30, 2015'' and inserting ''September 30, 2021''.

(b) RETAINING PHYSICIANS WHO HAVE PRACTICED IN MEDICALLY UNDERSERVED COMMUNITIES .—Section 201(b)(1) of the Immigration and Nationality Act (8 U.S.C. 1151(b)(1)) is amended by adding at the end the following:

''(F)(i) Alien physicians who have completed service requirements of a waiver re-

quested under section 203(b)(2)(B)(ii), including—

''(I) alien physicians who completed such service before the date of the enactment of the Conrad State 30 and Physician Access Act; and

''(II) the spouse or children of an alien physician described in subclause (I).

''(ii) Nothing in this subparagraph may be construed—

''(I) to prevent the filing of a petition with the Secretary of Homeland Security for classification under section 204(a) or the filing of an application for adjustment of status under section 245 by an alien physician described in this subparagraph before the date by which such alien physician has completed the service described in section 214(l) or worked full-time as a physician for an aggregate of 5 years at the location identified in the section 214(l) waiver or in an area or areas designated by the Secretary of Health and Human Services as having a shortage of health care professionals; or

''(II) to permit the Secretary of Homeland Security to grant a petition or application described in subclause (I) until the alien has satisfied all of the requirements of the waiver received under section 214(l).''.

(c) EMPLOYMENT PROTECTIONS FOR PHYSICIANS.—

(1) EXCEPTIONS TO 2-YEAR FOREIGN RESIDENCY REQUIREMENT.—Section 214(l)(1) of the Immigration and Nationality Act (8 U.S.C. 1184(l)(1)) is amended—

(A) in the matter preceding subparagraph (A), by striking ''Attorney General'' and inserting ''Secretary of Homeland Security'';

(B) in subparagraph (A), by striking ''Director of the United States Information Agency'' and inserting ''Secretary of State'';

(C) in subparagraph (B), by inserting '', except as provided in paragraphs (7) and (8)'' before the semicolon at the end;

(D) in subparagraph (C), by striking clauses (i) and (ii) and inserting the following:

''(i) the alien demonstrates a bona fide offer of full-time employment at a health facility or health care organization,

which employment has been determined by the Secretary of Homeland Security to be in the public interest;

''(ii) the alien—

''(I) has accepted employment with the health facility or health care organization in a geographic area or areas which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals;

''(II) begins employment by the later of the date that is—

''(aa) 120 days after receiving such waiver;

''(bb) 120 days after completing graduate medical education or training under a program approved pursuant to section 212(j)(1); or

''(cc) 120 days after receiving nonimmigrant status or employment authorization, if the alien or the alien's employer petitions for such nonimmigrant sta-

tus or employment authorization not later than 120 days after the date on which the alien completes his or her graduate medical education or training under a program approved pursuant to section 212(j)(1); and

''(III) agrees to continue to work for a total of not less than 3 years in the status authorized for such employment under this subsection, except as provided in paragraph (8).''; and

(E) in subparagraph (D), in the matter preceding clause (i), by inserting ''(except as provided in paragraph (8)).

(2) ALLOWABLE VISA STATUS FOR PHYSICIANS FULFILLING WAIVER REQUIREMENTS IN MEDICALLY UNDERSERVED AREAS.—Section 214(l)(2)(A) of such Act (8 U.S.C. 1184(l)(2)(A)) is amended to read as follows:

''(A) Upon the request of an interested Federal agency or an interested State agency for recommendation of a waiver under this section by a physician who is maintaining valid nonimmigrant status under section

101(a)(15)(J) and a favorable recommendation by the Secretary of State, the Secretary of Homeland Security may change the status of such physician to any status authorized for employment under this Act. The numerical limitations contained in subsection (g)(1)(A) shall not apply to any alien whose status is changed under this subparagraph.''.

(3) VIOLATION OF AGREEMENTS.—Section 214(l)(3)(A) of such Act (8 U.S.C. 1184(l)(3)(A)) is amended by inserting ''substantial requirement of an'' before ''agreement entered into''.

(4) PHYSICIAN EMPLOYMENT IN UNDERSERVED AREAS.—Section 214(l) of such Act (8 U.S.C. 1184(l)), as amended by this section, is further amended by adding at the end the following:

''(4)(A) If an interested State agency denies the application for a waiver under paragraph (1)(B) from a physician pursuing graduate medical education or training pursuant to section 101(a)(15)(J) because the State has requested the maximum number of waivers permitted for that fiscal year, the physician's nonimmigrant status shall be extended for up to 6 months if the physician agrees to seek a waiver under this subsection (except for paragraph

(1)(D)(ii)) to work for an employer described in paragraph (1)(C) in a State that has not yet requested the maximum number of waivers.

''(B) Such physician shall be authorized to work only for the employer referred to in subparagraph (A) from the date on which a new waiver application is filed with such State until the earlier of—

''(i) the date on which the Secretary of Homeland Security denies such waiver; or

''(ii) the date on which the Secretary approves an application for change of status under paragraph (2)(A) pursuant to the approval of such waiver.''.

(5) CONTRACT REQUIREMENTS.—Section 214(l) of such Act, as amended by this section, is further amended by adding at the end the following:

''(5) An alien granted a waiver under paragraph (1)(C) shall enter into an employment agreement with the contracting health facility or health care organization that—

''(A) specifies the maximum number of on-call hours per week (which may be a monthly average) that the alien will be expected to be

available and the compensation the alien will receive for on-call time;

''(B) specifies—

''(i) whether the contracting facility or organization will pay the alien's malpractice insurance premiums;

''(ii) whether the employer will provide malpractice insurance; and

''(iii) the amount of such insurance that will be provided;

''(C) describes all of the work locations that the alien will work and includes a statement that the contracting facility or organization will not add additional work locations without the approval of the Federal agency or State agency that requested the waiver; and

''(D) does not include a non-compete provision.

''(6) An alien granted a waiver under this subsection whose employment relationship with a health facility or health care organization terminates under paragraph (1)(C)(ii) during the 3-year service period required under paragraph (1) shall be considered to be maintaining lawful status in an authorized period of stay during the 120-day period referred to in

items (aa) and (bb) of subclause (III) of paragraph (1)(C)(ii) or the 45-day period referred to in subclause (III)(cc) of such paragraph.''.

(6) RECAPTURING WAIVER SLOTS LOST TO OTHER STATES.—Section 214(l) of such Act, as amended by this section, is further amended by adding at the end the following:

''(7) If a recipient of a waiver under this subsection terminates the recipient's employment with a health facility or health care organization pursuant to paragraph (1)(C)(ii), including termination of employment because of circumstances described in paragraph (1)(C)(ii)(III), and accepts new employment with such a facility or organization in a different State, the State from which the alien is departing may be accorded an additional waiver by the Secretary of State for use in the fiscal year in which the alien's employment was terminated.''.

(7) EXCEPTION TO 3–YEAR WORK REQUIREMENT.—Section 214(l) of such Act, as amended by this section, is further amended by adding at the end the following:

''(8) The 3-year work requirement set forth in subparagraphs (C) and (D) of paragraph (1) shall not apply if—

''(A)(i) the Secretary of Homeland Security determines that extenuating circumstances, including violations by the employer of the employment agreement with the alien or of labor and employment laws, exist that justify a lesser period of employment at such facility or organization; and

''(ii) the alien demonstrates, not later than 120 days after the employment termination date (unless the Secretary determines that extenuating circumstances would justify an extension), another bona fide offer of employment at a health facility or health care organization in a geographic area or areas which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals, for the remainder of such 3-year period;

''(B)(i) the interested State agency that requested the waiver attests that extenuating circumstances, including violations by the employer of the employment agreement with the alien or of labor and employment laws, exist that justify a lesser period of employment at such facility or organization; and

''(ii) the alien demonstrates, not later than 120 days after the employment termination date (unless the Secretary determines that extenuating circumstances would justify an extension), another bona fide offer of employment at a health facility or health care organization in a geographic area or areas which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals, for the remainder of such 3-year period; or

''(C) the alien—

''(i) elects not to pursue a determination of extenuating circumstances pursuant to subclause (A) or (B);

''(ii) terminates the alien's employment relationship with the health facility or health care organization at which the alien was employed;

''(iii) demonstrates, not later than 45 days after the employment termination date, another bona fide offer of employment at a health facility or health care organization in a geographic area or areas, in the State that requested the alien's

waiver, which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals; and

''(iv) agrees to be employed for the remainder of such 3-year period, and 1 additional year for each termination under clause (ii).''.

(d) ALLOTMENT OF CONRAD 30 WAIVERS.—

(1) IN GENERAL.—Section 214(l) of the Immigration and Nationality Act (8 U.S.C. 1184(l)), as amended by subsection (d), is further amended by adding at the end the following:

''(8)(A)(i) All States shall be allotted a total of 35 waivers under paragraph (1)(B) for a fiscal year if 90 percent of the waivers available to the States receiving at least 5 waivers were used in the previous fiscal year.

''(ii) When an allotment occurs under clause (i), all States shall be allotted an additional 5 waivers under paragraph (1)(B) for each subsequent fiscal year if 90 percent of the waivers available to the States receiving at least 5 waivers were used in the previous fiscal year. If the States are allotted 45 or more waivers for a fiscal year, the States will only receive an additional increase of 5 waivers the following fiscal year if 95 percent of the waiv-

ers available to the States receiving at least 1 waiver were used in the previous fiscal year.

''(B) Any increase in allotments under subparagraph (A) shall be maintained indefinitely, unless in a fiscal year, the total number of such waivers granted is 5 percent lower than in the last year in which there was an increase in the number of waivers allotted pursuant to this paragraph, in which case—

''(i) the number of waivers allotted shall be decreased by five for all States beginning in the next fiscal year; and

''(ii) each additional 5 percent decrease in such waivers granted from the last year in which there was an increase in the allotment, shall result in an additional decrease of 5 waivers allotted for all States, provided that the number of waivers allotted for all States shall not drop below 30.''.

(2) ACADEMIC MEDICAL CENTERS.—Section 214(l)(1)(D) of such Act is amended—

(A) in clause (ii), by striking ''and'' at the end;

(B) in clause (iii), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(iv) in the case of a request by an interested State agency—

''(I) the head of such agency determines that the alien is to practice medicine in, or be on the faculty of a residency program at, an academic medical center (as that term is defined in section 411.355(e)(2) of title 42, Code of Federal Regulations, or similar successor regulation), without regard to whether such facility is located within an area designated by the Secretary of Health and Human Services as having a shortage of health care professionals; and

''(II) the head of such agency determines that—

''(aa) the alien physician's work is in the public interest; and

''(bb) the grant of such waiver would not cause the number of the waivers granted on behalf of aliens for such State for a fiscal year (within the limitation in subparagraph (B) and subject to paragraph (6)) in ac-

cordance with the conditions of this clause to exceed 3.''.

(e) AMENDMENTS TO THE PROCEDURES, DEFINITIONS, AND OTHER PROVISIONS RELATED TO PHYSICIAN IMMIGRATION.—

(1) DUAL INTENT FOR PHYSICIANS SEEKING GRADUATE MEDICAL TRAINING.—Section 214(b) of the Immigration and Nationality Act (8 U.S.C. 1184(b)) is amended by striking ''(other than a nonimmigrant described in subparagraph (L) or (V) of section 101(a)(15), and other than a nonimmigrant described in any provision of section 101(a)(15)(H)(i) except subclause (b1) of such section)'' and inserting ''(other than a nonimmigrant described in subparagraph (L) or (V) of section 101(a)(15), a nonimmigrant described in any provision of section 101(a)(15)(H)(i) (except subclause (b1) of such section), and an alien coming to the United States to receive graduate medical education or training as described in section 212(j) or to take examinations required to receive graduate medical education or training as described in section 212(j))''.

(2) PHYSICIAN NATIONAL INTEREST WAIVER CLARIFICATIONS.—

(A) PRACTICE AND GEOGRAPHIC AREA.—Section 203(b)(2)(B)(ii)(I) of the Immigration and Nationality Act (8 U.S.C. 1153(b)(2)(B)(ii)(I)) is amended by striking items (aa) and (bb) and inserting the following:

"(aa) the alien physician agrees to work on a full-time basis practicing primary care, specialty medicine, or a combination thereof, in an area or areas designated by the Secretary of Health and Human Services as having a shortage of health care professionals, or at a health care facility under the jurisdiction of the Secretary of Veterans Affairs; or

"(bb) the alien physician is pursuing such waiver based upon service at a facility or facilities that serve patients who reside in a geographic area or areas designated by the Secretary of Health and Human Services as having a shortage of health care professionals (without regard to whether such facility or facilities are located within such an area) and a Federal agency, or a local, county, regional, or State department of public health deter-

mines the alien physician's work was or will be in the public interest.''.

(B) FIVE-YEAR SERVICE REQUIREMENT.—Section 203(b)(2)(B)(ii) of the Immigration and Nationality Act (8 U.S.C. 1153(B)(ii)) is amended—

(i) by moving subclauses (II), (III), and (IV) 4 ems to the left; and

(ii) in subclause (II)—

(I) by inserting ''(aa)'' after ''(II)''; and

(II) by adding at the end the following:

''(bb) The 5-year service requirement under item (aa) shall begin on the date on which the alien physician begins work in the shortage area in any legal status and not on the date on which an immigrant visa petition is filed or approved. Such service shall be aggregated without regard to when such service began and without regard to whether such service began during or in conjunction with a course of graduate medical education.

''(cc) An alien physician shall not be required to submit an employment contract with a term exceeding the balance of the 5-year commitment yet to be served or an employment contract dated within a minimum time period before filing a visa petition under this subsection.

''(dd) An alien physician shall not be required to file additional immigrant visa petitions upon a change of work location from the location approved in the original national interest immigrant petition.''.

(3) TECHNICAL CLARIFICATION REGARDING ADVANCED DEGREE FOR PHYSICIANS.—Section 203(b)(2)(A) of the Immigration and Nationality Act (8 U.S.C. 1153(b)(2)(A)) is amended by adding at the end the following: ''An alien physician holding a foreign medical degree that has been deemed sufficient for acceptance by an accredited United States medical residency or fellowship program is a member of the professions holding an advanced degree or its equivalent.''.

(4) SHORT-TERM WORK AUTHORIZATION FOR PHYSICIANS COMPLETING THEIR RESIDENCIES.—

(A) IN GENERAL.—A physician completing graduate medical education or training described in section 212(j) of the Immigration and Nationality Act (8 U.S.C. 1182(j)) as a nonimmigrant described in section 101(a)(15)(H)(i) of such Act (8 U.S.C. 1101(a)(15)(H)(i))—

(i) shall have such nonimmigrant status automatically extended until October 1 of the fiscal year for which a petition for a continuation of such nonimmigrant status has been submitted in a timely manner and the employment start date for the beneficiary of such petition is October 1 of that fiscal year; and

(ii) shall be authorized to be employed incident to status during the period between the filing of such petition and October 1 of such fiscal year.

(B) TERMINATION.—The physician's status and employment authorization shall terminate on the date that is 30 days after the date on which a petition described in clause (i)(I) is rejected, denied or revoked.

(C) AUTOMATIC EXTENSION.—A physician's status and employment authorization will automatically extend to October 1 of the next fiscal year if all of the visas described in section 101(a)(15)(H)(i) of such Act that were authorized to be issued for the fiscal year have been issued.

(5) APPLICABILITY OF SECTION 212(e) TO SPOUSES AND CHILDREN OF J–1 EXCHANGE VISITORS.—A spouse or child of an exchange visitor described in section 101(a)(15)(J) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(J)) shall not be subject to the requirements under section 212(e) of such Act (8 U.S.C. 1182(e)).

# TITLE IV—IMPROVING HEALTH CARE ACCESS AND QUALITY

## Subtitle A—Improvement of Coverage

### SEC. 401. REPEAL OF REQUIREMENT FOR DOCUMENTATION EVIDENCING CITIZENSHIP OR NATIONALITY UNDER THE MEDICAID PROGRAM.

(a) REPEAL.—Subsections (i)(22) and (x) of section 1903 of the Social Security Act (42 U.S.C. 1396b) are each repealed.

(b) CONFORMING AMENDMENTS.—

(1) STATE PAYMENTS FOR MEDICAL ASSISTANCE.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by amending paragraph (46) of subsection (a) to read as follows:

''(46) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act;'';

(B) in subsection (e)(13)(A)(i)—

(i) in the matter preceding subclause (I), by striking ''sections 1902(a)(46)(B) and 1137(d)'' and inserting ''section 1137(d)''; and

(ii) in subclause (IV), by striking ''1902(a)(46)(B) or''; and

(C) by striking subsection (ee).

(2) PAYMENT TO STATES.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(A) in subsection (i), by redesignating paragraphs (23) through (26) as paragraphs (22) through (25), respectively; and

(B) by redesignating subsections (y) and (z) as subsections (x) and (y), respectively.

(3) REPEAL.—Subsection (c) of section 6036 of the Deficit Reduction Act of 2005 (42 U.S.C. 1396b note) is repealed.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of the Deficit Reduction Act of 2005.

**SEC. 402. REMOVING CITIZENSHIP AND IMMIGRATION BARRIERS TO ACCESS TO AFFORDABLE HEALTH CARE UNDER ACA.**

(a) IN GENERAL.—

(1) PREMIUM TAX CREDITS.—Section 36B of the Internal Revenue Code of 1986 is amended—

(A) in subsection (c)(1)(B)—

(i) by amending the heading to read as follows: ''SPECIAL RULE FOR CERTAIN INDIVIDUALS INELIGIBLE FOR MEDICAID DUE TO STATUS'', and

(ii) in clause (ii), by striking ''lawfully present in the United States, but'' and inserting ''who'', and

(B) by striking subsection (e).

(2) COST-SHARING REDUCTIONS.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is amended by striking subsection (e).

(3) BASIC HEALTH PROGRAM ELIGIBILITY.—Section 1331(e)(1)(B) of the Patient Protection and Affordable Care Act (42 U.S.C. 18051(e)(1)(B)) is amended by striking ''lawfully present in the United States''.

(4) RESTRICTIONS ON FEDERAL PAYMENTS.—Section 1412 of the Patient Protection and Affordable Care Act (42 U.S.C. 18082) is amended by striking subsection (d).

(5) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—Section 5000A(d) of the Internal Revenue Code of 1986 is amended by striking paragraph (3) and by redesignating paragraph (4) as paragraph (3).

(b) CONFORMING AMENDMENTS.—

(1) Section 1411(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(a)) is amended by striking paragraph (1) and redesignating paragraphs (2), (3), and (4) as paragraphs (1), (2), and (3), respectively.

(2) Section 1312(f) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(f)) is amended—

(A) in the heading, by striking ''; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS''; and

(B) by striking paragraph (3).

**SEC. 403. STUDY ON THE UNINSURED.**

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall—

(1) conduct a study, in accordance with the standards under section 3101 of the Public Health Service Act (42 U.S.C. 300kk), on the demographic characteristics of the population of individuals who do not have health insurance coverage or oral health coverage; and

(2) predict, based on such study, the demographic characteristics of the population of individuals who would remain without health insurance coverage after the end of any annual open enrollment or any special enrollment period or upon enactment and implementation of any legislative changes to the Patient Protection and Affordable Care Act (Public Law 111–148) that affect the number of persons eligible for coverage.

(b) REPORTING REQUIREMENTS.—

(1) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act, the Secretary shall submit to the Congress the results of the study under subsection (a)(1) and the prediction made under subsection (a)(2).

(2) REPORTING OF DEMOGRAPHIC CHARACTERISTICS.—The Secretary shall—

(A) report the demographic characteristics under paragraphs (1) and (2) of subsection (a) on the basis of racial and ethnic group, and shall stratify the reporting on each racial and ethnic group by other demographic characteristics that can impact access to health insurance coverage, such as sexual orientation, gender identity, primary language, disability status, sex, socioeconomic status, age group, and citizenship and immigration status, in a manner consistent with title I of this Act, including the amendments made by such title; and

(B) not use such report to engage in or anticipate any deportation or immigration related enforcement action by any entity, including the Department of Homeland Security.

**SEC. 404. MEDICAID IN THE TERRITORIES.**

(a) ELIMINATION OF GENERAL MEDICAID FUNDING LIMITATIONS (''CAP'') FOR TERRITORIES.—

(1) IN GENERAL.—Section 1108 of the Social Security Act (42 U.S.C. 1308) is amended—

(A) in subsection (f), in the matter preceding paragraph (1), by striking ''subsection (g)'' and inserting ''subsections (g) and (h)'';

(B) in subsection (g)(2), in the matter preceding subparagraph (A), by inserting ''and subsection (h)'' after ''paragraphs (3) and (5)''; and

(C) by adding at the end the following new subsection:

''(h) SUNSET OF MEDICAID FUNDING LIMITATIONS FOR PUERTO RICO, THE VIRGIN ISLANDS OF THE UNITED STATES, GUAM, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA.—Subsections (f) and (g) shall not apply to Puerto Rico, the Virgin Islands of the United States, Guam, the Northern Mariana Islands, and American Samoa beginning with fiscal year 2020.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(j) of the Social Security Act (42 U.S.C. 1396a(j)) is amended by striking '', the limitation in section 1108(f),''.

(B) Section 1903(u) of the Social Security Act (42 U.S.C. 1396b(u)) is amended by striking paragraph (4).

(C) Section 1323(c)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18043(c)(1)) is amended by striking ''2019'' and inserting ''2018''.

(3) EFFECTIVE DATE.—The amendments made by this section shall apply beginning with fiscal year 2021.

(b) ELIMINATION OF SPECIFIC FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) LIMITATION FOR TERRITORIES.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in clause (2), by inserting ''for fiscal years before fiscal year 2020'' after ''American Samoa''.

(c) APPLICATION OF MEDICAID WAIVER AUTHORITY TO ALL OF THE TERRITORIES.—

(1) IN GENERAL.—Section 1902(j) of the Social Security Act (42 U.S.C. 1396a(j)) is amended—

(A) by striking ''American Samoa and the Northern Mariana Islands'' and inserting ''Puerto Rico, the Virgin Islands of the United States, Guam, the Northern Mariana Islands, and American Samoa'';

(B) by striking ''American Samoa or the Northern Mariana Islands'' and inserting ''Puerto Rico, the Virgin Islands of the United States, Guam, the Northern Mariana Islands, or American Samoa'';

(C) by inserting ''(1)'' after ''(j)'';

(D) by inserting ''except as otherwise provided in this subsection,'' after ''Notwithstanding any other requirement of this title''; and

(E) by adding at the end the following:

''(2) The Secretary may not waive under this subsection the requirement of subsection (a)(10)(A)(i)(IX) (relating to coverage of adults formerly under foster care) with respect to any territory.''.

(2) EFFECTIVE DATE.—The amendments made by this section shall apply beginning October 1, 2021.

(d) PERMITTING MEDICAID DSH ALLOTMENTS FOR TERRITORIES.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4) is amended—

(1) in paragraph (6), by adding at the end the following new subparagraph:

''(C) TERRITORIES.—

''(i) FISCAL YEAR 2020.—For fiscal year 2020, the DSH allotment for Puerto Rico, the Virgin Islands of the United States, Guam, the Northern Mariana Islands, and American Samoa shall bear the same ratio to $300,000,000 as the ratio of the number of individuals who are low-income or uninsured and residing in such respective territory (as estimated from time to time by the Secretary) bears to the sums of the number of such individuals residing in all of the territories.

''(ii) SUBSEQUENT FISCAL YEAR.—For each subsequent fiscal year, the DSH allotment for each such territory is subject to an increase in accordance with paragraph (2).''; and

(2) in paragraph (9), by inserting before the period at the end the following: '', and includes, beginning with fiscal year 2021, Puerto Rico, the Virgin Islands of the United States, Guam, the Northern Mariana Islands, and American Samoa''.

**SEC. 405. EXTENSION OF MEDICARE SECONDARY PAYER.**

(a) IN GENERAL.—Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence, by inserting ", and before January 1, 2021" after "prior to such date)"; and

(2) by adding at the end the following new sentence: "Effective for items and services furnished on or after January 1, 2021 (with respect to periods beginning on or after the date that is 42 months prior to such date), clauses (i) and (ii) shall be applied by substituting '42-month' for '12-month' each place it appears.".

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act. For purposes of determining an individual's status under section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)), as amended by subsection (a), an individual who is within the coordinating period as of the date of enactment of this Act shall have that period extended to the full 42 months described in the last sentence of such section, as added by the amendment made by subsection (a)(2).

**SEC. 406. INDIAN DEFINED IN TITLE I OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.**

(a) DEFINITION OF INDIAN.—Section 1304 of the Patient Protection and Affordable Care Act (42 U.S.C. 18024) is amended by adding at the end the following:

''(f) INDIAN.—

''(1) IN GENERAL.—In this title, the term 'Indian' means any individual—

''(A) described in paragraph (13) or (28) of section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603);

''(B) who is eligible for health services provided by the Indian Health Service under section 809 of the Indian Health Care Improvement Act (25 U.S.C. 1679);

''(C) who is of Indian descent and belongs to the Indian community served by the local facilities and program of the Indian Health Service; or

''(D) who is described in paragraph (2).

''(2) INCLUSIONS.—An individual is described in this paragraph if the individual is any of the following:

''(A) A member of a federally recognized Indian Tribe.

''(B) A resident of an urban center who meets any of the following criteria:

''(i) Membership in a Tribe, band, or other organized group of Indians, including those Tribes, bands, or groups terminated since 1940 and those recognized as of the date of enactment of the Health Equity and Accountability Act of 2018 or later by the State in which they reside, or being a descendant, in the first or second degree, of any such member.

''(ii) Is an Eskimo or Aleut or other Alaska Native.

''(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose.

''(iv) Is determined to be an Indian under regulations promulgated by the Secretary.

''(C) An individual who is considered by the Secretary of the Interior to be an Indian for any purpose.

''(D) An individual who is considered by the Secretary to be an Indian for purposes of eligibility for Indian health care services, includ-

ing as a California Indian, Eskimo, Aleut, or other Alaska Native.''.

(b) CONFORMING AMENDMENTS.—

(1) AFFORDABLE CHOICES HEALTH BENEFIT PLANS.—Section 1311(c)(6)(D) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(6)(D)) is amended by striking ''(as defined in section 4 of the Indian Health Care Improvement Act)''.

(2) REDUCED COST-SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.—Section 1402(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 18071(d)) is amended—

(A) in paragraph (1), in the matter preceding subparagraph (A), by striking ''(as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))''; and

(B) in paragraph (2), in the matter preceding subparagraph (A), by striking ''(as so defined)''.

(3) EXEMPTION FROM PENALTY FOR NOT MAINTAINING MINIMUM ESSENTIAL COVERAGE.—Section 5000A(e) of the Internal Revenue Code of

1986 is amended by striking paragraph (3) and inserting the following:

''(3) INDIANS.—Any applicable individual who is an Indian (as defined in section 1304(f) of the Patient Protection and Affordable Care Act).''.

**SEC. 407. REMOVING MEDICARE BARRIER TO HEALTH CARE.**

(a) PART A.—Section 1818(a)(3) of the Social Security Act (42 U.S.C. 1395i–2(a)(3)) is amended by striking ''an alien'' and all that follows through ''under this section'' and inserting ''an individual who is lawfully present in the United States''.

(b) PART B.—Section 1836(2) of the Social Security Act (42 U.S.C. 1395o(2)) is amended by striking ''an alien'' and all that follows through ''under this part'' and inserting ''an individual who is lawfully present in the United States''.

**SEC. 408. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED BY URBAN INDIAN HEALTH CENTERS.**

(a) IN GENERAL.—The third sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396(b)) is amended by inserting ''or are received through a program operated by an urban Indian organization through a grant or contract under title V of such Act'' after ''(as

defined in section 4 of the Indian Health Care Improvement Act)''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to medical assistance provided on or after the date of enactment of this Act.

**SEC. 409. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.**

(a) IN GENERAL.—The third sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), as amended by section 408(a), is amended by inserting before the period the following: '', and with respect to medical assistance provided to a Native Hawaiian (as defined in section 12(2) of the Native Hawaiian Health Care Improvement Act) through a federally qualified health center or a Native Hawaiian health care system (as defined in section 12(6) of such Act), whether directly, by referral, or under contract or other arrangement between such federally qualified health center or Native Hawaiian health care system and another health care provider''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to medical assistance provided on or after the date of enactment of this Act.

**SEC. 410. MEDICAID COVERAGE FOR CITIZENS OF FREELY ASSOCIATED STATES.**

(a) IN GENERAL.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at the end the following new subparagraph:

"(G) MEDICAID EXCEPTION FOR CITIZENS OF FREELY ASSOCIATED STATES.—With respect to eligibility for benefits for the designated Federal program described in paragraph (3)(C), section 401(a) and paragraph (1) shall not apply to any individual who lawfully resides in 1 of the 50 States or the District of Columbia in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau and shall not apply, at the option of the Governors of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa, respectively, as communicated to the Secretary of Health and Human Services in writing, to any individual who lawfully resides in the respective territory in accordance with such Compacts.".

(b) EXCEPTION TO 5-YEAR LIMITED ELIGIBILITY.—Section 403(d) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613(d)) is amended—

(1) in paragraph (1), by striking ''or'' at the end;

(2) in paragraph (2), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following new paragraph:

''(3) an individual described in section 402(b)(2)(G), but only with respect to the designated Federal program described in section 402(b)(3)(C).''.

(c) DEFINITION OF QUALIFIED ALIEN.—Section 431(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(b)) is amended—

(1) in paragraph (6), by striking ''; or'' at the end and inserting a comma;

(2) in paragraph (7), by striking the period at the end and inserting '', or''; and

(3) by adding at the end the following new paragraph:

''(8) an individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in section 402(b)(2)(G), but only with respect to the designated Federal program described in section 402(b)(3)(C) (relating to the Medicaid program).''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2021.

**SEC. 411. AT-RISK YOUTH MEDICAID PROTECTION.**

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking ''and'' at the end of paragraph (83);

(B) by striking the period at the end of paragraph (84) and inserting ''; and''; and

(C) by inserting after paragraph (84) the following new paragraph:

''(85) provide that—

''(A) the State shall not terminate eligibility for medical assistance under a State plan for an individual who is an eligible juvenile (as defined in subsection (nn)(2)) because the juvenile is an inmate of a public institution (as defined in subsection (nn)(3)), but may suspend

coverage during the period the juvenile is such an inmate;

''(B) the State shall restore coverage for such medical assistance to such an individual upon the individual's release from any such public institution, without requiring a new application from the individual, unless (and until such date as) there is a determination that the individual no longer meets the eligibility requirements for such medical assistance; and

''(C) the State shall process any application for medical assistance submitted by, or on behalf of, a juvenile who is an inmate of a public institution notwithstanding that the juvenile is such an inmate.''; and

(2) by adding at the end the following new subsection:

''(nn) JUVENILE; ELIGIBLE JUVENILE; PUBLIC INSTITUTION.—For purposes of subsection (a)(84) and this subsection:

''(1) JUVENILE.—The term 'juvenile' means an individual who is—

''(A) under 21 years of age; or

''(B) is described in subsection (a)(10)(A)(i)(IX).

''(2) ELIGIBLE JUVENILE.—The term 'eligible juvenile' means a juvenile who is an inmate of a public institution and was eligible for medical assistance under the State plan immediately before becoming an inmate of such a public institution or who becomes eligible for such medical assistance while an inmate of a public institution.

''(3) INMATE OF A PUBLIC INSTITUTION.—The term 'inmate of a public institution' has the meaning given such term for purposes of applying the subdivision (A) following paragraph (30) of section 1905(a), taking into account the exception in such subdivision for a patient of a medical institution.''.

(b) NO CHANGE IN EXCLUSION FROM MEDICAL ASSISTANCE FOR INMATES OF PUBLIC INSTITUTIONS.—Nothing in this section shall be construed as changing the exclusion from medical assistance under the subdivision (A) following paragraph (30) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), including any applicable restrictions on a State submitting claims for Federal financial participation under title XIX of such Act for such assistance.

(c) NO CHANGE IN CONTINUITY OF ELIGIBILITY BEFORE ADJUDICATION OR SENTENCING.—Nothing in this section shall be construed to mandate, encourage, or sug-

gest that a State suspend or terminate coverage for individuals before they have been adjudicated or sentenced.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by subsection (a) shall apply to eligibility for medical assistance under a State plan under title XIX of the Social Security Act of juveniles who become inmates of public institutions on or after the date that is 1 year after the date of the enactment of this Act.

(2) RULE FOR CHANGES REQUIRING STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous

sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

# Subtitle B—Expansion of Access

### SEC. 412. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title XXXIV of the Public Health Service Act, as amended by titles I, II, III, and IX of this Act, is further amended by inserting after subtitle D the following:

# "Subtitle E—Reconstruction and Improvement Grants for Public Health Care Facilities Serving Pacific Islanders and the Insular Areas

### "SEC. 3451. GRANT SUPPORT FOR QUALITY IMPROVEMENT INITIATIVES.

''(a) IN GENERAL.—The Secretary, in collaboration with the Administrator of the Health Resources and Services Administration, the Director of the Agency for Healthcare Research and Quality, and the Administrator of the Centers for Medicare & Medicaid Services, shall award grants to eligible entities for the conduct of demonstration projects to improve the quality of and access to health care.

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

''(1) be a health center, hospital, health plan, health system, community clinic, or other health entity determined appropriate by the Secretary—

''(A) that, by legal mandate or explicitly adopted mission, provides patients with access to services regardless of their ability to pay;

''(B) that provides care or treatment for a substantial number of patients who are uninsured, are receiving assistance under a State plan under title XIX of the Social Security Act (or under a waiver of such plan), or are members of vulnerable populations, as determined by the Secretary; and

''(C)(i) with respect to which, not less than 50 percent of the entity's patient population is made up of racial and ethnic minority groups; or

''(ii) that—

''(I) serves a disproportionate percentage of local patients that are from a racial and ethnic minority group, or that has a patient population, at least 50 percent of which is

composed of individuals with limited-English proficiency; and

''(II) provides an assurance that amounts received under the grant will be used only to support quality improvement activities in the racial and ethnic minority population served; and

''(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants under subsection (b)(2) that—

''(1) demonstrate an intent to operate as part of a health care partnership, network, collaborative, coalition, or alliance where each member entity contributes to the design, implementation, and evaluation of the proposed intervention; or

''(2) intend to use funds to carry out system-wide changes with respect to health care quality improvement, including—

''(A) improved systems for data collection and reporting;

''(B) innovative collaborative or similar processes;

''(C) group programs with behavioral or self-management interventions;

''(D) case management services;

''(E) physician or patient reminder systems;

''(F) educational interventions; or

''(G) other activities determined appropriate by the Secretary.

''(d) USE OF FUNDS.—An entity shall use amounts received under a grant under subsection (a) to support the implementation and evaluation of health care quality improvement activities or minority health and health care disparity reduction activities that include—

''(1) with respect to health care systems, activities relating to improving—

''(A) patient safety;

''(B) timeliness of care;

''(C) effectiveness of care;

''(D) efficiency of care;

''(E) patient centeredness; and

''(F) health information technology; and

''(2) with respect to patients, activities relating to—

''(A) staying healthy;

''(B) getting well, mentally and physically;

''(C) living effectively with illness or disability;

''(D) coping with end-of-life issues; and

''(E) shared decisionmaking.

''(e) COMMON DATA SYSTEMS.—The Secretary shall provide financial and other technical assistance to grantees under this section for the development of common data systems.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2026.

**''SEC. 3452. CENTERS OF EXCELLENCE.**

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall designate centers of excellence at public hospitals, and other health systems serving large numbers of minority patients, that—

''(1) meet the requirements of section 3451(b)(1);

''(2) demonstrate excellence in providing care to minority populations; and

''(3) demonstrate excellence in reducing disparities in health and health care.

''(b) REQUIREMENTS.—A hospital or health system that serves as a center of excellence under subsection (a) shall—

''(1) design, implement, and evaluate programs and policies relating to the delivery of care in racially, ethnically, and linguistically diverse populations;

''(2) provide training and technical assistance to other hospitals and health systems relating to the provision of quality health care to minority populations; and

''(3) develop activities for graduate or continuing medical education that institutionalize a focus on cultural competence training for health care providers.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2021 through 2026.

**"SEC. 3453. RECONSTRUCTION AND IMPROVEMENT GRANTS FOR PUBLIC HEALTH CARE FACILITIES SERVING PACIFIC ISLANDERS AND THE INSULAR AREAS.**

''(a) IN GENERAL.—The Secretary shall provide direct financial assistance to designated health care providers and community health centers in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii for the purposes of reconstructing and improving health care facilities and services in a culturally competent and sustainable manner.

''(b) ELIGIBILITY.—To be eligible to receive direct financial assistance under subsection (a), an entity shall be a public health facility or community health center located in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, or Hawaii that—

''(1) is owned or operated by—

''(A) the Government of American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, or Hawaii or a unit of local government; or

''(B) a nonprofit organization; and

''(2)(A) provides care or treatment for a substantial number of patients who are uninsured, receiving assistance under title XVIII of the Social Security Act, or a State plan under title XIX of such Act (or under a waiver of such plan), or who are members of a vulnerable population, as determined by the Secretary; or

''(B) serves a disproportionate percentage of local patients that are from a racial and ethnic minority group.

''(c) REPORT.—Not later than 180 days after the date of enactment of this title and annually thereafter, the Secretary shall submit to the Congress and the President a report that includes an assessment of health resources and facilities serving populations in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii. In preparing such report, the Secretary shall—

''(1) consult with and obtain information on all health care facilities needs from the entities receiving direct financial assistance under subsection (a);

''(2) include all amounts of Federal assistance received by each such entity in the preceding fiscal year;

''(3) review the total unmet needs of health care facilities serving American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii, including needs for renovation and expansion of existing facilities;

''(4) include a strategic plan for addressing the needs of each such population identified in the report; and

''(5) evaluate the effectiveness of the care provided by measuring patient outcomes and cost measures.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as necessary to carry out this section.''.

**SEC. 413. PROTECTING SENSITIVE LOCATIONS.**

Section 287 of the Immigration and Nationality Act (8 U.S.C. 1357) is amended—

(1) by striking ''Service'' each place such term appears and inserting ''Department of Homeland Security'';

(2) by striking ''Attorney General'' each place such term appears and inserting ''Secretary of Homeland Security'';

(3) in subsection (f)(1), by striking ''Commissioner'' and inserting ''Director of U.S. Citizenship and Immigration Services'';

(4) in subsection (h)—

(A) by striking ''of the Immigration and Nationality Act''; and

(B) by striking ''of such Act''; and

(5) by adding at the end the following:

''(i)(1) In this subsection:

''(A) The term 'appropriate committees of Congress' means—

''(i) the Committee on Homeland Security and Governmental Affairs of the Senate;

''(ii) the Committee on the Judiciary of the Senate;

''(iii) the Committee on Homeland Security of the House of Representatives; and

''(iv) the Committee on the Judiciary of the House of Representatives.

''(B) The term 'enforcement action'—

''(i) means an apprehension, arrest, interview, request for identification, search, or surveillance for the purposes of immigration enforcement; and

''(ii) includes an enforcement action at, or focused on, a sensitive location that is part of a joint case led by another law enforcement agency.

''(C) The term 'exigent circumstances' means a situation involving—

''(i) the imminent risk of death, violence, or physical harm to any person or property, including a situation implicating terrorism or the national security of the United States;

''(ii) the immediate arrest or pursuit of a dangerous felon, terrorist suspect, or other individual presenting an imminent danger; or

''(iii) the imminent risk of destruction of evidence that is material to an ongoing criminal case.

''(D) The term 'prior approval' means—

''(i) in the case of officers and agents of U.S. Immigration and Customs Enforcement, prior written approval to carry out an enforcement action involving a specific individual or individuals authorized by—

''(I) the Assistant Director of Operations, Homeland Security Investigations;

''(II) the Executive Associate Director, Homeland Security Investigations;

''(III) the Assistant Director for Field Operations, Enforcement and Removal Operations; or

''(IV) the Executive Associate Director for Field Operations, Enforcement and Removal Operations;

''(ii) in the case of officers and agents of U.S. Customs and Border Protection, prior written approval to carry out an enforcement action involving a specific individual or individuals authorized by—

''(I) a Chief Patrol Agent;

''(II) the Director of Field Operations;

''(III) the Director of Air and Marine Operations; or

''(IV) the Internal Affairs Special Agent in Charge; and

''(iii) in the case of other Federal, State, or local law enforcement officers, to carry out an enforcement action involving a specific individual or individuals authorized by—

''(I) the head of the Federal agency carrying out the enforcement action; or

''(II) the head of the State or local law enforcement agency carrying out the enforcement action.

''(E) The term 'sensitive location' includes all of the physical space located within 1,000 feet of—

''(i) any medical treatment or health care facility, including any hospital, doctor's office, accredited health clinic, alcohol or drug treatment center, or emergent or urgent care facility;

''(ii) any public or private school, including any known and licensed day care facility, preschool, other early learning program facility, primary school, secondary school, postsecondary school (including colleges and universities), or other institution of learning (including vocational or trade schools);

''(iii) any scholastic or education-related activity or event, including field trips and interscholastic events;

''(iv) any school bus or school bus stop during periods when school children are present on the bus or at the stop;

''(v) any organization or subdivision of government that—

''(I) assists children, pregnant women, victims of crime or abuse, or individuals with significant mental or physical disabilities; or

''(II) provides social services and assistance, including emergency and disaster services or assistance with food and nutrition, housing affordability and income or other services funded by state or local government, charitable giving, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or the United States Housing Act;

''(vi) any church, synagogue, mosque, or other place of worship, including buildings rented for the purpose of religious services, retreats, counseling, workshops, instruction, and education;

''(vii) any Federal, State, or local courthouse, including the office of an individual's legal counsel or representative, and a probation, parole, or supervised release office;

''(viii) the site of a funeral, wedding, or other religious ceremony or observance;

''(ix) any public demonstration, such as a march, rally, or parade;

''(x) any domestic violence shelter, rape crisis center, supervised visitation center, family justice center, or victim services provider; or

''(xi) any other location specified by the Secretary of Homeland Security for purposes of this subsection.

''(2)(A) An enforcement action may not take place at, or be focused on, a sensitive location unless—

''(i) the action involves exigent circumstances; and

''(ii) prior approval for the enforcement action was obtained from the appropriate official.

''(B) If an enforcement action is initiated pursuant to subparagraph (A) and the exigent circumstances permitting the enforcement action cease, the enforcement action shall be discontinued until such exigent circumstances reemerge.

''(C) If an enforcement action is carried out in violation of this subsection—

''(i) no information resulting from the enforcement action may be entered into the record or re-

ceived into evidence in a removal proceeding resulting from the enforcement action; and

''(ii) the alien who is the subject of such removal proceeding may file a motion for the immediate termination of the removal proceeding.

''(3)(A) This subsection shall apply to any enforcement action by officers or agents of the Department of Homeland Security, including—

''(i) officers or agents of U.S. Immigration and Customs Enforcement;

''(ii) officers or agents of U.S. Customs and Border Protection; and

''(iii) any individual designated to perform immigration enforcement functions pursuant to subsection (g).

''(B) While carrying out an enforcement action at a sensitive location, officers and agents referred to in subparagraph (A) shall make every effort—

''(i) to limit the time spent at the sensitive location;

''(ii) to limit the enforcement action at the sensitive location to the person or persons for whom prior approval was obtained; and

''(iii) to conduct themselves discreetly.

''(C) If, while carrying out an enforcement action that is not initiated at or focused on a sensitive location, officers or agents are led to a sensitive location, and no exigent circumstance and prior approval with respect to the sensitive location exists, such officers or agents shall—

''(i) cease before taking any further enforcement action;

''(ii) conduct themselves in a discreet manner;

''(iii) maintain surveillance; and

''(iv) immediately consult their supervisor in order to determine whether such enforcement action should be discontinued.

''(D) The limitations under this paragraph shall not apply to the transportation of an individual apprehended at or near a land or sea border to a hospital or health care provider for the purpose of providing medical care to such individual.

''(4)(A) Each official specified in subparagraph (B) shall ensure that the employees under his or her supervision receive annual training on compliance with—

''(i) the requirements under this subsection in enforcement actions at or focused on sensitive locations and enforcement actions that lead officers or agents to a sensitive location; and

''(ii) the requirements under section 239 of this Act and section 384 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (8 U.S.C. 1367).

''(B) The officials specified in this subparagraph are—

''(i) the Chief Counsel of U.S. Immigration and Customs Enforcement;

''(ii) the Field Office Directors of U.S. Immigration and Customs Enforcement;

''(iii) each Special Agent in Charge of U.S. Immigration and Customs Enforcement;

''(iv) each Chief Patrol Agent of U.S. Customs and Border Protection;

''(v) the Director of Field Operations of U.S. Customs and Border Protection;

''(vi) the Director of Air and Marine Operations of U.S. Customs and Border Protection;

''(vii) the Internal Affairs Special Agent in Charge of U.S. Customs and Border Protection; and

''(viii) the chief law enforcement officer of each State or local law enforcement agency that enters into a written agreement with the Department of Homeland Security pursuant to subsection (g).

''(5) The Secretary of Homeland Security shall modify the Notice to Appear form (I–862)—

''(A) to provide the subjects of an enforcement action with information, written in plain language, summarizing the restrictions against enforcement actions at sensitive locations set forth in this subsection and the remedies available to the alien if such action violates such restrictions;

''(B) so that the information described in subparagraph (A) is accessible to individuals with limited-English proficiency; and

''(C) so that subjects of an enforcement action are not permitted to verify that the officers or agents that carried out such action complied with the restrictions set forth in this subsection.

''(6)(A) The Director of U.S. Immigration and Customs Enforcement and the Commissioner of U.S. Customs and Border Protection shall each submit an annual report to the appropriate committees of Congress that includes the information set forth in subparagraph (B) with respect to the respective agency.

''(B) Each report submitted under subparagraph (A) shall include, with respect to the submitting agency during the reporting period—

''(i) the number of enforcement actions that were carried out at, or focused on, a sensitive location;

''(ii) the number of enforcement actions in which officers or agents were subsequently led to a sensitive location; and

''(iii) for each enforcement action described in clause (i) or (ii)—

''(I) the date on which it occurred;

''(II) the specific site, city, county, and State in which it occurred;

''(III) the components of the agency involved in the enforcement action;

''(IV) a description of the enforcement action, including the nature of the criminal activity of its intended target;

''(V) the number of individuals, if any, arrested or taken into custody;

''(VI) the number of collateral arrests, if any, and the reasons for each such arrest;

''(VII) a certification whether the location administrator was contacted before, during, or after the enforcement action; and

''(VIII) the percentage of all of the staff members and supervisors reporting to the offi-

cials listed in paragraph (4)(B) who completed the training required under paragraph (4)(A).

''(7) Nothing in the subsection may be construed—

''(A) to affect the authority of Federal, State, or local law enforcement agencies—

''(i) to enforce generally applicable Federal or State criminal laws unrelated to immigration; or

''(ii) to protect residents from imminent threats to public safety; or

''(B) to limit or override the protections provided in—

''(i) section 239; or

''(ii) section 384 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (8 U.S.C. 1367).''.

**SEC. 414. GRANTS FOR RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH.**

(a) PURPOSE.—It is the purpose of this section to award grants to assist communities in mobilizing and organizing resources in support of effective and sustainable programs that will reduce or eliminate disparities in health and health care experienced by racial and ethnic minority individuals.

(b) AUTHORITY TO AWARD GRANTS.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration (referred to in this section as the ''Secretary''), shall award grants to eligible entities to assist in designing, implementing, and evaluating culturally and linguistically appropriate, science-based, and community-driven sustainable strategies to eliminate racial and ethnic health and health care disparities.

(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall—

(1) represent a coalition—

(A) whose principal purpose is to develop and implement interventions to reduce or eliminate a health or health care disparity in a targeted racial or ethnic minority group in the community served by the coalition; and

(B) that includes—

(i) members selected from among—

(I) public health departments;

(II) community-based organizations;

(III) university and research organizations;

(IV) Indian tribes or tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304)), the Indian Health Service, or any other organization that serves Alaska Natives; and

(V) interested public or private health care providers or organizations as determined appropriate by the Secretary; and

(ii) at least 1 member from a community-based organization that represents the targeted racial or ethnic minority group; and

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, which shall include—

(A) a description of the targeted racial or ethnic populations in the community to be served under the grant;

(B) a description of at least 1 health disparity that exists in the racial or ethnic targeted populations, including health issues such

as infant mortality, breast and cervical cancer screening and management, musculoskeletal diseases and obesity, prostate cancer screening and management, cardiovascular disease, diabetes, child and adult immunization levels, oral disease, or other health priority areas as designated by the Secretary; and

(C) a demonstration of a proven record of accomplishment of the coalition members in serving and working with the targeted community.

(d) SUSTAINABILITY.—The Secretary shall give priority to an eligible entity under this section if the entity agrees that, with respect to the costs to be incurred by the entity in carrying out the activities for which the grant was awarded, the entity (and each of the participating partners in the coalition represented by the entity) will maintain its expenditures of non-Federal funds for such activities at a level that is not less than the level of such expenditures during the fiscal year immediately preceding the first fiscal year for which the grant is awarded.

(e) NONDUPLICATION.—Any funds provided to an eligible entity through a grant under this section shall—

(1) supplement, not supplant, any other Federal funds made available to the entity for the purposes of this section; and

(2) not be used to duplicate the activities of any other health disparity grant program under this Act, including an amendment made by this Act.

(f) TECHNICAL ASSISTANCE.—The Secretary may, either directly or by grant or contract, provide any entity that receives a grant under this section with technical and other nonfinancial assistance necessary to meet the requirements of this section.

(g) DISSEMINATION.—The Secretary shall encourage and enable eligible entities receiving grants under this section to share best practices, evaluation results, and reports with communities not affiliated with such entities, by using the Internet, conferences, and other pertinent information regarding the projects funded by this section, including through using outreach efforts of the Office of Minority Health and the Centers for Disease Control and Prevention.

(h) ADMINISTRATIVE BURDENS.—The Secretary shall make every effort to minimize duplicative or unnecessary administrative burdens on eligible entities receiving grants under this section.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

**SEC. 415. BORDER HEALTH GRANTS.**

(a) DEFINITIONS.—In this section:

(1) BORDER AREA.—The term ''border area'' means the United States-Mexico Border Area, as defined in section 8 of the United States-Mexico Border Health Commission Act (22 U.S.C. 290n–6).

(2) ELIGIBLE ENTITY.—The term ''eligible entity'' means an entity that is located in the border area and is any of the following:

(A) A State, local government, or Tribal government.

(B) A public institution of higher education.

(C) A nonprofit health organization.

(D) A community health center.

(E) A community clinic that is a health center receiving assistance under section 330 of the Public Health Service Act (42 U.S.C. 254b).

(b) AUTHORIZATION.—From funds appropriated under subsection (f), the Secretary of Health and Human Services (in this section referred to as the ''Secretary''),

acting through the United States members of the United States-Mexico Border Health Commission, shall award grants to eligible entities to address priorities and recommendations to improve the health of border area residents that are established by—

(1) the United States members of the United States-Mexico Border Health Commission;

(2) the State border health offices; and

(3) the Secretary.

(c) APPLICATION.—An eligible entity that desires a grant under subsection (b) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(d) USE OF FUNDS.—An eligible entity that receives a grant under subsection (b) shall use the grant funds for—

(1) programs relating to—

(A) maternal and child health;

(B) primary care and preventative health;

(C) public health and public health infrastructure;

(D) musculoskeletal health and obesity;

(E) health education and promotion;

(F) oral health;

(G) mental and behavioral health;

(H) substance use disorders;

(I) health conditions that have a high prevalence in the border area;

(J) medical and health services research;

(K) workforce training and development;

(L) community health workers, patient navigators, and promotoras;

(M) health care infrastructure problems in the border area (including planning and construction grants);

(N) health disparities in the border area;

(O) environmental health; and

(P) outreach and enrollment services with respect to Federal programs (including programs authorized under titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 et seq.; 42 U.S.C. 1397aa et seq.)); and

(2) other programs determined appropriate by the Secretary.

(e) SUPPLEMENT, NOT SUPPLANT.—Amounts provided to an eligible entity awarded a grant under subsection (b) shall be used to supplement and not supplant other funds available to the eligible entity to carry out the activities described in subsection (d).

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $200,000,000 for fiscal year 2021, and such sums as may be necessary for each succeeding fiscal year.

**SEC. 416. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.**

(a) ELIMINATION OF ISOLATION TEST FOR COST-BASED AMBULANCE REIMBURSEMENT.—

(1) IN GENERAL.—Section 1834(l)(8) of the Social Security Act (42 U.S.C. 1395m(l)(8)) is amended—

(A) in subparagraph (B)—

(i) by striking ''owned and''; and

(ii) by inserting ''(including when such services are provided by the entity under an arrangement with the hospital)'' after ''hospital''; and

(B) by striking the comma at the end of subparagraph (B) and all that follows and inserting a period.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2021.

(b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT REQUIREMENT.—

(1) IN GENERAL.—Section 1820(c)(2) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)) is amended—

(A) in subparagraph (B)(iii), by striking ''provides not more than'' and inserting ''subject to subparagraph (F), provides not more than''; and

(B) by adding at the end the following new subparagraph:

''(F) ALTERNATIVE TO 25 INPATIENT BED LIMIT REQUIREMENT.—

''(i) IN GENERAL.—A State may elect to treat a facility, with respect to the designation of the facility for a cost-reporting period, as satisfying the requirement of subparagraph (B)(iii) relating to a maximum number of acute care inpatient beds if the facility elects, in accordance with a method specified by the Secretary and before the beginning of the cost reporting period, to meet the requirement under clause (ii).

''(ii) ALTERNATE REQUIREMENT.—The requirement under this clause, with respect to a facility and a cost-reporting

period, is that the total number of inpatient bed days described in subparagraph (B)(iii) during such period will not exceed 7,300. For purposes of this subparagraph, an individual who is an inpatient in a bed in the facility for a single day shall be counted as one inpatient bed day.

''(iii) WITHDRAWAL OF ELECTION.—The option described in clause (i) shall not apply to a facility for a cost-reporting period if the facility (for any two consecutive cost-reporting periods during the previous 5 cost-reporting periods) was treated under such option and had a total number of inpatient bed days for each of such two cost-reporting periods that exceeded the number specified in such clause.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to cost-reporting periods beginning on or after the date of the enactment of this Act.

**SEC. 417. ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) PROGRAM.**

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section

205(b)(1), is amended by adding at the end of the following new subsection:

''Rural Community Hospital; Rural Community Hospital Services

''(kkk)(1) The term 'rural community hospital' means a hospital (as defined in subsection (e)) that—

''(A) is located in a rural area (as defined in section 1886(d)(2)(D)) or treated as being so located pursuant to section 1886(d)(8)(E);

''(B) subject to paragraph (2), has less than 51 acute care inpatient beds, as reported in its most recent cost report;

''(C) makes available 24-hour emergency care services;

''(D) subject to paragraph (3), has a provider agreement in effect with the Secretary and is open to the public as of January 1, 2010; and

''(E) applies to the Secretary for such designation.

''(2) For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

''(3) Paragraph (1)(D) shall not be construed to prohibit any of the following from qualifying as a rural community hospital:

''(A) A replacement facility (as defined by the Secretary in regulations in effect on January 1, 2012) with the same service area (as defined by the Secretary in regulations in effect on such date).

''(B) A facility obtaining a new provider number pursuant to a change of ownership.

''(C) A facility which has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a building as of January 1, 2012.

''(4) Nothing in this subsection shall be construed as prohibiting a critical access hospital from qualifying as a rural community hospital if the critical access hospital meets the conditions otherwise applicable to hospitals under subsection (e) and section 1866.

''(5) Nothing in this subsection shall be construed as prohibiting a rural community hospital participating in the demonstration program under section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2313) from qualifying as a rural community hospital if the rural community hospital meets the conditions otherwise applicable to hospitals under subsection (e) and section 1866.''.

(b) PAYMENT.—

(1) INPATIENT HOSPITAL SERVICES.—Section 1814 of the Social Security Act (42 U.S.C. 1395f) is amended by adding at the end the following new subsection:

''Payment for Inpatient Services Furnished in Rural Community Hospitals

''(m) The amount of payment under this part for inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is, at the election of the hospital in the application referred to in section 1861(kkk)(1)(E)—

''(1) 101 percent of the reasonable costs of providing such services, without regard to the amount of the customary or other charge, or

''(2) the amount of payment provided for under the prospective payment system for inpatient hospital services under section 1886(d).''.

(2) OUTPATIENT SERVICES.—Section 1834 of such Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(j) PAYMENT FOR OUTPATIENT SERVICES FURNISHED IN RURAL COMMUNITY HOSPITALS.—The amount of payment under this part for outpatient services furnished in a rural community hospital is, at the election

of the hospital in the application referred to in section 1861(kkk)(1)(E)—

''(1) 101 percent of the reasonable costs of providing such services, without regard to the amount of the customary or other charge and any limitation under section 1861(v)(1)(U), or

''(2) the amount of payment provided for under the prospective payment system for covered OPD services under section 1833(t).''.

(3) EXEMPTION FROM 30-PERCENT REDUCTION IN REIMBURSEMENT FOR BAD DEBT.—Section 1861(v)(1)(T) of such Act (42 U.S.C. 1395x(v)(1)(T)) is amended by inserting ''(other than for a rural community hospital)'' after ''In determining such reasonable costs for hospitals''.

(c) BENEFICIARY COST-SHARING FOR OUTPATIENT SERVICES.—Section 1834(j) of such Act (as added by subsection (b)(2)) is amended—

(1) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(2) by inserting ''(1)'' after ''(j)''; and

(3) by adding at the end the following:

''(2) The amounts of beneficiary cost-sharing for outpatient services furnished in a rural community hospital under this part shall be as follows:

''(A) For items and services that would have been paid under section 1833(t) if furnished by a hospital, the amount of cost-sharing determined under paragraph (8) of such section.

''(B) For items and services that would have been paid under section 1833(h) if furnished by a provider of services or supplier, no cost-sharing shall apply.

''(C) For all other items and services, the amount of cost-sharing that would apply to the item or service under the methodology that would be used to determine payment for such item or service if provided by a physician, provider of services, or supplier, as the case may be.''.

(d) CONFORMING AMENDMENTS.—

(1) PART A PAYMENT.—Section 1814(b) of such Act (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by inserting ''other than inpatient hospital services furnished by a rural community hospital,'' after ''critical access hospital services,''.

(2) PART B PAYMENT.—Section 1833(a) of such Act (42 U.S.C. 1395l(a)), as amended by section 205(b)(3), is amended—

(A) in paragraph (2), in the matter before subparagraph (A), by striking ''and (I)'' and inserting ''(I), and (K)'';

(B) by striking ''and'' at the end of paragraph (8);

(C) by striking the period at the end of paragraph (9) and inserting ''; and''; and

(D) by adding at the end the following:

''(10) in the case of outpatient services furnished by a rural community hospital, the amounts described in section 1834(j).''.

(3) TECHNICAL AMENDMENTS.—

(A) CONSULTATION WITH STATE AGENCIES.—Section 1863 of such Act (42 U.S.C. 1395z) is amended by striking ''and (dd)(2)'' and inserting ''(dd)(2), and (kkk)(1)''.

(B) PROVIDER AGREEMENTS.—Section 1866(a)(2)(A) of such Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting ''section 1834(j)(2),'' after ''section 1833(b),''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2021.

**SEC. 418. MEDICARE REMOTE MONITORING PILOT PROJECTS.**

(a) PILOT PROJECTS.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct pilot projects under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for the purpose of providing incentives to home health agencies to utilize home monitoring and communications technologies that—

(A) enhance health outcomes for Medicare beneficiaries; and

(B) reduce expenditures under such title.

(2) SITE REQUIREMENTS.—

(A) URBAN AND RURAL.—The Secretary shall conduct the pilot projects under this section in both urban and rural areas.

(B) SITE IN A SMALL STATE.—The Secretary shall conduct at least 3 of the pilot projects in a State with a population of less than 1,000,000.

(3) DEFINITION OF HOME HEALTH AGENCY.—In this section, the term ''home health agency'' has

the meaning given that term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(b) MEDICARE BENEFICIARIES WITHIN THE SCOPE OF PROJECTS.—The Secretary shall specify the criteria for identifying those Medicare beneficiaries who shall be considered within the scope of the pilot projects under this section for purposes of the application of subsection (c) and for the assessment of the effectiveness of the home health agency in achieving the objectives of this section. Such criteria may provide for the inclusion in the projects of Medicare beneficiaries who begin receiving home health services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) after the date of the implementation of the projects.

(c) INCENTIVES.—

(1) PERFORMANCE TARGETS.—The Secretary shall establish for each home health agency participating in a pilot project under this section a performance target using one of the following methodologies, as determined appropriate by the Secretary:

(A) ADJUSTED HISTORICAL PERFORMANCE TARGET.—The Secretary shall establish for the agency—

(i) a base expenditure amount equal to the average total payments made to the agency under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for Medicare beneficiaries determined to be within the scope of the pilot project in a base period determined by the Secretary; and

(ii) an annual per capita expenditure target for such beneficiaries, reflecting the base expenditure amount adjusted for risk and adjusted growth rates.

(B) COMPARATIVE PERFORMANCE TARGET.—The Secretary shall establish for the agency a comparative performance target equal to the average total payments under such parts A and B during the pilot project for comparable individuals in the same geographic area that are not determined to be within the scope of the pilot project.

(2) INCENTIVE.—Subject to paragraph (3), the Secretary shall pay to each participating home care agency an incentive payment for each year under the pilot project equal to a portion of the Medicare sav-

ings realized for such year relative to the performance target under paragraph (1).

(3) LIMITATION ON EXPENDITURES.—The Secretary shall limit incentive payments under this section in order to ensure that the aggregate expenditures under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (including incentive payments under this subsection) do not exceed the amount that the Secretary estimates would have been expended if the pilot projects under this section had not been implemented.

(d) WAIVER AUTHORITY.—The Secretary may waive such provisions of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 42 U.S.C. 1395 et seq.) as the Secretary determines to be appropriate for the conduct of the pilot projects under this section.

(e) REPORT TO CONGRESS.—Not later than 5 years after the date that the first pilot project under this section is implemented, the Secretary shall submit to Congress a report on the pilot projects. Such report shall contain a detailed description of issues related to the expansion of the projects under subsection (f) and recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(f) EXPANSION.—If the Secretary determines that any of the pilot projects under this section enhance health outcomes for Medicare beneficiaries and reduce expenditures under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the Secretary may initiate comparable projects in additional areas.

(g) INCENTIVE PAYMENTS HAVE NO EFFECT ON OTHER MEDICARE PAYMENTS TO AGENCIES.—An incentive payment under this section—

(1) shall be in addition to the payments that a home health agency would otherwise receive under title XVIII of the Social Security Act for the provision of home health services; and

(2) shall have no effect on the amount of such payments.

**SEC. 419. RURAL HEALTH QUALITY ADVISORY COMMISSION AND DEMONSTRATION PROJECTS.**

(a) RURAL HEALTH QUALITY ADVISORY COMMISSION.—

(1) ESTABLISHMENT.—Not later than 6 months after the date of the enactment of this section, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a commission to be known as the Rural

Health Quality Advisory Commission (in this section referred to as the ''Commission'').

(2) DUTIES OF COMMISSION.—

(A) NATIONAL PLAN.—The Commission shall develop, coordinate, and facilitate implementation of a national plan for rural health quality improvement. The national plan shall—

(i) identify objectives for rural health quality improvement;

(ii) identify strategies to eliminate known gaps in rural health system capacity and improve rural health quality; and

(iii) provide recommendations for Federal programs to identify opportunities for strengthening and aligning policies and programs to improve rural health quality.

(B) DEMONSTRATION PROJECTS.—The Commission shall design demonstration projects to recommend to the Secretary to test alternative models for rural health quality improvement, including with respect to both personal and population health.

(C) MONITORING.—The Commission shall monitor progress toward the objectives identified pursuant to paragraph (1)(A).

(3) MEMBERSHIP.—

(A) NUMBER.—The Commission shall be composed of 11 members appointed by the Secretary.

(B) SELECTION.—The Secretary shall select the members of the Commission from among individuals with significant rural health care and health care quality expertise, including expertise in clinical health care, health care quality research, population or public health, or purchaser organizations.

(4) CONTRACTING AUTHORITY.—Subject to the availability of funds, the Commission may enter into contracts and make other arrangements, as may be necessary to carry out the duties described in paragraph (2).

(5) STAFF.—Upon the request of the Commission, the Secretary may detail, on a reimbursable basis, any of the personnel of the Office of Rural Health Policy of the Health Resources and Services Administration, the Agency for Healthcare Quality and Research, or the Centers for Medicare & Medicaid Services to the Commission to assist in carrying out this subsection.

(6) REPORTS TO CONGRESS.—Not later than 1 year after the establishment of the Commission, and annually thereafter, the Commission shall submit a report to the Congress on rural health quality. Each such report shall include the following:

(A) An inventory of relevant programs and recommendations for improved coordination and integration of policy and programs.

(B) An assessment of achievement of the objectives identified in the national plan developed under paragraph (2) and recommendations for realizing such objectives.

(C) Recommendations on Federal legislation, regulations, or administrative policies to enhance rural health quality and outcomes.

(b) RURAL HEALTH QUALITY DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Not later than 270 days after the date of the enactment of this section, the Secretary, in consultation with the Rural Health Quality Advisory Commission, the Office of Rural Health Policy of the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services, shall make grants to eligible entities

for a total of 5 demonstration projects to implement and evaluate methods for improving the quality of health care in rural communities. Each such demonstration project shall include—

(A) alternative community models that—

(i) will achieve greater integration of personal and population health services; and

(ii) address safety, effectiveness, patient- or community-centeredness, timeliness, efficiency, and equity (the 6 aims identified by the Institute of Medicine of the National Academy of Sciences in its report entitled ''Crossing the Quality Chasm: A New Health System for the 21st Century'' released on March 1, 2001);

(B) innovative approaches to the financing and delivery of health services to achieve rural health quality goals; and

(C) development of quality improvement support structures to assist rural health systems and professionals (such as workforce support structures, quality monitoring and reporting, clinical care protocols, and information technology applications).

(2) ELIGIBLE ENTITIES.—In this subsection, the term ''eligible entity'' means a consortium that—

(A) shall include—

(i) at least one health care provider or health care delivery system located in a rural area; and

(ii) at least one organization representing multiple community stakeholders; and

(B) may include other partners such as rural research centers.

(3) CONSULTATION.—In developing the program for awarding grants under this subsection, the Secretary shall consult with the Administrator of the Agency for Healthcare Research and Quality, rural health care providers, rural health care researchers, and private and nonprofit groups (including national associations) which are undertaking similar efforts.

(4) EXPEDITED WAIVERS.—The Secretary shall expedite the processing of any waiver that—

(A) is authorized under title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 42 U.S.C. 1396 et seq.); and

(B) is necessary to carry out a demonstration project under this subsection.

(5) DEMONSTRATION PROJECT SITES.—The Secretary shall ensure that the 5 demonstration projects funded under this subsection are conducted at a variety of sites representing the diversity of rural communities in the United States.

(6) DURATION.—Each demonstration project under this subsection shall be for a period of 4 years.

(7) INDEPENDENT EVALUATION.—The Secretary shall enter into an arrangement with an entity that has experience working directly with rural health systems for the conduct of an independent evaluation of the program carried out under this subsection.

(8) REPORT.—Not later than 1 year after the conclusion of all of the demonstration projects funded under this subsection, the Secretary shall submit a report to the Congress on the results of such projects. The report shall include—

(A) an evaluation of patient access to care, patient outcomes, and an analysis of the cost effectiveness of each such project; and

(B) recommendations on Federal legislation, regulations, or administrative policies to enhance rural health quality and outcomes.

(c) APPROPRIATION.—

(1) IN GENERAL.—Out of funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section $30,000,000 for the period of fiscal years 2021 through 2025.

(2) AVAILABILITY.—

(A) IN GENERAL.—Funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year 2025.

(B) REPORT.—For purposes of carrying out subsection (b)(8), funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year 2026.

(3) RESERVATION.—Of the amount appropriated under paragraph (1), the Secretary shall reserve—

(A) $5,000,000 to carry out subsection (a); and

(B) $25,000,000 to carry out subsection (b), of which—

(i) 2 percent shall be for the provision of technical assistance to grant recipients; and

(ii) 5 percent shall be for independent evaluation under subsection (b)(7).

**SEC. 420. RURAL HEALTH CARE SERVICES.**

Section 330A of the Public Health Service Act (42 U.S.C. 254c) is amended to read as follows:

**"SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH, RURAL HEALTH NETWORK DEVELOPMENT, DELTA RURAL DISPARITIES AND HEALTH SYSTEMS DEVELOPMENT, AND SMALL RURAL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANT PROGRAMS.**

''(a) PURPOSE.—The purpose of this section is to provide for grants—

''(1) under subsection (b), to promote rural health care services outreach;

''(2) under subsection (c), to provide for the planning and implementation of integrated health care networks in rural areas;

''(3) under subsection (d), to assist rural communities in the Delta Region to reduce health disparities and to promote and enhance health system development; and

''(4) under subsection (e), to provide for the planning and implementation of small rural health care provider quality improvement activities.

''(b) RURAL HEALTH CARE SERVICES OUTREACH GRANTS.—

''(1) GRANTS.—The Director of the Office of Rural Health Policy of the Health Resources and Services Administration (referred to in this section as the 'Director') may award grants to eligible entities to promote rural health care services outreach by expanding the delivery of health care services to include new and enhanced services in rural areas. The Director may award the grants for periods of not more than 3 years.

''(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection for a project, an entity—

''(A) shall be a rural public or rural nonprofit private entity, a facility that qualifies as a rural health clinic under title XVIII of the Social Security Act, a public or nonprofit entity existing exclusively to provide services to migrant and seasonal farm workers in rural areas, or a Tribal government whose grant-funded ac-

tivities will be conducted within federally recognized Tribal areas;

''(B) shall represent a consortium composed of members—

''(i) that include 3 or more independently owned health care entities; and

''(ii) that may be nonprofit or for-profit entities; and

''(C) shall not previously have received a grant under this subsection for the same or a similar project, unless the entity is proposing to expand the scope of the project or the area that will be served through the project.

''(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—

''(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

''(B) a description of the manner in which the project funded under the grant will meet the health care needs of rural populations in the local community or region to be served;

"(C) a plan for quantifying how health care needs will be met through identification of the target population and benchmarks of service delivery or health status, such as—

"(i) quantifiable measurements of health status improvement for projects focusing on health promotion; or

"(ii) benchmarks of increased access to primary care, including tracking factors such as the number and type of primary care visits, identification of a medical home, or other general measures of such access;

"(D) a description of how the local community or region to be served will be involved in the development and ongoing operations of the project;

"(E) a plan for sustaining the project after Federal support for the project has ended;

"(F) a description of how the project will be evaluated;

"(G) the administrative capacity to submit annual performance data electronically as specified by the Director; and

"(H) other such information as the Director determines to be appropriate.

"(c) RURAL HEALTH NETWORK DEVELOPMENT GRANTS.—

"(1) GRANTS.—

"(A) IN GENERAL.—The Director may award rural health network development grants to eligible entities to promote, through planning and implementation, the development of integrated health care networks that have combined the functions of the entities participating in the networks in order to—

"(i) achieve efficiencies and economies of scale;

"(ii) expand access to, coordinate, and improve the quality of the health care delivery system through development of organizational efficiencies;

"(iii) implement health information technology to achieve efficiencies, reduce medical errors, and improve quality;

"(iv) coordinate care and manage chronic illness; and

"(v) strengthen the rural health care system as a whole in such a manner as to

show a quantifiable return on investment to the participants in the network.

''(B) GRANT PERIODS.—The Director may award such a rural health network development grant—

''(i) for a period of 3 years for implementation activities; or

''(ii) for a period of 1 year for planning activities to assist in the initial development of an integrated health care network, if the proposed participants in the network do not have a history of collaborative efforts and a 3-year grant would be inappropriate.

''(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection, an entity—

''(A) shall be a rural public or rural nonprofit private entity, a facility that qualifies as a rural health clinic under title XVIII of the Social Security Act, a public or nonprofit entity existing exclusively to provide services to migrant and seasonal farm workers in rural areas, or a Tribal government whose grant-funded activities will be conducted within federally recognized Tribal areas;

''(B) shall represent a network composed of participants—

''(i) that include 3 or more independently owned health care entities; and

''(ii) that may be nonprofit or for-profit entities; and

''(C) shall not previously have received a grant under this subsection (other than a 1-year grant for planning activities) for the same or a similar project.

''(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity, in consultation with the appropriate State office of rural health or another appropriate State entity, shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—

''(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

''(B) an explanation of the reasons why Federal assistance is required to carry out the project;

''(C) a description of—

''(i) the history of collaborative activities carried out by the participants in the network;

''(ii) the degree to which the participants are ready to integrate their functions; and

''(iii) how the local community or region to be served will benefit from and be involved in the activities carried out by the network;

''(D) a description of how the local community or region to be served will experience increased access to quality health care services across the continuum of care as a result of the integration activities carried out by the network, including a description of—

''(i) return on investment for the community and the network members; and

''(ii) other quantifiable performance measures that show the benefit of the network activities;

''(E) a plan for sustaining the project after Federal support for the project has ended;

''(F) a description of how the project will be evaluated;

''(G) the administrative capacity to submit annual performance data electronically as specified by the Director; and

''(H) other such information as the Director determines to be appropriate.

''(d) DELTA RURAL DISPARITIES AND HEALTH SYSTEMS DEVELOPMENT GRANTS.—

''(1) GRANTS.—The Director may award grants to eligible entities to support reduction of health disparities, improve access to health care, and enhance rural health system development in the Delta Region.

''(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection, an entity shall be a rural public or rural nonprofit private entity, a facility that qualifies as a rural health clinic under title XVIII of the Social Security Act, a public or nonprofit entity existing exclusively to provide services to migrant and seasonal farm workers in rural areas, or a Tribal government whose grant-funded activities will be conducted within federally recognized Tribal areas.

''(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity shall prepare and submit to the Director an application at

such time, in such manner, and containing such information as the Director may require, including—

''(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

''(B) an explanation of the reasons why Federal assistance is required to carry out the project;

''(C) a description of the manner in which the project funded under the grant will meet the health care needs of the Delta Region;

''(D) a description of how the local community or region to be served will experience increased access to quality health care services as a result of the activities carried out by the entity;

''(E) a description of how health disparities will be reduced or the health system will be improved;

''(F) a plan for sustaining the project after Federal support for the project has ended;

''(G) a description of how the project will be evaluated including process and outcome measures related to the quality of care provided

or how the health care system improves its performance;

''(H) a description of how the grantee will develop an advisory group made up of representatives of the communities to be served to provide guidance to the grantee to best meet community need; and

''(I) other such information as the Director determines to be appropriate.

''(e) SMALL RURAL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANTS.—

''(1) GRANTS.—The Director may award grants to provide for the planning and implementation of small rural health care provider quality improvement activities. The Director may award the grants for periods of 1 to 3 years.

''(2) ELIGIBILITY.—To be eligible for a grant under this subsection, an entity—

''(A) shall be—

''(i) a rural public or rural nonprofit private health care provider or provider of health care services, such as a rural health clinic; or

''(ii) another rural provider or network of small rural providers identified by

the Director as a key source of local care; and

''(B) shall not previously have received a grant under this subsection for the same or a similar project.

''(3) PREFERENCE.—In awarding grants under this subsection, the Director shall give preference to facilities that qualify as rural health clinics under title XVIII of the Social Security Act.

''(4) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—

''(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

''(B) an explanation of the reasons why Federal assistance is required to carry out the project;

''(C) a description of the manner in which the project funded under the grant will assure continuous quality improvement in the provision of services by the entity;

''(D) a description of how the local community or region to be served will experience increased access to quality health care services as a result of the activities carried out by the entity;

''(E) a plan for sustaining the project after Federal support for the project has ended;

''(F) a description of how the project will be evaluated including process and outcome measures related to the quality of care provided; and

''(G) other such information as the Director determines to be appropriate.

''(f) GENERAL REQUIREMENTS.—

''(1) PROHIBITED USES OF FUNDS.—An entity that receives a grant under this section may not use funds provided through the grant—

''(A) to build or acquire real property; or

''(B) for construction.

''(2) COORDINATION WITH OTHER AGENCIES.—The Director shall coordinate activities carried out under grant programs described in this section, to the extent practicable, with Federal and State agencies and nonprofit organizations that are operating

similar grant programs, to maximize the effect of public dollars in funding meritorious proposals.

''(g) REPORT.—Not later than September 30, 2022, the Secretary shall prepare and submit to the appropriate committees of Congress a report on the progress and accomplishments of the grant programs described in subsections (b), (c), (d), and (e).

''(h) DEFINITION OF DELTA REGION.—In this section, the term 'Delta Region' has the meaning given to the term 'region' in section 382A of the Consolidated Farm and Rural Development Act (7 U.S.C. 2009aa).

''(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $40,000,000 for fiscal year 2021, and such sums as may be necessary for each of fiscal years 2022 through 2025.''.

**SEC. 421. COMMUNITY HEALTH CENTER COLLABORATIVE ACCESS EXPANSION.**

Section 330(r)(4) of the Public Health Service Act (42 U.S.C. 254b(r)(4)) is amended—

(1) in subparagraph (A), by striking ''primary health care services'' each place it appears and inserting ''primary health care and other mental, dental, and physical health services''; and

(2) in subparagraph (B)—

(A) in clause (i), by striking ''and'' at the end;

(B) in clause (ii), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(iii) in the case of a rural health clinic described in such subparagraph—

''(I) that such clinic provides, to the extent possible, enabling services, such as transportation and language assistance (including translation and interpretation); and

''(II) that the primary health care and other services described in such subparagraph are subject to full reimbursement according to the prospective payment system for Federally qualified health center services under section 1834(o) of the Social Security Act.''.

**SEC. 422. FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.**

(a) IN GENERAL.—For purposes of expediting the provision of telehealth services, for which payment is made under the Medicare Program, across State lines, the Sec-

retary of Health and Human Services shall, in consultation with representatives of States, physicians, health care practitioners, and patient advocates, encourage and facilitate the adoption of provisions allowing for multistate practitioner practice across State lines.

(b) DEFINITIONS.—In subsection (a):

(1) TELEHEALTH SERVICE.—The term ''telehealth service'' has the meaning given that term in subparagraph (F) of section 1834(m)(4) of the Social Security Act (42 U.S.C. 1395m(m)(4)).

(2) PHYSICIAN, PRACTITIONER.—The terms ''physician'' and ''practitioner'' have the meaning given those terms in subparagraphs (D) and (E), respectively, of such section.

(3) MEDICARE PROGRAM.—The term ''Medicare Program'' means the program of health insurance administered by the Secretary of Health and Human Services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

**SEC. 423. SCORING OF PREVENTIVE HEALTH SAVINGS.**

Section 202 of the Congressional Budget and Impoundment Control Act of 1974 (2 U.S.C. 602) is amended by adding at the end the following:

''(h) SCORING OF PREVENTIVE HEALTH SAVINGS.—

''(1) DETERMINATION BY THE DIRECTOR.—Upon a request by the chairman or ranking minority member of the Committee on the Budget of the Senate, or by the chairman or ranking minority member of the Committee on the Budget of the House of Representatives, the Director shall determine if a proposed measure would result in reductions in budget outlays in budgetary outyears through the use of preventive health and preventive health services.

''(2) PROJECTIONS.—If the Director determines that a measure would result in substantial reductions in budget outlays as described in paragraph (1), the Director—

''(A) shall include, in any projection prepared by the Director, a description and estimate of the reductions in budget outlays in the budgetary outyears and a description of the basis for such conclusions; and

''(B) may prepare a budget projection that includes some or all of the budgetary outyears, notwithstanding the time periods for projections described in subsection (e) and sections 308, 402, and 424.

''(3) DEFINITIONS.—As used in this subsection—

''(A) the term 'budgetary outyears' means the 2 consecutive 10-year periods beginning with the first fiscal year that is 10 years after the budget year provided for in the most recently agreed to concurrent resolution on the budget; and

''(B) the term 'preventive health' means an action that focuses on the health of the public, individuals, and defined populations in order to protect, promote, and maintain health, wellness, and functional ability, and prevent disease, disability, and premature death that is demonstrated by credible and publicly available epidemiological projection models, incorporating clinical trials or observational studies in humans, to avoid future health care costs.''.

**SEC. 424. SENSE OF CONGRESS ON MAINTENANCE OF EFFORT PROVISIONS REGARDING CHILDREN'S HEALTH.**

It is the sense of the Congress that—

(1) the maintenance of effort provisions added to sections 1902 and 2105(d) of the Social Security Act (42 U.S.C. 1396a; 42 U.S.C. 1397ee(d)) by sec-

tions 2001(b) and 2101(b) of the Patient Protection and Affordable Care Act were intended to maintain the eligibility standards for the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and Children's Health Insurance Program under title XXI of such Act (42 U.S.C. 1397aa et seq.) until the American Health Benefit Exchanges in the States are fully operational;

(2) it is imperative that the maintenance of effort provisions are enforced to the strict standard intended by the Congress through September 30, 2027;

(3) waiving the maintenance of effort provisions should not be permitted;

(4) the maintenance of effort provisions ensure the continued success of the Medicaid program and Children's Health Insurance Program and were intended to specifically protect vulnerable and disabled adults, children, and senior citizens, many of whom are also members of communities of color; and

(5) the maintenance of effort provisions must be strictly enforced and proposals to weaken the maintenance of effort provisions must not be considered.

**SEC. 425. PROTECTION OF THE HHS OFFICES OF MINORITY HEALTH.**

(a) IN GENERAL.—Pursuant to section 1707A of the Public Health Service Act (42 U.S.C. 300u–6a), the Offices of Minority Health established within the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services, are offices that, regardless of change in the structure of the Department of Health and Human Services, shall report to the Secretary of Health and Human Services.

(b) SENSE OF CONGRESS.—It is the sense of the Congress that any effort to eliminate or consolidate such Offices of Minority Health undermines the progress achieved so far.

**SEC. 426. OFFICE OF MINORITY HEALTH IN VETERANS HEALTH ADMINISTRATION OF DEPARTMENT OF VETERANS AFFAIRS.**

(a) ESTABLISHMENT AND FUNCTIONS.—Subchapter I of chapter 73 of title 38, United States Code, is amended by adding at the end the following new section:

**"§ 7310. Office of Minority Health**

''(a) ESTABLISHMENT.—There is established in the Department within the Office of the Under Secretary for Health an office to be known as the 'Office of Minority Health' (in this section referred to as the 'Office').

''(b) HEAD.—The Director of the Office of Minority Health shall be the head of the Office. The Director of the Office of Minority Health shall be appointed by the Under Secretary for Health from among individuals qualified to perform the duties of the position.

''(c) FUNCTIONS.—The functions of the Office are as follows:

''(1) To establish short-range and long-range goals and objectives and coordinate all other activities within the Veterans Health Administration that relate to disease prevention, health promotion, health care services delivery, and health care research concerning veterans who are members of a racial or ethnic minority group.

''(2) To support research, demonstrations, and evaluations to test new and innovative models for the discharge of activities described in paragraph (1).

''(3) To increase knowledge and understanding of health risk factors for veterans who are members of a racial or ethnic minority group.

''(4) To develop mechanisms that support better health care information dissemination, education, prevention, and services delivery to veterans from disadvantaged backgrounds, including veterans who are members of a racial or ethnic minority group.

''(5) To enter into contracts or agreements with appropriate public and nonprofit private entities to develop and carry out programs to provide bilingual or interpretive services to assist veterans who are members of a racial or ethnic minority group and who lack proficiency in speaking the English language in accessing and receiving health care services through the Veterans Health Administration.

''(6) To carry out programs to improve access to health care services through the Veterans Health Administration for veterans with limited proficiency in speaking the English language, including the development and evaluation of demonstration and pilot projects for that purpose.

''(7) To advise the Under Secretary for Health on matters relating to the development, implementation, and evaluation of health professions education in decreasing disparities in health care outcomes between veterans who are members of a racial or ethnic minority group and other veterans, including cul-

tural competency as a method of eliminating such health disparities.

''(8) To perform such other functions and duties as the Secretary or the Under Secretary for Health considers appropriate.

''(d) DEFINITIONS.—In this section:

''(1) The term 'racial or ethnic minority group' means any of the following:

''(A) American Indians (including Alaska Natives, Eskimos, and Aleuts).

''(B) Asian Americans.

''(C) Native Hawaiians and other Pacific Islanders.

''(D) Blacks.

''(E) Hispanics.

''(2) The term 'Hispanic' means individuals whose origin is Mexican, Puerto Rican, Cuban, Central or South American, or any other Spanish-speaking country.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 7309A the following new item:

''7310. Office of Minority Health.''.

**SEC. 427. STUDY OF DSH PAYMENTS TO ENSURE HOSPITAL ACCESS FOR LOW-INCOME PATIENTS.**

(a) IN GENERAL.—Not later than January 1, 2021, the Comptroller General of the United States shall conduct a study on how amendments made by the Patient Protection and Affordable Care Act (Public Law 111–148) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152) to titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 42 U.S.C. 1396 et seq.) relating to disproportionate share hospital adjustment payments under Medicare and Medicaid (and subsequent amendments made with respect to such payments) affect the timely access to health care services for low-income patients. Such study shall—

(1) evaluate and examine whether States electing to make medical assistance available under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) (including States making such an election through a waiver of the State plan) to individuals described in such section mitigate the need for payments to disproportionate share hospitals under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) and section 1923 of such Act (42 U.S.C. 1396r–4), including the impact of such

States electing to make medical assistance available to such individuals on—

(A) the number of individuals in the United States who are without health insurance and the distribution of such individuals in relation to areas primarily served by disproportionate share hospitals; and

(B) the low-income utilization rate of such hospitals and the resulting fiscal sustainability of such hospitals;

(2) evaluate the appropriate level and distribution of such payments among such disproportionate share hospitals for purposes of—

(A) sufficiently accounting for the level of uncompensated care provided by such hospitals to low-income patients; and

(B) providing timely access to health services for individuals in medically underserved areas; and

(3) assess, with respect to such disproportionate share hospitals—

(A) the role played by such hospitals in providing critical access to emergency, inpatient, and outpatient health services, as well as

the location of such hospitals in relation to medically underserved areas; and

(B) the extent to which such hospitals satisfy the requirements established for charitable hospital organizations under section 501(r) of the Internal Revenue Code of 1986 with respect to community health needs assessments, financial assistance policy requirements, limitations on charges, and billing and collection requirements.

(b) REPORTS.—

(1) REPORT TO CONGRESS.—Not later than 180 days after the date on which the study under subsection (a) is completed, the Comptroller General of the United States shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that contains—

(A) the results of the study;

(B) recommendations to Congress for any legislative changes to the payments to disproportionate share hospitals under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) and section 1923 of such Act (42 U.S.C. 1396r–4) that are needed

to ensure access to health services for low-income patients that—

(i) are based on the number of individuals without health insurance, the amount of uncompensated care provided by such hospitals, and the impact of reduced payment levels on low-income communities; and

(ii) takes into account any reports submitted by the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to Congressional committees regarding the costs incurred by charitable hospital organizations for charity care, bad debt, nonreimbursed expenses for services provided to individuals under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act, and any community benefit activities provided by such organizations.

(2) REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES.—Not later than 180 days after the date on which the study under subsection (a) is completed, the Comptroller General of the

United States shall submit to the Secretary of Health and Human Services a report that contains—

(A) the results of the study; and

(B) any recommendations for purposes of assisting in the development of the methodology for the adjustment of payments to disproportionate share hospitals, as required under section 1886(r) of the Social Security Act (42 U.S.C. 1395ww(r)) and the reduction of such payments under section 1923(f)(7) of such Act (42 U.S.C. 1396r–4(f)(7)), taking into account the reports referred to in paragraph (1)(B)(ii).

**SEC. 428. ASSISTANT SECRETARY OF THE INDIAN HEALTH SERVICE.**

(a) REFERENCES.—Any reference in a law, regulation, document, paper, or other record of the United States to the Director of the Indian Health Service shall be deemed to be a reference to the Assistant Secretary of the Indian Health Service.

(b) EXECUTIVE SCHEDULE.—Section 5315 of title 5, United States Code, is amended in the matter relating to the Assistant Secretaries of Health and Human Services by striking ''(6)'' and inserting ''(7), 1 of whom shall be the Assistant Secretary of the Indian Health Service''.

(c) CONFORMING AMENDMENT.—Section 5316 of title 5, United States Code, is amended by striking ''Director, Indian Health Service, Department of Health and Human Services.''.

**SEC. 429. REAUTHORIZATION OF THE NATIVE HAWAIIAN HEALTH CARE IMPROVEMENT ACT.**

(a) NATIVE HAWAIIAN HEALTH CARE SYSTEMS.—Section 6(h)(1) of the Native Hawaiian Health Care Improvement Act (42 U.S.C. 11705(h)(1)) is amended by striking ''may be necessary for fiscal years 1993 through 2019'' and inserting ''are necessary''.

(b) ADMINISTRATIVE GRANT FOR PAPA OLA LOKAHI.—Section 7(b) of the Native Hawaiian Health Care Improvement Act (42 U.S.C. 11706(b)) is amended by striking ''may be necessary for fiscal years 1993 through 2019'' and inserting ''are necessary''.

(c) NATIVE HAWAIIAN HEALTH SCHOLARSHIPS.—Section 10(c) of the Native Hawaiian Health Care Improvement Act (42 U.S.C. 11709(c)) is amended by striking ''may be necessary for fiscal years 1993 through 2019'' and inserting ''are necessary''.

**SEC. 430. AVAILABILITY OF NON-ENGLISH LANGUAGE SPEAKING PROVIDERS.**

(a) IN GENERAL.—Section 1311(c)(1)(B) of the Patient Protection and Affordable Care Act (42 U.S.C.

18031(c)(1)(B)) is amended by inserting before the semicolon the following: ''and the ability of such provider to provide care in a language other than English either through the provider speaking such language or by the provider having a qualified interpreter for an individual with limited-English proficiency (as defined in section 3400 of such Act) who speaks such language available during office hours''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall not apply to any plan beginning on or prior to the date that is 1 year after the date of the enactment of this Act.

**SEC. 431. ACCESS TO ESSENTIAL COMMUNITY PROVIDERS.**

(a) ESSENTIAL COMMUNITY PROVIDERS.—Section 1311(c)(1)(C) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(1)(C)) is amended—

(1) by inserting ''(i)'' after ''(C)''; and

(2) by adding at the end the following new clauses:

''(ii) not later than January 1, 2020, increase the percentage of essential community providers as described in clause (i) included in its network by 10 percent annually (based on the level in the plan for 2016) until 90 percent of all federally-qualified health centers and 75

percent of all other such essential community providers in the contract service area are in-network; and

''(iii) include at least one essential community provider in each of the essential community provider categories described in section 156.235(a)(2)(ii)(B) of title 45, Code of Federal Regulations (as in effect on the date of enactment of the Health Equity and Accountability Act of 2020) in each county in the service area, where available;''.

(b) REPORTING REQUIREMENTS.—Section 1311(e)(3) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(e)(3)) is amended by adding at the end the following new subparagraph:

''(E) DATA ON ESSENTIAL COMMUNITY PROVIDERS.—The Secretary shall require qualified health plans to submit annually to the Secretary data on the percentage of essential community providers as described in clause (ii) of subsection (c)(1)(C), by county, that contract with each qualified health plan offered in that county and the percentage of such essential community providers, by category as described in clause (iii) of such subsection, that contract

with each qualified health plan offered in that county. Such data shall be made available to the general public.''.

(c) ESSENTIAL COMMUNITY PROVIDER PROVISIONS APPLIED UNDER MEDICARE AND MEDICAID.—

(1) MEDICARE.—Section 1852(d)(1) of the Social Security Act (42 U.S.C. 1395w–22(d)(1)) is amended—

(A) by striking ''and'' at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

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

''(F) the plan meets the requirements of clauses (ii) and (iii) of section 1311(c)(1)(C) of the Patient Protection and Affordable Care Act (relating to inclusion in networks of essential community providers).''.

(2) MEDICAID.—Section 1932(b)(5) of the Social Security Act (42 U.S.C. 1396u–2(b)(5)) is amended—

(A) by striking ''and'' at the end of subparagraph (A);

(B) by striking the period at the end of subparagraph (B) and inserting ''; and''; and

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

''(C) meets the requirements of clauses (ii) and (iii) of section 1311(c)(1)(C) of the Patient Protection and Affordable Care Act (relating to inclusion in networks of essential community providers) with respect to services offered in the service area involved.''.

**SEC. 432. PROVIDER NETWORK ADEQUACY IN COMMUNITIES OF COLOR.**

(a) IN GENERAL.—Section 1311(c)(1)(B) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(1)(B)), as amended by section 428(a), is further amended—

(1) by inserting ''(i)'' after ''(B)''; and

(2) by adding at the end the following the following new clauses:

''(ii) meet such network adequacy standards as the Secretary may establish with regard to—

''(I) appointment wait time;

''(II) travel time and distance to health care provider facilities and providers by public and private transit;

''(III) hours of operation to accommodate individuals who cannot come to provider appointments during standard business hours; and

''(IV) other network adequacy standards to ensure that care through these plans is accessible to diverse communities, including individuals with limited-English proficiency as defined in section 3400 of such Act; and

''(iii) provide coverage for services for enrollees through out-of-network providers at no additional cost to the enrollees in cases where in-network providers are unable to comply with the standards established under subclause (III) or (IV) of clause (ii) for such services and the out-of-network providers can deliver such services in compliance with such standards.

''(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall not apply to plans beginning on or prior to the date that is 1 year after the date of the enact-

ment of the Health Equity and Accountability Act of 2020.''.

**SEC. 433. IMPROVING ACCESS TO DENTAL CARE.**

(a) REPORTS TO CONGRESS.—

(1) GAO REPORTS.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress—

(A) a report on the Alaska Dental Health Aide Therapists program and the Dental Therapist and Advanced Dental Therapist programs in Minnesota, to assess the effectiveness of dental therapists in—

(i) improving access to timely dental care among communities of color;

(ii) providing high quality care; and

(iii) providing culturally competent care; and

(iv) providing accessible care to people with disabilities;

(B) a report on State variations in the use of dental hygienists and the effectiveness of expanding the scope of practice for dental hygienists in—

(i) improving access to timely dental care among communities of color;

(ii) providing high quality care;

(iii) providing culturally competent care; and

(iv) providing accessible care to people with disabilities; and

(C) the reports shall also explain how telehealth service is used to enhance services provided by dental hygienists and therapists and shall recommend any modifications in Medicare and Medicaid to better provide for telehealth consultations in conjunction with therapists' and hygienists' care.

(2) HRSA REPORT ON DENTAL SHORTAGE AREAS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, shall submit to Congress a report which details geographic dental access shortages and the preparedness of dental providers to offer culturally and linguistically appropriate, affordable, accessible, and timely services.

(b) EXPANSION OF DENTAL HEALTH AID THERAPISTS IN TRIBAL COMMUNITIES.—Section 119(d) of the Indian Health Care Improvement Act (25 U.S.C. 1616l(d)) is amended—

(1) in paragraph (2), by striking ''Subject to'' and all that follows and inserting ''Subject to paragraph (3), in establishing a national program under paragraph (1), the Secretary shall not reduce the amounts provided for the Community Health Aide Program described in subsections (a) and (b).'';

(2) by striking paragraph (3); and

(3) by redesignating paragraph (4) as paragraph (3).

(c) COVERAGE OF DENTAL SERVICES UNDER THE MEDICARE PROGRAM.—

(1) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (GG), by striking ''and'' at the end;

(B) in subparagraph (HH), by adding ''and'' after the semicolon at the end; and

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

''(II) oral health services (as defined in subsection (kkk));''.

(2) ORAL HEALTH SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by sections 205(b) and 413(a), is amended by adding at the end the following new subsection:

''Oral Health Services

''(kkk)(1) The term 'oral health services' means services (as defined by the Secretary) that are necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

''(2) For purposes of paragraph (1), such term shall include mobile and portable oral health services (as defined by the Secretary) that—

''(A) are provided for the purpose of overcoming mobility, transportation, and access barriers for individuals; and

''(B) satisfy the standards and certification requirements established under section 1902(a)(82)(B) for the State in which the services are provided.''.

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

(A) by striking ''and'' before ''(CC)''; and

(B) by inserting before the semicolon at the end the following: '', and (DD) with respect to oral health services (as defined in section 1861(kkk)), the amount paid shall be (i) in the case of such services that are preventive, 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848, and (ii) in the case of all other such services, 80 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848''.

(4) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(II),'' after ''risk assessment),''.

(5) DENTURES.—Section 1861(s)(8) of the Social Security Act (42 U.S.C. 1395x(s)(8)) is amended—

(A) by striking ''(other than dental)'' and inserting ''(including dentures)''; and

(B) by striking ''internal body''.

(6) REPEAL OF GROUND FOR EXCLUSION.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y) is amended by striking paragraph (12).

(7) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2021.

(d) COVERAGE OF DENTAL SERVICES UNDER THE MEDICAID PROGRAM.—

(1) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(A) in subsection (a)(10), by striking ''dental services'' and inserting ''oral health services (as defined in subsection (ff)(1))''; and

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

''(ff)(1) Subject to paragraphs (2) and (3), for purposes of this title, the term 'oral health services' means services (as defined by the Secretary) that are necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. These services shall include, in the case of pregnant or postpartum women, such services as are necessary to address oral health conditions that exist or are exacerbated by pregnancy or childbirth or which, if left

untreated, could adversely affect fetal or child development.

''(2) For purposes of paragraph (1), such term shall include—

''(A) dentures; and

''(B) mobile and portable oral health services (as defined by the Secretary) that—

''(i) are provided for the purpose of overcoming mobility, transportation, and access barriers for individuals; and

''(ii) satisfy the standards and certification requirements established under section 1902(a)(84)(C) for the State in which the services are provided.

''(3) For purposes of paragraph (1), such term shall not include dental care or services provided to individuals under the age of 21 under subsection (r)(3).''.

(2) CONFORMING AMENDMENTS.—

(A) STATE PLAN REQUIREMENTS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(i) in paragraph (10)(A), in the matter preceding clause (i), by inserting ''(10),'' after ''(5),'';

(ii) in paragraph (82), by striking ''and'' at the end;

(iii) in paragraph (83), by striking the period at the end and inserting ''; and''; and

(iv) by inserting after paragraph (83) the following:

''(84) provide for—

''(A) informing, in writing, all individuals who have been determined to be eligible for medical assistance of the availability of oral health services (as defined in section 1905(ff));

''(B) conducting targeted outreach to pregnant women who have been determined to be eligible for medical assistance about the availability of medical assistance for such dental services and the importance of receiving dental care while pregnant; and

''(C) establishing and maintaining standards for and certification of mobile and portable oral health services (as described in subsections (r)(3)(C) and (ff)(2)(B) of section 1905).''.

(B) DEFINITION OF MEDICAL ASSISTANCE.—Section 1905(a)(12) of the Social Secu-

rity Act (42 U.S.C. 1396d(a)(12)) is amended by striking ", dentures,".

(3) MOBILE AND PORTABLE ORAL HEALTH SERVICES UNDER EPSDT.—Section 1905(r)(3) of the Social Security Act (42 U.S.C. 1396d(r)(3)) is amended—

(A) in subparagraph (A)(ii), by striking "; and" and inserting a semicolon;

(B) in subparagraph (B), by striking the period at the end and inserting "; and"; and

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

"(C) which shall include mobile and portable oral health services (as defined by the Secretary) that—

"(i) are provided for the purpose of overcoming mobility, transportation, or access barriers for children; and

"(ii) satisfy the standards and certification requirements established under section 1902(a)(82)(C) for the State in which the services are provided.".

(e) ORAL HEALTH SERVICES AS AN ESSENTIAL HEALTH BENEFIT.—Section 1302(b) of the Patient Pro-

tection and Affordable Care Act (42 U.S.C. 18022(b)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (J), by striking ''oral and''; and

(B) by adding at the end the following:

''(K) Oral health services for children and adults.''; and

(2) by adding at the end the following:

''(6) ORAL HEALTH SERVICES.—For purposes of paragraph (1)(K), the term 'oral health services' means services (as defined by the Secretary), that are necessary to prevent any oral disease and promote oral health, restore oral structures to health and function, and treat emergency oral conditions.''.

(f) DEMONSTRATION PROGRAM ON TRAINING AND EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR VETERANS IN RURAL AND OTHER UNDERSERVED COMMUNITIES.—

(1) DEMONSTRATION PROGRAM AUTHORIZED.—The Secretary of Veterans Affairs may carry out a demonstration program to establish programs to train and employ alternative dental health care providers in order to increase access to dental health

care services for veterans who are entitled to such services from the Department of Veterans Affairs and reside in rural and other underserved communities.

(2) TELEHEALTH.—For purposes of alternative dental health care providers and other dental care providers who are licensed to provide clinical care, dental services provided under the demonstration program under this subsection may be administered by such providers through telehealth-enabled collaboration and supervision when appropriate and feasible.

(3) ALTERNATIVE DENTAL HEALTH CARE PROVIDERS DEFINED.—In this subsection, the term ''alternative dental health care providers'' has the meaning given that term in section 340G–1(a)(2) of the Public Health Service Act (42 U.S.C. 256g–1(a)(2)).

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the demonstration program under this subsection.

(g) DEMONSTRATION PROGRAM ON TRAINING AND EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR

MEMBERS OF THE ARMED FORCES AND DEPENDENTS LACKING READY ACCESS TO SUCH SERVICES.—

(1) DEMONSTRATION PROGRAM AUTHORIZED.—The Secretary of Defense may carry out a demonstration program to establish programs to train and employ alternative dental health care providers in order to increase access to dental health care services for members of the Armed Forces and their dependents who lack ready access to such services, including the following:

(A) Members and dependents who reside in rural areas or areas otherwise underserved by dental health care providers.

(B) Members of the National Guard and Reserves in active status who are potentially deployable.

(2) TELEHEALTH.—For purposes of alternative dental health care providers and other dental care providers who are licensed to provide clinical care, dental services provided under the demonstration program under this subsection may be administered by such providers through telehealth-enabled collaboration and supervision when appropriate and feasible.

(3) ALTERNATIVE DENTAL HEALTH CARE PROVIDERS DEFINED.—In this subsection, the term ''alternative dental health care providers'' has the meaning given that term in section 340G–1(a)(2) of the Public Health Service Act (42 U.S.C. 256g–1(a)(2)).

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the demonstration program under this subsection.

(h) DEMONSTRATION PROGRAM ON TRAINING AND EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR PRISONERS WITHIN THE CUSTODY OF THE BUREAU OF PRISONS.—

(1) DEMONSTRATION PROGRAM AUTHORIZED.—The Attorney General, acting through the Director of the Bureau of Prisons, may carry out a demonstration program to establish programs to train and employ alternative dental health care providers in order to increase access to dental health services for prisoners within the custody of the Bureau of Prisons.

(2) TELEHEALTH.—For purposes of alternative dental health care providers and other dental care

providers who are licensed to provide clinical care, dental services provided under the demonstration program under this subsection may be administered by such providers through telehealth-enabled collaboration and supervision when appropriate and feasible.

(3) ALTERNATIVE DENTAL HEALTH CARE PROVIDERS DEFINED.—In this subsection and subsection (i), the term ''alternative dental health care providers'' has the meaning given that term in section 340G–1(a)(2) of the Public Health Service Act (42 U.S.C. 256g–1(a)(2)).

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the demonstration program under this subsection.

(i) DEMONSTRATION PROGRAM ON TRAINING AND EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE PROVIDERS FOR DENTAL HEALTH CARE SERVICES UNDER THE INDIAN HEALTH SERVICE.—

(1) DEMONSTRATION PROGRAM AUTHORIZED.—The Secretary of Health and Human Services, acting through the Indian Health Service, may carry out a demonstration program to establish programs to train and employ alternative dental health care

providers in order to help eliminate oral health disparities and increase access to dental services through health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations (as the preceding 3 terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)).

(2) TELEHEALTH.—For purposes of alternative dental health care providers and other dental care providers who are licensed to provide clinical care, dental services provided under the demonstration program under this subsection may be administered by such providers through telehealth-enabled collaboration and supervision when appropriate and feasible.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the demonstration program under this subsection.

**SEC. 434. PROVIDING FOR A SPECIAL ENROLLMENT PERIOD FOR PREGNANT INDIVIDUALS.**

(a) PUBLIC HEALTH SERVICE ACT.—Section 2702(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–1(b)(2)) is amended by inserting ''including a special enrollment period for pregnant individuals, beginning

on the date on which the pregnancy is reported to the health insurance issuer'' before the period at the end.

(b) PATIENT PROTECTION AND AFFORDABLE CARE ACT.—Section 1311(c)(6) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(6)) is amended—

(1) in subparagraph (C), by striking ''and'' at the end;

(2) by redesignating subparagraph (D) as subparagraph (E); and

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

''(D) a special enrollment period for pregnant individuals, beginning on the date on which the pregnancy is reported to the Exchange; and''.

(c) SPECIAL ENROLLMENT PERIODS.—

(1) INTERNAL REVENUE CODE.—Section 9801(f) of the Internal Revenue Code of 1986 (26 U.S.C. 9801(f)) is amended by adding at the end the following new paragraph:

''(4) FOR PREGNANT INDIVIDUALS.—

''(A) A group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a de-

pendent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan upon pregnancy, with the special enrollment period beginning on the date on which the pregnancy is reported to the group health plan or the pregnancy is confirmed by a health care provider.

''(B) The Secretary shall promulgate regulations with respect to the special enrollment period under subparagraph (A), including establishing a time period for pregnant individuals to enroll in coverage and effective date of such coverage.''.

(2) ERISA.—Section 701(f) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(f)) is amended by adding at the end the following:

''(4) FOR PREGNANT INDIVIDUALS.—

''(A) A group health plan or health insurance issuer in connection with a group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for

coverage under such terms) to enroll for coverage under the terms of the plan upon pregnancy, with the special enrollment period beginning on the date on which the pregnancy is reported to the group health plan or health insurance issuer or the pregnancy is confirmed by a health care provider.

''(B) The Secretary shall promulgate regulations with respect to the special enrollment period under subparagraph (A), including establishing a time period for pregnant individuals to enroll in coverage and effective date of such coverage.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning after the 2021 plan year.

**SEC. 435. COVERAGE OF MATERNITY CARE FOR DEPENDENT CHILDREN.**

Section 2719A of the Public Health Service Act (42 U.S.C. 300gg–19a) is amended by adding at the end the following:

''(e) COVERAGE OF MATERNITY CARE.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, that provides coverage for dependants shall ensure that such plan or cov-

erage includes coverage for maternity care associated with pregnancy, childbirth, and postpartum care for all participants, beneficiaries, or enrollees, including dependants, including coverage of labor and delivery. Such coverage shall be provided to all pregnant dependents regardless of age.''.

**SEC. 436. FEDERAL EMPLOYEE HEALTH BENEFIT PLANS.**

(a) COVERAGE OF PREGNANCY.—

(1) IN GENERAL.—The Director of the Office of Personnel Management shall issue such regulations as are necessary to ensure that pregnancy is considered a change in family status and a qualifying life event for an individual who is eligible to enroll, but is not enrolled, in a health benefit plan under chapter 89 title 5, United States Code.

(2) EFFECTIVE DATE.—The requirement in paragraph (1) shall apply with respect to any contract entered into under section 8902 of such title beginning 12 months after the date of enactment of this Act.

(b) DESIGNATING CERTAIN FEHBP-RELATED SERVICES AS EXCEPTED SERVICES UNDER THE ANTI-DEFICIENCY ACT.—

(1) IN GENERAL.—Section 8905 of title 5, United States Code, is amended by adding at the end the following:

''(i) Any services by an officer or employee under this chapter relating to enrolling individuals in a health benefits plan under this chapter, or changing the enrollment of an individual already so enrolled due to an event described in section 5(a)(1) of the Healthy MOM Act, shall be deemed, for purposes of section 1342 of title 31, services for emergencies involving the safety of human life or the protection of property.''.

(2) APPLICATION.—The amendment made by paragraph (1) shall apply to any lapse in appropriations beginning on or after the date of enactment of this Act.

**SEC. 437. CONTINUATION OF MEDICAID INCOME ELIGIBILITY STANDARD FOR PREGNANT INDIVIDUALS AND INFANTS.**

Section 1902(l)(2)(A) of the Social Security Act (42 U.S.C. 1396a(l)(2)(A)) is amended—

(1) in clause (i), by striking ''and not more than 185 percent'';

(2) in clause (ii)—

(A) in subclause (I), by striking ''and'' after the comma;

(B) in subclause (II), by striking the period at the end and inserting ", and"; and

(C) by adding at the end the following:

"(III) January 1, 2020, is the percentage provided under clause (v)."; and

(3) by adding at the end the following new clause:

"(v) The percentage provided under clause (ii) for medical assistance provided on or after January 1, 2020, with respect to individuals described in subparagraph (A) or (B) of paragraph (1) shall not be less than—

"(I) the percentage specified for such individuals by the State in an amendment to its State plan (whether approved or not) as of January 1, 2014; or

"(II) if no such percentage is specified as of January 1, 2014, the percentage established for such individuals under the State's authorizing legislation or provided for under the

State's appropriations as of that date.''.

# Subtitle C—Advancing Health Equity Through Payment and Delivery Reform

**SEC. 441. SENSE OF CONGRESS.**

It is the Sense of Congress that—

(1) the sustainability of the health care system in the United States hinges on restructuring how health care is paid for, shifting away from paying for the volume of services provided to the value the services provide;

(2) high value care is care that provides higher quality care more efficiently, achieving greater health improvement and better health outcomes at lower cost (per patient and overall);

(3) a high value health care system must deliver timely, accessible, well-coordinated, high-quality, culturally centered, and language-appropriate care to everyone;

(4) eliminating health disparities and achieving health equity must be central to efforts to achieve a high value health care system;

(5) eliminating such disparities and achieving such equity will require tailored interventions and

targeted investments to address inequities in health and health care to make sure that health care delivery and payment efforts are responsive to and inclusive of the needs of communities of color and other communities experiencing disparities; and

(6) new models of value-based payment and care delivery should consider the holistic needs of the patient population and behavioral health,oral health, their history of adverse childhood experiences and adverse community environments, social determinants of health, social risk factors, unmet social needs, and the burden of intergenerational racial and other inequities.

**SEC. 442. CENTERS FOR MEDICARE & MEDICAID SERVICES REPORTING AND VALUE BASED PROGRAMS.**

(a) ADVANCING HEALTH EQUITY IN REPORTING AND VALUE BASED PAYMENT PROGRAMS.—

(1) IN GENERAL.—The Administrator shall require that a clinician or other professional participating in any pay-for-reporting or value based payment program stratify clinical quality measures by disparity variables, including race, ethnicity, sex, primary language, disability status, sexual orientation, gender identity, and socioeconomic status. A clinician or other professional may use existing demo-

graphic data collection fields in certified electronic health record technology (as defined in section 1848(o)(4) of the Social Security Act (42 U.S.C. 1395w–4(o)(4)) to carry out such data stratification under the preceding sentence. Such stratified data will assist clinicians and other professionals in the identification of disparities obscured in aggregated data and assist with the provision of interventions that target reducing those disparities.

(2) CLINICIAN.—In assessing performance in any value-based payment program, the Administrator shall incorporate a clinician or other professional's performance in reducing disparities across race, ethnicity, sex, primary language, disability status, sexual orientation, gender identity, and socioeconomic status. Linking performance payments to the reduction of health care disparities across such variables will assist in holding clinicians and other professionals accountable for providing quality care that can lead to decreased health inequities.

(3) REQUIREMENT OF ADOPTION OF CERT.—All entities, clinicians, or other professionals participating in the Quality Payment Program shall be required to adopt 2015 certified electronic health

record technology (as so defined) as a condition of participating in the Quality Payment Program.

(b) QUALITY IMPROVEMENT ACTIVITIES.—The Administrator, upon yearly review of the Quality Payment Program, shall add quality improvement activities that implement the Culturally and Linguistically Accessible Standards (CLAS) standards as Improvement Activities under the Quality Payment Program.

**SEC. 443. DEVELOPMENT AND TESTING OF DISPARITY REDUCING DELIVERY AND PAYMENT MODELS.**

(a) IN GENERAL.—The Center for Medicare and Medicaid Innovation established under section 1115A of the Social Security Act (42 U.S.C. 1315a) (in this section referred to as the ''CMI'') shall establish a dedicated fund to identify, test, evaluate, and scale delivery and payment models under the applicable titles (as defined in subsection (a)(4)(B) of such section) that target health disparities among racial and ethnic minorities, including models that support high-value non-medical services that address socially determined barriers to health, including English proficiency status, low health literacy, case management, transportation, enrollment assistance needs, stable and affordable housing, utility assistance, employment and career development, and nutrition and food security which

will help to reduce disparities and impact the overall cost of care.

(b) AMENDMENT TO SOCIAL SECURITY ACT.—Section 1115A(a)(1) of the Social Security Act (42 U.S.C. 1315a(a)(1)) is amended as follows:

''(1) The purpose of the CMMI is to test innovative payment and service delivery models to reduce program expenditures and improve health equity under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles.''.

(c) PILOT PROGRAMS.—The CMI shall prioritize the testing of models under such section 1115A that include partnerships with entities, including community based organizations or other non-profit entities, to help address socially determined barriers to health and health care.

(d) ALTERNATIVES.—Any model tested by the CMI under such 1115A shall include measures to assess and track the impact of the model on health disparities, using existing measures such as the Healthcare Disparities and Cultural Competency Measures endorsed by the entity with a contract under section 1890(a) of the Social Security Act (42 U.S.C. 1395aaa(a)), and stratified by race, ethnicity, English proficiency, gender identity, sexual orientation, and disability status.

**SEC. 444. DIVERSITY IN CENTERS FOR MEDICARE AND MEDICAID CONSULTATION.**

(a) IN GENERAL.—In carrying out the duties under this section, the CMI shall consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management, specifically such experts with expertise in—

(1) the health care needs of minority, rural, and underserved populations; and

(2) the financial needs of safety net, community based, rural, and critical access providers, including federally qualified health centers.

(b) OPEN DOOR FORUMS.—The CMI shall use open door forums or other mechanisms to seek external feedback from interested parties and incorporate that feedback into the development of models.

**SEC. 445. SUPPORTING SAFETY NET AND COMMUNITY-BASED PROVIDERS TO COMPETE IN VALUE-BASED PAYMENT SYSTEMS.**

(a) IN GENERAL.—Any pay-for-performance or alternative payment model that is developed and tested by the Center for Medicare and Medicaid Innovation established under section 1115A of the Social Security Act (42 U.S.C. 1315a), or any other agency of the Department of Health and Human Services with respect to the programs under titles XVIII, XIX, or XXI of such Act, shall be assessed

for potential impact on safety net, community based, and critical access providers, including Federally qualified health centers.

(b) NEW MODELS.—The rollout of any such models shall include training and additional up front resources for community based and safety net providers to enable those providers to participate in the model.

# Subtitle D—Health Empowerment Zones

**SEC. 451. SHORT TITLE.**

This subtitle may be cited as the ''Health Empowerment Zone Act of 2020''.

**SEC. 452. FINDINGS.**

Congress finds the following:

(1) Numerous studies and reports, including the 2015 National Healthcare Quality and Disparities Report of the Agency for Healthcare Research and Quality and the 2002 report of the Institute of Medicine entitled ''Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care'', document the extensiveness to which health disparities exist across the country.

(2) These studies have found that, on average, racial and ethnic minorities are disproportionately afflicted with chronic and acute conditions—such as

cancer, diabetes, musculoskeletal disease, obesity, and hypertension—and suffer worse health outcomes, worse health status, and higher mortality rates than their White counterparts.

(3) Several recent studies also show that health disparities are a function of not only access to health care, but also the social determinants of health—including the environment, the physical structure of communities, nutrition and food options, educational attainment and health literacy, employment, race, ethnicity, immigration status, geography, and language preference—that directly and indirectly affect the health, health care, and wellness of individuals and communities.

(4) Integrally involving and fully supporting the communities most affected by health inequities in the assessment, planning, launch, and evaluation of health disparity elimination efforts are among the leading recommendations made to adequately address and ultimately reduce health disparities.

(5) Recommendations also include supporting the efforts of community stakeholders from a broad cross section—including local businesses, local departments of commerce, education, labor, urban planning, and transportation, and community-based

and other nonprofit organizations, including national and regional intermediaries with demonstrated capacity to serve low-income urban communities—to find areas of common ground around health disparity elimination and collaborate to improve the overall health and wellness of a community and its residents.

**SEC. 453. DESIGNATION OF HEALTH EMPOWERMENT ZONES.**

(a) IN GENERAL.—The Secretary may, at the request of an eligible community partnership described in subsection (b)(1), designate an eligible area described in subsection (b)(2) as a health empowerment zone for the purpose of eligibility for a grant under section 455.

(b) ELIGIBILITY CRITERIA.—

(1) ELIGIBLE COMMUNITY PARTNERSHIP.—A community partnership is eligible to submit a request under this section if the partnership—

(A) demonstrates widespread public support from key individuals and entities in the eligible area, including members of the target community, State and local governments, nonprofit organizations including national and regional intermediaries with demonstrated capacity to serve low-income urban communities, and

community and industry leaders, for designation of the eligible area as a health empowerment zone; and

(B) includes representatives of—

(i) a broad cross section of stakeholders and residents from communities in the eligible area experiencing disproportionate disparities in health status and health care; and

(ii) organizations, facilities, and institutions that have a history of working within and serving such communities.

(2) ELIGIBLE AREA.—An area is eligible to be designated as a health empowerment zone under this section if one or more communities in the area experience disproportionate disparities in health status and health care. In determining whether a community experiences such disparities, the Secretary shall consider data collected by the Department of Health and Human Services focusing on the following areas:

(A) Access to affordable, high-quality health services.

(B) The prevalence of disproportionate rates of certain illnesses or diseases including the following:

(i) Arthritis, osteoporosis, chronic back conditions, and other musculoskeletal diseases.

(ii) Cancer.

(iii) Chronic kidney disease.

(iv) Diabetes.

(v) Injury (intentional and unintentional).

(vi) Violence (intimate and non-intimate).

(vii) Maternal and paternal illnesses and diseases.

(viii) Infant mortality.

(ix) Mental illness and other disabilities.

(x) Substance use disorder treatment and prevention, including underage drinking.

(xi) Nutrition, obesity, and overweight conditions.

(xii) Heart disease.

(xiii) Hypertension.

(xiv) Cerebrovascular disease or stroke.

(xv) Tuberculosis.

(xvi) HIV/AIDS and other sexually transmitted infections.

(xvii) Viral hepatitis.

(xviii) Asthma.

(xix) Tooth decay and other oral health issues.

(C) Within the community, the historical and persistent presence of conditions that have been found to contribute to health disparities including any such conditions respecting any of the following:

(i) Poverty.

(ii) Educational status and the quality of community schools.

(iii) Income.

(iv) Access to high-quality affordable health care.

(v) Work and work environment.

(vi) Environmental conditions in the community, including with respect to clean water, clean air, and the presence or absence of pollutants.

(vii) Language and English proficiency.

(viii) Access to affordable healthy food.

(ix) Access to ethnically and culturally diverse health and human service providers and practitioners.

(x) Access to culturally and linguistically competent health and human services and health and human service providers.

(xi) Health-supporting infrastructure.

(xii) Health insurance that is adequate and affordable.

(xiii) Race, racism, and bigotry (conscious and unconscious).

(xiv) Sexual orientation.

(xv) Health literacy.

(xvi) Place of residence (such as urban areas, rural areas, and reservations of Indian tribes).

(xvii) Stress.

(c) PROCEDURE.—

(1) REQUEST.—A request under subsection (a) shall—

(A) describe the bounds of the area to be designated as a health empowerment zone and the process used to select those bounds;

(B) demonstrate that the partnership submitting the request is an eligible community partnership described in subsection (b)(1);

(C) demonstrate that the area is an eligible area described in subsection (b)(2);

(D) include a comprehensive assessment of disparities in health status and health care experience by one or more communities in the area;

(E) set forth—

(i) a vision and a set of values for the area; and

(ii) a comprehensive and holistic set of goals to be achieved in the area through designation as a health empowerment zone; and

(F) include a strategic plan and an action plan for achieving the goals described in subparagraph (E)(ii).

(2) APPROVAL.—Not later than 60 days after the receipt of a request for designation of an area as a health empowerment zone under this section,

the Secretary shall approve or disapprove the request.

(d) MINIMUM NUMBER.—The Secretary—

(1) shall designate not more than 110 health empowerment zones under this section; and

(2) shall designate at least one health empowerment zone in each of the several States, the District of Columbia, and each territory or possession of the United States.

**SEC. 454. ASSISTANCE TO THOSE SEEKING DESIGNATION.**

At the request of any organization or entity seeking to submit a request under section 453(a), the Secretary shall provide technical assistance, and may award a grant, to assist such organization or entity—

(1) to form an eligible community partnership described in section 453(b)(1);

(2) to complete a health assessment, including an assessment of health disparities under section 453(c)(1)(D); or

(3) to prepare and submit a request, including a strategic plan, in accordance with section 453.

**SEC. 455. BENEFITS OF DESIGNATION.**

(a) PRIORITY.—In awarding a grant under subsection (b), a Federal official shall give priority to any applicant that—

(1) meets the eligibility criteria for the grant;

(2) proposes to use the grant for activities in a health empowerment zone; and

(3) demonstrates that such activities will directly and significantly further the goals of the strategic plan approved for such zone under section 453.

(b) GRANTS FOR INITIAL IMPLEMENTATION OF STRATEGIC PLAN.—

(1) IN GENERAL.—Upon designating an eligible area as a health empowerment zone at the request of an eligible community partnership, the Secretary shall, subject to the availability of appropriations, make a grant to the community partnership for implementation of the strategic plan for such zone.

(2) GRANT PERIOD.—A grant under paragraph (1) for a health empowerment zone shall be for a period of 2 years and may be renewed, except that the total period of grants under paragraph (1) for such zone may not exceed 10 years.

(3) LIMITATION.—In awarding grants under this subsection, the Secretary shall not give less priority to an applicant or reduce the amount of a grant because the Secretary rendered technical assistance or made a grant to the same applicant under section 454.

(4) REPORTING.—The Secretary shall establish metrics for measuring the progress of grantees under this subsection and, based on such metrics, require each such grantee to report to the Secretary not less than every 6 months on the progress in implementing the strategic plan for the health empowerment zone.

**SEC. 456. DEFINITION OF SECRETARY.**

In this subtitle, the term ''Secretary'' means the Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration and the Deputy Assistant Secretary for Minority Health, and in cooperation with the Director of the Office of Community Services and the Director of the National Institute on Minority Health and Health Disparities.

**SEC. 457. AUTHORIZATION OF APPROPRIATIONS.**

To carry out this subtitle, there is authorized to be appropriated $100,000,000 for fiscal year 2021.

# TITLE V—IMPROVING HEALTH OUTCOMES FOR WOMEN, CHILDREN, AND FAMILIES

## Subtitle A—In General

### SEC. 501. GRANTS TO PROMOTE HEALTH FOR UNDERSERVED COMMUNITIES.

Part Q of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

### "SEC. 399Z–3. GRANTS TO PROMOTE HEALTH FOR UNDERSERVED COMMUNITIES.

''(a) GRANTS AUTHORIZED.—The Secretary, in collaboration with the Administrator of the Health Resources and Services Administration and other Federal officials determined appropriate by the Secretary, is authorized to award grants to eligible entities—

''(1) to promote health for underserved communities, with preference given to projects that benefit racial and ethnic minority women, racial and ethnic minority children, adolescents, and lesbian, gay, bisexual, transgender, queer, or questioning communities; and

''(2) to strengthen health outreach initiatives in medically underserved communities, including linguistically isolated populations.

''(b) USE OF FUNDS.—Grants awarded pursuant to subsection (a) may be used to support the activities of community health workers, including such activities—

''(1) to educate and provide outreach regarding enrollment in health insurance including the State Children's Health Insurance Program under title XXI of the Social Security Act, Medicare under title XVIII of such Act, and Medicaid under title XIX of such Act;

''(2) to educate and provide outreach in a community setting regarding health problems prevalent among underserved communities, and especially among racial and ethnic minority women, racial and ethnic minority children, adolescents, and lesbian, gay, bisexual, transgender, queer, or questioning communities;

''(3) to educate and provide experiential learning opportunities and target risk factors and healthy behaviors that impede or contribute to achieving positive health outcomes, including—

''(A) healthy nutrition;

''(B) physical activity;

''(C) overweight or obesity;

''(D) tobacco use, including the use of e-cigarettes and vaping;

''(E) alcohol and substance use;

''(F) injury and violence;

''(G) sexual health;

''(H) mental health;

''(I) musculoskeletal health and arthritis;

''(J) prenatal and postnatal care;

''(K) dental and oral health;

''(L) understanding informed consent;

''(M) stigma; and

''(N) environmental hazards;

''(4) to promote community wellness and awareness; and

''(5) to educate and refer target populations to appropriate health care agencies and community-based programs and organizations in order to increase access to quality health care services, including preventive health services.

''(c) APPLICATION.—

''(1) IN GENERAL.—Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

''(2) CONTENTS.—Each application submitted pursuant to paragraph (1) shall—

''(A) describe the activities for which assistance under this section is sought;

''(B) contain an assurance that, with respect to each community health worker program receiving funds under the grant awarded, such program provides in-language training and supervision to community health workers to enable such workers to provide authorized program activities in (at least) the most commonly used languages within a particular geographic region;

''(C) contain an assurance that the applicant will evaluate the effectiveness of community health worker programs receiving funds under the grant;

''(D) contain an assurance that each community health worker program receiving funds under the grant will provide culturally competent services in the linguistic context most appropriate for the individuals served by the program;

''(E) contain a plan to document and disseminate project descriptions and results to other States and organizations as identified by the Secretary; and

''(F) describe plans to enhance the capacity of individuals to utilize health services and health-related social services under Federal, State, and local programs by—

''(i) assisting individuals in establishing eligibility under the programs and in receiving the services or other benefits of the programs; and

''(ii) providing other services, as the Secretary determines to be appropriate, which may include transportation and translation services.

''(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to those applicants—

''(1) who propose to target geographic areas that—

''(A)(i) have a high percentage of residents who are uninsured or underinsured (if the targeted geographic area is located in a State that has elected to make medical assistance available under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act to individuals described in such section);

''(ii) have a high percentage of underinsured residents in a particular geographic area (if the targeted geographic area is located in a State that has not so elected); or

''(iii) have a high number of households experiencing extreme poverty; and

''(B) have a high percentage of families for whom English is not their primary language or including smaller limited-English-proficient communities within the region that are not otherwise reached by linguistically appropriate health services;

''(2) with experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

''(3) with documented community activity and experience with community health workers.

''(e) COLLABORATION WITH ACADEMIC INSTITUTIONS.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions, including minority-serving institutions. Nothing in this section shall be construed to require such collaboration.

''(f) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for ensur-

ing the quality of the training and supervision of community health workers under the programs funded under this section and for ensuring the cost effectiveness of such programs.

''(g) MONITORING.—The Secretary shall monitor community health worker programs identified in approved applications and shall determine whether such programs are in compliance with the guidelines established under subsection (f).

''(h) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to community health worker programs identified in approved applications with respect to planning, developing, and operating programs under the grant.

''(i) REPORT TO CONGRESS.—

''(1) IN GENERAL.—Not later than 4 years after the date on which the Secretary first awards grants under subsection (a), the Secretary shall submit to Congress a report regarding the grant project.

''(2) CONTENTS.—The report required under paragraph (1) shall include the following:

''(A) A description of the programs for which grant funds were used.

''(B) The number of individuals served.

''(C) An evaluation of—

''(i) the effectiveness of these programs;

''(ii) the cost of these programs; and

''(iii) the impact of these programs on the health outcomes of the community residents.

''(D) Recommendations for sustaining the community health worker programs developed or assisted under this section.

''(E) Recommendations regarding training to enhance career opportunities for community health workers.

''(j) DEFINITIONS.—In this section:

''(1) COMMUNITY HEALTH WORKER.—The term 'community health worker' means an individual who promotes health or nutrition within the community in which the individual resides—

''(A) by serving as a liaison between communities and health care agencies;

''(B) by providing guidance and social assistance to community residents;

''(C) by enhancing community residents' ability to effectively communicate with health care providers;

''(D) by providing culturally and linguistically appropriate health or nutrition education;

''(E) by advocating for individual and community health, including dental, oral, mental, and environmental health, or nutrition needs;

''(F) by taking into consideration the needs of the communities served, including the prevalence rates of risk factors that impede achieving positive healthy outcomes among women and children, especially among racial and ethnic minority women and children; and

''(G) by providing referral and followup services.

''(2) COMMUNITY SETTING.—The term 'community setting' means a home or a community organization that serves a population.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' means—

''(A) a unit of State, territorial, local, or Tribal government (including a federally recognized Tribe or Alaska Native village); or

''(B) a community-based organization.

''(4) MEDICALLY UNDERSERVED COMMUNITY.—The term 'medically underserved community' means a community—

''(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3);

''(B) a significant portion of which is a health professional shortage area as designated under section 332; and

''(C) that includes populations that are linguistically isolated, such as geographic areas with a shortage of health professionals able to provide linguistically appropriate services.

''(5) SUPPORT.—The term 'support' means the provision of training, supervision, and materials needed to effectively deliver the services described in subsection (b), reimbursement for services, and other benefits.

''(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2021 through 2025.''.

**SEC. 502. REMOVING BARRIERS TO HEALTH CARE AND NUTRITION ASSISTANCE FOR CHILDREN, PREGNANT PERSONS, AND LAWFULLY PRESENT INDIVIDUALS.**

(a) MEDICAID.—Section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)) is amended by striking paragraph (4) and inserting the following new paragraph:

''(4)(A) Notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and paragraph (1), payment shall be made to a State under this section for medical assistance furnished to an alien under this title (including an alien described in such paragraph) who meets any of the following conditions:

''(i) The alien is otherwise eligible for such assistance under the State plan approved under this title (other than the requirement of the receipt of aid or assistance under title IV, supplemental security income benefits under title XVI, or a State supplementary payment) within either or both of the following eligibility categories:

''(I) Children under 21 years of age, including any optional targeted low-income child (as such term is defined in section 1905(u)(2)(B)).

''(II) Pregnant persons during pregnancy and during the 12-month period beginning on the last day of the pregnancy.

''(ii) The alien is lawfully present in the United States.

''(B) No debt shall accrue under an affidavit of support against any sponsor of an alien who meets the conditions specified in subparagraph (A) on the basis of the provision of medical assistance to such alien under this paragraph and the cost of such assistance shall not be considered as an unreimbursed cost.''.

(b) SCHIP.—Subparagraph (N) of section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended to read as follows:

''(N) Paragraph (4) of section 1903(v) (relating to coverage of categories of children, pregnant persons, and other lawfully present individuals).''.

(c) SUPPLEMENTAL NUTRITION ASSISTANCE.—Notwithstanding sections 401(a), 402(a), and 403(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(a); 1612(a); 1613(a)) and section 6(f) of the Food and Nutrition Act of 2008 (7 U.S.C. 2015(f)), persons who are lawfully present in the United States shall be not be ineligible for benefits

under the supplemental nutrition assistance program on the basis of their immigration status or date of entry into the United States.

(d) ELIGIBILITY FOR FAMILIES WITH CHILDREN.—Section 421(d)(3) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1631(d)(3)) is amended by striking ''to the extent that a qualified alien is eligible under section 402(a)(2)(J)'' and inserting, ''to the extent that a child is a member of a household under the supplemental nutrition assistance program''.

(e) ENSURING PROPER SCREENING.—Section 11(e)(2)(B) of the Food and Nutrition Act of 2008 (7 U.S.C. 2020(e)(2)(B)) is amended—

(1) by redesignating clauses (vi) and (vii) as clauses (vii) and (viii); and

(2) by inserting after clause (v) the following:

''(vi) shall provide a method for implementing section 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1631) that does not require any unnecessary information from persons who may be exempt from that provision;''.

**SEC. 503. REPEAL OF DENIAL OF BENEFITS.**

Section 115 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (21 U.S.C. 862a) is amended—

(1) in subsection (a), by striking ''for—'' and all that follows and inserting ''for assistance under any State program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).'';

(2) in subsection (b)—

(A) by striking ''(1) PROGRAM OF TEMPORARY ASSISTANCE FOR NEEDY FAMILIES.—''; and

(B) by striking paragraph (2); and

(3) in subsection (e), by striking ''it—'' and all that follows and inserting ''the term in section 419(5) of the Social Security Act (42 U.S.C. 619(5)) when referring to assistance provided under a State program funded under paragraph A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).''.

**SEC. 504. BIRTH DEFECTS PREVENTION, RISK REDUCTION, AND AWARENESS.**

(a) IN GENERAL.—The Secretary shall establish and implement a birth defects prevention and public awareness program, consisting of the activities described in subsections (c) and (d).

(b) DEFINITIONS.—In this section:

(1) MATERNAL.—The term ''maternal'' refers to persons who are pregnant or breastfeeding of all gender identities.

(2) PREGNANCY AND BREASTFEEDING INFORMATION SERVICES.—The term ''pregnancy and breastfeeding information services'' includes only—

(A) information services to provide accurate, evidence-based, clinical information regarding maternal exposures during pregnancy that may be associated with birth defects or other health risks, such as exposures to medications, chemicals, infections, foodborne pathogens, illnesses, nutrition, or lifestyle factors;

(B) information services to provide accurate, evidence-based, clinical information regarding maternal exposures during breastfeeding that may be associated with health risks to a breast-fed infant, such as exposures to medications, chemicals, infections, foodborne pathogens, illnesses, nutrition, lifestyle, or climate and weather-related factors;

(C) the provision of accurate, evidence-based information weighing risks of exposures

during breastfeeding against the benefits of breastfeeding; and

(D) the provision of information described in subparagraph (A), (B), or (C) through counselors, Websites, fact sheets, telephonic or electronic communication, community outreach efforts, or other appropriate means.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention.

(c) NATIONWIDE MEDIA CAMPAIGN.—In carrying out subsection (a), the Secretary shall conduct or support a nationwide media campaign to increase awareness among health care providers and at-risk populations about pregnancy and breastfeeding information services.

(d) GRANTS FOR PREGNANCY AND BREASTFEEDING INFORMATION SERVICES.—

(1) IN GENERAL.—In carrying out subsection (a), the Secretary shall award grants to State or regional agencies or organizations for any of the following:

(A) INFORMATION SERVICES.—The provision of, or campaigns to increase awareness

about, pregnancy and breastfeeding information services.

(B) SURVEILLANCE AND RESEARCH.—The conduct or support of—

(i) surveillance of or research on—

(I) maternal exposures and maternal health conditions that may influence the risk of birth defects, prematurity, or other adverse pregnancy outcomes; and

(II) maternal exposures that may influence health risks to a breastfed infant; or

(ii) networking to facilitate surveillance or research described in this subparagraph.

(2) PREFERENCE FOR CERTAIN STATES.—The Secretary, in making any grant under this subsection, shall give preference to States, otherwise equally qualified, that have a pregnancy and breastfeeding information service in place.

(3) MATCHING FUNDS.—The Secretary may only award a grant under this subsection to a State or regional agency or organization that agrees, with respect to the costs to be incurred in carrying out

the grant activities, to make available (directly or through donations from public or private entities) non-Federal funds toward such costs in an amount equal to not less than 25 percent of the amount of the grant.

(4) COORDINATION.—The Secretary shall ensure that activities funded through a grant under this subsection are coordinated, to the maximum extent practicable, with other birth defects prevention and environmental health activities of the Federal Government, including with respect to pediatric environmental health specialty units and children's environmental health centers.

(e) EVALUATION.—In furtherance of the program under subsection (a), the Secretary shall provide for an evaluation of pregnancy and breastfeeding information services to identify efficient and effective models of—

(1) providing information;

(2) raising awareness and increasing knowledge about birth defects prevention measures and targeting education to at-risk groups;

(3) modifying risk behaviors; or

(4) other outcome measures as determined appropriate by the Secretary.

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $5,000,000 for fiscal year 2021, $6,000,000 for fiscal year 2022, $7,000,000 for fiscal year 2023, $8,000,000 for fiscal year 2024, and $9,000,000 for fiscal year 2025.

**SEC. 505. MOMMA'S ACT.**

(a) SHORT TITLE.—This section may be cited as the ''Mothers and Offspring Mortality and Morbidity Awareness Act'' or the ''MOMMA's Act''.

(b) FINDINGS.—Congress finds the following:

(1) Every year, across the United States, 4,000,000 women give birth, about 700 women suffer fatal complications during pregnancy, while giving birth or during the postpartum period, and 70,000 women suffer near-fatal, partum-related complications.

(2) The maternal mortality rate is often used as a proxy to measure the overall health of a population. While the infant mortality rate in the United States has reached its lowest point, the risk of death for women in the United States during pregnancy, childbirth, or the postpartum period is higher than such risk in many other developed nations. The estimated maternal mortality rate (per 100,000 live births) for the 48 contiguous States and Wash-

ington, DC increased from 18.8 percent in 2000 to 23.8 percent in 2014 to 26.6 percent in 2018. This estimated rate is on par with such rate for underdeveloped nations such as Iraq and Afghanistan.

(3) International studies estimate the 2015 maternal mortality rate in the United States as 26.4 per 100,000 live births, which is almost twice the 2015 World Health Organization estimation of 14 per 100,000 live births.

(4) It is estimated that more than 60 percent of maternal deaths in the United States are preventable.

(5) According to the Centers for Disease Control and Prevention, the maternal mortality rate varies drastically for women by race and ethnicity. There are 12.7 deaths per 100,000 live births for White women, 43.5 deaths per 100,000 live births for African-American women, and 14.4 deaths per 100,000 live births for women of other ethnicities. While maternal mortality disparately impacts African-American women, this urgent public health crisis traverses race, ethnicity, socioeconomic status, educational background, and geography.

(6) African-American women are 3 to 4 times more likely to die from causes related to pregnancy

and childbirth compared to non-Hispanic White women.

(7) The findings described in paragraphs (1) through (6) are of major concern to researchers, academics, members of the business community, and providers across the obstetrical continuum represented by organizations such as March of Dimes; the Preeclampsia Foundation; the American College of Obstetricians and Gynecologists; the Society for Maternal-Fetal Medicine; the Association of Women's Health, Obstetric, and Neonatal Nurses; the California Maternal Quality Care Collaborative; Black Women's Health Imperative; the National Birth Equity Collaborative; Black Mamas Matter Alliance; EverThrive Illinois; the National Association of Certified Professional Midwives; PCOS Challenge: The National Polycystic Ovary Syndrome Association; and the American College of Nurse Midwives.

(8) Hemorrhage, cardiovascular and coronary conditions, cardiomyopathy, infection, embolism, mental health conditions, preeclampsia and eclampsia, polycystic ovary syndrome, infection and sepsis, and anesthesia complications are the predominant medical causes of maternal-related deaths and com-

plications. Most of these conditions are largely preventable or manageable.

(9) Oral health is an important part of perinatal health. Reducing bacteria in a woman's mouth during pregnancy can significantly reduce her risk of developing oral diseases and spreading decay-causing bacteria to her baby. Moreover, some evidence suggests that women with periodontal disease during pregnancy could be at greater risk for poor birth outcomes, such as preeclampsia, pre-term birth, and low-birth weight. Furthermore, a woman's oral health during pregnancy is a good predictor of her newborn's oral health, and since mothers can unintentionally spread oral bacteria to their babies, putting their children at higher risk for tooth decay, prevention efforts should happen even before children are born, as a matter of pre-pregnancy health and prenatal care during pregnancy.

(10) The United States has not been able to submit a formal maternal mortality rate to international data repositories since 2007. Thus, no official maternal mortality rate exists for the United States. There can be no maternal mortality rate without streamlining maternal mortality-related data

from the State level and extrapolating such data to the Federal level.

(11) In the United States, death reporting and analysis is a State function rather than a Federal process. States report all deaths—including maternal deaths—on a semi-voluntary basis, without standardization across States. While the Centers for Disease Control and Prevention has the capacity and system for collecting death-related data based on death certificates, these data are not sufficiently reported by States in an organized and standard format across States such that the Centers for Disease Control and Prevention is able to identify causes of maternal death and best practices for the prevention of such death.

(12) Vital statistics systems often underestimate maternal mortality and are insufficient data sources from which to derive a full scope of medical and social determinant factors contributing to maternal deaths. While the addition of pregnancy checkboxes on death certificates since 2003 have likely improved States' abilities to identify pregnancy-related deaths, they are not generally completed by obstetrical providers or persons trained to recognize pregnancy-related mortality. Thus, these

vital forms may be missing information or may capture inconsistent data. Due to varying maternal mortality-related analyses, lack of reliability, and granularity in data, current maternal mortality informatics do not fully encapsulate the myriad medical and socially determinant factors that contribute to such high maternal mortality rates within the United States compared to other developed nations. Lack of standardization of data and data sharing across States and between Federal entities, health networks, and research institutions keep the Nation in the dark about ways to prevent maternal deaths.

(13) Having reliable and valid State data aggregated at the Federal level are critical to the Nation's ability to quell surges in maternal death and imperative for researchers to identify long-lasting interventions.

(14) Leaders in maternal wellness highly recommend that maternal deaths be investigated at the State level first, and that standardized, streamlined, de-identified data regarding maternal deaths be sent annually to the Centers for Disease Control and Prevention. Such data standardization and collection would be similar in operation and effect to the National Program of Cancer Registries of the Centers

for Disease Control and Prevention and akin to the Confidential Enquiry in Maternal Deaths Programme in the United Kingdom. Such a maternal mortalities and morbidities registry and surveillance system would help providers, academicians, lawmakers, and the public to address questions concerning the types of, causes of, and best practices to thwart, pregnancy-related or pregnancy-associated mortality and morbidity.

(15) The United Nations' Millennium Development Goal 5a aimed to reduce by 75 percent, between 1990 and 2015, the maternal mortality rate, yet this metric has not been achieved. In fact, the maternal mortality rate in the United States has been estimated to have more than doubled between 2000 and 2014. Yet, because national data are not fully available, the United States does not have an official maternal mortality rate.

(16) Many States have struggled to establish or maintain Maternal Mortality Review Committees (referred to in this section as ''MMRC''). On the State level, MMRCs have lagged because States have not had the resources to mount local reviews. State-level reviews are necessary as only the State departments of health have the authority to request med-

ical records, autopsy reports, and police reports critical to the function of the MMRC.

(17) The United Kingdom regards maternal deaths as a health systems failure and a national committee of obstetrics experts review each maternal death or near-fatal childbirth complication. Such committee also establishes the predominant course of maternal-related deaths from conditions such as preeclampsia. Consequently, the United Kingdom has been able to reduce its incidence of preeclampsia to less than one in 10,000 women—its lowest rate since 1952.

(18) The United States has no comparable, coordinated Federal process by which to review cases of maternal mortality, systems failures, or best practices. Many States have active MMRCs and leverage their work to impact maternal wellness. For example, the State of California has worked extensively with their State health departments, health and hospital systems, and research collaborative organizations, including the California Maternal Quality Care Collaborative and the Alliance for Innovation on Maternal Health, to establish MMRCs, wherein such State has determined the most prevalent causes of maternal mortality and recorded and shared data

with providers and researchers, who have developed and implemented safety bundles and care protocols related to preeclampsia, maternal hemorrhage, and the like. In this way, the State of California has been able to leverage its maternal mortality review board system, generate data, and apply those data to effect changes in maternal care-related protocol. To date, the State of California has reduced its maternal mortality rate, which is now comparable to the low rates of the United Kingdom.

(19) Hospitals and health systems across the United States lack standardization of emergency obstetrical protocols before, during, and after delivery. Consequently, many providers are delayed in recognizing critical signs indicating maternal distress that quickly escalate into fatal or near-fatal incidences. Moreover, any attempt to address an obstetrical emergency that does not consider both clinical and public health approaches falls woefully under the mark of excellent care delivery. State-based maternal quality collaborative organizations, such as the California Maternal Quality Care Collaborative or entities participating in the Alliance for Innovation on Maternal Health (AIM), have formed obstetrical protocols, tool kits, and other resources to improve sys-

tem care and response as they relate to maternal complications and warning signs for such conditions as maternal hemorrhage, hypertension, and preeclampsia.

(20) The Centers for Disease Control and Prevention reports that nearly half of all maternal deaths occur in the immediate postpartum period—the 42 days following a pregnancy—whereas more than one-third of pregnancy-related or pregnancy-associated deaths occur while a person is still pregnant. Yet, for women eligible for the Medicaid program on the basis of pregnancy, such Medicaid coverage lapses at the end of the month on which the 60th postpartum day lands.

(21) The experience of serious traumatic events, such as being exposed to domestic violence, substance use disorder, or pervasive racism, can over-activate the body's stress-response system. Known as toxic stress, the repetition of high-doses of cortisol to the brain, can harm healthy neurological development, which can have cascading physical and mental health consequences, as documented in the Adverse Childhood Experiences study of the Centers for Disease Control and Prevention.

(22) A growing body of evidence-based research has shown the correlation between the stress associated with one's race—the stress of racism—and one's birthing outcomes. The stress of sex and race discrimination and institutional racism has been demonstrated to contribute to a higher risk of maternal mortality, irrespective of one's gestational age, maternal age, socioeconomic status, or individual-level health risk factors, including poverty, limited access to prenatal care, and poor physical and mental health (although these are not nominal factors). African-American women remain the most at risk for pregnancy-associated or pregnancy-related causes of death. When it comes to preeclampsia, for example, which is related to obesity, African-American women of normal weight remain the most at risk of dying during the perinatal period compared to non-African-American obese women.

(23) The rising maternal mortality rate in the United States is driven predominantly by the disproportionately high rates of African-American maternal mortality.

(24) African-American women are 3 to 4 times more likely to die from pregnancy or maternal-re-

lated distress than are White women, yielding one of the greatest and most disconcerting racial disparities in public health.

(25) Compared to women from other racial and ethnic demographics, African-American women across the socioeconomic spectrum experience prolonged, unrelenting stress related to racial and gender discrimination, contributing to higher rates of maternal mortality, giving birth to low-weight babies, and experiencing pre-term birth. Racism is a risk-factor for these aforementioned experiences. This cumulative stress often extends across the life course and is situated in everyday spaces where African-American women establish livelihood. Structural barriers, lack of access to care, and genetic predispositions to health vulnerabilities exacerbate African-American women's likelihood to experience poor or fatal birthing outcomes, but do not fully account for the great disparity.

(26) African-American women are twice as likely to experience postpartum depression, and disproportionately higher rates of preeclampsia compared to White women.

(27) Racism is deeply ingrained in United States systems, including in health care delivery sys-

tems between patients and providers, often resulting in disparate treatment for pain, irreverence for cultural norms with respect to health, and dismissiveness. Research has demonstrated that patients respond more warmly and adhere to medical treatment plans at a higher degree with providers of the same race or ethnicity or with providers with great ability to exercise empathy. However, the provider pool is not primed with many people of color, nor are providers (whether student-doctors in training or licensed practitioners) consistently required to undergo implicit bias, cultural competency, or empathy training on a consistent, on-going basis.

(c) IMPROVING FEDERAL EFFORTS WITH RESPECT TO PREVENTION OF MATERNAL MORTALITY.—

(1) TECHNICAL ASSISTANCE FOR STATES WITH RESPECT TO REPORTING MATERNAL MORTALITY.—Not later than one year after the date of enactment of this Act, the Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director''), in consultation with the Administrator of the Health Resources and Services Administration, shall provide technical assistance to States that elect to report comprehensive data on maternal mortality, including oral, mental, and

breastfeeding health information, for the purpose of encouraging uniformity in the reporting of such data and to encourage the sharing of such data among the respective States.

(2) BEST PRACTICES RELATING TO PREVENTION OF MATERNAL MORTALITY.—

(A) IN GENERAL.—Not later than one year after the date of enactment of this Act—

(i) the Director, in consultation with relevant patient and provider groups, shall issue best practices to State maternal mortality review committees on how best to identify and review maternal mortality cases, taking into account any data made available by States relating to maternal mortality, including data on oral, mental, and breastfeeding health, and utilization of any emergency services; and

(ii) the Director, working in collaboration with the Health Resources and Services Administration, shall issue best practices to hospitals, State professional society groups, and perinatal quality collaboratives on how best to prevent maternal mortality.

(B) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this subsection, there is authorized to be appropriated $5,000,000 for each of fiscal years 2021 through 2025.

(3) ALLIANCE FOR INNOVATION ON MATERNAL HEALTH GRANT PROGRAM.—

(A) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary''), acting through the Associate Administrator of the Maternal and Child Health Bureau of the Health Resources and Services Administration, shall establish a grant program to be known as the Alliance for Innovation on Maternal Health Grant Program (referred to in this subsection as ''AIM'') under which the Secretary shall award grants to eligible entities for the purpose of—

(i) directing widespread adoption and implementation of maternal safety bundles through collaborative State-based teams; and

(ii) collecting and analyzing process, structure, and outcome data to drive continuous improvement in the implementation of such safety bundles by such State-based teams with the ultimate goal of eliminating preventable maternal mortality and severe maternal morbidity in the United States.

(B) ELIGIBLE ENTITIES.—In order to be eligible for a grant under paragraph (1), an entity shall—

(i) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

(ii) demonstrate in such application that the entity is an interdisciplinary, multi-stakeholder, national organization with a national data-driven maternal safety and quality improvement initiative based on implementation approaches that have been proven to improve maternal safety and outcomes in the United States.

(C) USE OF FUNDS.—An eligible entity that receives a grant under paragraph (1) shall use such grant funds—

(i) to develop and implement, through a robust, multi-stakeholder process, maternal safety bundles to assist States and health care systems in aligning national, State, and hospital-level quality improvement efforts to improve maternal health outcomes, specifically the reduction of maternal mortality and severe maternal morbidity;

(ii) to ensure, in developing and implementing maternal safety bundles under subparagraph (A), that such maternal safety bundles—

(I) satisfy the quality improvement needs of a State or health care system by factoring in the results and findings of relevant data reviews, such as reviews conducted by a State maternal mortality review committee; and

(II) address topics such as—

(aa) obstetric hemorrhage;

(bb) maternal mental health;

(cc) the maternal venous system;

(dd) obstetric care for women with substance use disorders, including opioid use disorder;

(ee) postpartum care basics for maternal safety;

(ff) reduction of peripartum racial and ethnic disparities;

(gg) reduction of primary caesarean birth;

(hh) severe hypertension in pregnancy;

(ii) severe maternal morbidity reviews;

(jj) support after a severe maternal morbidity event;

(kk) thromboembolism;

(ll) optimization of support for breastfeeding; and

(mm) maternal oral health; and

(iii) to provide ongoing technical assistance at the national and State levels to support implementation of maternal safety bundles under subparagraph (A).

(D) MATERNAL SAFETY BUNDLE DEFINED.—For purposes of this subsection, the term ''maternal safety bundle'' means standardized, evidence-informed processes for maternal health care.

(E) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this subsection, there is authorized to be appropriated $10,000,000 for each of fiscal years 2021 through 2025.

(4) FUNDING FOR STATE-BASED PERINATAL QUALITY COLLABORATIVES DEVELOPMENT AND SUSTAINABILITY.—

(A) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary''), acting through the Division of Reproductive Health of the Centers for Disease Control and Prevention, shall establish a grant program to be known as the State-Based Perinatal Quality Collaborative

grant program under which the Secretary awards grants to eligible entities for the purpose of development and sustainability of perinatal quality collaboratives in every State, the District of Columbia, and eligible territories, in order to measurably improve perinatal care and perinatal health outcomes for pregnant and postpartum women and their infants.

(B) GRANT AMOUNTS.—Grants awarded under this subsection shall be in amounts not to exceed $250,000 per year, for the duration of the grant period.

(C) STATE-BASED PERINATAL QUALITY COLLABORATIVE DEFINED.—For purposes of this subsection, the term ''State-based perinatal quality collaborative'' means a network of multidisciplinary teams that—

(i) work to improve measurable outcomes for maternal and infant health by advancing evidence-informed clinical practices using quality improvement principles;

(ii) work with hospital-based or outpatient facility-based clinical teams, experts, and stakeholders, including patients and families, to spread best practices and

optimize resources to improve perinatal care and outcomes;

(iii) employ strategies that include the use of the collaborative learning model to provide opportunities for hospitals and clinical teams to collaborate on improvement strategies, rapid-response data to provide timely feedback to hospital and other clinical teams to track progress, and quality improvement science to provide support and coaching to hospital and clinical teams; and

(iv) have the goal of improving population-level outcomes in maternal and infant health.

(D) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this subsection, there is authorized to be appropriated $14,000,000 per year for each of fiscal years 2021 through 2025.

(5) EXPANSION OF MEDICAID AND CHIP COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—

(A) REQUIRING COVERAGE OF ORAL HEALTH SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.—

(i) MEDICAID.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(I) in subsection (a)(4)—

(aa) by striking ''; and (D)'' and inserting ''; (D)''; and

(bb) by inserting ''; and (E) oral health services for pregnant and postpartum women (as defined in subsection (ee))'' after ''subsection (bb))''; and

(II) by adding at the end the following new subsection:

''(ee) ORAL HEALTH SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.—

''(1) IN GENERAL.—For purposes of this title, the term 'oral health services for pregnant and postpartum women' means dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions that are furnished to a woman during pregnancy (or during the 1-year period beginning on the last day of the pregnancy).

''(2) COVERAGE REQUIREMENTS.—To satisfy the requirement to provide oral health services for

pregnant and postpartum women, a State shall, at a minimum, provide coverage for preventive, diagnostic, periodontal, and restorative care consistent with recommendations for perinatal oral health care and dental care during pregnancy from the American Academy of Pediatric Dentistry and the American College of Obstetricians and Gynecologists.''.

(ii) CHIP.—Section 2103(c)(5)(A) of the Social Security Act (42 U.S.C. 1397cc(c)(5)(A)) is amended by inserting ''or a targeted low-income pregnant woman'' after ''targeted low-income child''.

(B) EXTENDING MEDICAID COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(i) in subsection (e)—

(I) in paragraph (5)—

(aa) by inserting ''(including oral health services for pregnant and postpartum women (as defined in section 1905(ee))'' after ''postpartum medical assistance under the plan''; and

(bb) by striking ''60-day'' and inserting ''1-year''; and

(II) in paragraph (6), by striking ''60-day'' and inserting ''1-year''; and

(ii) in subsection (l)(1)(A), by striking ''60-day'' and inserting ''1-year''.

(C) EXTENDING MEDICAID COVERAGE FOR LAWFUL RESIDENTS.—Section 1903(v)(4)(A) of the Social Security Act (42 U.S.C. 1396b(v)(4)(A)) is amended by striking ''60-day'' and inserting ''1-year''.

(D) EXTENDING CHIP COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—Section 2112(d)(2)(A) of the Social Security Act (42 U.S.C. 1397ll(d)(2)(A)) is amended by striking ''60-day'' and inserting ''1-year''.

(E) MAINTENANCE OF EFFORT.—

(i) MEDICAID.—Section 1902(l) of the Social Security Act (42 U.S.C. 1396a(l)) is amended by adding at the end the following new paragraph:

''(5) During the period that begins on the date of enactment of this paragraph and ends on the date that is five years after such date of enactment, as a condition for receiving any Federal payments under section 1903(a)

for calendar quarters occurring during such period, a State shall not have in effect, with respect to women who are eligible for medical assistance under the State plan or under a waiver of such plan on the basis of being pregnant or having been pregnant, eligibility standards, methodologies, or procedures under the State plan or waiver that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan or waiver that are in effect on the date of enactment of this paragraph.''.

(ii) CHIP.—Section 2105(d) of the Social Security Act (42 U.S.C. 1397ee(d)) is amended by adding at the end the following new paragraph:

''(4) IN ELIGIBILITY STANDARDS FOR TARGETED LOW-INCOME PREGNANT WOMEN.—During the period that begins on the date of enactment of this paragraph and ends on the date that is five years after such date of enactment, as a condition of receiving payments under subsection (a) and section 1903(a), a State that elects to provide assistance to women on the basis of being pregnant (including pregnancy-related assistance provided to targeted low-income pregnant women (as defined in section 2112(d)), pregnancy-related assistance pro-

vided to women who are eligible for such assistance through application of section 1902(v)(4)(A)(i) under section 2107(e)(1), or any other assistance under the State child health plan (or a waiver of such plan) which is provided to women on the basis of being pregnant) shall not have in effect, with respect to such women, eligibility standards, methodologies, or procedures under such plan (or waiver) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) that are in effect on the date of enactment of this paragraph.''.

(F) INFORMATION ON BENEFITS.—The Secretary of Health and Human Services shall make publicly available on the Internet website of the Department of Health and Human Services, information regarding benefits available to pregnant and postpartum women and under the Medicaid program and the Children's Health Insurance Program, including information on—

(i) benefits that States are required to provide to pregnant and postpartum women under such programs;

(ii) optional benefits that States may provide to pregnant and postpartum women under such programs; and

(iii) the availability of different kinds of benefits for pregnant and postpartum women, including oral health and mental health benefits, under such programs.

(G) FEDERAL FUNDING FOR COST OF EXTENDED MEDICAID AND CHIP COVERAGE FOR POSTPARTUM WOMEN.—

(i) MEDICAID.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by paragraph (1), is further amended—

(I) in subsection (b), by striking ''and (aa)'' and inserting ''(aa), and (ff)''; and

(II) by adding at the end the following:

''(ff) INCREASED FMAP FOR EXTENDED MEDICAL ASSISTANCE FOR POSTPARTUM WOMEN.—Notwithstanding subsection (b), the Federal medical assistance percentage for a State, with respect to amounts expended by such State for medical assistance for a woman who is eligible for such assistance on the basis of being pregnant

or having been pregnant that is provided during the 305-day period that begins on the 60th day after the last day of her pregnancy (including any such assistance provided during the month in which such period ends), shall be equal to—

''(1) 100 percent for the first 20 calendar quarters during which this subsection is in effect; and

''(2) 90 percent for calendar quarters thereafter.''.

(ii) CHIP.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(12) ENHANCED PAYMENT FOR EXTENDED ASSISTANCE PROVIDED TO PREGNANT WOMEN.—Notwithstanding subsection (b), the enhanced FMAP, with respect to payments under subsection (a) for expenditures under the State child health plan (or a waiver of such plan) for assistance provided under the plan (or waiver) to a woman who is eligible for such assistance on the basis of being pregnant (including pregnancy-related assistance provided to a targeted low-income pregnant woman (as defined in section 2112(d)), pregnancy-related assistance provided to a woman who is eligible for

such assistance through application of section 1902(v)(4)(A)(i) under section 2107(e)(1), or any other assistance under the plan (or waiver) provided to a woman who is eligible for such assistance on the basis of being pregnant) during the 305-day period that begins on the 60th day after the last day of her pregnancy (including any such assistance provided during the month in which such period ends), shall be equal to—

''(A) 100 percent for the first 20 calendar quarters during which this paragraph is in effect; and

''(B) 90 percent for calendar quarters thereafter.''.

(H) EFFECTIVE DATE.—

(i) IN GENERAL.—Subject to subparagraph (B), the amendments made by this subsection shall take effect on the first day of the first calendar quarter that begins on or after the date that is one year after the date of enactment of this Act.

(ii) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act or a State child health plan under title XXI of

such Act that the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by amendments made by this subsection, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

(6) REGIONAL CENTERS OF EXCELLENCE.—Part P of title III of the Public Health Service Act is amended by adding at the end the following new section:

**"SEC. 399V–7. REGIONAL CENTERS OF EXCELLENCE ADDRESSING IMPLICIT BIAS AND CULTURAL COMPETENCY IN PATIENT-PROVIDER INTERACTIONS EDUCATION.**

''(a) IN GENERAL.—Not later than one year after the date of enactment of this section, the Secretary, in consultation with such other agency heads as the Secretary determines appropriate, shall award cooperative agreements for the establishment or support of regional centers of excellence addressing implicit bias and cultural competency in patient-provider interactions education for the purpose of enhancing and improving how health care professionals are educated in implicit bias and delivering culturally competent health care.

''(b) ELIGIBILITY.—To be eligible to receive a cooperative agreement under subsection (a), an entity shall—

''(1) be a public or other nonprofit entity specified by the Secretary that provides educational and training opportunities for students and health care professionals, which may be a health system, teaching hospital, community health center, medical school, school of public health, dental school, social work school, school of professional psychology, or any other health professional school or program at an institution of higher education (as defined in section 101 of the Higher Education Act of 1965) fo-

cused on the prevention, treatment, or recovery of health conditions that contribute to maternal mortality and the prevention of maternal mortality and severe maternal morbidity;

''(2) demonstrate community engagement and participation, such as through partnerships with home visiting and case management programs; and

''(3) provide to the Secretary such information, at such time and in such manner, as the Secretary may require.

''(c) DIVERSITY.—In awarding a cooperative agreement under subsection (a), the Secretary shall take into account any regional differences among eligible entities and make an effort to ensure geographic diversity among award recipients.

''(d) DISSEMINATION OF INFORMATION.—

''(1) PUBLIC AVAILABILITY.—The Secretary shall make publicly available on the internet website of the Department of Health and Human Services information submitted to the Secretary under subsection (b)(3).

''(2) EVALUATION.—The Secretary shall evaluate each regional center of excellence established or supported pursuant to subsection (a) and dissemi-

nate the findings resulting from each such evaluation to the appropriate public and private entities.

''(3) DISTRIBUTION.—The Secretary shall share evaluations and overall findings with State departments of health and other relevant State level offices to inform State and local best practices.

''(e) MATERNAL MORTALITY DEFINED.—In this section, the term 'maternal mortality' means death of a woman that occurs during pregnancy or within the one-year period following the end of such pregnancy.

''(f) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there is authorized to be appropriated $5,000,000 for each of fiscal years 2021 through 2025.''.

(7) SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN.—Section 17(d)(3)(A)(ii) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(d)(3)(A)(ii)) is amended—

(A) by striking the clause designation and heading and all that follows through ''A State'' and inserting the following:

''(ii) WOMEN.—

''(I) BREASTFEEDING WOMEN.—

A State'';

(B) in subclause (I) (as so designated), by striking ''1 year'' and all that follows through ''earlier'' and inserting ''2 years postpartum''; and

(C) by adding at the end the following:

''(II) POSTPARTUM WOMEN.—A State may elect to certify a postpartum woman for a period of 2 years.''.

(8) DEFINITIONS.—In this section:

(A) MATERNAL MORTALITY.—The term ''maternal mortality'' means death of a woman that occurs during pregnancy or within the one-year period following the end of such pregnancy.

(B) SEVERE MATERNAL MORBIDITY.—The term ''severe maternal morbidity'' includes unexpected outcomes of labor and delivery that result in significant short-term or long-term consequences to a woman's health.

(d) INCREASING EXCISE TAXES ON CIGARETTES AND ESTABLISHING EXCISE TAX EQUITY AMONG ALL TOBACCO PRODUCT TAX RATES.—

(1) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO.—Section 5701(g) of the Internal Revenue

Code of 1986 is amended by striking ''$24.78'' and inserting ''$49.56''.

(2) TAX PARITY FOR PIPE TOBACCO.—Section 5701(f) of the Internal Revenue Code of 1986 is amended by striking ''$2.8311 cents'' and inserting ''$49.56''.

(3) TAX PARITY FOR SMOKELESS TOBACCO.—

(A) Section 5701(e) of the Internal Revenue Code of 1986 is amended—

(i) in paragraph (1), by striking ''$1.51'' and inserting ''$26.84'';

(ii) in paragraph (2), by striking ''50.33 cents'' and inserting ''$10.74''; and

(iii) by adding at the end the following:

''(3) SMOKELESS TOBACCO SOLD IN DISCRETE SINGLE-USE UNITS.—On discrete single-use units, $100.66 per thousand.''.

(B) Section 5702(m) of such Code is amended—

(i) in paragraph (1), by striking ''or chewing tobacco'' and inserting '', chewing tobacco, or discrete single-use unit'';

(ii) in paragraphs (2) and (3), by inserting ''that is not a discrete single-use

unit'' before the period in each such paragraph; and

(iii) by adding at the end the following:

''(4) DISCRETE SINGLE-USE UNIT.—The term 'discrete single-use unit' means any product containing tobacco that—

''(A) is not intended to be smoked; and

''(B) is in the form of a lozenge, tablet, pill, pouch, dissolvable strip, or other discrete single-use or single-dose unit.''.

(4) TAX PARITY FOR SMALL CIGARS.—Paragraph (1) of section 5701(a) of the Internal Revenue Code of 1986 is amended by striking ''$50.33'' and inserting ''$100.66''.

(5) TAX PARITY FOR LARGE CIGARS.—

(A) IN GENERAL.—Paragraph (2) of section 5701(a) of the Internal Revenue Code of 1986 is amended by striking ''52.75 percent'' and all that follows through the period and inserting the following: ''$49.56 per pound and a proportionate tax at the like rate on all fractional parts of a pound but not less than 10.066 cents per cigar.''.

(B) GUIDANCE.—The Secretary of the Treasury, or the Secretary's delegate, may issue guidance regarding the appropriate method for determining the weight of large cigars for purposes of calculating the applicable tax under section 5701(a)(2) of the Internal Revenue Code of 1986.

(6) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO AND CERTAIN PROCESSED TOBACCO.—Subsection (o) of section 5702 of the Internal Revenue Code of 1986 is amended by inserting ", and includes processed tobacco that is removed for delivery or delivered to a person other than a person with a permit provided under section 5713, but does not include removals of processed tobacco for exportation" after "wrappers thereof".

(7) CLARIFYING TAX RATE FOR OTHER TOBACCO PRODUCTS.—

(A) IN GENERAL.—Section 5701 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(i) OTHER TOBACCO PRODUCTS.—Any product not otherwise described under this section that has been determined to be a tobacco product by the Food and Drug Administration through its authorities under the Family

Smoking Prevention and Tobacco Control Act shall be taxed at a level of tax equivalent to the tax rate for cigarettes on an estimated per use basis as determined by the Secretary.''.

(B) ESTABLISHING PER USE BASIS.—For purposes of section 5701(i) of the Internal Revenue Code of 1986, not later than 12 months after the later of the date of the enactment of this Act or the date that a product has been determined to be a tobacco product by the Food and Drug Administration, the Secretary of the Treasury (or the Secretary of the Treasury's delegate) shall issue final regulations establishing the level of tax for such product that is equivalent to the tax rate for cigarettes on an estimated per use basis.

(8) CLARIFYING DEFINITION OF TOBACCO PRODUCTS.—

(A) IN GENERAL.—Subsection (c) of section 5702 of the Internal Revenue Code of 1986 is amended to read as follows:

''(c) TOBACCO PRODUCTS.—The term 'tobacco products' means—

''(1) cigars, cigarettes, smokeless tobacco, pipe tobacco, and roll-your-own tobacco, and

''(2) any other product subject to tax pursuant to section 5701(i).''.

(B) CONFORMING AMENDMENTS.—Subsection (d) of section 5702 of such Code is amended by striking ''cigars, cigarettes, smokeless tobacco, pipe tobacco, or roll-your-own tobacco'' each place it appears and inserting ''tobacco products''.

(9) INCREASING TAX ON CIGARETTES.—

(A) SMALL CIGARETTES.—Section 5701(b)(1) of such Code is amended by striking ''$50.33'' and inserting ''$100.66''.

(B) LARGE CIGARETTES.—Section 5701(b)(2) of such Code is amended by striking ''$105.69'' and inserting ''$211.38''.

(10) TAX RATES ADJUSTED FOR INFLATION.—Section 5701 of such Code, as amended by subsection (g), is amended by adding at the end the following new subsection:

''(j) INFLATION ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any calendar year beginning after 2021, the dollar amounts provided under this chapter shall each be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2017' for 'calendar year 2016' in subparagraph (A)(ii) thereof.

''(2) ROUNDING.—If any amount as adjusted under paragraph (1) is not a multiple of $0.01, such amount shall be rounded to the next highest multiple of $0.01.''.

(11) FLOOR STOCKS TAXES.—

(A) IMPOSITION OF TAX.—On tobacco products manufactured in or imported into the United States which are removed before any tax increase date and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(i) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(ii) the prior tax (if any) imposed under section 5701 of such Code on such article.

(B) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes

imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on such date for which such person is liable.

(C) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(i) LIABILITY FOR TAX.—A person holding tobacco products on any tax increase date to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(ii) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(iii) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before the date that is 120 days after the effective date of the tax rate increase.

(D) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (commonly known as the Foreign Trade Zone Act, 48 Stat. 998, 19 U.S.C. 81a et seq.), or any other provision of law, any article which is located in a foreign trade zone on any tax in-

crease date shall be subject to the tax imposed by paragraph (1) if—

(i) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act; or

(ii) such article is held on such date under the supervision of an officer of the United States Customs and Border Protection of the Department of Homeland Security pursuant to the 2d proviso of such section 3(a).

(E) DEFINITIONS.—For purposes of this subsection—

(i) IN GENERAL.—Any term used in this subsection which is also used in section 5702 of such Code shall have the same meaning as such term has in such section.

(ii) TAX INCREASE DATE.—The term ''tax increase date'' means the effective date of any increase in any tobacco product excise tax rate pursuant to the amend-

ments made by this section (other than subsection (j) thereof).

(iii) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(F) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(G) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

(12) EFFECTIVE DATES.—

(A) IN GENERAL.—Except as provided in paragraphs (2) through (4), the amendments made by this section shall apply to articles re-

moved (as defined in section 5702(j) of the Internal Revenue Code of 1986) after the last day of the month which includes the date of the enactment of this Act.

(B) DISCRETE SINGLE-USE UNITS AND PROCESSED TOBACCO.—The amendments made by subsections (c)(1)(C), (c)(2), and (f) shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue Code of 1986) after the date that is 6 months after the date of the enactment of this Act.

(C) LARGE CIGARS.—The amendments made by subsection (e) shall apply to articles removed after December 31, 2021.

(D) OTHER TOBACCO PRODUCTS.—The amendments made by subsection (g)(1) shall apply to products removed after the last day of the month which includes the date that the Secretary of the Treasury (or the Secretary of the Treasury's delegate) issues final regulations establishing the level of tax for such product.

**SEC. 506. RURAL MATERNAL AND OBSTETRIC MODERNIZATION OF SERVICES.**

(a) SHORT TITLE.—This section may be cited as the ''Rural Maternal and Obstetric Modernization of Services Act'' or the ''Rural MOMS Act''.

(b) IMPROVING RURAL MATERNAL AND OBSTETRIC CARE DATA.—

(1) MATERNAL MORTALITY AND MORBIDITY ACTIVITIES.—Section 301 of the Public Health Service Act (42 U.S.C. 241) is amended—

(A) by redesignating subsections (e) through (h) as subsections (f) through (i), respectively; and

(B) by inserting after subsection (d), the following:

''(e) The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall expand, intensify, and coordinate the activities of the Centers for Disease Control and Prevention with respect to maternal mortality and morbidity.''.

(2) OFFICE OF WOMEN'S HEALTH.—Section 310A(b)(1) of the Public Health Service Act (42 U.S.C. 242s(b)(1)) is amended by inserting ''sociocultural (race, ethnicity, language, class, income), including among American Indians and Alaska Natives, as such terms are defined in section 4

of the Indian Health Care Improvement Act, and geographic contexts,'' after ''biological,''.

(3) SAFE MOTHERHOOD.—Section 317K(b)(2) of the Public Health Service Act (42 U.S.C. 247b–12(b)(2)) is amended—

(A) in subparagraph (L), by striking ''and'' at the end;

(B) by redesignating subparagraph (M) as subparagraph (N); and

(C) by inserting after subparagraph (L), the following:

''(M) an examination of the relationship between maternal health services in rural areas and outcomes in delivery and postpartum care; and''.

(4) OFFICE OF RESEARCH ON WOMEN'S HEALTH.—Section 486 of the Public Health Service Act (42 U.S.C. 287d) is amended—

(A) in subsection (b)—

(i) by redesignating paragraphs (4) through (9) as paragraphs (5) through (10), respectively;

(ii) by inserting after paragraph (3) the following:

''(4) carry out paragraphs (1) and (2) with respect to pregnancy, with priority given to deaths related to pregnancy;''; and

(iii) in paragraph (5) (as so redesignated), by striking ''through (3)'' and inserting ''through (4)''; and

(B) in subsection (d)(4)(A)(iv), by inserting '', including maternal mortality and other maternal morbidity outcomes'' before the semicolon.

(c) RURAL OBSTETRIC NETWORK GRANTS.—The Public Health Service Act is amended by inserting after section 317L–1 (42 U.S.C. 247b–13a) the following:

**''SEC. 317L–2. RURAL OBSTETRIC NETWORK GRANTS.**

''(a) IN GENERAL.—For the purpose of enabling the Secretary (through grants, contracts, or otherwise), acting through the Administrator of the Health Resources and Services Administration, to establish collaborative improvement and innovation networks (referred to in this section as 'rural obstetric networks') to improve outcomes in birth and maternal morbidity and mortality, there is appropriated to the Secretary, out of any money in the Treasury not otherwise appropriated, $3,000,000 for each of fiscal years 2020 through 2024. Such amounts shall remain available until expended.

''(b) USE OF FUNDS.—Amount appropriated under subsection (a) shall be used for the establishment of collaborative improvement and innovation networks to improve maternal health in rural areas by improving outcomes in birth and maternal morbidity and mortality. Rural obstetric networks established in accordance with this section shall—

''(1) assist pregnant women and individuals in rural areas connect with prenatal, labor and birth, and postpartum care to improve outcomes in birth and maternal mortality and morbidity;

''(2) identify successful prenatal, labor and birth, and postpartum health delivery models for individuals in rural areas, including evidence-based home visiting programs and successful, culturally competent models with positive maternal health outcomes that advance health equity;

''(3) develop a model for collaboration between health facilities that have an obstetric health unit and health facilities that do not have an obstetric health unit;

''(4) provide training and guidance for health facilities that do not have obstetric health units;

''(5) collaborate with academic institutions that can provide regional expertise and research on ac-

cess, outcomes, needs assessments, and other identified data; and

''(6) measure and address inequities in birth outcomes among rural residents, with an emphasis on Black and American Indians and Alaska Native residents, as such terms are defined in section 4 of the Indian Health Care Improvement Act.

''(c) REQUIREMENTS.—

''(1) ESTABLISHMENT.—Not later than October 1, 2020, the Secretary shall establish rural obstetric health networks in at least 5 regions.

''(2) DEFINITIONS.—In this section:

''(A) FRONTIER AREA.—The term 'frontier area' means a frontier county, as defined in section 1886(d)(3)(E)(iii)(III) of the Social Security Act.

''(B) INDIAN TRIBE.—The term 'Indian tribe' has the meaning given such term in section 4 of the Indian Health Care Improvement Act.

''(C) NATIVE HAWAIIAN HEALTH CARE SYSTEM.—The term 'Native Hawaiian Health Care System' has the meaning given such term in section 12 of the Native Hawaiian Health Care Improvement Act.

"(D) REGION.—The term 'region' means a State, Indian tribe, rural area, or frontier area.

"(E) RURAL AREA.—The term 'rural area' has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act.

"(F) TRIBAL ORGANIZATION.—The term 'tribal organization' has the meaning given such term in the Indian Self-Determination Act.

"(G) STATE.—The term 'State' has the meaning given that term for purposes of title V of the Social Security Act.".

(d) TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS.—Section 330I of the Public Health Service Act (42 U.S.C. 254c–14) is amended—

(1) in subsection (f)(1)(B)(iii), by adding at the end the following:

"(XIII) Providers of maternal, including prenatal, labor and birth, and postpartum care services and entities operation obstetric care units.";

(2) in subsection (i)(1)(B), by inserting "labor and birth, postpartum," before "or prenatal"; and

(3) in subsection (k)(1)(B), by inserting "equipment useful for caring for pregnant women and indi-

viduals, including ultrasound machines and fetal monitoring equipment,'' before ''and other equipment''.

(e) RURAL MATERNAL AND OBSTETRIC CARE TRAINING DEMONSTRATION.—Part D of title VII of the Public Health Service Act is amended by inserting after section 760 (42 U.S.C. 294k) the following:

**''SEC. 760A. RURAL MATERNAL AND OBSTETRIC CARE TRAINING DEMONSTRATION.**

''(a) IN GENERAL.—The Secretary shall establish a training demonstration program to award grants to eligible entities to support—

''(1) training for physicians, medical residents, including family medicine and obstetrics and gynecology residents, and fellows to practice maternal and obstetric medicine in rural community-based settings;

''(2) training for licensed and accredited nurse practitioners, physician assistants, certified nurse midwives, certified midwives, certified professional midwives, home visiting nurses, or non-clinical professionals such as doulas and community health workers, to provide maternal care services in rural community-based settings; and

''(3) establishing, maintaining, or improving academic units or programs that—

''(A) provide training for students or faculty, including through clinical experiences and research, to improve maternal care in rural areas; or

''(B) develop evidence-based practices or recommendations for the design of the units or programs described in subparagraph (A), including curriculum content standards.

''(b) ACTIVITIES.—

''(1) TRAINING FOR MEDICAL RESIDENTS AND FELLOWS.—A recipient of a grant under subsection (a)(1)—

''(A) shall use the grant funds—

''(i) to plan, develop, and operate a training program to provide obstetric care in rural areas for family practice or obstetrics and gynecology residents and fellows; or

''(ii) to train new family practice or obstetrics and gynecology residents and fellows in maternal and obstetric health care to provide and expand access to maternal

and obstetric health care in rural areas; and

''(B) may use the grant funds to provide additional support for the administration of the program or to meet the costs of projects to establish, maintain, or improve faculty development, or departments, divisions, or other units necessary to implement such training.

''(2) TRAINING FOR OTHER PROVIDERS.—A recipient of a grant under subsection (a)(2)—

''(A) shall use the grant funds to plan, develop, or operate a training program to provide maternal health care services in rural, community-based settings; and

''(B) may use the grant funds to provide additional support for the administration of the program or to meet the costs of projects to establish, maintain, or improve faculty development, or departments, divisions, or other units necessary to implement such program.

''(3) ACADEMIC UNITS OR PROGRAMS.—A recipient of a grant under subsection (a)(3) shall enter into a partnership with organizations such as an education accrediting organization (such as the Liaison Committee on Medical Education, the Accredita-

tion Council for Graduate Medical Education, the Commission on Osteopathic College Accreditation, the Accreditation Commission for Education in Nursing, the Commission on Collegiate Nursing Education, the Accreditation Commission for Midwifery Education, or the Accreditation Review Commission on Education for the Physician Assistant) to carry out activities under subsection (a)(3).

''(4) TRAINING PROGRAM REQUIREMENTS.—The recipient of a grant under subsection (a)(1) or (a)(2) shall ensure that training programs carried out under the grant include instruction on—

''(A) maternal mental health, including perinatal depression and anxiety and postpartum depression;

''(B) maternal substance use disorder;

''(C) social determinants of health that impact individuals living in rural communities, including poverty, social isolation, access to nutrition, education, transportation, and housing; and

''(D) implicit bias.

''(c) ELIGIBLE ENTITIES.—

''(1) TRAINING FOR MEDICAL RESIDENTS AND FELLOWS.—To be eligible to receive a grant under subsection (a)(1), an entity shall—

''(A) be a consortium consisting of—

''(i) at least one teaching health center; or

''(ii) the sponsoring institution (or parent institution of the sponsoring institution) of—

''(I) an obstetrics and gynecology or family medicine residency program that is accredited by the Accreditation Council of Graduate Medical Education (or the parent institution of such a program); or

''(II) a fellowship in maternal or obstetric medicine, as determined appropriate by the Secretary; or

''(B) be an entity described in subparagraph (A)(ii) that provides opportunities for medical residents or fellows to train in rural community-based settings.

''(2) TRAINING FOR OTHER PROVIDERS.—To be eligible to receive a grant under subsection (a)(2), an entity shall be—

"(A) a teaching health center (as defined in section 749A(f));

"(B) a federally qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act);

"(C) a community mental health center (as defined in section 1861(ff)(3)(B) of the Social Security Act);

"(D) a rural health clinic (as defined in section 1861(aa) of the Social Security Act);

"(E) a freestanding birth center (as defined in section 1905(l)(3) of the Social Security Act);

"(F) a health center operated by the Indian Health Service, an Indian tribe, a tribal organization, or a Native Hawaiian Health Care System (as such terms are defined in section 4 of the Indian Health Care Improvement Act and section 12 of the Native Hawaiian Health Care Improvement Act); or

"(G) an entity with a demonstrated record of success in providing academic training for nurse practitioners, physician assistants, certified nurse-midwives, certified midwives, certified professional midwives, home visiting

nurses, or non-clinical professionals, such as doulas and community health workers.

''(3) ACADEMIC UNITS OR PROGRAMS.—To be eligible to receive a grant under subsection (a)(3), an entity shall be a school of medicine or osteopathic medicine, a nursing school, a physician assistant training program, an accredited public or nonprofit private hospital, an accredited medical residency program, a school accredited by the Midwifery Education and Accreditation Council, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant.

''(4) APPLICATION.—To be eligible to receive a grant under subsection (a), an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including an estimate of the amount to be expended to conduct training activities under the grant (including ancillary and administrative costs).

''(d) DURATION.—Grants awarded under this section shall be for a minimum of 5 years.

''(e) STUDY AND REPORT.—

''(1) STUDY.—

''(A) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall conduct a study on the results of the demonstration program under this section.

''(B) DATA SUBMISSION.—Not later than 90 days after the completion of the first year of the training program, and each subsequent year for the duration of the grant, that the program is in effect, each recipient of a grant under subsection (a) shall submit to the Secretary such data as the Secretary may require for analysis for the report described in paragraph (2).

''(2) REPORT TO CONGRESS.—Not later than 1 year after receipt of the data described in paragraph (1)(B), the Secretary shall submit to Congress a report that includes—

''(A) an analysis of the effect of the demonstration program under this section on the quality, quantity, and distribution of maternal, including prenatal, labor and birth, and postpartum care services and the demographics of the recipients of those services;

''(B) an analysis of maternal and infant health outcomes (including quality of care, morbidity, and mortality) before and after implementation of the program in the communities served by entities participating in the demonstration; and

''(C) recommendations on whether the demonstration program should be expanded.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $5,000,000 for each of fiscal years 2020 through 2024.''.

(f) GAO REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to the appropriate committees of Congress a report on the maternal, including prenatal, labor and birth, and postpartum care in rural areas. Such report shall include the following:

(1) The location of gaps in maternal and obstetric clinicians and health professionals, including non-clinical professionals such as doulas and community health workers.

(2) The location of gaps in facilities able to provide maternal, including prenatal, labor and birth, and postpartum care in rural areas, including care for high-risk pregnancies.

(3) The gaps in data on maternal mortality and recommendations to standardize the format on collecting data related to maternal mortality and morbidity.

(4) The gaps in maternal health by race and ethnicity in rural communities, with a focus on racial inequities for Black residents and among Indian Tribes and American Indian/Alaska Native rural residents (as such terms are defined in section 4 of the Indian Health Care Improvement Act).

(5) A list of specific activities that the Secretary of Health and Human Services plans to conduct on maternal, including prenatal, labor and birth, and postpartum care.

(6) A plan for completing such activities.

(7) An explanation of Federal agency involvement and coordination needed to conduct such activities.

(8) A budget for conducting such activities.

(9) Other information that the Comptroller General determines appropriate.

**SEC. 507. DECREASING THE RISK FACTORS FOR SUDDEN UNEXPECTED INFANT DEATH AND SUDDEN UNEXPLAINED DEATH IN CHILDHOOD.**

(a) ESTABLISHMENT.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health (in this section referred to as the ''Secretary''), shall establish and implement a culturally and linguistically competent public health awareness and education campaign to provide information that is focused on decreasing the risk factors for sudden unexpected infant death and sudden unexplained death in childhood, including educating individuals about safe sleep environments, sleep positions, and reducing exposure to smoking during pregnancy and after birth.

(b) TARGETED POPULATIONS.—The campaign under subsection (a) shall be designed to reduce health disparities through the targeting of populations with high rates of sudden unexpected infant death and sudden unexplained death in childhood.

(c) CONSULTATION.—In establishing and implementing the campaign under subsection (a), the Secretary shall consult with national organizations representing health care providers, including nurses and physicians,

parents, child care providers, children's advocacy and safety organizations, maternal and child health programs, nutrition professionals focusing on women, infants, and children, and other individuals and groups determined necessary by the Secretary for such establishment and implementation.

(d) GRANTS.—

(1) IN GENERAL.—In carrying out the campaign under subsection (a), the Secretary shall award grants to national organizations, State and local health departments, and community-based organizations for the conduct of education and outreach programs for nurses, parents, child care providers, public health agencies, and community organizations.

(2) APPLICATION.—To be eligible to receive a grant under paragraph (1), an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

**SEC. 508. REDUCING UNINTENDED TEENAGE PREGNANCIES.**

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

**"PART W—YOUTH ACCESS TO SEXUAL HEALTH SERVICES**

**"SEC. 399OO. AUTHORIZATION OF GRANTS TO SUPPORT THE ACCESS OF MARGINALIZED YOUTH TO SEXUAL HEALTH SERVICES.**

''(a) GRANTS.—The Secretary may award grants on a competitive basis to eligible entities to support the access of marginalized youth to sexual health services.

''(b) USE OF FUNDS.—An eligible entity that is awarded a grant under subsection (a) may use the funds to—

''(1) provide medically accurate and complete and age-, developmentally, and culturally appropriate sexual health information to marginalized youth, including information on how to access sexual health services;

''(2) promote effective communication regarding sexual health among marginalized youth;

''(3) promote and support better health, education, and economic opportunities for school-age parents; and

''(4) train individuals who work with marginalized youth to promote—

''(A) the prevention of unintended pregnancy;

''(B) the prevention of sexually transmitted infections, including the human immunodeficiency virus (HIV);

''(C) healthy relationships; and

''(D) the development of safe and supportive environments.

''(c) APPLICATION.—To be awarded a grant under subsection (a), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to eligible entities—

''(1) with a history of supporting the access of marginalized youth to sexuality education or sexual health services; and

''(2) that plan to serve marginalized youth that are not served by Federal adolescent programs for the prevention of pregnancy, HIV, and other sexually transmitted infections.

''(e) REQUIREMENTS.—The Secretary may not award a grant under subsection (a) to an eligible entity unless—

''(1) such eligible entity has formed a partnership with a community organization; and

''(2) such eligible entity agrees—

''(A) to employ a scientifically effective strategy;

''(B) that all information provided to marginalized youth will be—

''(i) age- and developmentally appropriate;

''(ii) medically accurate and complete;

''(iii) scientifically based; and

''(iv) provided in the language and cultural context that is most appropriate for the individuals served by the eligible entity; and

''(C) that for each year the eligible entity receives grant funds under subsection (a), the eligible entity will submit to the Secretary an annual report that includes—

''(i) the use of grant funds by the eligible entity;

''(ii) how the use of grant funds has increased the access of marginalized youth to sexual health services; and

''(iii) such other information as the Secretary may require.

''(f) PUBLICATION AND EVALUATIONS.—

''(1) EVALUATIONS.—Not less than once every two years after the date of the enactment of this part, the Secretary shall evaluate the effectiveness of whichever of the following is greater:

''(A) Eight grants awarded under subsection (a).

''(B) Ten percent of the grants awarded under subsection (a).

''(2) PUBLICATION.—The Secretary shall make available to the public—

''(A) the evaluations required under paragraph (1); and

''(B) the reports required under subsection (e)(2)(C).

''(g) LIMITATIONS.—No funds made available to an eligible entity under this section may be used by such entity to provide access to sexual health services that—

''(1) withhold sexual health-promoting or life-saving information;

''(2) are medically inaccurate or have been scientifically shown to be ineffective;

''(3) promote gender stereotypes;

''(4) are insensitive or unresponsive to the needs of young people, including—

''(A) youth with varying gender identities, gender expressions, and sexual orientations;

''(B) sexually active youth;

''(C) pregnant or parenting youth;

''(D) survivors of sexual abuse or assault; and

''(E) youth of all physical, developmental, and mental abilities; or

''(5) are inconsistent with the ethical imperatives of medicine and public health.

''(h) TRANSFER OF FUNDS.—Any unobligated balance of funds made available under section 510(d) of the Social Security Act (42 U.S.C. 710(d)) (as in effect on the day before the date of the enactment of this part) are hereby transferred and made available to the Secretary to carry out this section. The amounts transferred and made available to carry out this section shall remain available until expended.

''(i) DEFINITIONS.—In this section:

''(1) COMMUNITY ORGANIZATION.—The term 'community organization' includes a State or local health or education agency, public school, youth-focused organization that is faith-based and community-based, juvenile justice entity, or other organization that provides confidential and appropriate sexuality education or sexual health services to marginalized youth.

''(2) ELIGIBLE ENTITY.—The term 'eligible entity' includes a State or local health or education agency, public school, nonprofit organization, hospital, or an Indian Tribe or Tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304)).

''(3) MARGINALIZED YOUTH.—The term 'marginalized youth' means a person under the age of 26 that is disadvantaged by underlying structural barriers and social inequity.

''(4) MEDICALLY ACCURATE AND COMPLETE.—The term 'medically accurate and complete', when used with respect to information, means information that—

''(A) is supported by research and recognized as accurate, objective, and complete by

leading medical, psychological, psychiatric, or public health organizations and agencies; and

''(B) does not withhold any information relating to the effectiveness and benefits of correct and consistent use of condoms or other contraceptives and pregnancy prevention methods.

''(5) SCIENTIFICALLY EFFECTIVE STRATEGY.—The term 'scientifically effective strategy' means a strategy that—

''(A) is widely recognized by leading medical and public health agencies as effective in promoting sexual health awareness and healthy behavior; and

''(B) either—

''(i) has been demonstrated to be effective on the basis of rigorous scientific research; or

''(ii) incorporates characteristics of effective programs.

''(6) SEXUAL HEALTH SERVICES.—The term 'sexual health services' includes—

''(A) sexual health information, education, and counseling;

''(B) contraception;

''(C) emergency contraception;

''(D) condoms and other barrier methods to prevent pregnancy or sexually transmitted infections;

''(E) routine gynecological care, including human papillomavirus (HPV) vaccines and cancer screenings;

''(F) pre-exposure prophylaxis or post-exposure prophylaxis;

''(G) mental health services;

''(H) sexual assault survivor services; and

''(I) other prevention, care, or treatment.''.

**SEC. 509. GESTATIONAL DIABETES.**

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by adding after section 317H the following:

**''SEC. 317H–1. GESTATIONAL DIABETES.**

''(a) UNDERSTANDING AND MONITORING GESTATIONAL DIABETES.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, in consultation with the Diabetes Mellitus Interagency Coordinating Committee established under section 429 and representatives of appropriate national health organizations, shall de-

velop a multisite gestational diabetes research project within the diabetes program of the Centers for Disease Control and Prevention to expand and enhance surveillance data and public health research on gestational diabetes.

''(2) AREAS TO BE ADDRESSED.—The research project developed under paragraph (1) shall address—

''(A) procedures to establish accurate and efficient systems for the collection of gestational diabetes data within each State and commonwealth, territory, or possession of the United States;

''(B) the progress of collaborative activities with the National Vital Statistics System, the National Center for Health Statistics, and State health departments with respect to the standard birth certificate, in order to improve surveillance of gestational diabetes;

''(C) postpartum methods of tracking individuals with gestational diabetes after delivery as well as targeted interventions proven to lower the incidence of type 2 diabetes in that population;

"(D) variations in the distribution of diagnosed and undiagnosed gestational diabetes, and of impaired fasting glucose tolerance and impaired fasting glucose, within and among groups of pregnant individuals; and

"(E) factors and culturally sensitive interventions that influence risks and reduce the incidence of gestational diabetes and related complications during childbirth, including cultural, behavioral, racial, ethnic, geographic, demographic, socioeconomic, and genetic factors.

"(3) REPORT.—Not later than 2 years after the date of the enactment of this section, and annually thereafter, the Secretary shall generate a report on the findings and recommendations of the research project including prevalence of gestational diabetes in the multisite area and disseminate the report to the appropriate Federal and non-Federal agencies.

"(b) EXPANSION OF GESTATIONAL DIABETES RESEARCH.—

"(1) IN GENERAL.—The Secretary shall expand and intensify public health research regarding gestational diabetes. Such research may include—

"(A) developing and testing novel approaches for improving postpartum diabetes

testing or screening and for preventing type 2 diabetes in individuals who can become pregnant with a history of gestational diabetes; and

''(B) conducting public health research to further understanding of the epidemiologic, socioenvironmental, behavioral, translation, and biomedical factors and health systems that influence the risk of gestational diabetes and the development of type 2 diabetes in individuals who can become pregnant with a history of gestational diabetes.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $5,000,000 for each of fiscal years 2021 through 2025.

''(c) DEMONSTRATION GRANTS TO LOWER THE RATE OF GESTATIONAL DIABETES.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award grants, on a competitive basis, to eligible entities for demonstration projects that implement evidence-based interventions to reduce the incidence of gestational diabetes, the recurrence of gestational diabetes in subsequent pregnancies, and the development of type 2 di-

abetes in individuals who can become pregnant with a history of gestational diabetes.

''(2) PRIORITY.—In making grants under this subsection, the Secretary shall give priority to projects focusing on—

''(A) helping individuals who can become pregnant who have 1 or more risk factors for developing gestational diabetes;

''(B) working with individuals who can become pregnant with a history of gestational diabetes during a previous pregnancy;

''(C) providing postpartum care for individuals who can become pregnant with gestational diabetes;

''(D) tracking cases where individuals who can become pregnant with a history of gestational diabetes developed type 2 diabetes;

''(E) educating mothers with a history of gestational diabetes about the increased risk of their child developing diabetes;

''(F) working to prevent gestational diabetes and prevent or delay the development of type 2 diabetes in individuals who can become pregnant with a history of gestational diabetes; and

''(G) achieving outcomes designed to assess the efficacy and cost-effectiveness of interventions that can inform decisions on long-term sustainability, including third-party reimbursement.

''(3) APPLICATION.—An eligible entity desiring to receive a grant under this subsection shall submit to the Secretary—

''(A) an application at such time, in such manner, and containing such information as the Secretary may require; and

''(B) a plan to—

''(i) lower the rate of gestational diabetes during pregnancy; or

''(ii) develop methods of tracking individuals who can become pregnant with a history of gestational diabetes and develop effective interventions to lower the incidence of the recurrence of gestational diabetes in subsequent pregnancies and the development of type 2 diabetes.

''(4) USES OF FUNDS.—An eligible entity receiving a grant under this subsection shall use the grant funds to carry out demonstration projects described in paragraph (1), including—

''(A) expanding community-based health promotion education, activities, and incentives focused on the prevention of gestational diabetes and development of type 2 diabetes in individuals who can become pregnant with a history of gestational diabetes;

''(B) aiding State- and Tribal-based diabetes prevention and control programs to collect, analyze, disseminate, and report surveillance data on individuals who can become pregnant with, and at risk for, gestational diabetes, the recurrence of gestational diabetes in subsequent pregnancies, and, for individuals who can become pregnant with a history of gestational diabetes, the development of type 2 diabetes; and

''(C) training and encouraging health care providers—

''(i) to promote risk assessment, high-quality care, and self-management for gestational diabetes and the recurrence of gestational diabetes in subsequent pregnancies; and

''(ii) to prevent the development of type 2 diabetes in individuals who can become pregnant with a history of gesta-

tional diabetes, and its complications in the practice settings of the health care providers.

''(5) REPORT.—Not later than 4 years after the date of the enactment of this section, the Secretary shall prepare and submit to the Congress a report concerning the results of the demonstration projects conducted through the grants awarded under this subsection.

''(6) DEFINITION OF ELIGIBLE ENTITY.—In this subsection, the term 'eligible entity' means a nonprofit organization (such as a nonprofit academic center or community health center) or a State, Tribal, or local health agency.

''(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $5,000,000 for each of fiscal years 2021 through 2025.

''(d) POSTPARTUM FOLLOWUP REGARDING GESTATIONAL DIABETES.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall work with the State- and Tribal-based diabetes prevention and control programs assisted by the Centers to encourage postpartum followup after gestational diabetes, as medically appropriate, for the purpose of reducing

the incidence of gestational diabetes, the recurrence of gestational diabetes in subsequent pregnancies, the development of type 2 diabetes in individuals with a history of gestational diabetes, and related complications.''.

**SEC. 510. EMERGENCY CONTRACEPTION EDUCATION AND INFORMATION PROGRAMS.**

(a) EMERGENCY CONTRACEPTION PUBLIC EDUCATION PROGRAM.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall develop and disseminate to the public medically accurate and complete information on emergency contraceptives.

(2) DISSEMINATION.—The Secretary may disseminate medically accurate and complete information under paragraph (1) directly or through arrangements with nonprofit organizations, community health workers including promotoras, consumer groups, institutions of higher education, clinics, the media, and Federal, State, and local agencies.

(3) INFORMATION.—The information disseminated under paragraph (1) shall—

(A) include, at a minimum, a description of emergency contraceptives and an explanation of the use, safety, efficacy, affordability, and

availability, including over-the-counter access, of such contraceptives and options for access without cost-sharing through insurance and other programs;

(B) include emergency contraception to health care providers, including pharmacists; and

(C) be pilot tested for consumer comprehension, cultural and linguistic appropriateness, and acceptance of the messages across geographically, racially, ethnically, and linguistically diverse populations.

(b) EMERGENCY CONTRACEPTION INFORMATION PROGRAM FOR HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with major medical and public health organizations, shall develop and disseminate to health care providers, including pharmacists, information on emergency contraceptives.

(2) INFORMATION.—The information disseminated under paragraph (1) shall include, at a minimum—

(A) information describing the use, safety, efficacy, and availability of emergency contraceptives, and options for access without cost-sharing through insurance and other programs;

(B) a recommendation regarding the use of such contraceptives; and

(C) information explaining how to obtain copies of the information developed under subsection (a) for distribution to the patients of the providers.

(c) DEFINITIONS.—In this section:

(1) HEALTH CARE PROVIDER.—The term ''health care provider'' means an individual who is licensed or certified under State law to provide health care services and who is operating within the scope of such license. Such term shall include a pharmacist.

(2) INSTITUTION OF HIGHER EDUCATION.—The term ''institution of higher education'' has the same meaning given such term in section 101(a) of the Higher Education Act of 1965 (20 U.S.C. 1001(a)).

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

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section

such sums as may be necessary for each of the fiscal years 2021 through 2025.

**SEC. 511. COMPREHENSIVE SEX EDUCATION PROGRAMS.**

(a) PURPOSES; FINDING; SENSE OF CONGRESS.—

(1) PURPOSES.—The purposes of this section are to provide young people with comprehensive sex education programs that—

(A) promote and uphold the rights of young people to information in order to make healthy decisions about their sexual health;

(B) provide the information and skills all young people need to make informed, responsible, and healthy decisions in order to become sexually healthy adults and have healthy relationships;

(C) provide information about the prevention of unintended pregnancy, sexually transmitted infections, including HIV, dating violence, sexual assault, bullying, and harassment; and

(D) provide resources and information on topics ranging from gender stereotyping and gender roles and stigma and socio-cultural influences surrounding sex and sexuality.

(2) FINDING ON REQUIRED RESOURCES.—In order to provide the comprehensive sex education described in paragraph (1), Congress finds that increased resources are required for sex education programs that—

(A) substantially incorporate elements of evidence-based programs or characteristics of effective programs;

(B) cover a broad range of topics, including medically accurate and complete information that is age and developmentally appropriate about all the aspects of sex, sexual health, and sexuality;

(C) are gender and gender identity-sensitive, emphasizing the importance of equality and the social environment for achieving sexual and reproductive health and overall well-being;

(D) promote educational achievement, critical thinking, decisionmaking, self-esteem, and self-efficacy;

(E) help develop healthy attitudes and insights necessary for understanding relationships between oneself and others and society;

(F) foster leadership skills and community engagement by—

(i) promoting principles of fairness, human dignity, and respect; and

(ii) engaging young people as partners in their communities; and

(G) are culturally and linguistically appropriate, reflecting the diverse circumstances and realities of young people.

(3) SENSE OF CONGRESS.—It is the sense of Congress that—

(A) federally funded sex education programs should aim to—

(i) provide information about a range of human sexuality topics, including—

(I) human development, healthy relationships, personal skills;

(II) sexual behavior including abstinence;

(III) sexual health including preventing unintended pregnancy;

(IV) sexually transmitted infections including HIV; and

(V) society and culture;

(ii) promote safe and healthy relationships;

(iii) promote gender equity;

(iv) use, and be informed by, the best scientific information available;

(v) be culturally appropriate and inclusive of youth with varying gender identities, gender expressions, and sexual orientations;

(vi) be built on characteristics of effective programs;

(vii) expand the existing body of research on comprehensive sex education programs through program evaluation;

(viii) expand training programs for teachers of comprehensive sex education;

(ix) build on programs funded under section 513 of the Social Security Act (42 U.S.C. 713) and the Office of Adolescent Health's Teen Pregnancy Prevention Program, funded under title II of the Consolidated Appropriations Act, 2010 (Public Law 111–117; 123 Stat. 3253), and on programs supported through the Centers for Disease Control and Prevention (CDC); and

(x) promote and uphold the rights of young people to information in order to

make healthy and autonomous decisions about their sexual health; and

(B) no Federal funds should be used for health education programs that—

(i) withhold health-promoting or life-saving information about sexuality-related topics, including HIV;

(ii) are medically inaccurate or have been scientifically shown to be ineffective;

(iii) promote gender or racial stereotypes;

(iv) are insensitive and unresponsive to the needs of sexually active young people;

(v) are insensitive and unresponsive to the needs of survivors of sexual violence;

(vi) are insensitive and unresponsive to the needs of youth of all physical, developmental, and mental abilities;

(vii) are insensitive and unresponsive to the needs of youth with varying gender identities, gender expressions, and sexual orientations; or

(viii) are inconsistent with the ethical imperatives of medicine and public health.

(b) GRANTS FOR COMPREHENSIVE SEX EDUCATION FOR ADOLESCENTS.—

(1) PROGRAM AUTHORIZED.—The Secretary of Health and Human Services, in coordination with the Associate Commissioner of the Family and Youth Services Bureau of the Administration on Children, Youth, and Families of the Department of Health and Human Services, the Director of the Office of Adolescent Health, the Director of the Division of Adolescent and School Health within the Centers for Disease Control and Prevention and the Secretary of Education, shall award grants, on a competitive basis, to eligible entities to enable such eligible entities to carry out programs that provide adolescents with comprehensive sex education, as described in paragraph (6).

(2) DURATION.—Grants awarded under this section shall be for a period of 5 years.

(3) ELIGIBLE ENTITY.—In this section, the term ''eligible entity'' means a public or private entity that focuses on adolescent health and education or has experience working with adolescents.

(4) APPLICATIONS.—An eligible entity desiring a grant under this subsection shall submit an application to the Secretary at such time, in such man-

ner, and containing such information as the Secretary may require, including an assurance to participate in the evaluation described in subsection (e).

(5) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to eligible entities that—

(A) are State or local public entities;

(B) are entities not currently receiving funds under—

(i) section 513 of the Social Security Act (42 U.S.C. 713);

(ii) the Office of Adolescent Health's Teen Pregnancy Prevention Program, funded under title II of the Consolidated Appropriations Act, 2010 (Public Law 111–117; 123 Stat. 3253), or any substantially similar successive program; or

(iii) the Centers for Disease Control and Prevention's Division of Adolescent and School Health; and

(C) address health inequities among young people that face systemic barriers resulting in disproportionate rates of not less than one of the following:

(i) Unintended pregnancies.

(ii) Sexually transmitted infections, including HIV.

(iii) Dating violence and sexual violence.

(6) USE OF FUNDS.—

(A) IN GENERAL.—Each eligible entity that receives a grant under this section shall use the grant funds to carry out an education program that provides adolescents with comprehensive sex education that—

(i) is age and developmentally appropriate;

(ii) is medically accurate and complete;

(iii) substantially incorporates elements of evidence-based sex education instruction; or

(iv) creates a demonstration project based on characteristics of effective programs.

(B) CONTENTS OF COMPREHENSIVE SEX EDUCATION PROGRAMS.—The comprehensive sex education programs funded under this section shall include instruction and materials that address—

(i) the physical, social, and emotional changes of human development including, human anatomy, reproduction, and sexual development;

(ii) healthy relationships, including friendships, within families, and society, that are based on mutual respect, and the ability to distinguish between healthy and unhealthy relationships, including—

(I) effective communication, negotiation and refusal skills, including the skills to recognize and report inappropriate or abusive sexual advances;

(II) bodily autonomy, setting and respecting personal boundaries, practicing personal safety, and consent; and

(III) the limitations and harm of gender- role stereotypes, violence, coercion, bullying, harassment, and intimidation in relationships;

(iii) healthy decisionmaking skills about sexuality and relationships that include—

(I) critical thinking, problem solving, self-efficacy, stress-management, self-care, and decisionmaking;

(II) individual values and attitudes;

(III) the promotion of positive body images;

(IV) developing an understanding that there are a range of body types and encouraging positive feeling about students' own body types;

(V) information on how to respect others and ensure safety on the internet and when using other forms of digital communication;

(VI) information on local services and resources where students can obtain additional information related to bullying, harassment, dating violence and sexual assault, suicide prevention, and other related care;

(VII) encouragement for youth to communicate with their parents or guardians, health and social service professionals, and other trusted adults

about sexuality and intimate relationships;

(VIII) information on how to create a safe environment for all students and others in society;

(IX) examples of varying types of relationships, couples, and family structures; and

(X) affirmative representation of varying gender identities, gender expressions, and sexual orientations, including individuals and relationships between same sex couples and their families;

(iv) abstinence, delaying age of first sexual activity, the use of condoms, preventive medication, vaccination, birth control, and other sexually transmitted infection prevention measures, and the options for pregnancy, including parenting, adoption, and abortion, including—

(I) the importance of effectively using condoms, preventive medication, and applicable vaccinations to protect

against sexually transmitted infections, including HIV;

(II) the benefits of effective contraceptive and condom use in avoiding unintended pregnancy;

(III) the relationship between substance use and sexual health and behaviors; and

(IV) information about local health services where students can obtain additional information and services related to sexual and reproductive health and other related care;

(v) through affirmative recognition, the roles that traditions, values, religion, norms, gender roles, acculturation, family structure, health beliefs, and political power play in how students make decisions that affect their sexual health, using examples of various types of races, ethnicities, cultures, and families, including single-parent households and young families;

(vi) information about gender identity, gender expression, and sexual orientation for all students, including—

(I) affirmative recognition that people have different gender identities, gender expressions, and sexual orientations; and

(II) community resources that can provide additional support for individuals with varying gender identities, gender expressions, and sexual orientations; and

(vii) opportunities to explore the roles that race, ethnicity, immigration status, disability status, economic status, homelessness, foster care status, and language within different communities affect sexual attitudes in society and culture and how this may impact student sexual health.

(c) GRANTS FOR COMPREHENSIVE SEX EDUCATION AT INSTITUTIONS OF HIGHER EDUCATION.—

(1) PROGRAM AUTHORIZED.—The Secretary, in coordination with the Secretary of Education, shall award grants, on a competitive basis, to institutions of higher education or consortia of such institutions to enable such institutions to provide young people with comprehensive sex education, as described in paragraph (5)(B).

(2) DURATION.—Grants awarded under this subsection shall be for a period of 5 years.

(3) APPLICATIONS.—An institution of higher education or consortium of such institutions desiring a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including an assurance to participate in the evaluation described in subsection (e).

(4) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to an institution of higher education that—

(A) has an enrollment of needy students, as defined in section 318(b) of the Higher Education Act of 1965 (20 U.S.C. 1059e(b));

(B) is a Hispanic-serving institution, as defined in section 502(a) of such Act (20 U.S.C. 1101a(a));

(C) is a Tribal College or University, as defined in section 316(b) of such Act (20 U.S.C. 1059c(b));

(D) is an Alaska Native-serving institution, as defined in section 317(b) of such Act (20 U.S.C. 1059d(b));

(E) is a Native Hawaiian-serving institution, as defined in section 317(b) of such Act (20 U.S.C. 1059d(b));

(F) is a Predominately Black Institution, as defined in section 318(b) of such Act (20 U.S.C. 1059e(b));

(G) is a Native American-serving, nontribal institution, as defined in section 319(b) of such Act (20 U.S.C. 1059f(b));

(H) is an Asian American and Native American Pacific Islander-serving institution, as defined in section 320(b) of such Act (20 U.S.C. 1059g(b)); or

(I) is a minority institution, as defined in section 365 of such Act (20 U.S.C. 1067k), with an enrollment of needy students, as defined in section 312 of such Act (20 U.S.C. 1058).

(5) USES OF FUNDS.—

(A) IN GENERAL.—An institution of higher education, or a consortium, receiving a grant under this subsection shall use grant funds to integrate issues relating to comprehensive sex education into the institution of higher education, or consortium, in order to reach a large

number of students, by carrying out 1 or more of the following activities:

(i) Developing or adopting educational content for issues relating to comprehensive sex education that will be incorporated into student orientation, general education, or core courses.

(ii) Developing or adopting, and implementing schoolwide educational programming outside of class that delivers elements of comprehensive sex education programs to students, faculty, and staff.

(iii) Developing or adopting innovative technology-based approaches to deliver sex education to students, faculty, and staff.

(iv) Developing or adopting, and implementing peer-outreach and education programs to generate discussion, educate, and raise awareness among students about issues relating to comprehensive sex education.

(B) CONTENTS OF SEX EDUCATION PROGRAMS.—Each institution of higher education's program of comprehensive sex education funded under this section shall include instruction and

materials that address the contents required under subsection (b)(6).

(d) GRANTS FOR PRE-SERVICE AND IN-SERVICE TEACHER TRAINING.—

(1) PROGRAM AUTHORIZED.—The Secretary, in coordination with the Director of the Centers for Disease Control and Prevention and the Secretary of Education, shall award grants, on a competitive basis, to eligible entities to enable such eligible entities to carry out the activities described in paragraph (5).

(2) DURATION.—Grants awarded under this section shall be for a period of 5 years.

(3) ELIGIBLE ENTITY.—In this section, the term ''eligible entity'' means—

(A) a State educational agency, as defined in section 8101 of the Elementary and Secondary Education of 1965 (20 U.S.C. 7801);

(B) a local educational agency, as defined in section 8101 of the Elementary and Secondary Education of 1965 (20 U.S.C. 7801);

(C) a Tribe or Tribal organization, as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304);

(D) a State or local department of health;

(E) a State or local department of education;

(F) an educational service agency, as defined in section 8101 of the Elementary and Secondary Education of 1965 (20 U.S.C. 7801);;

(G) a nonprofit institution of higher education, as defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001);

(H) a national or statewide nonprofit organization that has as its primary purpose the improvement of provision of comprehensive sex education through training and effective teaching of comprehensive sex education; or

(I) a consortium of nonprofit organizations that has as its primary purpose the improvement of provision of comprehensive sex education through training and effective teaching of comprehensive sex education.

(4) APPLICATION.—An eligible entity desiring a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary

may require, including an assurance to participate in the evaluation described in subsection (e).

(5) AUTHORIZED ACTIVITIES.—

(A) REQUIRED ACTIVITY.—Each eligible entity receiving a grant under this section shall use grant funds for professional development and training of relevant faculty, school administrators, teachers, and staff, in order to increase effective teaching of comprehensive sex education students.

(B) PERMISSIBLE ACTIVITIES.—Each eligible entity receiving a grant under this section may use grant funds to—

(i) provide research-based training of teachers for comprehensive sex education for adolescents as a means of broadening student knowledge about issues related to human development, healthy relationships, personal skills, and sexual behavior, including abstinence, sexual health, and society and culture;

(ii) support the dissemination of information on effective practices and research findings concerning the teaching of comprehensive sex education;

(iii) support research on—

(I) effective comprehensive sex education teaching practices; and

(II) the development of assessment instruments and strategies to document—

(aa) student understanding of comprehensive sex education; and

(bb) the effects of comprehensive sex education;

(iv) convene national conferences on comprehensive sex education, in order to effectively train teachers in the provision of comprehensive sex education; and

(v) develop and disseminate appropriate research-based materials to foster comprehensive sex education.

(C) SUBGRANTS.—Each eligible entity receiving a grant under this subsection may award subgrants to nonprofit organizations that possess a demonstrated record of providing training to faculty, school administrators, teachers, and staff on comprehensive sex education to—

(i) train teachers in comprehensive sex education;

(ii) support Internet or distance learning related to comprehensive sex education;

(iii) promote rigorous academic standards and assessment techniques to guide and measure student performance in comprehensive sex education;

(iv) encourage replication of best practices and model programs to promote comprehensive sex education;

(v) develop and disseminate effective, research-based comprehensive sex education learning materials;

(vi) develop academic courses on the pedagogy of sex education at institutions of higher education; or

(vii) convene State-based conferences to train teachers in comprehensive sex education and to identify strategies for improvement.

(e) IMPACT EVALUATION AND REPORTING.—

(1) MULTI-YEAR EVALUATION.—

(A) IN GENERAL.—Not later than 6 months after the date of the enactment of this

Act, the Secretary shall enter into a contract with a nonprofit organization with experience in conducting impact evaluations, to conduct a multi-year evaluation on the impact of the grants under subsections (b), (c), and (d), and to report to Congress and the Secretary on the findings of such evaluation.

(B) EVALUATION.—The evaluation conducted under this subsection shall—

(i) be conducted in a manner consistent with relevant, nationally recognized professional and technical evaluation standards;

(ii) use sound statistical methods and techniques relating to the behavioral sciences, including quasi-experimental designs, inferential statistics, and other methodologies and techniques that allow for conclusions to be reached;

(iii) be carried out by an independent organization that has not received a grant under subsection (b), (c), or (d); and

(iv) be designed to provide information on—

(I) output measures, such as the number of individuals served under the grant and the number of hours of instruction;

(II) outcome measures, including measures relating to—

(aa) the knowledge that individuals participating in the grant program have gained in each of the following age and developmentally appropriate areas—

(AA) growth and development;

(BB) relationship dynamics;

(CC) ways to prevent unintended pregnancy and sexually transmitted infections, including HIV; and

(DD) sexual health;

(bb) the age and developmentally appropriate skills that individuals participating in the

grant program have gained regarding—

(AA) negotiation and communication;

(BB) decisionmaking and goal-setting;

(CC) interpersonal skills and healthy relationships; and

(DD) condom use; and

(cc) the behaviors of adolescents participating in the grant program, including data about—

(AA) age of first intercourse;

(BB) condom and contraceptive use at first intercourse;

(CC) recent condom and contraceptive use;

(DD) substance use;

(EE) dating abuse and lifetime history of sexual assault, dating violence, bul-

lying, harassment, stalking; and

(FF) academic performance; and

(III) other measures necessary to evaluate the impact of the grant program.

(C) REPORT.—Not later than 6 years after the date of enactment of this Act, the organization conducting the evaluation under this subsection shall prepare and submit to the appropriate committees of Congress and the Secretary an evaluation report. Such report shall be made publicly available, including on the website of the Department of Health and Human Services.

(2) SECRETARY'S REPORT TO CONGRESS.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter for a period of 5 years, the Secretary shall prepare and submit to the appropriate committees of Congress a report on the activities to provide adolescents and young people with comprehensive sex education and pre-service and in-service teacher training funded under this

section. The Secretary's report to Congress shall include—

(A) a statement of how grants awarded by the Secretary meet the purposes described in subsection (a)(1); and

(B) information about—

(i) the number of eligible entities and institutions of higher education that are receiving grant funds under subsections (b), (c), and (d);

(ii) the specific activities supported by grant funds awarded under subsections (b), (c), and (d);

(iii) the number of adolescents served by grant programs funded under subsection (b);

(iv) the number of young people served by grant programs funded under subsection (c);

(v) the number of faculty, school administrators, teachers, and staff trained under subsection (d); and

(vi) the status of the evaluation required under paragraph (1).

(f) NONDISCRIMINATION.—Programs funded under this section shall not discriminate on the basis of actual or perceived sex, race, color, ethnicity, national origin, disability, sexual orientation, gender identity, or religion. Nothing in this section shall be construed to invalidate or limit rights, remedies, procedures, or legal standards available under any other Federal law or any law of a State or a political subdivision of a State, including the Civil Rights Act of 1964 (42 U.S.C. 2000a et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), and section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116).

(g) LIMITATION.—No Federal funds provided under this section may be used for health education programs that—

(1) withhold health-promoting or life-saving information about sexuality-related topics, including HIV;

(2) are medically inaccurate or have been scientifically shown to be ineffective;

(3) promote gender or racial stereotypes;

(4) are insensitive and unresponsive to the needs of sexually active young people;

(5) are insensitive and unresponsive to the needs of pregnant or parenting young people;

(6) are insensitive and unresponsive to the needs of survivors of sexual abuse or assault;

(7) are insensitive and unresponsive to the needs of youth of all physical, developmental, or mental abilities;

(8) are insensitive and unresponsive to individuals with varying gender identities, gender expressions, and sexual orientations; or

(9) are inconsistent with the ethical imperatives of medicine and public health.

(h) AMENDMENTS TO OTHER LAWS.—

(1) AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.—Section 2500 of the Public Health Service Act (42 U.S.C. 300ee) is amended by striking subsections (b) through (d) and inserting the following:

''(b) CONTENTS OF PROGRAMS.—All programs of education and information receiving funds under this subchapter shall include information about the potential effects of intravenous substance abuse.''.

(2) AMENDMENTS TO THE ELEMENTARY AND SECONDARY EDUCATION ACT OF 1965.—Section 8526

of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7906) is amended—

(A) by striking paragraph (3);

(B) by redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively;

(C) in paragraph (4), by inserting ''or'' after the semicolon;

(D) in paragraph (5), by striking ''; or'' and inserting a period; and

(E) by striking paragraph (6).

(i) DEFINITIONS.—In this section:

(1) ADOLESCENTS.—The term ''adolescents'' means individuals who are ages 10 through 19 at the time of commencement of participation in a program supported under this section.

(2) AGE AND DEVELOPMENTALLY APPROPRIATE.—The term ''age and developmentally appropriate'' means topics, messages, and teaching methods suitable to particular age, age group of children and adolescents, or developmental levels, based on cognitive, emotional, social, and behavioral capacity of most students at that age level.

(3) APPROPRIATE COMMITTEES OF CONGRESS.—The term ''appropriate committees of Congress'' means the Committee on Health, Education,

Labor, and Pensions of the Senate, the Committee on Appropriations of the Senate, the Committee on Energy and Commerce of the House of Representatives, the Committee on Education and the Workforce of the House of Representatives, and the Committee on Appropriations of the House of Representatives.

(4) CHARACTERISTICS OF EFFECTIVE PROGRAMS.—The term ''characteristics of effective programs'' means the aspects of evidence-based programs, including development, content, and implementation of such programs, that—

(A) have been shown to be effective in terms of increasing knowledge, clarifying values and attitudes, increasing skills, and impacting upon behavior; and

(B) are widely recognized by leading medical and public health agencies to be effective in changing sexual behaviors that lead to sexually transmitted infections, including HIV, unintended pregnancy, and dating violence and sexual assault among young people.

(5) COMPREHENSIVE SEX EDUCATION.—The term ''comprehensive sex education'' means instructional part of a comprehensive school health edu-

cation approach which addresses the physical, mental, emotional, and social dimensions of human sexuality; designed to motivate and assist students to maintain and improve their sexual health, prevent disease and reduce sexual health-related risk behaviors; and enable and empower students to develop and demonstrate age and developmentally appropriate sexuality and sexual health-related knowledge, attitudes, skills, and practices.

(6) CONSENT.—The term ''consent'' means affirmative, conscious, and voluntary agreement to engage in interpersonal, physical, or sexual activity.

(7) CULTURALLY APPROPRIATE.—The term ''culturally appropriate'' means materials and instruction that respond to culturally diverse individuals, families and communities in an inclusive, respectful and effective manner; including materials and instruction that are inclusive of race, ethnicity, languages, cultural background, religion, sex, gender identity, sexual orientation, and different abilities.

(8) EVIDENCE-BASED.—The term ''evidence-based'', when used with respect to sex education instruction, means a sex education program that has been proven through rigorous evaluation to be effective in changing sexual behavior or incorporates ele-

ments of other programs that have been proven to be effective in changing sexual behavior.

(9) GENDER EXPRESSION.—The term ''gender expression'', when used with respect to a sex education program, means the expression of one's gender, such as through behavior, clothing, haircut, or voice, and which may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine.

(10) GENDER IDENTITY.—Except with respect to subsection (f), the term ''gender identity'', when used with respect to a sex education program, means the gender-related identity, appearance, mannerisms, or other gender-related characteristics of an individual, regardless of the individual's designated sex at birth including a person's deeply held sense or knowledge of their own gender; such as male, female, both or neither.

(11) INCLUSIVE.—The term ''inclusive'', when used with respect to a sex education program, means curriculum that ensures that students from historically marginalized communities are reflected in classroom materials and lessons.

(12) INSTITUTION OF HIGHER EDUCATION.—The term ''institution of higher education'' has the

meaning given the term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

(13) MEDICALLY ACCURATE AND COMPLETE.—The term ''medically accurate and complete'', when used with respect to a sex education program, means that—

(A) the information provided through the program is verified or supported by the weight of research conducted in compliance with accepted scientific methods and is published in peer-reviewed journals, where applicable; or

(B)(i) the program contains information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete; and

(ii) the program does not withhold information about the effectiveness and benefits of correct and consistent use of condoms and other contraceptives.

(14) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(15) SEXUAL DEVELOPMENT.—The term ''sexual development'' means the lifelong process of physical, behavioral, cognitive, and emotional growth and change as it relates to an individual's sexuality and

sexual maturation, including puberty, identity development, socio-cultural influences, and sexual behaviors.

(16) SEXUAL ORIENTATION.—Except with respect to subsection (f), the term ''sexual orientation'', when used with respect to a sex education program, means an individual's attraction, including physical or emotional, to the same or different gender.

(17) YOUNG PEOPLE.—The term ''young people'' means individuals who are ages 10 through 24 at the time of commencement of participation in a program supported under this section.

(j) FUNDING.—

(1) APPROPRIATION.—For the purpose of carrying out this section, there is appropriated $75,000,000 for each of fiscal years 2021 through 2026. Amounts appropriated under this subsection shall remain available until expended.

(2) RESERVATIONS OF FUNDS.—

(A) The Secretary shall reserve 50 percent of the amount appropriated under paragraph (1) for the purposes of awarding grants for comprehensive sex education for adolescents under subsection (c).

(B) The Secretary shall reserve 25 percent of the amount appropriated under paragraph (1) for the purposes of awarding grants for comprehensive sex education at institutes of higher education under subsection (d).

(C) The Secretary shall reserve 20 percent of the amount appropriated under paragraph (1) for the purposes of awarding grants for pre-service and in-service teacher training under subsection (e).

(D) The Secretary shall reserve 2 percent of the amount appropriated under paragraph (1) for the purpose of carrying out the impact evaluation and reporting required under subsection (a).

(3) SECRETARIAL RESPONSIBILITIES.—The Secretary shall reserve 3 percent of the amount appropriated under paragraph (1) for each fiscal year for expenditures by the Secretary to provide, directly or through a competitive grant process, research, training, and technical assistance, including dissemination of research and information regarding effective and promising practices, providing consultation and resources, and developing resources and materials to support the activities of recipients of grants.

In carrying out such functions, the Secretary shall collaborate with a variety of entities that have expertise in adolescent sexual health development, education, and promotion.

(4) REPROGRAMMING OF ABSTINENCE ONLY UNTIL MARRIAGE PROGRAM FUNDING.—The unobligated balance of funds made available to carry out section 510 of the Social Security Act (42 U.S.C. 710) (as in effect on the day before the date of enactment of this Act) are hereby transferred and shall be used by the Secretary to carry out this section. The amounts transferred and made available to carry out this section shall remain available until expended.

(5) REPEAL OF ABSTINENCE ONLY UNTIL MARRIAGE PROGRAM.—Section 510 of the Social Security Act (42 U.S.C. 710) is repealed.

**SEC. 512. COMPASSIONATE ASSISTANCE FOR RAPE EMERGENCIES.**

(a) MEDICARE.—

(1) LIMITATION ON PAYMENT.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by moving the indentation of subparagraph (W) 2 ems to the left;

(B) in subparagraph (X)—

(i) by moving the indentation 2 ems to the left; and

(ii) by striking ''and'' at the end;

(C) in subparagraph (Y), by striking the period at the end and inserting ''; and''; and

(D) by inserting after subparagraph (Y) the following new subparagraph:

''(Z) in the case of a hospital or critical access hospital, to adopt and enforce a policy to ensure compliance with the requirements of subsection (l) and to meet the requirements of such subsection.''.

(2) ASSISTANCE TO VICTIMS.—Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

''(l) COMPASSIONATE ASSISTANCE FOR RAPE EMERGENCIES.—

''(1) IN GENERAL.—For purposes of section 1866(a)(1)(Z), a hospital meets the requirements of this subsection if the hospital provides each of the services described in paragraph (2) to each individual, whether or not eligible for benefits under this title or under any other form of health insurance,

who comes to the hospital on or after January 1, 2021, and—

"(A) who states to hospital personnel that they are victims of sexual assault;

"(B) who is accompanied by an individual who states to hospital personnel that the individual is a victim of sexual assault; or

"(C) whom hospital personnel, during the course of treatment and care for the individual, have reason to believe is a victim of sexual assault.

"(2) REQUIRED SERVICES DESCRIBED.—For purposes of paragraph (1), the services described in this subparagraph are the following:

"(A) Provision of medically and factually accurate and unbiased written and oral information about emergency contraception that—

"(i) is written in clear and concise language;

"(ii) is readily comprehensible;

"(iii) includes an explanation that emergency contraceptives—

"(I) has been approved by the Food and Drug Administration for individuals and is a safe and effective

way to prevent pregnancy after unprotected intercourse or contraceptive failure if taken in a timely manner;

''(II) is more effective the sooner it is taken; and

''(III) does not cause an abortion and cannot interrupt an established pregnancy;

''(iv) meets such conditions regarding the provision of such information in languages other than English as the Secretary may establish; and

''(v) is provided without regard to the ability of the individual or their family to pay costs associated with the provision of such information to the individual.

''(B) Immediate offer to provide emergency contraception to the individual at the hospital and, in the case that the individual accepts such offer, immediate provision to the individual of such contraception on the same day it is requested without regard to the inability of the individual or their family to pay costs associated with the offer and provision of such contraception.

''(C) Development and implementation of a written policy to ensure that an individual is present at the hospital, or on-call, who—

''(i) has authority to dispense or prescribe emergency contraception, independently, or under a protocol prepared by a physician for the administration of emergency contraception at the hospital to a victim of sexual assault; and

''(ii) is trained to comply with the requirements of this section.

''(D) Provision of medically and factually accurate and unbiased written and oral information and counseling about post-exposure prophylaxis (PEP) protocol for the prevention of HIV.

''(E) Immediately offer to begin PEP to the individual at the hospital except in cases where the medical professional's best judgement is that further evaluation is required or that such a regimen will be substantially detrimental to the individual's health. Such provision shall be offered regardless of the individual's ability to pay. Hospitals shall be responsible for ensur-

ing adequate supply of PEP medications to provide to patients.

''(3) HOSPITAL DEFINED.—For purposes of this paragraph, the term 'hospital' includes a critical access hospital, as defined in section 1861(mm)(1).''.

(b) LIMITATION ON PAYMENT UNDER MEDICAID.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended by inserting after paragraph (8) the following new paragraph:

''(9) with respect to any amount expended for care or services furnished under the plan by a hospital on or after January 1, 2021, unless such hospital meets the requirements specified in section 1866(l) for purposes of title XVIII.''.

**SEC. 513. ACCESS TO BIRTH CONTROL DUTIES OF PHARMACIES TO ENSURE PROVISION OF FDA-APPROVED CONTRACEPTION.**

Part B of title II of the Public Health Service Act (42 U.S.C. 238 et seq.) is amended by adding at the end the following:

**''SEC. 249. DUTIES OF PHARMACIES TO ENSURE PROVISION OF FDA-APPROVED CONTRACEPTION.**

''(a) IN GENERAL.—Subject to subsection (c), a pharmacy that receives Food and Drug Administration-

approved drugs or devices in interstate commerce shall maintain compliance with the following:

''(1) If a customer requests a contraceptive or a medication related to a contraceptive, including emergency contraception, that is in stock, the pharmacy shall ensure that the contraceptive is provided to the customer without delay;

''(2) If a customer requests a contraceptive or a medication related to a contraceptive that is not in stock and the pharmacy in the normal course of business stocks contraception, the pharmacy shall immediately inform the customer that the contraceptive is not in stock and without delay offer the customer the following options:

''(A) If the customer prefers to obtain the contraceptive or a medication related to a contraceptive through a referral or transfer, the pharmacy shall—

''(i) locate a pharmacy of the customer's choice or the closest pharmacy confirmed to have the contraceptive or a medication related to a contraceptive in stock; and

''(ii) refer the customer or transfer the prescription to that pharmacy.

''(B) If the customer prefers for the pharmacy to order the contraceptive or a medication related to a contraceptive, the pharmacy shall obtain the contraceptive or medication under the pharmacy's standard procedure for expedited ordering of medication and notify the customer when the contraceptive or medication arrives.

''(3) The pharmacy shall ensure that—

''(A) the pharmacy does not operate an environment in which customers are intimidated, threatened, or harassed in the delivery of services relating to a request for contraception or a medication related to a contraceptive;

''(B) the pharmacy's employees do not interfere with or obstruct the delivery of services relating to a request for contraception or a medication related to a contraceptive;

''(C) the pharmacy's employees do not intentionally misrepresent or deceive customers about the availability of a contraceptive or a medication related to a contraceptive, or the mechanism of action of such contraceptive or medication;

''(D) the pharmacy's employees doe not breach medical confidentiality with respect to a request for a contraceptive or a medication related to a contraceptive or threaten to breach such confidentiality; or

''(E) the pharmacy's employees do not refuse to return a valid, lawful prescription for a contraceptive or a medication related to a contraceptive upon customer request.

''(b) CONTRACEPTIVES NOT ORDINARILY STOCKED.—Nothing in subsection (a)(2) shall be construed to require any pharmacy to comply with such subsection if the pharmacy does not ordinarily stock contraceptives or a medication related to a contraceptive in the normal course of business.

''(c) REFUSALS PURSUANT TO STANDARD PHARMACY PRACTICE.—This section does not prohibit a pharmacy from refusing to provide a contraceptive or a medication related to a contraceptive to a customer in accordance with any of the following:

''(1) If it is unlawful to dispense the contraceptive or a medication related to a contraceptive to the customer without a valid, lawful prescription and no such prescription is presented.

''(2) If the customer is unable to pay for the contraceptive or the medication related to a contraceptive.

''(3) If the employee of the pharmacy refuses to provide the contraceptive or a medication related to a contraceptive on the basis of a professional clinical judgment.

''(d) RELATION TO OTHER LAW.—

''(1) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to invalidate or limit rights, remedies, procedures, or legal standards under title VII of the Civil Rights Act of 1964.

''(2) CERTAIN CLAIMS.—The Religious Freedom Restoration Act of 1993 shall not provide a claim concerning, or a defense to a claim under this section, or provide a basis for challenging the application or enforcement of this section.

''(e) PREEMPTION.—This section does not preempt any provision of State law or any professional obligation made applicable by a State board or other entity responsible for licensing or discipline of pharmacies or pharmacists, to the extent that such State law or professional obligation provides protections for customers that are greater than the protections provided by this section.

''(f) ENFORCEMENT.—

''(1) CIVIL PENALTY.—A pharmacy that violates a requirement of subsection (a) is liable to the United States for a civil penalty in an amount not exceeding $1,000 per day of violation, not to exceed $100,000 for all violations adjudicated in a single proceeding.

''(2) PRIVATE CAUSE OF ACTION.—Any person aggrieved as a result of a violation of a requirement of subsection (a) may, in any court of competent jurisdiction, commence a civil action against the pharmacy involved to obtain appropriate relief, including actual and punitive damages, injunctive relief, and a reasonable attorney's fee and cost.

''(3) LIMITATIONS.—A civil action under paragraph (1) or (2) may not be commenced against a pharmacy after the expiration of the 5-year period beginning on the date on which the pharmacy allegedly engaged in the violation involved.

''(g) DEFINITIONS.—In this section:

''(1) CONTRACEPTION.—The term 'contraception' or 'contraceptive' means any drug or device approved by the Food and Drug Administration to prevent pregnancy.

''(2) EMPLOYEE.—The term 'employee' means a person hired, by contract or any other form of an agreement, by a pharmacy.

''(3) MEDICATION RELATED TO A CONTRACEPTIVE.—The term 'medication related to a contraceptive' means any drug or device approved by the Food and Drug Administration that a medical professional determines necessary to use before or in conjunction with a contraceptive.

''(4) PHARMACY.—The term 'pharmacy' means an entity that—

''(A) is authorized by a State to engage in the business of selling prescription drugs at retail; and

''(B) employs one or more employees.

''(5) PRODUCT.—The term 'product' means a Food and Drug Administration-approved drug or device.

''(6) PROFESSIONAL CLINICAL JUDGMENT.—The term 'professional clinical judgment' means the use of professional knowledge and skills to form a clinical judgment, in accordance with prevailing medical standards.

''(7) WITHOUT DELAY.—The term 'without delay', with respect to a pharmacy providing, pro-

viding a referral for, or ordering contraception, or transferring the prescription for contraception, means within the usual and customary timeframe at the pharmacy for providing, providing a referral for, or ordering other products, or transferring the prescription for other products, respectively.

''(h) EFFECTIVE DATE.—This section shall take effect on the 31st day after the date of the enactment of this section, without regard to whether the Secretary has issued any guidance or final rule regarding this section.''.

**SEC. 514. ADDITIONAL FOCUS AREA FOR THE OFFICE ON WOMEN'S HEALTH.**

Section 229(b) of the Public Health Service Act (42 U.S.C. 237a(b)) is amended—

(1) in paragraph (6), at the end, by striking ''and'';

(2) in paragraph (7), at the end, by striking the period and inserting a semicolon; and

(3) by adding at the end the following new paragraph:

''(8) facilitate policymakers, health system leaders and providers, consumers, and other stakeholders in understanding optimal maternity care and support for the provision of such care, including the priorities of—

"(A) protecting, promoting, and supporting the innate capacities of childbearing individuals and their newborns for childbirth, breastfeeding, and attachment;

"(B) using obstetric interventions only when such interventions are supported by strong, high-quality evidence, and minimizing overuse of maternity practices that have been shown to have benefit in limited situations and that can expose women, infants, or both to risk of harm if used routinely and indiscriminately, including continuous electronic fetal monitoring, labor induction, epidural analgesia, primary cesarean section, and routine repeat cesarean birth;

"(C) reliably incorporating noninvasive, evidence-based practices that have documented correlation with considerable improvement in outcomes with no detrimental side effects, such as smoking cessation programs in pregnancy and proven models of group prenatal care that integrate health assessment, education, and support into a unified program and supporting evidence-based breastfeeding promotion efforts

with respect for a breastfeeding individual's personal decisionmaking;

''(D) a shared understanding of the qualifications of licensed providers of maternity care and the best evidence about the safety, satisfaction, outcomes, and costs of their care, and appropriate deployment of such caregivers within the maternity care workforce to address the needs of childbearing individuals and newborns and the growing shortage of maternity caregivers;

''(E) a shared understanding of the results of the best available research comparing hospital, birth center, and planned home births, including information about each setting's safety, satisfaction, outcomes, and costs;

''(F) high-quality, evidence-based childbirth education that promotes a natural, healthy, and safe approach to pregnancy, childbirth, and early parenting; is taught by certified educators, peer counselors, and health professionals; and promotes informed decisionmaking by childbearing individual; and

''(G) developing measures that enable a more robust, balanced set of standardized ma-

ternity care measures, including performance and quality measures;''.

**SEC. 515. INTERAGENCY COORDINATING COMMITTEE ON THE PROMOTION OF OPTIMAL MATERNITY OUTCOMES.**

(a) IN GENERAL.—Part A of title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

**''SEC. 229A. INTERAGENCY COORDINATING COMMITTEE ON THE PROMOTION OF OPTIMAL MATERNITY OUTCOMES.**

''(a) IN GENERAL.—The Secretary, acting through the Deputy Assistant Secretary for Women's Health under section 229 and in collaboration with the Federal officials specified in subsection (b), shall establish the Interagency Coordinating Committee on the Promotion of Optimal Maternity Outcomes (referred to in this section as the 'ICCPOM').

''(b) OTHER AGENCIES.—The officials specified in this subsection are the Secretary of Labor, the Secretary of Defense, the Secretary of Veterans Affairs, the Surgeon General, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Resources and Services Administration, the Administrator of the Centers for Medicare & Medicaid Services, the Direc-

tor of the Indian Health Service, the Administrator of the Substance Abuse and Mental Health Services Administration, the Director of the National Institute on Child Health and Development, the Director of the Agency for Healthcare Research and Quality, the Assistant Secretary for Children and Families, the Deputy Assistant Secretary for Minority Health, the Director of the Office of Personnel Management, and such other Federal officials as the Secretary of Health and Human Services determines to be appropriate.

''(c) CHAIR.—The Deputy Assistant Secretary for Women's Health shall serve as the chair of the ICCPOM.

''(d) DUTIES.—The ICCPOM shall guide policy and program development across the Federal Government with respect to promotion of optimal maternity care, provided, however, that nothing in this section shall be construed as transferring regulatory or program authority from an agency to the ICCPOM.

''(e) CONSULTATIONS.—The ICCPOM shall actively seek the input of, and shall consult with, all appropriate and interested stakeholders, including State health departments, public health research and interest groups, foundations, childbearing individuals and their advocates, and maternity care professional associations and organiza-

tions, reflecting racially, ethnically, demographically, and geographically diverse communities.

''(f) ANNUAL REPORT.—

''(1) IN GENERAL.—The Secretary, on behalf of the ICCPOM, shall annually submit to Congress a report that summarizes—

''(A) all programs and policies of Federal agencies (including the Medicare Program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act) designed to promote optimal maternity care, focusing particularly on programs and policies that support the adoption of evidence based maternity care, as defined by timely, scientifically sound systematic reviews;

''(B) all programs and policies of Federal agencies (including the Medicare Program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act) designed to address the problems of maternal mortality and morbidity, infant mortality, prematurity, and low birth weight, including such programs and policies designed to address racial and ethnic disparities with respect to each of such problems;

"(C) the extent of progress in reducing maternal mortality and infant mortality, low birth weight, and prematurity at State and national levels; and

"(D) such other information regarding optimal maternity care (such as quality and performance measures) as the Secretary determines to be appropriate.

The information specified in subparagraph (C) shall be included in each such report in a manner that disaggregates such information by race, ethnicity, and indigenous status in order to determine the extent of progress in reducing racial and ethnic disparities and disparities related to indigenous status.

"(2) CERTAIN INFORMATION.—Each report under paragraph (1) shall include information (disaggregated by race, ethnicity, and indigenous status, as applicable) on the following rates and costs by State:

"(A) The rate of primary cesarean deliveries and repeat cesarean deliveries.

"(B) The rate of vaginal births after cesarean.

"(C) The rate of vaginal breech births.

"(D) The rate of induction of labor.

"(E) The rate of freestanding birth center births.

"(F) The rate of planned and unplanned home birth.

"(G) The rate of attended births by provider, including by an obstetrician-gynecologist, family practice physician, obstetrician-gynecologist physician assistant, certified nurse-midwife, certified midwife, and certified professional midwife.

"(H) The cost of maternity care disaggregated by place of birth and provider of care, including—

"(i) uncomplicated vaginal birth;

"(ii) complicated vaginal birth;

"(iii) uncomplicated cesarean birth; and

"(iv) complicated cesarean birth.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, in addition to amounts authorized to be appropriated under section 229(e), to carry out this section $1,000,000 for each of the fiscal years 2021 through 2025.".

(b) CONFORMING AMENDMENTS.—

(1) INCLUSION AS DUTY OF HHS OFFICE ON WOMEN'S HEALTH.—Section 229(b) of such Act (42 U.S.C. 237a(b)), as amended by section 514, is further amended by adding at the end the following new paragraph:

''(9) establish the Interagency Coordinating Committee on the Promotion of Optimal Maternity Outcomes in accordance with section 229A; and''.

(2) TREATMENT OF BIENNIAL REPORTS.—Section 229(d) of such Act (42 U.S.C. 237a(d)) is amended by inserting ''(other than under subsection (b)(9))'' after ''under this section''.

**SEC. 516. CONSUMER EDUCATION CAMPAIGN.**

Section 229(b) of the Public Health Service Act (42 U.S.C. 237a(b)), as amended by sections 514 and 515, is further amended by adding at the end the following:

''(10) not later than one year after the date of the enactment of the Health Equity and Accountability Act of 2020, develop and implement a 4-year culturally and linguistically appropriate multimedia consumer education campaign that is designed to promote understanding and acceptance of evidence-based maternity practices and models of care for optimal maternity outcomes among individuals of

childbearing ages and families of such individuals and that—

"(A) highlights the importance of protecting, promoting, and supporting the innate capacities of childbearing individuals and their newborns for childbirth, breastfeeding, and attachment;

"(B) promotes understanding of the importance of using obstetric interventions when medically necessary and when supported by strong, high-quality evidence;

"(C) highlights the widespread overuse of maternity practices that have been shown to have benefit when used appropriately in situations of medical necessity, but which can expose pregnant individuals, infants, or both to risk of harm if used routinely and indiscriminately, including continuous fetal monitoring, labor induction, epidural anesthesia, elective primary cesarean section, and repeat cesarean delivery;

"(D) emphasizes the noninvasive maternity practices that have strong proven correlation or may be associated with considerable improvement in outcomes with no detrimental side effects, and are significantly underused in the

United States, including smoking cessation programs in pregnancy, group model prenatal care, continuous labor support, nonsupine positions for birth, and external version to turn breech babies at term;

''(E) educates consumers about the qualifications of licensed providers of maternity care and the best evidence about their safety, satisfaction, outcomes, and costs;

''(F) informs consumers about the best available research comparing birth center births, planned home births, and hospital births, including information about each setting's safety, satisfaction, outcomes, and costs;

''(G) fosters participation in high-quality, evidence-based childbirth education that promotes a natural, healthy, and safe approach to pregnancy, childbirth, and early parenting; is taught by certified educators, peer counselors, and health professionals; and promotes informed decisionmaking by childbearing individuals; and

''(H) is pilot tested for consumer comprehension, cultural sensitivity, and acceptance of the messages across geographically, racially,

ethnically, and linguistically diverse populations.''.

**SEC. 517. BIBLIOGRAPHIC DATABASE OF SYSTEMATIC REVIEWS FOR CARE OF CHILDBEARING INDIVIDUALS AND NEWBORNS.**

(a) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services, through the Agency for Healthcare Research and Quality, shall—

(1) make publicly available an online bibliographic database identifying systematic reviews, including an explanation of the level and quality of evidence, for care of childbearing individuals and newborns; and

(2) initiate regular updates that incorporate newly issued and updated systematic reviews.

(b) SOURCES.—To aim for a comprehensive inventory of systematic reviews relevant to maternal and newborn care, the database shall identify reviews from diverse sources, including—

(1) scientific peer-reviewed journals;

(2) databases, including Cochrane Database of Systematic Reviews, Clinical Evidence, and Database of Abstracts of Reviews of Effects; and

(3) Internet Websites of agencies and organizations throughout the world that produce such systematic reviews.

(c) FEATURES.—The database shall—

(1) provide bibliographic citations for each record within the database, and for each such citation include an explanation of the level and quality of evidence;

(2) include abstracts, as available;

(3) provide reference to companion documents as may exist for each review, such as evidence tables and guidelines or consumer educational materials developed from the review;

(4) provide links to the source of the full review and to any companion documents;

(5) provide links to the source of a previous version or update of the review;

(6) be searchable by intervention or other topic of the review, reported outcomes, author, title, and source; and

(7) offer to users periodic electronic notification of database updates relating to users' topics of interest.

(d) OUTREACH.—Not later than the first date the database is made publicly available and periodically there-

after, the Secretary of Health and Human Services shall publicize the availability, features, and uses of the database under this section to the stakeholders described in subsection (e).

(e) CONSULTATION.—For purposes of developing the database under this section and maintaining and updating such database, the Secretary of Health and Human Services shall convene and consult with an advisory committee composed of relevant stakeholders, including—

(1) Federal Medicaid administrators and State agencies administrating State plans under title XIX of the Social Security Act pursuant to section 1902(a)(5) of such Act (42 U.S.C. 1396a(a)(5));

(2) providers of maternity and newborn care from both academic and community-based settings, including obstetrician-gynecologists, family physicians, certified nurse midwives, certified midwives, certified professional midwives, physician assistants, perinatal nurses, pediatricians, and nurse practitioners;

(3) maternal-fetal medicine specialists;

(4) neonatologists;

(5) childbearing individuals and advocates for such individuals, including childbirth educators certified by a nationally accredited program, rep-

resenting communities that are diverse in terms of race, ethnicity, indigenous status, and geographic area;

(6) employers and purchasers;

(7) health facility and system leaders, including both hospital and birth center facilities;

(8) journalists; and

(9) bibliographic informatics specialists.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $2,500,000 for each of the fiscal years 2021 through 2023 for the purpose of developing the database and such sums as may be necessary for each subsequent fiscal year for updating the database and providing outreach and notification to users, as described in this section.

**SEC. 518. EXPANSION OF CDC PREVENTION RESEARCH CENTERS PROGRAM TO INCLUDE CENTERS ON OPTIMAL MATERNITY OUTCOMES.**

(a) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services, shall support the establishment of additional Prevention Research Centers under the Prevention Research Center Program administered by the Centers for Disease Control and Prevention. Such additional

centers shall each be known as a Center for Excellence on Optimal Maternity Outcomes.

(b) RESEARCH.—Each Center for Excellence on Optimal Maternity Outcomes shall—

(1) conduct at least one focused program of research to improve maternity outcomes, including the reduction of cesarean birth rates, elective inductions, prematurity rates, and low birth weight rates within an underserved population that has a disproportionately large burden of suboptimal maternity outcomes, including maternal mortality and morbidity, infant mortality, prematurity, or low birth weight, and developing performance and quality measures for accountability;

(2) work with partners on special interest projects, as specified by the Centers for Disease Control and Prevention and other relevant agencies within the Department of Health and Human Services, and on projects funded by other sources; and

(3) involve a minimum of two distinct birth setting models, such as a hospital labor and delivery model and freestanding birth center model; or a hospital labor and delivery model and planned home birth model.

(c) INTERDISCIPLINARY PROVIDERS.—Each Center for Excellence on Optimal Maternity Outcomes shall include the following interdisciplinary providers of maternity care:

(1) Obstetrician-gynecologists.

(2) At least two of the following providers:

(A) Family practice physicians.

(B) Nurse practitioners.

(C) Physician assistants.

(D) Certified professional midwives.

(d) SERVICES.—Research conducted by each Center for Excellence on Optimal Maternity Outcomes shall include at least 2 (and preferably more) of the following supportive provider services:

(1) Mental health.

(2) Doula labor support.

(3) Nutrition education.

(4) Childbirth education.

(5) Social work.

(6) Physical therapy or occupation therapy.

(7) Substance abuse services.

(8) Home visiting.

(e) COORDINATION.—The programs of research at each of the two Centers of Excellence on Optimal Mater-

nity Outcomes shall compliment and not replicate the work of the other.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,000,000 for each of the fiscal years 2021 through 2025.

**SEC. 519. EXPANDING MODELS ALLOWED TO BE TESTED BY CENTER FOR MEDICARE & MEDICAID INNOVATION TO INCLUDE MATERNITY CARE MODELS.**

Section 1115A(b)(2)(B) of the Social Security Act (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the end the following new clause:

''(xxviii) Promoting evidence-based models of care that have been associated with reductions in maternal and infant health disparities, including incorporating the use of doula and promotoras support for pregnant and childbearing individuals into evidence-based models of prenatal care, labor and delivery, and postpartum care, and supporting the appropriate use of out-of-hospital birth models, including births at home and in freestanding birth centers.''.

**SEC. 520. DEVELOPMENT OF INTERPROFESSIONAL MATERNITY CARE EDUCATIONAL MODELS AND TOOLS.**

(a) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services, acting in conjunction with the Administrator of Health Resources and Services Administration, shall convene, for a 1-year period, an Interprofessional Maternity Provider Education Commission to discuss and make recommendations for—

(1) a consensus standard physiologic maternity care curriculum that takes into account the core competencies for basic midwifery practice such as those developed by the American College of Nurse Midwives and the North American Registry of Midwives, and the educational objectives for physicians practicing in obstetrics and gynecology as determined by the Council on Resident Education in Obstetrics and Gynecology;

(2) suggestions for multidisciplinary use of the consensus physiologic curriculum;

(3) strategies to integrate and coordinate education across maternity care disciplines, including recommendations to increase medical and midwifery student exposure to out-of-hospital birth; and

(4) pilot demonstrations of interprofessional educational models.

(b) PARTICIPANTS.—The Commission shall include maternity care educators, curriculum developers, service leaders, certification leaders, and accreditation leaders from the various professions that provide maternity care in the United States. Such professions shall include obstetrician gynecologists, certified nurse midwives or certified midwives, family practice physicians, nurse practitioners, physician assistants, certified professional midwives, and perinatal nurses. Additionally, the Commission shall include representation from maternity care consumer advocates.

(c) CURRICULUM.—The consensus standard physiologic maternity care curriculum described in subsection (a)(1) shall—

(1) have a public health focus with a foundation in health promotion and disease prevention;

(2) foster physiologic childbearing and woman and family centered care;

(3) integrate strategies to reduce maternal and infant morbidity and mortality;

(4) incorporate recommendations to ensure respectful, safe, and seamless consultation, referral, transport, and transfer of care when necessary;

(5) include cultural sensitivity and strategies to decrease disparities in maternity outcomes; and

(6) include implicit bias training.

(d) REPORT.—Not later than 6 months after the final meeting of the Commission, the Secretary of Health and Human Services shall—

(1) submit to Congress a report containing the recommendations made by the Commission under this section; and

(2) make such report publicly available.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,000,000 for each of the fiscal years 2021 and 2022, and such sums as are necessary for each of the fiscal years 2023 through 2025.

**SEC. 521. INCLUDING SERVICES FURNISHED BY CERTAIN STUDENTS, INTERNS, AND RESIDENTS SUPERVISED BY CERTIFIED NURSE MIDWIVES WITHIN INPATIENT HOSPITAL SERVICES UNDER MEDICARE.**

(a) IN GENERAL.—Section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b)) is amended—

(1) in paragraph (6), by striking ''; or'' at the end and inserting '', or in the case of services in a hospital or osteopathic hospital by a student midwife

or an intern or resident-in-training under a teaching program previously described in this paragraph who is in the field of obstetrics and gynecology, if such student midwife, intern, or resident-in-training is supervised by a certified nurse-midwife to the extent permitted under applicable State law and as may be authorized by the hospital;'';

(2) in paragraph (7), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following new paragraph:

''(8) a certified nurse-midwife where the hospital has a teaching program approved as specified in paragraph (6), if—

''(A) the hospital elects to receive any payment due under this title for reasonable costs of such services; and

''(B) all certified nurse-midwives in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after the date of the enactment of this Act.

**SEC. 522. GRANTS TO PROFESSIONAL ORGANIZATIONS TO INCREASE DIVERSITY IN MATERNAL, REPRODUCTIVE, AND SEXUAL HEALTH PROFESSIONALS.**

(a) IN GENERAL.—The Secretary of Health and Human Services, through the Administrator of the Health Resources and Services Administration, shall carry out a grant program under which the Secretary may make to eligible organizations—

(1) for fiscal year 2021, planning grants described in subsection (b); and

(2) for the subsequent 4-year period, implementation grants described in subsection (c).

(b) PLANNING GRANTS.—

(1) IN GENERAL.—Planning grants described in this subsection are grants for the following purposes:

(A) To collect data and identify any workforce disparities, with respect to a health profession, at each of the following areas along the health professional continuum:

(i) Pipeline availability with respect to students at the high school and college or university levels considering and working toward entrance in the profession, including barriers triggered by criminal records.

(ii) Entrance into the training program for the profession.

(iii) Graduation from such training program.

(iv) Entrance into practice, including barriers triggered by criminal records.

(v) Retention in practice for more than a 5-year period.

(B) To develop one or more strategies to address the workforce disparities within the health profession, as identified under (and in response to the findings pursuant to) subparagraph (A).

(2) APPLICATION.—To be eligible to receive a grant under this subsection, an eligible health professional organization shall submit to the Secretary of Health and Human Services an application in such form and manner and containing such information as specified by the Secretary.

(3) AMOUNT.—Each grant awarded under this subsection shall be for an amount not to exceed $300,000.

(4) REPORT.—Each recipient of a grant under this subsection shall submit to the Secretary of Health and Human Services a report containing—

(A) information on the extent and distribution of workforce disparities identified through the grant; and

(B) reasonable objectives and strategies developed to address such disparities within a 5-, 10-, and 25-year period.

(c) IMPLEMENTATION GRANTS.—

(1) IN GENERAL.—Implementation grants described in this subsection are grants to implement one or more of the strategies developed pursuant to a planning grant awarded under subsection (b).

(2) APPLICATION.—To be eligible to receive a grant under this subsection, an eligible health professional organization shall submit to the Secretary of Health and Human Services an application in such form and manner as specified by the Secretary. Each such application shall contain information on the capability of the organization to carry out a strategy described in paragraph (1), involvement of partners or coalitions, plans for developing sustainability of the efforts after the culmination of the grant cycle, and any other information specified by the Secretary.

(3) AMOUNT.—Each grant awarded under this subsection shall be for an amount not to exceed

$500,000 each year during the 4-year period of the grant.

(4) REPORTS.—For each of the first 3 years for which an eligible health professional organization is awarded a grant under this subsection, the organization shall submit to the Secretary of Health and Human Services a report on the activities carried out by such organization through the grant during such year and objectives for the subsequent year. For the fourth year for which an eligible health professional organization is awarded a grant under this subsection, the organization shall submit to the Secretary a report that includes an analysis of all the activities carried out by the organization through the grant and a detailed plan for continuation of outreach efforts.

(d) ELIGIBLE HEALTH PROFESSIONAL ORGANIZATION DEFINED.—For purposes of this section, the term ''eligible health professional organization'' means a professional organization representing obstetrician-gynecologists, certified nurse midwives, certified midwives, family practice physicians, nurse practitioners whose scope of practice includes maternity or sexual and reproductive health care, physician assistants whose scope of practice includes obstetrical or sexual and reproductive health care,

or certified professional midwives adolescent medicine specialists, and pediatricians who provide sexual and reproductive health care.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,000,000 for fiscal year 2021 and $3,000,000 for each of the fiscal years 2022 through 2025.

**SEC. 523. INTERAGENCY UPDATE TO THE QUALITY FAMILY PLANNING GUIDELINES.**

(a) IN GENERAL.—Not later than six months after the date of enactment of this Act, the Director of the Centers for Disease Control and Prevention and the Office of Population Affairs shall review and expand the 2014 Quality Family Planning Guidelines to address—

(1) health disparities; and

(2) the importance of patient-directed contraceptive decisionmaking.

(b) CONSULTATION.—In carrying out subsection (a), the Director of the Centers for Disease Control and Prevention and the Office of Population Affairs shall convene a meeting, and solicit the views of, stakeholders including experts on health disparities, experts on reproductive coercion, representatives of provider organizations, patient advocates, reproductive justice organizations, organizations that represent racial and ethnic minority communities, or-

ganizations that represent people with disabilities, organizations that represent LGBTQ persons, and organizations that represent people with limited-English proficiency.

**SEC. 524. DISSEMINATION OF THE QUALITY FAMILY PLANNING GUIDELINES.**

(a) IN GENERAL.—Not later than six months after the date of enactment of this Act, the Secretary of Health and Human Services and the Director of the Centers for Disease Control and Prevention shall—

(1) develop a plan for outreach to publicly funded health care providers, including federally qualified health centers and branches of the Indian Health Service, about the quality family planning guidelines referred to in section 524; and

(2) award grants to eligible entities to implement these guidelines for all patients seeking family planning services.

(b) DEFINITION.—In this section, the term ''eligible entity'' means a publicly funded health care provider that serves persons of reproductive age.

# Subtitle B—Pregnancy Screening

## SEC. 531. PREGNANCY INTENTION SCREENING INITIATIVE DEMONSTRATION PROGRAM.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

### "SEC. 399V–7. PREGNANCY INTENTION SCREENING INITIATIVE DEMONSTRATION PROGRAM.

''(a) PROGRAM ESTABLISHMENT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a demonstration program to facilitate the clinical adoption of pregnancy intention screening initiatives by health care and social services providers.

''(b) GRANTS.—The Secretary may carry out the demonstration program through awarding grants to eligible entities to implement pregnancy intention screening initiatives, collect data, and evaluate such initiatives.

''(c) ELIGIBLE ENTITIES.—

''(1) IN GENERAL.—An eligible entity under this section is an entity described in paragraph (2) that provides non-directive, comprehensive, medically accurate information.

''(2) ENTITIES DESCRIBED.—For purposes of paragraph (1), an entity described in this paragraph

is a community-based organization, voluntary health organization, public health department, community health center, or other interested public or private primary, behavioral, or other health care or social service provider or organization.

''(d) PREGNANCY INTENTION SCREENING INITIATIVE.—For purposes of this section, the term 'pregnancy intention screening initiative' means any initiative by an eligible entity to routinely screen women with respect to their pregnancy intentions and goals to either prevent unintended pregnancies or improve the likelihood of healthy pregnancies, in order to better provide health care that meets the contraceptive or pre-pregnancy needs and goals of such women.

''(e) EVALUATION.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall, by grant or contract, and after consultation as described in paragraph (2), conduct an evaluation of the demonstration program, with respect to pregnancy intention screening initiatives, conducted under this section. Such evaluation shall include:

''(A) Assessment of the implementation of pregnancy intention screening protocols among

a diverse group of patients and providers, including collecting data on the experiences and outcomes for diverse patient populations in a variety of clinical settings.

''(B) Analysis of outcome measures that will facilitate effective and widespread adoption of such protocols by health care providers for inquiring about and responding to pregnancy goals of women with both contraceptive and pre-pregnancy care.

''(C) Consideration of health disparities among the population served.

''(D) Assessment of the equitable and voluntary application of such initiatives to minority and medically underserved communities.

''(E) Assessment of the training, capacity, and ongoing technical assistance needed for providers to effectively implement such pregnancy intention screening protocols.

''(F) Assessment of whether referral systems for selected protocols follow evidence-based standards that ensure access to comprehensive health services and appropriate follow-up care.

"(G) Measuring through rigorous methods the effect of such initiatives on key health outcomes.

"(2) CONSULTATION WITH INDEPENDENT, EXPERT ADVISORY PANEL.—In conducting evaluation under paragraph (1), the Director of the Centers for Disease Control and Prevention shall consult with physicians, physician assistants,advanced practice registered nurses, nurse midwives, and other health care providers who specialize in women's health, and other experts in public health, clinical practice, program evaluation, and research.

"(3) REPORT.—Not later than one year after the last day of the demonstration program under this section, the Director of the Centers for Disease Control and Prevention shall submit to Congress a report on the results of the evaluation conducted under paragraph (1) and shall make the report publicly available.

"(f) FUNDING.—

"(1) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $10,000,000 for each of fiscal years 2021 through 2025.

''(2) LIMITATION.—Not more than 20 percent of funds appropriated to carry out this section pursuant to paragraph (1) for a fiscal year may be used for purposes of the evaluation under subsection (e).''.

# TITLE VI—MENTAL HEALTH

**SEC. 601. MENTAL HEALTH FINDINGS.**

Congress finds the following:

(1) Despite the existence of effective treatments, inequities lie in the availability, accessibility, and quality of mental health services for racial and ethnic minorities and people with disabilities.

(2) These inequities have powerful significance for minority groups and for society as a whole.

(3) Racial and ethnic minorities and people with disabilities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity.

(4) Improving community conditions and one's home environment, paired with high-quality, accessible, and culturally tailored mental health services, can reduce the likelihood, frequency, and intensity of challenges to one's mental health.

(5) The presence of strong social connections and trust, opportunities to experience and share cul-

tural identity, safe gathering places, and economic opportunity are community factors that benefit mental health.

(6) The social, physical, and economic conditions in communities can have tremendous influence on daily stressors that shape mental health outcomes.

(7) The foremost barriers include the cost of care, societal stigma, and the fragmented organization of services.

(8) People with disabilities who are racial or ethnic minorities may have co-occurring mental health conditions which, without proper accommodations and support, further stigmatize them and limit their participation in society.

(9) African-American, Latinx, Asian American, Pacific Islander, Native, and other people of color have attitudes toward mental health challenges that are another barrier to seeking mental health care.

(10) Mental illness retains considerable stigma in many communities of color, including those of Asian Americans and Pacific Islanders, and seeking treatment is not always encouraged.

(11) Addressing mental health stigma and increasing culturally appropriate treatment modalities

in communities will help to increase utilization of mental health services for people who have trouble functioning because of mental health challenges.

(12) There is a link between mental health diagnosis and the likelihood of an individual committing suicide.

(13) A comprehensive public health approach to behavioral health fosters protective factors in racial and ethnic communities that support mental health.

(14) Approaches to mental health and addressing trauma must keep in mind the historical and cultural trauma that has impacted many communities of color.

(15) Treatment modalities must keep individual communities' approaches to mental health in mind, for example—

(A) cultural healing practices; and

(B) the mental health professionals needed to provide those services such as peer support specialists.

(16) Approaches to mental health and addressing trauma must keep in mind the concept of intersectionality of individuals; that individuals may have many inequities that shape the way they process and experience everyday life.

**SEC. 602. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES, MENTAL HEALTH COUNSELOR SERVICES, AND SUBSTANCE ABUSE COUNSELOR SERVICES UNDER PART B OF THE MEDICARE PROGRAM.**

(a) COVERAGE OF SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 431(c), is amended—

(A) in subparagraph (GG), by striking ''and'' at the end;

(B) in subparagraph (HH), by inserting ''and'' at the end; and

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

''(II) marriage and family therapist services (as defined in subsection (lll)(1)) and mental health counselor services (as defined in subsection (lll)(3)) and substance abuse counselor services (as defined in subsection (lll)(5));''.

(2) DEFINITIONS.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by sections 205(b)(a), 413(a), and 431(c), is amended by adding at the end the following new subsection:

''Marriage and Family Therapist Services; Marriage and Family Therapist; Mental Health Counselor Services; Mental Health Counselor; Substance Abuse Counselor Services; Substance Abuse Counselor; Peer Support Specialist

''(lll)(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'marriage and family therapist' means an individual who—

''(A) possesses a master's or doctoral degree that qualifies for licensure or certification as a marriage and family therapist pursuant to State law, including but not limited to, clinical social workers and occupational therapists;

''(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

''(C) in the case of an individual performing services in a State that provides for licensure or certification of marriage and family therapists, is licensed or certified as a marriage and family therapist in such State.

''(3) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (4)) for the diagnosis and treatment of mental illnesses that the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(4) The term 'mental health counselor' means an individual who—

''(A) possesses a master's or doctor's degree in mental health counseling or a related field, including clinical social workers and occupational therapists;

''(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

''(C) in the case of an individual performing services in a State that provides for licensure or certification of mental health counselors or professional counselors, is licensed or certified as a mental health counselor or professional counselor in such State.

''(5) The term 'substance abuse counselor services' means services performed by a substance abuse counselor (as defined in paragraph (6)) for the diagnosis and treatment of substance abuse and addiction that the substance abuse counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(6) The term 'substance abuse counselor' means an individual who—

''(A) has performed at least 2 years of supervised substance abuse counselor practice;

''(B) in the case of an individual performing services in a State that provides for licensure or certification of substance abuse counselors or professional counselors, is licensed or certified as a substance abuse counselor or professional counselor in such State; or

''(C) is a drug and alcohol counselor as defined in section 40.281 of title 49, Code of Federal Regulations.

''(7) The term 'peer support specialist' means an individual who—

''(A) is an individual living in recovery with mental illness, addiction, or systems involvement;

''(B) has skills learned in formal training; and

''(C) delivers services in behavioral health settings to promote mind-body recovery and resiliency.''.

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)) is amended—

(A) by striking ''and'' at the end of clause (iv); and

(B) by adding at the end the following new clause:

''(v) marriage and family therapist services, mental health counselor services, and substance abuse counselor services; and''.

(4) AMOUNT OF PAYMENT.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 431(c)(3), is amended—

(A) by striking ''and'' before ''(DD)''; and

(B) by inserting before the semicolon at the end the following: '', and (EE) with respect to marriage and family therapist services, mental health counselor services, and substance abuse counselor services under section 1861(s)(2)(II), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under subparagraph (L)''.

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES, MENTAL HEALTH COUNSELOR SERVICES, AND PEER SUPPORT SPECIALIST SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting ''mar-

riage and family therapist services (as defined in section 1861(lll)(1)), mental health counselor services (as defined in section 1861(lll)(3)),'' after ''qualified psychologist services,''.

(6) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS, MENTAL HEALTH COUNSELORS, AND SUBSTANCE ABUSE COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clauses:

''(vii) A marriage and family therapist (as defined in section 1861(lll)(2)).

''(viii) A mental health counselor (as defined in section 1861(lll)(4)).

''(ix) A substance abuse counselor (as defined in section 1861(lll)(6)).

''(x) A peer support specialist (as defined in section 1861(III)(7)).''.

(b) COVERAGE OF CERTAIN MENTAL HEALTH SERVICES PROVIDED IN CERTAIN SETTINGS.—

(1) RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ''or

by a clinical social worker (as defined in subsection (hh)(1))," and inserting ", by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection (lll)(2)), or by a mental health counselor (as defined in subsection (lll)(4)), or by a substance abuse counselor (as defined in section 1861 (lll)(6))."

(2) HOSPICE PROGRAMS.—Section 1861(dd)(2)(B)(i)(III) of the Social Security Act (42 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by inserting "or one marriage and family therapist (as defined in subsection (lll)(2))" after "social worker".

(c) AUTHORIZATION OF MARRIAGE AND FAMILY THERAPISTS TO DEVELOP DISCHARGE PLANS FOR POSTHOSPITAL SERVICES.—Section 1861(ee)(2)(G) of the Social Security Act (42 U.S.C. 1395x(ee)(2)(G)) is amended by inserting "marriage and family therapist (as defined in subsection (lll)(2))," after "social worker,".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished on or after January 1, 2021.

**SEC. 603. INTEGRATED HEALTH CARE DEMONSTRATION PROGRAM.**

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

**"SEC. 553. INTERPROFESSIONAL HEALTH CARE TEAMS FOR PROVISION OF BEHAVIORAL HEALTH CARE IN PRIMARY CARE SETTINGS.**

''(a) GRANTS.—The Secretary, acting through the Assistant Secretary for Mental Health and Substance Abuse, shall award grants to eligible entities for the purpose of establishing interprofessional health care teams that provide behavioral health care.

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

''(c) LOAN FORGIVENESS.—To encourage qualified allied health professionals to enter the mental health field, an eligible entity receiving a grant under this section shall agree to use at least $10,000 of the grant on a loan for-

giveness program for practitioners who commit to working in the mental health field for a period of two years.

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

''(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $20,000,000 for each of fiscal years 2021 through 2025.''.

**SEC. 604. ADDRESSING RACIAL AND ETHNIC MENTAL HEALTH DISPARITIES RESEARCH GAPS.**

(a) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act, the Director of the National Institute on Minority Health and Health Disparities shall enter into an arrangement with the National Academy of Sciences to carry out the activities under subsection (b), or, if the National Academy of Sciences declines to enter into such an arrangement, the Director of the National Institute on Minority Health and Health Disparities, in cooperation with the Agency for Healthcare Research and Quality, shall carry out the activities under subsection (b).

(b) ACTIVITIES.—The applicable entity under subsection (a) shall—

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

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

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

(B) the degree of the co-occurrence of mental conditions with other disabilities in such racial and ethnic groups, including physical disabilities, mental disabilities, and mental disorders or mental health conditions which co-occur with one another;

(C) a compilation of information on the impact of exposure to community violence, community trauma, adverse childhood experiences, weather extremes worsened by climate change (such as heat waves, hurricanes, and wildfires), substance use ,and other psychological traumas, on mental disorders in such racial and minority groups, stratified by household income level;

(D) a compilation of information on the impact of the intersectionality of transgender men in racial and ethnic minority groups; and

(E) a description of how protective factors contrast and compare among different communities of color, identifying cultural strengths.

**SEC. 605. HEALTH PROFESSIONS COMPETENCIES TO ADDRESS RACIAL AND ETHNIC MENTAL HEALTH DISPARITIES.**

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Assistant Secretary for Mental Health and Substance Use, shall award grants to qualified national organizations for the purposes of—

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

(2) certifying community health workers and peer wellness specialists with respect to such curricula and core competencies and integrating and expanding the use of such workers and specialists into

health care and community-based settings to address mental health disparities among racial and ethnic minority groups.

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

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

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

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

(4) Establishing external stakeholder advisory boards to provide meaningful input into policy and program development and best practices to reduce

mental health inequities among racial and ethnic groups, including participation from communities of color with lived experience of the impacts of mental health disparities.

(c) DEFINITIONS.—In this section:

(1) QUALIFIED NATIONAL ORGANIZATION.—The term ''qualified national organization'' means a national organization that focuses on the education of students in programs of social work, occupational therapy, psychology, psychiatry, and marriage and family therapy.

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

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

**SEC. 606. GEOACCESS STUDY.**

The Assistant Secretary for Mental Health and Substance Use shall—

(1) conduct a study to—

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

(B) assess the preparedness of speciality mental health providers to deliver culturally and linguistically appropriate, affordable, and accessible services; and

(2) submit a report to Congress on the results of such study.

**SEC. 607. ASIAN AMERICAN, NATIVE HAWAIIAN, PACIFIC ISLANDER, AND HISPANIC AND LATINO BEHAVIORAL AND MENTAL HEALTH OUTREACH AND EDUCATION STRATEGIES.**

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.), as amended by section 603, is further amended by adding at the end the following new section:

**"SEC. 554. BEHAVIORAL AND MENTAL HEALTH OUTREACH AND EDUCATION STRATEGIES.**

''(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Mental Health and Substance Use, shall, in coordination with advocacy and behavioral and mental health organizations serving populations of Asian American, Native Hawaiian, Pacific Islander, and Hispanic and Latino individuals or communities, develop

and implement an outreach and education strategy to promote behavioral and mental health, clarify that behavioral and mental health conditions are treatable and that reasonable accommodations are required under section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) and titles II and III of the Americans with Disabilities Act of 1990 (42 U.S.C. 12131 et seq.), and reduce stigma associated with mental health conditions and substance abuse among the Asian American, Native Hawaiian, and Pacific Islander and Hispanic and Latino populations. Such strategy shall—

''(1) be designed to—

''(A) meet the diverse cultural and language needs of the various Asian American, Native Hawaiian, Pacific Islander, and Hispanic and Latino populations; and

''(B) ensure such strategies are developmentally (with respect to the beneficiary's relative age and experience) and age appropriate, as well as cognitively accessible to persons with cognitive disabilities;

''(2) increase awareness of symptoms of mental illnesses common among such populations, taking into account differences within subgroups (such as

gender, gender identity, age, sexual orientation, disability, and ethnicity) of such populations;

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

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

''(5) seek to broaden the perspective among both individuals in such communities and stakeholders serving such communities to use a comprehensive public health approach to promoting behavioral health that addresses a holistic view of health by focusing on the intersection between behavioral and physical health.

''(b) REPORTS.—Beginning not later than 1 year after the date of the enactment of this section and annually thereafter, the Secretary, acting through the Assistant Secretary, shall submit to Congress, and make publicly available, a report on the extent to which the strategy developed and implemented under subsection (a) increased behavioral and mental health outcomes associated with mental health conditions and substance abuse among Asian American, Native Hawaiian, Pacific Islander, and Hispanic and Latino populations.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $300,000 for fiscal year 2021.''.

**SEC. 608. MENTAL HEALTH IN SCHOOLS.**

(a) PURPOSE.—It is the purpose of this section to—

(1) revise, increase funding for, and expand the scope of the Project AWARE State Educational Agency Grant Program carried out by the Secretary of Health and Human Services, in order to provide access to more comprehensive school-based mental health services and supports;

(2) provide for comprehensive staff development for school and community service personnel working in the school;

(3) provide for comprehensive training to improve health and academic outcomes for children with, or at risk for, mental health conditions, for parents or guardians, siblings, and other family members of such children, and for concerned members of the community;

(4) provide for comprehensive, universal, evidence-based screening to identify children and adolescents with potential mental health conditions or unmet emotional health needs;

(5) recognize best practices for the delivery of mental health care in school-based settings, including school-based health centers;

(6) provide for comprehensive training for parents or guardians, siblings, other family members, and concerned members of the community on behalf of children and adolescents experiencing mental health trauma, disorder, or disability; and

(7) establish formal working relationships between health, human service, and educational entities that support the mental and emotional health of children and adolescents in the school setting.

(b) TECHNICAL AMENDMENTS.—The second part G (relating to services provided through religious organizations) of title V of the Public Health Service Act (42 U.S.C. 290kk et seq.) is amended—

(1) by redesignating such part as part J; and

(2) by redesignating sections 581 through 584 as sections 596 through 596C, respectively.

(c) SCHOOL-BASED MENTAL HEALTH AND CHILDREN AND VIOLENCE.—Section 581 of the Public Health Service Act (42 U.S.C. 290hh) is amended to read as follows:

**"SEC. 581. SCHOOL-BASED MENTAL HEALTH; CHILDREN AND ADOLESCENTS AND TRAUMA.**

"(a) IN GENERAL.—The Secretary, in collaboration with the Secretary of Education, shall, directly or through grants, contracts, or cooperative agreements awarded to eligible entities described in subsection (c), assist local communities and schools (including schools funded by the Bureau of Indian Education) in applying a public health approach to mental health services both in schools and in the community. Such approach should provide comprehensive developmentally appropriate services and supports, that are linguistically and culturally appropriate and trauma-informed, and incorporate developmentally appropriate strategies of positive behavioral interventions and supports. A comprehensive school mental health program funded under this section shall assist children in dealing with traumatic experiences, grief, bereavement, risk of suicide, violence, and individual and community trauma that children may experience, and shall be implemented with a focus on positive youth development. Causes of trauma for children may include but are not limited to exposure to multiple forms of violence and abuse, structural racism and discrimination, family housing instability, family job loss, and climate-related disasters.

"(b) ACTIVITIES.—Under the program under subsection (a), the Secretary may—

''(1) provide financial support to enable local communities to implement a comprehensive culturally and linguistically appropriate, trauma-informed, and developmentally appropriate, school-based mental health program that—

''(A) builds awareness of multiple forms of trauma, individual trauma, and intergenerational, continuum of impacts of trauma, on populations;

''(B) trains appropriate staff and educators to identify, and screen for, signs of trauma exposure, mental health conditions, or risk of suicide; and

''(C) incorporates positive behavioral interventions, family engagement, student treatment, and multi-generational supports to foster the health and development of children, prevent mental health conditions, and ameliorate the impacts of trauma;

''(2) provide technical assistance to local communities with respect to the development of programs described in paragraph (1);

''(3) provide assistance to local communities in the development of policies to address child and adolescent trauma and mental health conditions;

''(4) facilitate community partnerships among families, students, law enforcement agencies, education agencies, mental health and substance use disorder systems, family-based mental health service systems, child welfare agencies, health care providers (including primary care physicians, mental health professionals, and other professionals who specialize in children's mental health such as child and adolescent psychiatrists), institutions of higher education, faith-based programs, trauma networks, public health, youth development and recreation, youth employment organizations, and other community-based systems; and

''(5) establish and promote trauma-informed, culturally-based, and supportive mechanisms for children and adolescents to share their experiences of individual and community trauma, including their exposure to violence, with trusted adults.

''(c) REQUIREMENTS.—

''(1) IN GENERAL.—To be eligible for a grant, contract, or cooperative agreement under subsection (a), an entity shall—

''(A) be a partnership that includes—

''(i) a State educational agency (as defined in section 8101 of the Elementary

and Secondary Education Act of 1965) in coordination with one or more local educational agencies (as defined in section 8101 of such Act) or a consortium of entities described in subparagraph (B), (C), (D), or (E) of the definition of a local educational agency in section 8101 of such Act; and

''(ii) in accordance with paragraph (2)(A)(i), appropriate public or private entities that employ interventions that are evidence-based (as defined in section 8101 of the Elementary and Secondary Education Act of 1965); and

''(B) submit an application, endorsed by all members of the partnership, that—

''(i) specifies which members will serve as the lead partners; and

''(ii) contains the assurances described in paragraph (2).

''(2) REQUIRED ASSURANCES.—An application under paragraph (1) shall contain assurances as follows:

''(A) The eligible entity will ensure that, in carrying out activities under this section, the el-

igible entity will enter into a memorandum of understanding—

''(i) with at least 2 entities from the following categories: community-based, public or private mental-health providers, health care entities, public health entities, law enforcement or juvenile justice entities, child welfare agencies, family-based mental health entities, trauma networks, community-based entities, or other entities as determined by the Secretary (which may include a human services agency or institution of higher education); and

''(ii) that clearly states—

''(I) the responsibilities of each partner with respect to the activities to be carried out, including how family and community engagement will be incorporated in the activities;

''(II) how school-employed and school-based mental health professionals will be utilized for carrying out such responsibilities;

''(III) how each such partner will be accountable for carrying out such responsibilities; and

''(IV) the amount of non-Federal funding or in-kind contributions that each such partner will contribute in order to sustain the program.

''(B) The comprehensive school-based mental health program carried out under this section supports the flexible use of funds to address—

''(i) universal prevention, through the promotion of the social, emotional, mental, and behavioral health of all students in an environment that is conducive to learning;

''(ii) the reduction in the likelihood of at-risk students developing social, emotional, or behavioral health problems, or substance use disorders;

''(iii) the screening for, and early identification of, social, emotional, mental, and behavioral problems, or substance use disorders and the provision of early intervention services;

''(iv) the treatment or referral for treatment of students with existing social, emotional, and mental behavioral health problems, or substance use disorders;

''(v) the development and implementation of evidence-based programs (including program curricula, school supports, and after-school programs) to assist children who are experiencing or have been exposed to individual and community trauma or exposed to multiple forms of violence; and

''(vi) the development and implementation of evidence-based programs to assist children who are grieving, which may include training for school personnel on the impact of trauma and bereavement on children, and services to provide support to grieving children.

''(C) The comprehensive school-based mental health program carried out under this section will provide for in-service training of all school personnel, including ancillary staff and volunteers, in—

''(i) the techniques and supports needed to promote early identification of chil-

dren with trauma histories, children who are grieving, and children with a mental health condition or at risk of developing a mental health condition, or who are at risk of suicide;

''(ii) the use of referral mechanisms that effectively link such children to appropriate prevention, treatment, and intervention services in the school and in the community and to followup when services are not available;

''(iii) strategies that promote a schoolwide positive environment, including strategies to prevent bullying, which includes cyber-bullying;

''(iv) strategies for promoting the social, emotional, mental, and behavioral health of all students;

''(v) strategies for promoting the social, emotional, mental, and behavioral health of all students; and

''(vi) strategies to increase the knowledge and skills of school and community leaders about the impact of individual and community trauma and exposure to mul-

tiple forms of violence on the application of a public health approach to comprehensive school-based mental health programs.

''(D) The comprehensive school-based mental health program carried out under this section will include comprehensive training for parents or guardians, siblings, and other family members of children with mental health conditions, and for concerned members of the community, in—

''(i) the techniques and supports needed to promote early identification of children with trauma histories, children who are grieving, children with a mental health condition or at risk of developing a mental health condition, and children who are at risk of suicide;

''(ii) the use of referral mechanisms that effectively link such children to appropriate prevention, treatment, and intervention services in the school and in the community and followup when such services are not available; and

''(iii) strategies that promote a school- and community-wide positive environment,

including strategies to prevent bullying, including cyber-bullying.

''(E) The comprehensive school-based mental health program carried out under this section will demonstrate the measures to be taken to sustain the program (which may include seeking funding for the program under a State Medicaid plan under title XIX of the Social Security Act or a waiver of such a plan, or under a State plan under subpart 1 of part B or part E of title IV of the Social Security Act).

''(F) The eligible entity is supported by the State agency with primary responsibility for behavioral health to ensure that comprehensive school-based mental health program carried out under this section will be sustainable after funding under this section terminates.

''(G) The comprehensive school-based mental health program carried out under this section will be coordinated with early intervening activities carried out under the Individuals with Disabilities Education Act or activities funded under Part A of title IV of the Elementary and Secondary Education Act of 1965.

''(H) The comprehensive school-based mental health program carried out under this section will be coordinated with early intervening activities carried out under the Individuals with Disabilities Education Act.

''(I) The comprehensive school-based mental health program carried out under this section will be trauma-informed, evidence based, and developmentally, culturally, and linguistically appropriate.

''(J) The comprehensive school-based mental health program carried out under this section will include a broad needs assessment of youth who drop out or are expelled from school due to policies of 'zero tolerance' with respect to drugs, alcohol, or weapons and an inability to obtain appropriate services.

''(K) The mental health services provided through the comprehensive school-based mental health program carried out under this section will be provided by qualified mental and behavioral health professionals who are—

''(i) certified, credentialed, or licensed by the State involved in compliance with applicable Federal and State law; and

''(ii) practicing within their area of expertise.

''(L) The comprehensive school-based mental health program carried out under this section will permit students to self-refer to the program for mental health care and self-consent for mental health crisis care to the extent permitted by State or other applicable law.

''(3) COORDINATOR.—Any entity that is a member of a partnership described in paragraph (1)(A) may serve as the coordinator of funding and activities under the grant if all members of the partnership agree.

''(4) COMPLIANCE WITH HIPAA.—A grantee under this section shall be deemed to be a covered entity for purposes of compliance with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 with respect to any patient records developed through activities under the grant.

''(5) COMPLIANCE WITH FERPA.—Section 444 of the General Education Provisions Act (commonly known as the 'Family Educational Rights and Privacy Act of 1974') shall apply to any entity that is a member of the partnership in the same manner

that such section applies to an educational agency or institution (as that term is defined in such section).

''(d) GEOGRAPHICAL DISTRIBUTION.—The Secretary shall ensure that grants, contracts, or cooperative agreements under subsection (a) will be distributed equitably among the regions of the country and among urban and rural areas.

''(e) DURATION OF AWARDS.—With respect to the award of a grant, contract, or cooperative agreement under subsection (a), the award shall be for a period of 5 years and may be renewed for subsequent 5-year periods.

''(f) EVALUATION AND MEASURES OF OUTCOMES.—

''(1) DEVELOPMENT OF PROCESS.—The Assistant Secretary shall develop a fiscally appropriate process for evaluating activities carried out under this section. Such process shall include—

''(A) the development of guidelines for the submission of program data by grant, contract, or cooperative agreement recipients;

''(B) the development of measures of outcomes (in accordance with paragraph (2)) to be applied by such recipients in evaluating programs carried out under this section; and

"(C) the submission of annual reports by such recipients concerning the effectiveness of programs carried out under this section.

"(2) MEASURES OF OUTCOMES.—

"(A) IN GENERAL.—The Assistant Secretary shall develop measures of outcomes to be applied by recipients of assistance under this section, and the Assistant Secretary, in evaluating the effectiveness of programs carried out under this section. Such measures shall include student and family measures as provided for in subparagraph (B) and local educational measures as provided for under subparagraph (C).

"(B) STUDENT AND FAMILY MEASURES OF OUTCOMES.—The measures of outcomes developed under paragraph (1)(B) relating to students and families shall, with respect to activities and interventions carried out under a program under this section, at a minimum include provisions to evaluate whether the program is effective in—

"(i) enhancing the social skills and emotional resilience of all students, as well as providing support to students who experience peer-inflicted bullying and isolation;

"(ii) improving academic outcomes, including as measured by proficiency on the annual assessments under section 1111(b)(2) of the Elementary and Secondary Education Act of 1965;

"(iii) reducing the incidence of behaviors that harm the self or others, or otherwise disrupt the learning environment of other students, when such behavior cannot be reduced by the presence of reasonable accommodations;

"(iv) improving participation and engagement in classroom activities in children with mental health conditions;

"(v) reducing substance use disorders;

"(vi) reducing rates of suicide;

"(vii) reducing suspensions, truancy, expulsions, and violence;

"(viii) increasing high school graduation rates, calculated using the four-year adjusted cohort graduation rate or the extended-year adjusted cohort graduation rate (as such terms are defined in section 8101 of the Elementary and Secondary Education Act of 1965); and

''(ix) improving attendance rates and rates of chronic absenteeism;

''(x) improving access to care for mental health conditions, including access to mental health services that are trauma-informed, and developmentally, linguistically, and culturally appropriate;

''(xi) improving health outcomes; and

''(xii) decreasing disparities among vulnerable and protected populations in outcomes described in clauses (i) through (xi).

''(C) LOCAL EDUCATIONAL OUTCOMES.—The outcome measures developed under paragraph (1)(B) relating to local educational systems shall, with respect to activities carried out under a program under this section, at a minimum include provisions to evaluate—

''(i) the effectiveness of comprehensive school mental health programs established under this section;

''(ii) the effectiveness of formal partnership linkages among child and family serving institutions, community support systems, and the educational system;

''(iii) the progress made in sustaining the program once funding under the grant has expired;

''(iv) the effectiveness of training and professional development programs for all school personnel that incorporate indicators that measure cultural and linguistic competencies under the program in a manner that incorporates appropriate cultural and linguistic training;

''(v) the improvement in perception of a safe and supportive learning environment among school staff, students, and parents;

''(vi) the improvement in case-finding of students in need of more intensive services and referral of identified students to early intervention and clinical services;

''(vii) the improvement in the immediate availability of clinical assessment and treatment services within the context of the local community to students posing a danger to themselves or others;

''(viii) the increased successful matriculation to postsecondary school;

''(ix) reduced suicide rates;

''(x) referrals to juvenile justice; and

''(xi) increased educational equity.

''(3) SUBMISSION OF ANNUAL DATA.—An eligible entity described in subsection (c) that receives a grant, contract, or cooperative agreement under this section shall annually submit to the Assistant Secretary a report that includes data to evaluate the success of the program carried out by the entity based on whether such program is achieving the purposes of the program. Such reports shall utilize the measures of outcomes under paragraph (2) in a reasonable manner to demonstrate the progress of the program in achieving such purposes.

''(4) EVALUATION BY ASSISTANT SECRETARY.—Based on the data submitted under paragraph (3), the Assistant Secretary shall annually submit to Congress a report concerning the results and effectiveness of the programs carried out with assistance received under this section.

''(5) LIMITATION.—An eligible entity shall use not more than 20 percent of amounts received under a grant under this section to carry out evaluation activities under this subsection.

''(g) INFORMATION AND EDUCATION.—The Secretary shall establish comprehensive information and edu-

cation programs to disseminate the findings of the knowledge development and application under this section to the general public and to health care professionals.

''(h) AMOUNT OF GRANTS AND AUTHORIZATION OF APPROPRIATIONS.—

''(1) AMOUNT OF GRANTS.—A grant under this section shall be in an amount that is not more than $2,000,000 for each of the first 5 fiscal years following the date of enactment of the Mental Health Services for Students Act of 2019. The Secretary shall determine the amount of each such grant based on the population of children up to age 21 of the area to be served under the grant.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $200,000,000 for each of the first 5 fiscal years following the date of enactment of the Immigrants' Mental Health Act of 2020.''.

(d) CONFORMING AMENDMENT.—Part G of title V of the Public Health Service Act (42 U.S.C. 290hh et seq.), as amended by this section, is further amended by striking the part heading and inserting the following:

**"PART G—SCHOOL-BASED MENTAL HEALTH".**

**SEC. 609. BUILDING AN EFFECTIVE WORKFORCE IN MENTAL HEALTH.**

(a) IN GENERAL.—The Secretary of Health and Human Services, in coordination with the Assistant Secretary for Mental Health and Substance Use, the Administrator of the Health Resources and Services Administration, and the Secretary of Labor, shall, in coordination with advocacy and behavioral and mental health organizations serving people of color—

(1) develop, strengthen, and implement strategies to bolster career pathways for mental health professionals; and

(2) identify the breadth of settings where mental and behavioral health care can take place.

(b) CONTENTS.—Strategies under subsection (a) shall include—

(1) the variety of settings where mental health professionals are needed, including community-based organizations, women's centers, shelters, organizations focused on youth development, workforce agencies, job placement and development centers, emergency rooms, the special supplemental nutrition program for women, infants, and children under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786), food banks, legal aid, and benefit issuers as

defined in section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012);

(2) defining career pathways in mental and behavioral health, to help communities understand the variety of careers in mental health that are available;

(3) building career pathways in mental and behavioral health as part of the curriculum at the postsecondary education level;

(4) providing accessible training and certification pathways for lay health workers such as community health workers and other peer support individuals to ensure that careers pay a living wage;

(5) creating incentives for students in the fields of occupational therapy, social work, medicine, and nursing to learn more about mental health, and to include a mental health rotation as a part of the health professional curricula;

(6) including training and education for teachers about the basics of section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) and individualized education programs (as defined in section 614(d) of the Individuals with Disabilities in Education Act (20 U.S.C. 1414.(d));

(7) researching, developing, and implementing programs for mental and behavioral health professionals to prevent burnout;

(8) finding better and increased avenues to ensure equity by providing better loan forgiveness programs, including a focus area within the National Health Service Corps focused on community trauma.

**SEC. 610. MENTAL HEALTH AT THE BORDER.**

(a) SHORT TITLE.—This section may be cited as the ''Immigrants' Mental Health Act of 2020''.

(b) TRAINING FOR CERTAIN CBP PERSONNEL IN MENTAL HEALTH ISSUES.—

(1) TRAINING TO IDENTIFY RISK FACTORS AND WARNING SIGNS IN IMMIGRANTS AND REFUGEES.—

(A) IN GENERAL.—The Commissioner of U.S. Customs and Border Protection, in consultation with the Assistant Secretary for Mental Health and Substance Use, the Administrator of the Health Resources and Services Administration, and nongovernmental experts in the delivery of health care in humanitarian crises and in the delivery of health care to children, shall develop and implement a training curriculum for U.S. Customs and Border Protection agents and officers assigned to U.S.

Customs and Border Protection facilities to enable such agents and officers to identify the risk factors and warning signs in immigrants and refugees of mental health issues relating to trauma.

(B) REQUIREMENTS.—The training curriculum described in subparagraph (A) shall—

(i) apply to all U.S. Customs and Border Protection agents and officers working at U.S. Customs and Border Protection facilities;

(ii) provide for crisis intervention using a trauma-informed approach; and

(iii) provide for mental health screenings for immigrants and refugees arriving at the border in their preferred language or with appropriate language assistance.

(2) TRAINING TO ADDRESS MENTAL HEALTH AND WELLNESS OF CBP AGENTS AND OFFICERS.—

(A) IN GENERAL.—The Commissioner of U.S. Customs and Border Protection, in consultation with the Assistant Secretary for Mental Health and Substance Use, the Administrator of the Health Resources and Services Ad-

ministration, and nongovernmental experts in the delivery of mental health care, shall develop and implement a training curriculum for U.S. Customs and Border Protection agents and officers assigned to U.S. Customs and Border Protection facilities to address the mental health and wellness of individuals working at such facilities.

(B) REQUIREMENT.—The training curriculum described in subparagraph (A) shall be designed to help U.S. Customs and Border Protection agents and officers working at U.S. Customs and Border Protection facilities to—

(i) better manage their own stress and the stress of their coworkers; and

(ii) be more aware of the psychological pressures experienced during their jobs.

(3) ANNUAL REVIEW OF TRAINING.—Beginning with respect to fiscal year 2022, the Assistant Secretary for Mental Health and Substance Use shall—

(A) conduct an annual review of the training implemented pursuant to paragraphs (1) and (2); and

(B) submit the results of each such review, including any recommendations for improvement of such training, to—

(i) the Commissioner of U.S. Customs and Border Protection; and

(ii) the Committees on Appropriations, Energy and Commerce, Homeland Security, and the Judiciary of the House of Representatives and the Committees on Appropriations, Health, Education, Labor, and Pensions, and Homeland Security and Governmental Affairs of the Senate.

(4) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there is authorized to be appropriated—

(A) for fiscal year 2021, $50,000 to develop the training under paragraphs (1) and (2); and

(B) for each of fiscal years 2022 through 2026—

(i) $20,000 to implement such training pursuant to paragraphs (1) and (2); and

(ii) such sums as may be necessary to review and make recommendations for such training pursuant to paragraph (3).

(c) STAFFING BORDER FACILITIES AND DETENTION CENTERS.—

(1) IN GENERAL.—To adequately evaluate the mental health needs of immigrants, refugees, border patrol agents, and staff, the Commissioner of U.S. Customs and Border Protection shall assign at least one qualified mental or behavioral health expert to each U.S. Customs and Border Protection facility.

(2) QUALIFICATIONS.—To be qualified for purposes of paragraph (1), a mental or behavioral health expert shall be—

(A) bilingual;

(B) well-versed in culturally appropriate and trauma-informed interventions; and

(C) have particular expertise in child or adolescent mental health or family mental health.

(3) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there is authorized to be appropriated $3,000,000 for each of fiscal years 2021 through 2025.

(d) NO SHARING OF DEPARTMENT OF HEALTH AND HUMAN SERVICES MENTAL HEALTH INFORMATION FOR ASYLUM DETERMINATIONS, IMMIGRATION HEARINGS, OR DEPORTATION PROCEEDINGS.—The officers, employees, and agents of the Department of Health and Human Services, including the Office of Refugee Resettlement, may not share with the Department of Homeland Security, and the officers, employees, and agents of the Department of Homeland Security may not request or receive from the Department of Health and Human Services, for the purposes of an asylum determination, immigration hearing, or deportation proceeding, any information or record that—

(1) concerns the mental health of an alien; and

(2) was obtained or produced by a mental or behavioral health professional while the alien was in a shelter or otherwise in the custody of the Federal Government.

(e) DEFINITIONS.—In this section:

(1) The term ''U.S. Customs and Border Protection facility'' means any of the following facilities that typically detain migrants on behalf of U.S. Customs and Border Protection:

(A) U.S. Border Patrol stations.

(B) Ports of entry.

(C) Checkpoints.

(D) Forward operating bases.

(E) Secondary inspection areas.

(F) Short-term custody facilities.

(2) The term ''forward operating base'' means a permanent facility established by U.S. Customs and Border Protection in forward or remote locations, and designated as such by U.S. Customs and Border Protection.

# TITLE VII—ADDRESSING HIGH IMPACT MINORITY DISEASES

## Subtitle A—Cancer

### SEC. 701. LUNG CANCER MORTALITY REDUCTION.

(a) SHORT TITLE.—This section may be cited as the ''Lung Cancer Mortality Reduction Act of 2020''.

(b) FINDINGS.—Congress makes the following findings:

(1) Lung cancer is the leading cause of cancer death for both men and women, accounting for 25 percent of all cancer deaths.

(2) Lung cancer kills more people annually than breast cancer, prostate cancer, colon cancer, liver cancer, melanoma, and kidney cancer combined.

(3) Since the National Cancer Act of 1971 (Public Law 92–218; 85 Stat. 778), coordinated and

comprehensive research has raised the 5-year survival rates for breast cancer to 90 percent, for prostate cancer to 99 percent, and for colon cancer to 64 percent.

(4) The 5-year survival rate for lung cancer is still only 18 percent, and a similar coordinated and comprehensive research effort is required to achieve increases in lung cancer survivability rates.

(5) Sixty percent of lung cancer cases are now diagnosed in nonsmokers or former smokers.

(6) Two-thirds of nonsmokers diagnosed with lung cancer are women.

(7) Certain minority populations, such as African-American males, have disproportionately high rates of lung cancer incidence and mortality, despite their smoking rate being similar to other racial groups.

(8) Members of the Baby Boomer Generation are entering their 60s, the most common age at which people develop lung cancer.

(9) Tobacco addiction and exposure to other lung cancer carcinogens such as Agent Orange and other herbicides and battlefield emissions are serious problems among military personnel and war veterans.

(10) Significant and rapid improvements in lung cancer mortality can be expected through greater use and access to lung cancer screening tests for at-risk individuals.

(11) Recent research has shown that screening with low-dose computed tomography scan reduced lung cancer death mortality by 20 percent for those with a high risk of lung cancer through early detection. The Centers for Medicare & Medicaid Services supports annual lung cancer screening for high-risk patients with low-dose computed tomography.

(12) Additional strategies are necessary to further enhance the existing tests and therapies available to diagnose and treat lung cancer in the future.

(13) The August 2001 Report of the Lung Cancer Progress Review Group of the National Cancer Institute stated that funding for lung cancer research was ''far below the levels characterized for other common malignancies and far out of proportion to its massive health impact''.

(14) The Report of the Lung Cancer Progress Review Group identified as its ''highest priority'' the creation of integrated, multidisciplinary, multi-institutional research consortia organized around the

problem of lung cancer rather than around specific research disciplines.

(15) The United States must enhance its response to the issues raised in the Report of the Lung Cancer Progress Review Group, and this can be accomplished through the establishment of a coordinated effort designed to reduce the lung cancer mortality rate by 50 percent by 2020 and targeted funding to support this coordinated effort.

(c) SENSE OF CONGRESS CONCERNING INVESTMENT IN LUNG CANCER RESEARCH.—It is the sense of the Congress that—

(1) lung cancer mortality reduction should be made a national public health priority; and

(2) a comprehensive mortality reduction program coordinated by the Secretary of Health and Human Services is justified and necessary to adequately address and reduce lung cancer mortality.

(d) LUNG CANCER MORTALITY REDUCTION PROGRAM.—

(1) IN GENERAL.—Subpart 1 of part C of title IV of the Public Health Service Act (42 U.S.C. 285 et seq.) is amended by adding at the end the following:

**"SEC. 417H. LUNG CANCER MORTALITY REDUCTION PROGRAM.**

"(a) IN GENERAL.—Not later than 6 months after the date of the enactment of the Health Equity and Accountability Act of 2020, the Secretary, in consultation with the Secretary of Defense, the Secretary of Veterans Affairs, the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, the Commissioner of Food and Drugs, the Administrator of the Centers for Medicare & Medicaid Services, the Director of the National Institute on Minority Health and Health Disparities, and other members of the Lung Cancer Advisory Board established under section 701 of the Health Equity and Accountability Act of 2020, shall implement a comprehensive program, to be known as the Lung Cancer Mortality Reduction Program, to achieve a reduction of at least 25 percent in the mortality rate of lung cancer by 2020.

"(b) REQUIREMENTS.—The Program shall include at least the following:

"(1) With respect to the National Institutes of Health—

"(A) a strategic review and prioritization by the National Cancer Institute of research grants to achieve the goal of the Lung Cancer

Mortality Reduction Program in reducing lung cancer mortality;

''(B) the provision of funds to enable the Airway Biology and Disease Branch of the National Heart, Lung, and Blood Institute to expand its research programs to include predispositions to lung cancer, the interrelationship between lung cancer and other pulmonary and cardiac disease, and the diagnosis and treatment of those interrelationships;

''(C) the provision of funds to enable the National Institute of Biomedical Imaging and Bioengineering to expedite the development of computer-assisted diagnostic, surgical, treatment, and drug-testing innovations to reduce lung cancer mortality, such as through expansion of the Institute's Quantum Grant Program and Image-Guided Interventions programs; and

''(D) the provision of funds to enable the National Institute of Environmental Health Sciences to implement research programs relative to the lung cancer incidence.

''(2) With respect to the Food and Drug Administration—

''(A) activities under section 529B of the Federal Food, Drug, and Cosmetic Act; and

''(B) activities under section 561 of the Federal Food, Drug, and Cosmetic Act to expand access to investigational drugs and devices for the diagnosis, monitoring, or treatment of lung cancer.

''(3) With respect to the Centers for Disease Control and Prevention, the establishment of an early disease research and management program under section 1511.

''(4) With respect to the Agency for Healthcare Research and Quality, the conduct of a biannual review of lung cancer screening, diagnostic, and treatment protocols, and the issuance of updated guidelines.

''(5) The promotion (including education) of lung cancer screening within minority and rural populations and the study of the effectiveness of efforts to increase such screening.

''(6) The cooperation and coordination of all minority and health disparity programs within the Department of Health and Human Services to ensure that all aspects of the Lung Cancer Mortality Reduction Program under this section adequately

address the burden of lung cancer on minority and rural populations.

''(7) The cooperation and coordination of all tobacco control and cessation programs within agencies of the Department of Health and Human Services to achieve the goals of the Lung Cancer Mortality Reduction Program under this section with particular emphasis on the coordination of drug and other cessation treatments with early detection protocols.''.

(2) FEDERAL FOOD, DRUG, AND COSMETIC ACT.—Subchapter B of chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360aaa et seq.) is amended by adding at the end the following:

**''SEC. 529B. DRUGS RELATING TO LUNG CANCER.**

''(a) IN GENERAL.—The provisions of this subchapter shall apply to a drug described in subsection (b) to the same extent and in the same manner as such provisions apply to a drug for a rare disease or condition.

''(b) QUALIFIED DRUGS.—A drug described in this subsection is—

''(1) a chemoprevention drug for precancerous conditions of the lung;

''(2) a drug for targeted therapeutic treatments, including any vaccine, for lung cancer; or

''(3) a drug to curtail or prevent nicotine addiction.

''(c) BOARD.—The Board established under section 701 of the Health Equity and Accountability Act of 2020 shall monitor the program implemented under this section.''.

(3) ACCESS TO UNAPPROVED THERAPIES.—Section 561(e) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb(e)) is amended by inserting before the period the following: ''and shall include expanding access to drugs under section 529B, with substantial consideration being given to whether the totality of information available to the Secretary regarding the safety and effectiveness of an investigational drug, as compared to the risk of morbidity and death from the disease, indicates that a patient may obtain more benefit than risk if treated with the drug''.

(4) CDC.—Title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) is amended by adding at the end the following:

**''SEC. 1511. EARLY DISEASE RESEARCH AND MANAGEMENT PROGRAM.**

''The Secretary shall establish and implement an early disease research and management program targeted

at the high incidence and mortality rates of lung cancer among minority and low-income populations.''.

(e) DEPARTMENT OF DEFENSE AND THE DEPARTMENT OF VETERANS AFFAIRS.—The Secretary of Defense and the Secretary of Veterans Affairs, each in coordination with the Secretary of Health and Human Services, shall engage—

(1) in the implementation within the Department of Defense and the Department of Veterans Affairs of an early detection and disease management research program for military personnel and veterans whose smoking history and exposure to carcinogens during active duty service has increased their risk for lung cancer; and

(2) in the implementation of coordinated care programs for military personnel and veterans diagnosed with lung cancer.

(f) LUNG CANCER ADVISORY BOARD.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall convene a Lung Cancer Advisory Board (referred to in this section as the ''Board'')—

(A) to monitor the programs established under this section (and the amendments made by this section); and

(B) to provide annual reports to the Congress concerning benchmarks, expenditures, lung cancer statistics, and the public health impact of such programs.

(2) COMPOSITION.—The Board shall be comprised of—

(A) the Secretary of Health and Human Services;

(B) the Secretary of Defense;

(C) the Secretary of Veterans Affairs; and

(D) 2 representatives each from the fields of clinical medicine focused on lung cancer, lung cancer research, imaging, drug development, and lung cancer advocacy, to be appointed by the Secretary of Health and Human Services.

(g) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—To carry out this section (and the amendments made by this section), there are authorized to be appropriated $75,000,0000 for fiscal year 2021 and such sums as may be necessary for each of fiscal years 2022 through 2025.

(2) LUNG CANCER MORTALITY REDUCTION PROGRAM.—The amounts appropriated under paragraph (1) shall be allocated as follows:

(A) $25,000,000 for fiscal year 2021, and such sums as may be necessary for each of fiscal years 2022 through 2025, for the activities described in section 417H(b)(1)(B) of the Public Health Service Act, as added by subsection (d);

(B) $25,000,000 for fiscal year 2021, and such sums as may be necessary for each of fiscal years 2022 through 2025, for the activities described in section 417H(b)(1)(C) of the Public Health Service Act;

(C) $10,000,000 for fiscal year 2021, and such sums as may be necessary for each of fiscal years 2022 through 2025, for the activities described in section 417H(b)(1)(D) of the Public Health Service Act; and

(D) $15,000,000 for fiscal year 2021, and such sums as may be necessary for each of fiscal years 2022 through 2025, for the activities described in section 417H(b)(3) of the Public Health Service Act.

**SEC. 702. EXPANDING PROSTATE CANCER RESEARCH, OUTREACH, SCREENING, TESTING, ACCESS, AND TREATMENT EFFECTIVENESS.**

(a) SHORT TITLE.—This section may be cited as the ''Prostate Research, Outreach, Screening, Testing, Access, and Treatment Effectiveness Act of 2020'' or the ''PROSTATE Act''.

(b) FINDINGS.—Congress makes the following findings:

(1) Prostate cancer is the second leading cause of cancer death among men.

(2) In 2018, an estimated 164,690 men will be diagnosed with prostate cancer and more than 29,000 will die from this disease.

(3) Roughly 2,000,000 to 3,000,000 people in the United States are living with a diagnosis of prostate cancer and its consequences.

(4) While prostate cancer generally affects older individuals, younger men are also at risk for the disease, and when prostate cancer appears in early middle age, it frequently takes on a more aggressive form.

(5) There are significant racial and ethnic disparities that demand attention; African Americans have prostate cancer mortality rates that are more than double those in the White population.

(6) Underserved rural populations have higher rates of mortality compared to their urban counterparts, and innovative and cost-efficient methods to improve rural access to high-quality care should take advantage of advances in telehealth to diagnose and treat prostate cancer when appropriate.

(7) Certain veterans populations may have nearly twice the incidence of prostate cancer as the general population of the United States.

(8) Urologists may constitute the specialists who diagnose and treat the vast majority of prostate cancer patients.

(9) Although much basic and translational research has been completed and much is currently known, there are still many unanswered questions, such as the extent to which known disparities are attributable to disease etiology, access to care, or education and awareness in the community.

(10) Causes of prostate cancer are not known. There is not good information regarding how to differentiate accurately, early on, between aggressive and indolent forms of the disease. As a result, there is significant overtreatment in prostate cancer. There are no treatments that can durably arrest

growth or cure prostate cancer once it has metastasized.

(11) A significant proportion (about 23 to 54 percent) of cases may be clinically indolent and ''overdiagnosed'', resulting in significant overtreatment. More accurate tests will allow men and their families to face less physical, psychological, financial, and emotional trauma, and billions of dollars could be saved in private and public health care systems in an area that has been identified by the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as one of 8 high-volume, high-cost areas in the Resource Utilization Report Program established under the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275).

(12) Prostate cancer research and health care programs across Federal agencies should be coordinated to improve accountability and actively encourage the translation of research into practice, to identify and implement best practices, in order to foster an integrated and consistent focus on effective prevention, diagnosis, and treatment of this disease.

(c) PROSTATE CANCER COORDINATION AND EDUCATION.—

(1) INTERAGENCY PROSTATE CANCER COORDINATION AND EDUCATION TASK FORCE.—Not later than 180 days after the date of the enactment of this section, the Secretary of Veterans Affairs, in cooperation with the Secretary of Defense and the Secretary of Health and Human Services, shall establish an Interagency Prostate Cancer Coordination and Education Task Force (in this section referred to as the ''Prostate Cancer Task Force'').

(2) DUTIES.—The Prostate Cancer Task Force shall—

(A) develop a summary of advances in prostate cancer research supported or conducted by Federal agencies relevant to the diagnosis, prevention, and treatment of prostate cancer, including psychosocial impairments related to prostate cancer treatment, and compile a list of best practices that warrant broader adoption in health care programs;

(B) consider establishing, and advocating for, a guidance to enable physicians to allow screening of men who are over age 74, on a case-by-case basis, taking into account quality of life and family history of prostate cancer;

(C) share and coordinate information on Federal research and health care program activities, including activities related to—

(i) determining how to improve research and health care programs, including psychosocial impairments related to prostate cancer treatment;

(ii) identifying any gaps in the overall research inventory and in health care programs;

(iii) identifying opportunities to promote translation of research into practice; and

(iv) maximizing the effects of Federal efforts by identifying opportunities for collaboration and leveraging of resources in research and health care programs that serve individuals who are susceptible to or diagnosed with prostate cancer;

(D) develop a comprehensive interagency strategy and advise relevant Federal agencies in the solicitation of proposals for collaborative, multidisciplinary research and health care programs, including proposals to evaluate factors

that may be related to the etiology of prostate cancer, that would—

(i) result in innovative approaches to study emerging scientific opportunities or eliminate knowledge gaps in research to improve the prostate cancer research portfolio of the Federal Government;

(ii) outline key research questions, methodologies, and knowledge gaps; and

(iii) ensure consistent action, as outlined by section 402(b) of the Public Health Service Act;

(E) develop a coordinated message related to screening and treatment for prostate cancer to be reflected in educational and beneficiary materials for Federal health programs as such documents are updated; and

(F) not later than 2 years after the date of the establishment of the Prostate Cancer Task Force, submit to the Expert Advisory Panel to be reviewed and returned within 30 days, and then within 90 days submitted to Congress recommendations—

(i) regarding any appropriate changes to research and health care programs, in-

cluding recommendations to improve the research portfolio of the Department of Veterans Affairs, the Department of Defense, National Institutes of Health, and other Federal agencies to ensure that scientifically based strategic planning is implemented in support of research and health care program priorities;

(ii) designed to ensure that the research and health care programs and activities of the Department of Veterans Affairs, the Department of Defense, the Department of Health and Human Services, and other Federal agencies are free of unnecessary duplication;

(iii) regarding public participation in decisions relating to prostate cancer research and health care programs to increase the involvement of patient advocates, community organizations, and medical associations representing a broad geographical area;

(iv) on how to best disseminate information on prostate cancer research and progress achieved by health care programs;

(v) about how to expand partnerships between public entities, including Federal agencies, and private entities to encourage collaborative, cross-cutting research and health care delivery;

(vi) assessing any cost savings and efficiencies realized through the efforts identified and supported in this section and recommending expansion of those efforts that have proved most promising while also ensuring against any conflicts in directives from other congressional or statutory mandates or enabling statutes;

(vii) identifying key priority action items from among the recommendations; and

(viii) with respect to the level of funding needed by each agency to implement the recommendations contained in the report.

(3) MEMBERS OF THE PROSTATE CANCER TASK FORCE.—The Prostate Cancer Task Force described in this subsection shall be comprised of representatives from such Federal agencies, as each head of such applicable agencies determines necessary, to co-

ordinate a uniform message relating to prostate cancer screening and treatment where appropriate, including representatives of the following:

(A) The Department of Veterans Affairs, including representatives of each relevant program area of the Department of Veterans Affairs.

(B) The Prostate Cancer Research Program of the Congressionally Directed Medical Research program of the Department of Defense.

(C) The Department of Health and Human Services, including at a minimum representatives of each of the following:

(i) The National Institutes of Health.

(ii) National research institutes and centers, including the National Cancer Institute, the National Institute of Allergy and Infectious Diseases, and the Office of Minority Health.

(iii) The Centers for Medicare & Medicaid Services.

(iv) The Food and Drug Administration.

(v) The Centers for Disease Control and Prevention.

(vi) The Agency for Healthcare Research and Quality.

(vii) The Health Resources and Services Administration.

(4) APPOINTING EXPERT ADVISORY PANELS.—The Prostate Cancer Task Force shall appoint expert advisory panels, as such task force determines appropriate, to provide input and concurrence from individuals and organizations from the medical, prostate cancer patient and advocate, research, and delivery communities with expertise in prostate cancer diagnosis, treatment, and research, including practicing urologists, primary care providers, and others and individuals with expertise in education and outreach to underserved populations affected by prostate cancer.

(5) MEETINGS.—The Prostate Cancer Task Force shall convene not less than twice a year, or more frequently as the Secretary of Veterans Affairs determines to be appropriate.

(6) FEDERAL ADVISORY COMMITTEE ACT.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the Federal Advisory Com-

mittee Act (5 U.S.C. App.) shall apply to the Prostate Cancer Task Force.

(B) EXCEPTION.—Section 14(a)(2)(B) of such Act (relating to the termination of advisory committees) shall not apply to the Prostate Cancer Task Force.

(7) SUNSET DATE.—The Prostate Cancer Task Force shall terminate on September 30, 2025.

(d) PROSTATE CANCER RESEARCH.—

(1) RESEARCH COORDINATION.—The Secretary of Veterans Affairs, in coordination with the Secretary of Defense and the Secretary of Health and Human Services, shall establish and carry out a program to coordinate and intensify prostate cancer research. Such research program shall—

(A) develop advances in diagnostic and prognostic methods and tests, including biomarkers and an improved prostate cancer screening blood test, including improvements or alternatives to the prostate specific antigen test and additional tests to distinguish indolent from aggressive disease;

(B) develop better understanding of the etiology of the disease (including an analysis of lifestyle factors proven to be involved in higher

rates of prostate cancer, such as obesity and diet, and in different ethnic, racial, and socio-economic groups, such as the African-American, Latino or Hispanic, and American Indian populations and men with a family history of prostate cancer) to improve prevention efforts;

(C) expand basic research into prostate cancer, including studies of fundamental molecular and cellular mechanisms;

(D) identify and provide clinical testing of novel agents for the prevention and treatment of prostate cancer;

(E) establish clinical registries for prostate cancer;

(F) use the National Institute of Biomedical Imaging and Bioengineering and the National Cancer Institute for assessment of appropriate imaging modalities; and

(G) address such other matters relating to prostate cancer research as may be identified by the Federal agencies participating in the program under this subsection.

(2) PROSTATE CANCER ADVISORY BOARD.—There is established in the Office of the Chief Scientist of the Food and Drug Administration a Pros-

tate Cancer Scientific Advisory Board. Such board shall be responsible for accelerating real-time sharing of the latest research data and accelerating movement of new medicines to patients.

(3) UNDERSERVED MINORITY GRANT PROGRAM.—In carrying out such program, the Secretary shall—

(A) award grants to eligible entities to carry out components of the research outlined in paragraph (1);

(B) integrate and build upon existing knowledge gained from comparative effectiveness research; and

(C) recognize and address—

(i) the racial and ethnic disparities in the incidence and mortality rates of prostate cancer and men with a family history of prostate cancer;

(ii) any barriers in access to care and participation in clinical trials that are specific to racial, ethnic, and other underserved minorities and men with a family history of prostate cancer;

(iii) outreach and educational efforts to raise awareness among the populations described in clause (ii); and

(iv) appropriate access and utilization of imaging modalities.

(e) TELEHEALTH AND RURAL ACCESS PILOT PROJECTS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs, in cooperation with the Secretary of Defense and the Secretary of Health and Human Services (referred to in this section collectively as the ''Secretaries'') shall establish 4-year telehealth pilot projects for the purpose of analyzing the clinical outcomes and cost-effectiveness associated with telehealth services in a variety of geographic areas that contain high proportions of medically underserved populations, including African Americans, Latinos or Hispanics, American Indians or Alaska Natives, and those in rural areas. Such projects shall promote efficient use of specialist care through better coordination of primary care and physician extender teams in underserved areas and more effectively employ tumor boards to better counsel patients.

(2) ELIGIBLE ENTITIES.—

(A) IN GENERAL.—The Secretaries shall select eligible entities to participate in the pilot projects under this section.

(B) PRIORITY.—In selecting eligible entities to participate in the pilot projects under this section, the Secretaries shall give priority to such entities located in medically underserved areas, particularly those that include African Americans, Latinos and Hispanics, and facilities of the Indian Health Service, including Indian Health Service-operated facilities, tribally operated facilities, and Urban Indian Clinics, and those in rural areas.

(3) EVALUATION.—The Secretaries shall, through the pilot projects, evaluate—

(A) the effective and economic delivery of care in diagnosing and treating prostate cancer with the use of telehealth services in medically underserved and Tribal areas including collaborative uses of health professionals and integration of the range of telehealth and other technologies;

(B) the effectiveness of improving the capacity of nonmedical providers and nonspecialized medical providers to provide health services

for prostate cancer in medically underserved and Tribal areas, including the exploration of innovative medical home models with collaboration between urologists, other relevant medical specialists, including oncologists, radiologists, and primary care teams and coordination of care through the efficient use of primary care teams and physician extenders; and

(C) the effectiveness of using telehealth services to provide prostate cancer treatment in medically underserved areas, including the use of tumor boards to facilitate better patient counseling.

(4) REPORT.—Not later than 1 year after the completion of the pilot projects under this subsection, the Secretaries shall submit to Congress a report describing the outcomes of such pilot projects, including any cost savings and efficiencies realized, and providing recommendations, if any, for expanding the use of telehealth services.

(f) EDUCATION AND AWARENESS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs (referred to in this subsection as the ''Secretary'') shall develop a national education campaign for prostate cancer. Such campaign shall involve the

use of written educational materials and public service announcements consistent with the findings of the Prostate Cancer Task Force under subsection (c), that are intended to encourage men to seek prostate cancer screening when appropriate.

(2) RACIAL DISPARITIES AND THE POPULATION OF MEN WITH A FAMILY HISTORY OF PROSTATE CANCER.—In developing the national campaign under paragraph (1), the Secretary shall ensure that such educational materials and public service announcements are more readily available in communities experiencing racial disparities in the incidence and mortality rates of prostate cancer and by men of any race classification with a family history of prostate cancer.

(3) GRANTS.—In carrying out the national campaign under this section, the Secretary shall award grants to nonprofit private entities to enable such entities to test alternative outreach and education strategies.

(g) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There is authorized to be appropriated to carry out this section for the period of fiscal years 2021 through 2025 an amount equal to the savings described in paragraph (2).

(2) CORRESPONDING REDUCTION.—The savings described in this paragraph is the amount authorized to be appropriated by provisions of law other than this section for the period of fiscal years 2021 through 2025 for Federal research and health care program activities related to prostate cancer, reduced by the amount of Federal savings projected to be achieved over such period by implementation of this section.

**SEC. 703. PROSTATE RESEARCH, IMAGING, AND MEN'S EDUCATION (PRIME).**

(a) SHORT TITLE.—This section may be cited as the ''Prostate Research, Imaging, and Men's Education Act of 2020'' or the ''PRIME Act of 2020''.

(b) FINDINGS.—Congress makes the following findings:

(1) Prostate cancer has reached epidemic proportions, particularly among African-American men, and strikes and kills men in numbers comparable to the number of women who lose their lives from breast cancer.

(2) Life-saving breakthroughs in screening, diagnosis, and treatment of breast cancer resulted from the development of advanced imaging technologies led by the Federal Government.

(3) Men should have accurate and affordable prostate cancer screening exams and minimally-invasive treatment tools, similar to what women have for breast cancer.

(4) While it is important for men to take advantage of current prostate cancer screening techniques, a recent NCI-funded study demonstrated that the most common available methods of detecting prostate cancer (PSA blood test and physical exams) are not foolproof, causing numerous false alarms and false reassurances.

(5) The absence of advanced imaging technologies for prostate cancer causes the lack of accurate information critical for clinical decisions, resulting in missed cancers and lost lives, as well as unnecessary and costly medical procedures, with related complications.

(6) With prostate imaging tools, men and their families would face less physical, psychological, financial and emotional trauma and billions of dollars could be saved in private and public health care systems.

(c) RESEARCH AND DEVELOPMENT OF PROSTATE CANCER IMAGING TECHNOLOGIES.—

(1) EXPANSION OF RESEARCH.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the National Institutes of Health and the Administrator of the Health Resources and Services Administration, and in consultation with the Secretary of Defense, shall carry out a program to expand and intensify research to develop innovative advanced imaging technologies for prostate cancer detection, diagnosis, and treatment comparable to state-of-the-art mammography technologies.

(2) EARLY STAGE RESEARCH.—In implementing the program under paragraph (1), the Secretary, acting through the Administrator of the Health Resources and Services Administration, shall carry out a grant program to encourage the early stages of research in prostate imaging to develop and implement new ideas, proof of concepts, and pilot studies for high-risk technologic innovation in prostate cancer imaging that would have a high potential impact for improving patient care, including individualized care, quality of life, and cost-effectiveness.

(3) LARGE SCALE LATER STAGE RESEARCH.—In implementing the program under paragraph (1),

the Secretary, acting through the Director of the National Institutes of Health, shall utilize the National Institute of Biomedical Imaging and Bioengineering and the National Cancer Institute for advanced stages of research in prostate imaging, including technology development and clinical trials for projects determined by the Secretary to have demonstrated promising preliminary results and proof of concept.

(4) INTERDISCIPLINARY PRIVATE-PUBLIC PARTNERSHIPS.—In developing the program under paragraph (1), the Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish interdisciplinary private-public partnerships to develop and implement research strategies for expedited innovation in imaging and image-guided treatment and to conduct such research.

(5) RACIAL DISPARITIES.—In developing the program under paragraph (1), the Secretary shall recognize and address—

(A) the racial disparities in the incidences of prostate cancer and mortality rates with respect to such disease; and

(B) any barriers in access to care and participation in clinical trials that are specific to racial minorities.

(6) AUTHORIZATION OF APPROPRIATIONS.—

(A) IN GENERAL.—Subject to subparagraph (B), there is authorized to be appropriated to carry out this section, $100,000,000 for each of the fiscal years 2021 through 2025.

(B) SPECIFIC ALLOCATIONS.—Of the amount authorized to be appropriated under subparagraph (A) for each of the fiscal years described in such paragraph—

(i) no less than 10 percent may be appropriated to carry out the grant program under paragraph (2); and

(ii) no more than 1 percent may be appropriated to carry out paragraph (4).

(d) PUBLIC AWARENESS AND EDUCATION CAMPAIGN.—

(1) NATIONAL CAMPAIGN.—The Secretary shall carry out a national campaign to increase the awareness and knowledge of Americans with respect to the need for prostate cancer screening and for improved detection technologies.

(2) REQUIREMENTS.—The national campaign conducted shall include—

(A) roles for the Health Resources Services Administration, the Office on Minority Health of the Department of Health and Human Services, the Centers for Disease Control and Prevention, and the Office of Minority Health of the Centers for Disease Control and Prevention; and

(B) the development and distribution of written educational materials, and the development and placing of public service announcements, that are intended to encourage men to seek prostate cancer screening and to create awareness of the need for improved imaging technologies for prostate cancer screening and diagnosis, including in vitro blood testing and imaging technologies.

(3) RACIAL DISPARITIES.—In developing the national campaign under paragraph (1), the Secretary shall recognize and address—

(A) the racial disparities in the incidences of prostate cancer and mortality rates with respect to such disease; and

(B) any barriers in access to care and participation in clinical trials that are specific to racial minorities.

(4) GRANTS.—The Secretary shall establish a program to award grants to nonprofit private entities to enable such entities to test alternative outreach and education strategies to increase the awareness and knowledge of Americans with respect to the need for prostate cancer screening and improved imaging technologies.

(5) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $10,000,000 for each of the fiscal years 2021 through 2025.

(e) IMPROVING PROSTATE CANCER SCREENING BLOOD TESTS.—

(1) IN GENERAL.—The Secretary, in coordination with the Secretary of Defense, shall carry out research to develop an improved prostate cancer screening blood test using in-vitro detection.

(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $20,000,000 for each of fiscal years 2021 through 2025.

(f) REPORTING AND COMPLIANCE.—

(1) REPORT AND STRATEGY.—Not later than 12 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report that details the strategy of the Secretary for implementing the requirements of this section and the status of such efforts.

(2) FULL COMPLIANCE.—Not later than 36 months after the date of the enactment of this Act, and annually thereafter, the Secretary shall submit to Congress a report that—

(A) describes the research and development and public awareness and education campaigns funded under this section;

(B) provides evidence that projects involving high-risk, high impact technologic innovation, proof of concept, and pilot studies are prioritized;

(C) provides evidence that the Secretary recognizes and addresses any barriers in access to care and participation in clinical trials that are specific to racial minorities in the implementation of this section;

(D) contains assurances that the all other provisions of this section are fully implemented; and

(E) certifies compliance with the provisions of this section, or in the case of a Federal agency that has not complied with any of such provisions, an explanation as to such failure to comply.

**SEC. 704. PROSTATE CANCER DETECTION RESEARCH AND EDUCATION.**

(a) SHORT TITLE.—This section may be cited as the ''Prostate Cancer Detection Research and Education Act''.

(b) PLAN TO DEVELOP AND VALIDATE A TEST OR TESTS FOR PROSTATE CANCER.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the National Institutes of Health, shall establish an advisory council on prostate cancer (referred to in this section as the ''advisory council'') to draft a plan for the development and validation of an accurate test or tests, such as biomarkers or imaging, to detect and diagnose prostate cancer.

(2) ADVISORY COUNCIL.—

(A) MEMBERSHIP.—

(i) FEDERAL MEMBERS.—The advisory council shall be comprised of the following experts:

(I) A designee of the Centers for Disease Control and Prevention.

(II) A designee of the Centers for Medicare & Medicaid Services.

(III) A designee of the Office of the Director of the National Cancer Institute.

(IV) A designee of the Director of the Department of Defense Congressionally Directed Medical Research Program.

(V) A designee of the Director of the National Institute of Biomedical Imaging and Bioengineering.

(VI) A designee of the Director of the National Institute of General Medical Sciences.

(VII) A designee of the Director of the National Institute on Minority Health and Health Disparities.

(VIII) A designee of the Office of the Director of the National Institutes of Health.

(IX) A designee of the Food and Drug Administration.

(X) A designee of the Agency for Healthcare Research and Quality.

(XI) A designee of the Director of the Telemedicine and Advanced Technology Research Center of the Department of Defense.

(ii) NON-FEDERAL MEMBERS.—In addition to the members described in clause (i), the advisory council shall include 8 expert members from outside the Federal Government to be appointed by the Secretary, which shall include—

(I) 2 prostate cancer patient advocates;

(II) 2 health care providers with a range of expertise and experience in prostate cancer; and

(III) 4 leading researchers with prostate cancer-related expertise in a range of clinical disciplines.

(B) MEETINGS.—The advisory council shall meet quarterly and such meetings shall be open to the public.

(C) ADVICE.—The advisory council shall advise the Secretary, or the Secretary's designee.

(D) ANNUAL REPORT.—Not later than 1 year after the date of enactment of this Act, the advisory council shall provide to the Secretary, or the Secretary's designee and Congress—

(i) an initial evaluation of all federally funded efforts in prostate cancer research relating to the development and validation of an accurate test or tests to detect and diagnose prostate cancer;

(ii) a plan for the development and validation of a reliable test or tests for the detection and accurate diagnosis of prostate cancer; and

(iii) a set of standards for prostate cancer screening, developed in coordination with the United States Preventive Services Task Force, to ensure that any tools for screening, detection, and diagnosis developed in accordance with the plan under

clause (ii) will meet the requirements of the Task Force for recommendation as a proven preventive or diagnostic service.

(E) TERMINATION.—The advisory council shall terminate on December 31, 2024.

(3) FUNDING.—The Secretary may make available $1,000,000 from amounts appropriated to the National Institutes of Health for each of fiscal years 2021 through 2025 to carry out this subsection.

(c) COORDINATION AND INTENSIFICATION OF PROSTATE CANCER RESEARCH.—

(1) IN GENERAL.—The Director of the National Institutes of Health, in consultation with the Secretary of Defense, shall coordinate and intensify research in accordance with the plan, with particular attention provided to leveraging existing research to develop and validate a test or tests, such as biomarkers or imaging, to detect and accurately diagnose prostate cancer in order to improve quality of life for millions of Americans, and decrease health care system costs.

(2) FUNDING.—The Secretary may make available $30,000,000 from amounts appropriated to the National Institutes of Health for each of fiscal years 2022 through 2026 to carry out this subsection.

(d) PUBLIC AWARENESS AND EDUCATION CAMPAIGN.—

(1) NATIONAL CAMPAIGN.—The Secretary, in coordination with the Director of the National Institutes of Health and the Director of the Centers for Disease Control and Prevention, shall carry out a national campaign to increase the awareness and knowledge of prostate cancer.

(2) REQUIREMENTS.—The national campaign conducted under paragraph (1) shall include—

(A) roles for the National Cancer Institute, the National Institute on Minority Health and Health Disparities, the Office on Minority Health of the Department of Health and Human Services, and the Office of Minority Health of the Centers for Disease Control and Prevention; and

(B) the development and distribution of written educational materials, and the development and placing of public service announcements, that are intended to encourage men to seek prostate cancer screening when symptoms are present, when they have a family history of prostate cancer, or if they belong to a high-risk population.

(3) RACIAL DISPARITIES.—In developing the national campaign under paragraph (1), the Secretary shall recognize and address—

(A) the racial disparities in the incidences of prostate cancer and mortality rates with respect to such disease; and

(B) any barriers in access to patient care and participation in clinical trials that are specific to racial minorities.

(4) GRANTS.—The Secretary shall establish a program to award grants to nonprofit private entities to enable such entities to test alternative outreach and education strategies to increase the awareness and knowledge of Americans with respect to prostate cancer.

(5) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, $5,000,000 for each of fiscal years 2021 through 2025.

**SEC. 705. NATIONAL PROSTATE CANCER COUNCIL.**

(a) SHORT TITLE.—This section may be cited as the ''National Prostate Cancer Plan Act''.

(b) NATIONAL PROSTATE CANCER COUNCIL.—

(1) ESTABLISHMENT.—There is established in the Office of the Secretary of Health and Human

Services (referred to in this section as the ''Secretary'') the National Prostate Cancer Council on Screening, Early Detection, Assessment, and Monitoring of Prostate Cancer (referred to in this section as the ''Council'').

(2) PURPOSE OF THE COUNCIL.—The Council shall—

(A) develop and implement a national strategic plan for the accelerated creation, advancement, and testing of diagnostic tools to improve screening, early detection, assessment, and monitoring of prostate cancer, including—

(i) early detection of aggressive prostate cancer to save lives;

(ii) monitoring of tumor response to treatment, including recurrence and progression; and

(iii) accurate assessment and surveillance of indolent disease to reduce unnecessary biopsies and treatment;

(B) provide information and coordination of prostate cancer research and services across all Federal agencies;

(C) review diagnostic tools and their overall effectiveness at screening, detecting, assessing, and monitoring of prostate cancer;

(D) evaluate all programs in prostate cancer that are in existence on the date of enactment of this Act, including Federal budget requests and approvals and public-private partnerships;

(E) submit an annual report to the Secretary and Congress on the creation and implementation of the national strategic plan under subparagraph (A); and

(F) ensure the inclusion of men at high-risk for prostate cancer, including men from ethnic and racial populations and men who are least likely to receive care, in clinical, research, and service efforts, with the purpose of decreasing health disparities.

(3) MEMBERSHIP.—

(A) FEDERAL MEMBERS.—The Council shall be led by the Secretary or designee and comprised of the following experts:

(i) Two representatives of the National Institutes of Health, including 1 representative of the National Institute of

Biomedical Imaging and Bioengineering and 1 representative of the National Cancer Institute.

(ii) A representative of the Centers for Disease Control and Prevention.

(iii) A representative of the Centers for Medicare and Medicaid Services.

(iv) A designee of the Director of the Department of Defense Congressionally Directed Medical Research Program.

(v) A designee of the Director of the Office of Minority Health.

(vi) A representative of the Food and Drug Administration.

(vii) A representative of the Agency for Healthcare Research and Quality.

(B) NON-FEDERAL MEMBERS.—In addition to the members described in subparagraph (A), the Council shall include 14 expert members from outside the Federal Government, which shall include—

(i) 6 prostate cancer patient advocates, including—

(I) 2 patient-survivors;

(II) 2 caregivers of prostate cancer patients; and

(III) 2 representatives from national prostate cancer disease organizations that fund research or have demonstrated experience in providing assistance to patients, families, and medical professionals, including information on health care options, education, and referral; and

(ii) 8 health care stakeholders with specific expertise in prostate cancer research in the critical areas of clinical expertise, including medical oncology, radiology, radiation oncology, urology, and pathology.

(4) MEETINGS.—The Council shall meet quarterly and meetings shall be open to the public.

(5) ADVICE.—The Council shall advise the Secretary, or the Secretary's designee.

(6) ANNUAL REPORT.—The Council shall submit annual reports, beginning not later than 1 year after the date of enactment of this Act, to the Secretary or the Secretary's designee and to Congress. The annual report shall include—

(A) in the first year—

(i) an evaluation of all federally funded efforts in prostate cancer research and gaps relating to the development and validation of diagnostic tools for prostate cancer; and

(ii) recommendations for priority actions to expand, eliminate, coordinate, or condense programs based on the performance, mission, and purpose of the programs; and

(B) annually thereafter for 5 years—

(i) an outline for the development and implementation of a national research plan for creation and validation of accurate diagnostic tools to improve prostate cancer care in accordance with paragraph (1);

(ii) roles for the National Cancer Institute, National Institute on Minority Health and Health Disparities, and the Office on Minority Health of the Department of Health and Human Services;

(iii) an analysis of the disparities in the incidence and mortality rates of prostate cancer in men at high risk of the dis-

ease, including individuals with family history, increasing age, or African-American heritage; and

(iv) a review of the progress towards the realization of the proposed strategic plan.

(7) TERMINATION.—The Council shall terminate on December 31, 2025.

**SEC. 706. IMPROVED MEDICAID COVERAGE FOR CERTAIN BREAST AND CERVICAL CANCER PATIENTS IN THE TERRITORIES.**

(a) ELIMINATION OF FUNDING LIMITATIONS.—

(1) IN GENERAL.—Section 1108(g)(4) of the Social Security Act (42 U.S.C. 1308(g)(4)) is amended by adding at the end the following: ''With respect to fiscal years beginning with fiscal year 2021, payment for medical assistance for individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII) shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), (3), and (5) of this subsection) to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa for such fiscal year.''.

(2) TECHNICAL AMENDMENT.—Such section is further amended by striking ''(3), and (4)'' and inserting ''(3), and (5)''.

(b) APPLICATION OF ENHANCED FMAP FOR HIGHEST STATE.—Section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by adding at the end the following: ''Notwithstanding the first sentence of this subsection, with respect to medical assistance described in clause (4) of such sentence that is furnished in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa in a fiscal year, the Federal medical assistance percentage is equal to the highest such percentage applied under such clause for such fiscal year for any of the 50 States or the District of Columbia that provides such medical assistance for any portion of such fiscal year.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for medical assistance for items and services furnished on or after October 1, 2021.

**SEC. 707. CANCER PREVENTION AND TREATMENT DEMONSTRATION FOR ETHNIC AND RACIAL MINORITIES.**

(a) DEMONSTRATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall conduct demonstration projects for the purpose of developing models and evaluating methods that—

(A) improve the quality of items and services provided to target individuals in order to facilitate reduced disparities in early detection and treatment of cancer;

(B) improve clinical outcomes, satisfaction, quality of life, appropriate use of items and services covered under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), and referral patterns with respect to target individuals with cancer;

(C) eliminate disparities in the rate of preventive cancer screening measures, such as Pap smears, prostate cancer screenings, colon cancer screenings, breast cancer screenings, and computed tomography scans, for lung cancer among target individuals;

(D) promote collaboration with community-based organizations to ensure cultural competency of health care professionals and lin-

guistic access for target individuals who are persons with limited-English proficiency; and

(E) encourage the incorporation of community health workers to increase the efficiency and appropriateness of cancer screening programs.

(2) COMMUNITY HEALTH WORKER DEFINED.—In this section, the term ''community health worker'' includes a community health advocate, a lay health worker, a community health representative, a peer health promoter, a community health outreach worker, and a promotore de salud, who promotes health or nutrition within the community in which the individual resides.

(3) TARGET INDIVIDUAL DEFINED.—In this section, the term ''target individual'' means an individual of a racial and ethnic minority group, as defined in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)), who is entitled to benefits under part A, and enrolled under part B, of title XVIII of the Social Security Act.

(b) PROGRAM DESIGN.—

(1) INITIAL DESIGN.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall evaluate best practices in the private

sector, community programs, and academic research of methods that reduce disparities among individuals of racial and ethnic minority groups in the prevention and treatment of cancer and shall design the demonstration projects based on such evaluation.

(2) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall implement at least 9 demonstration projects, including the following:

(A) Two projects, each of which shall target different ethnic subpopulations, for each of the 4 following major racial and ethnic minority groups:

(i) American Indians and Alaska Natives, Eskimos, and Aleuts.

(ii) Asian Americans.

(iii) Blacks and African Americans.

(iv) Latinos and Hispanics.

(v) Native Hawaiians and other Pacific Islanders.

(B) One project within the Pacific Islands or United States insular areas.

(C) At least one project in a rural area.

(D) At least one project in an inner-city area.

(3) EXPANSION OF PROJECTS; IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—The Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects if the initial report under subsection (c) contains an evaluation that demonstration projects—

(A) reduce expenditures under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.); or

(B) do not increase expenditures under such Medicare program and reduce racial and ethnic health disparities in the quality of health care services provided to target individuals and increase satisfaction of Medicare beneficiaries and health care providers.

(c) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 2 years after the date the Secretary implements the initial demonstration projects, and biannually thereafter, the Secretary shall submit to Congress a report regarding the demonstration projects.

(2) CONTENT OF REPORT.—Each report under paragraph (1) shall include the following:

(A) A description of the demonstration projects.

(B) An evaluation of—

(i) the cost-effectiveness of the demonstration projects;

(ii) the quality of the health care services provided to target individuals under the demonstration projects; and

(iii) beneficiary and health care provider satisfaction under the demonstration projects.

(C) Any other information regarding the demonstration projects that the Secretary determines to be appropriate.

(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

**SEC. 708. REDUCING CANCER DISPARITIES WITHIN MEDICARE.**

(a) DEVELOPMENT OF MEASURES OF DISPARITIES IN QUALITY OF CANCER CARE.—

(1) DEVELOPMENT OF MEASURES.—The Secretary of Health and Human Services (in this sec-

tion referred to as the ''Secretary'') shall enter into an agreement with an entity that specializes in developing quality measures for cancer care under which the entity shall develop a uniform set of measures to evaluate disparities in the quality of cancer care and annually update such set of measures.

(2) MEASURES TO BE INCLUDED.—Such set of measures shall include, with respect to the treatment of cancer, measures of patient outcomes, the process for delivering medical care related to such treatment, patient counseling and engagement in decision-making, patient experience of care, resource use, and practice capabilities, such as care coordination.

(b) ESTABLISHMENT OF REPORTING PROCESS.—

(1) IN GENERAL.—The Secretary shall establish a reporting process that requires and provides for a method for health care providers specified under paragraph (2) to submit to the Secretary and make public data on the performance of such providers during each reporting period through use of the measures developed pursuant to subsection (a). Such data shall be submitted in a form and manner and at a time specified by the Secretary.

(2) SPECIFICATION OF PROVIDERS TO REPORT ON MEASURES.—The Secretary shall specify the classes of Medicare providers of services and suppliers, including hospitals, cancer centers, physicians, primary care providers, and specialty providers, that will be required under such process to publicly report on the measures specified under subsection (a).

(3) ASSESSMENT OF CHANGES.—Under such reporting process, the Secretary shall establish a format that assesses changes in both the absolute and relative disparities in cancer care over time. These measures shall be presented in an easily comprehensible format, such as those presented in the final publications relating to Healthy People 2010 or the National Healthcare Disparities Report.

(4) INITIAL IMPLEMENTATION.—The Secretary shall implement the reporting process under this subsection for reporting periods beginning not later than 6 months after the date that measures are first established under subsection (a).

**SEC. 709. CANCER CLINICAL TRIALS.**

(a) SHORT TITLE.—This section may be cited as the ''Henrietta Lacks Enhancing Cancer Research Act of 2020''.

(b) FINDINGS.—Congress finds as follows:

(1) Only a small percent of patients participate in cancer clinical trials, even though most express an interest in clinical research. There are several obstacles that restrict individuals from participating including lack of available local trials, restrictive eligibility criteria, transportation to trial sites, taking time off from work, and potentially increased medical and nonmedical costs. Ultimately, about 1 in 5 cancer clinical trials fail because of lack of patient enrollment.

(2) Groups that are generally underrepresented in clinical trials include racial and ethnic minorities and older, rural, and lower-income individuals.

(3) Henrietta Lacks, an African-American woman, was diagnosed with cervical cancer at the age of 31, and despite receiving painful radium treatments, passed away on October 4, 1951.

(4) Medical researchers took samples of Henrietta Lacks' tumor during her treatment and the HeLa cell line from her tumor proved remarkably resilient.

(5) HeLa cells were the first immortal line of human cells. Henrietta Lacks' cells were unique, growing by the millions, commercialized and distrib-

uted worldwide to researchers, resulting in advances in medicine.

(6) Henrietta Lacks' prolific cells continue to grow and contribute to remarkable advances in medicine, including the development of the polio vaccine, as well as drugs for treating the effects of cancer, HIV/AIDS, hemophilia, leukemia, and Parkinson's disease. These cells have been used in research that has contributed to our understanding of the effects of radiation and zero gravity on human cells. These immortal cells have informed research on chromosomal conditions, cancer, gene mapping, and precision medicine.

(7) Henrietta Lacks and her immortal cells have made a significant contribution to global health, scientific research, quality of life, and patient rights.

(8) For more than 20 years, the advances made possible by Henrietta Lacks' cells were without her or her family's consent, and the revenues they generated were not known to or shared with her family.

(9) Henrietta Lacks and her family's experience is fundamental to modern and future bioethics policies and informed consent laws that benefit patients nationwide by building patient trust; promoting eth-

ical research that benefits all individuals, including traditionally underrepresented populations; and protecting research participants.

(c) GAO STUDY ON BARRIERS TO PARTICIPATION IN FEDERALLY FUNDED CANCER CLINICAL TRIALS BY POPULATIONS THAT HAVE BEEN TRADITIONALLY UNDERREPRESENTED IN SUCH TRIALS.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Comptroller General of the United States shall—

(A) complete a study that—

(i) reviews what actions Federal agencies have taken to help to address barriers to participation in federally funded cancer clinical trials by populations that have been traditionally underrepresented in such trials, and identifies challenges, if any, in implementing such actions; and

(ii) identifies additional actions that can be taken by Federal agencies to address barriers to participation in federally funded cancer clinical trials by populations that have been traditionally underrepresented in such trials; and

(B) submit a report to the Congress on the results of such study, including recommendations on potential changes in practices and policies to improve participation in such trials by such populations.

(2) INCLUSION OF CLINICAL TRIALS.—The study under paragraph (1)(A) should include review of cancer clinical trials that are largely funded by Federal agencies, including the National Institutes of Health, the Department of Defense, the Department of Veterans Affairs, the Agency for Health Research and Quality, the Food and Drug Administration, and such other Federal agencies as the Comptroller General of the United States may identify.

# Subtitle B—Viral Hepatitis and Liver Cancer Control and Prevention

### SEC. 711. VIRAL HEPATITIS AND LIVER CANCER CONTROL AND PREVENTION.

(a) SHORT TITLE.—This subtitle may be cited as the ''Viral Hepatitis and Liver Cancer Control and Prevention Act of 2020''.

(b) FINDINGS.—Congress finds the following:

(1) In the United States, nearly 5,000,000 persons are living with the hepatitis B virus (referred

to in this section as ''HBV'') or the hepatitis C virus (referred to in this section as ''HCV'').

(2) In the United States, chronic HBV and HCV are the most common causes of liver cancer, the second deadliest and fastest growing cancer in this country. Such viruses are the most common cause of chronic liver disease, liver cirrhosis, and the most common indications for liver transplantation. At least 21,000 deaths per year in the United States can be attributed to chronic HBV and HCV. Chronic HCV is also a leading cause of death in Americans living with HIV/AIDS; many of those living with HIV/AIDS are coinfected with chronic HBV, chronic HCV, or both.

(3) According to the Centers for Disease Control and Prevention (referred to in this section as the ''CDC''), approximately 2 percent of the population of the United States is living with chronic HBV, chronic HCV, or both. The CDC has recognized HCV as the Nation's most common chronic bloodborne virus infection and HBV as the deadliest vaccine-preventable disease.

(4) HBV is transmitted through contact with infectious blood, semen, or other bodily fluids and is 100 times more infectious than HIV. HCV is trans-

mitted by contact with infectious blood, particularly through percutaneous exposures (such as puncture through the skin).

(5) The CDC estimates that in 2016, more than 41,000 people in the United States were newly infected with HCV and nearly 21,000 people in the United States were newly infected with HBV. These estimates could be much higher due to many reasons, including lack of screening education and awareness, and perceived marginalization of the populations at risk.

(6) In 2012, CDC released new guidelines recommending every person born between 1945 and 1965 receive a one-time test for HCV. Among the estimated 102,000,000 (1,600,000 chronically HCV-infected) eligible for screening, birth-cohort screening leads to 84,000 fewer cases of decompensated cirrhosis, 46,000 fewer cases of hepatocellular carcinoma, 10,000 fewer liver transplants, and 78,000 fewer HCV-related deaths gained versus risk-based screening.

(7) In 2013, the United States Preventive Services Task Force (referred to in this section as the ''USPSTF'') issued a Grade B rating for screening for HCV infection in persons at high risk for infec-

tion and adults born between 1945 and 1965. In 2014, the USPSTF issued a Grade B for screening for HBV in persons at high-risk of hepatitis B infection. In 2009, the USPSTF issued a Grade A for screening pregnant women for HBV during their first prenatal visit, and in 2019, reaffirmed this grade.

(8) There were 59 outbreaks (24 of HBV and 36 of HCV, including one of both HBV and HCV) reported to CDC for investigation from 2008 through 2016 related to health care-associated infection of HBV and HCV, 56 of which occurred in non-hospital settings. There were more than 115,983 patients potentially exposed to one of the viruses.

(9) Chronic HBV and chronic HCV usually do not cause symptoms early in the course of the disease, but after many years of a clinically ''silent'' phase, CDC estimates show more than 33 percent of infected individuals will develop cirrhosis, end-stage liver disease, or liver cancer. Since most individuals with chronic HBV, HCV, or both are unaware of their infection, they do not know to take precautions to prevent the spread of their infection and can unknowingly exacerbate their own disease progression.

(10) HBV and HCV disproportionately affect certain populations in the United States. Although representing only about 6 percent of the population, Asian Americans and Pacific Islanders account for half of all chronic HBV cases in the United States. Baby Boomers (those born between 1945 and 1965) account for approximately 75 percent of domestic chronic HCV cases. In addition, African Americans, Latinos, and American Indian and Native Alaskans are among the groups which have disproportionately high rates of HBV or HCV infections in the United States.

(11) For both chronic HBV and chronic HCV, behavioral changes and appropriate medical care can slow disease progression if diagnosis is made early. Early diagnosis, which is determined through simple blood tests, can reduce the risk of transmission and disease progression through education and vaccination of household members and other susceptible persons at risk.

(12) Advancements have led to the development of improved diagnostic tests for viral hepatitis. These tests, including rapid, point of care testing and others in development, can facilitate testing, notification of results and post-test counseling, and re-

ferral to care at the time of the testing visit. In particular, these tests are also advantageous because they can be used simultaneously with HIV rapid testing for persons at risk for both HCV and HIV infections.

(13) For those chronically infected with HBV or HCV, regular monitoring can lead to the early detection of liver cancer at a stage where a cure is still possible. Liver cancer is the second deadliest cancer in the United States; however, liver cancer has received little funding for research, prevention, or treatment.

(14) Treatment for chronic HCV can eradicate the disease in approximately 90 percent of those currently treated. While there is no cure for chronic HBV, available treatments can effectively suppress viral replication in the overwhelming majority of those treated, thereby reducing the risk of transmission and progression to liver scarring or liver cancer.

(15) To combat the viral hepatitis epidemic in the United States, in February 2017, the Department of Health and Human Services released its ''National Viral Hepatitis Action Plan 2017–2020'' (referred to in this section as the ''HHS Action

Plan''). In March 2017, the National Academies of Sciences, Engineering, and Medicine released a report entitled, ''A National Strategy for the Elimination of Hepatitis B and C: Phase Two Report'' (referred to in this section as the ''NAS report''), recommending specific actions to eliminate viral hepatitis as public health problems in the United States by 2030.

(16) The annual health care costs attributable to HBV and HCV in the United States are significant. For HBV, it is estimated to be approximately $2,500,000,000 ($2,000 per infected person). In 2000, the lifetime cost of HBV—before the availability of most current therapies—was approximately $80,000 per chronically infected person, totaling more than $100,000,000,000. For HCV, medical costs for patients are expected to increase from $30,000,000,000 in 2009 to over $85,000,000,000 in 2024. Avoiding these costs by screening and diagnosing individuals earlier—and connecting them to appropriate treatment and care, will save lives and critical health care dollars. Currently, without a comprehensive screening, testing, and diagnosis program, most patients are diagnosed too late when they need a liver transplant costing at least

$314,000 for uncomplicated cases or when they have liver cancer or end-stage liver disease which costs $30,980 to $110,576 per hospital admission. As health care costs continue to grow, it is critical that the Federal Government invests in effective mechanisms to avoid documented cost drivers.

(17) According to the NAS report in 2010, chronic HBV and HCV infections cause substantial morbidity and mortality despite being preventable and treatable. Deficiencies in the implementation of established guidelines for the prevention, diagnosis, and medical management of chronic HBV and HCV infections perpetuate personal and economic burdens. Existing grants are not sufficient for the scale of the health burden presented by HBV and HCV.

(18) Screening and testing for HBV and HCV is aligned with the goal of Healthy People 2020 to increase immunization rates and reduce preventable infectious diseases. Awareness of disease and access to prevention and treatment remain essential components for reducing infectious disease transmission.

(19) Federal support is necessary to increase knowledge and awareness of HBV and HCV and to assist State and local prevention and control efforts

in reducing the morbidity and mortality of these epidemics.

(20) The Centers for Disease Control and Prevention reported a 233 percent increase in hepatitis C cases from 2010 to 2016, stemming from the opioid, heroin, and overdose epidemics affecting communities nationwide. From 2014 to 2015, the number of reported cases of acute hepatitis B infection in the United States rose for the first time since 2006, increasing by 20.7 percent, which is also largely attributable to the opioid epidemic.

(21) The Secretary of Health and Human Services has the discretion to carry out this subtitle (including the amendments made by this subtitle) directly and through whichever of the agencies of the Public Health Service the Secretary determines to be appropriate, which may (in the Secretary's discretion) include the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the National Institutes of Health (including the National Institute on Minority Health and Health Disparities), and other agencies of such Service.

(c) BIENNIAL ASSESSMENT OF HHS HEPATITIS B AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH, AND MEDICAL MANAGEMENT PLAN.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by title V, is further amended—

(1) by striking section 317N (42 U.S.C. 247b–15); and

(2) by adding after part W, as added by section 508, the following:

**"PART X—BIENNIAL ASSESSMENT OF HHS HEPATITIS B AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH, AND MEDICAL MANAGEMENT PLAN**

**"SEC. 399PP. BIENNIAL UPDATE OF THE PLAN.**

''(a) IN GENERAL.—The Secretary shall conduct a biennial assessment of the Secretary's plan for the prevention, control, and medical management of, and education and research relating to, hepatitis B and hepatitis C, for the purposes of—

''(1) incorporating into such plan new knowledge or observations relating to hepatitis B and hepatitis C (such as knowledge and observations that may be derived from clinical, laboratory, and epidemiological research and disease detection, prevention, and surveillance outcomes);

''(2) addressing gaps in the coverage or effectiveness of the plan; and

''(3) evaluating and, if appropriate, updating recommendations, guidelines, or educational materials of the Centers for Disease Control and Prevention or the National Institutes of Health for health care providers or the public on viral hepatitis in order to be consistent with the plan.

''(b) PUBLICATION OF NOTICE OF ASSESSMENTS.—Not later than October 1 of the first even-numbered year beginning after the date of the enactment of this part, and October 1 of each even-numbered year thereafter, the Secretary shall publish in the Federal Register a notice of the results of the assessments conducted under paragraph (1). Such notice shall include—

''(1) a description of any revisions to the plan referred to in subsection (a) as a result of the assessment;

''(2) an explanation of the basis for any such revisions, including the ways in which such revisions can reasonably be expected to further promote the original goals and objectives of the plan; and

''(3) in the case of a determination by the Secretary that the plan does not need revision, an explanation of the basis for such determination.

**"SEC. 399PP–1. ELEMENTS OF PROGRAM.**

"(a) EDUCATION AND AWARENESS PROGRAMS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Resources and Services Administration, and the Administrator of the Substance Abuse and Mental Health Services Administration, and in accordance with the plan referred to in section 399PP(a), shall implement programs to increase awareness and enhance knowledge and understanding of hepatitis B and hepatitis C. Such programs shall include—

"(1) the conduct of culturally and linguistically appropriate health education in primary and secondary schools, college campuses, public awareness campaigns, and community outreach activities (especially to the ethnic communities with high rates of chronic hepatitis B and chronic hepatitis C and other high-risk groups) to promote public awareness and knowledge about the value of hepatitis A and hepatitis B immunization; risk factors, transmission, and prevention of hepatitis B and hepatitis C; the value of screening for the early detection of hepatitis B and hepatitis C; and options available for the treatment of chronic hepatitis B and chronic hepatitis C;

''(2) the promotion of immunization programs that increase awareness and access to hepatitis A and hepatitis B vaccines for susceptible adults and children;

''(3) the training of health care professionals regarding the importance of vaccinating individuals infected with hepatitis C and individuals who are at risk for hepatitis C infection against hepatitis A and hepatitis B;

''(4) the training of health care professionals regarding the importance of vaccinating individuals chronically infected with hepatitis B and individuals who are at risk for chronic hepatitis B infection against the hepatitis A virus;

''(5) the training of health care professionals and health educators to make them aware of the high rates of chronic hepatitis B and chronic hepatitis C in certain adult ethnic populations, and the importance of prevention, detection, and medical management of hepatitis B and hepatitis C and of liver cancer screening;

''(6) the development and distribution of health education curricula (including information relating to the special needs of individuals infected with or at risk of hepatitis B and hepatitis C, such as the

importance of prevention and early intervention, regular monitoring, the recognition of psychosocial needs, appropriate treatment, and liver cancer screening) for individuals providing hepatitis B and hepatitis C counseling; and

''(7) support for the implementation curricula described in paragraph (6) by State and local public health agencies.

''(b) IMMUNIZATION, PREVENTION, AND CONTROL PROGRAMS.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall support the integration of activities described in paragraph (3) into existing clinical and public health programs at State, local, territorial, and Tribal levels (including community health clinics, programs for the prevention and treatment of HIV/AIDS, sexually transmitted infections, and substance abuse, and programs for individuals in correctional settings).

''(2) COORDINATION OF DEVELOPMENT OF FEDERAL SCREENING GUIDELINES.—

''(A) REFERENCES.—For purposes of this subsection, the term 'CDC Director' means the Director of the Centers for Disease Control and

Prevention, and the term 'AHRQ Director' means the Director of the Agency for Healthcare Research and Quality.

''(B) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.—Due to the rapidly evolving standard of care associated with diagnosing and treating viral hepatitis infection, the AHRQ Director shall convene the Preventive Services Task Force under section 915(a) to review its recommendation for screening for HBV and HCV infection every 3 years.

''(3) ACTIVITIES.—

''(A) VOLUNTARY TESTING PROGRAMS.—

''(i) IN GENERAL.—The Secretary shall establish a mechanism by which to support and promote the development of State, local, territorial, and tribal voluntary hepatitis B and hepatitis C testing programs to screen the high-prevalence populations to aid in the early identification of chronically infected individuals.

''(ii) CONFIDENTIALITY OF THE TEST RESULTS.—The Secretary shall prohibit the use of the results of a hepatitis B or hepatitis C test conducted by a testing pro-

gram developed or supported under this subparagraph for any of the following:

''(I) Issues relating to health insurance.

''(II) To screen or determine suitability for employment.

''(III) To discharge a person from employment.

''(B) COUNSELING REGARDING VIRAL HEPATITIS.—The Secretary shall support State, local, territorial, and tribal programs in a wide variety of settings, including those providing primary and specialty health care services in nonprofit private and public sectors, to—

''(i) provide individuals with ongoing risk factors for hepatitis B and hepatitis C infection with client-centered education and counseling which concentrates on—

''(I) promoting testing of individuals that have been exposed to their blood, family members, and their sexual partners; and

''(II) changing behaviors that place individuals at risk for infection;

''(ii) provide individuals chronically infected with hepatitis B or hepatitis C with education, health information, and counseling to reduce their risk of—

''(I) dying from end-stage liver disease and liver cancer; and

''(II) transmitting viral hepatitis to others; and

''(iii) provide women chronically infected with hepatitis B or hepatitis C who are pregnant or of childbearing age with culturally and linguistically appropriate health information, such as how to prevent hepatitis B perinatal infection, and to alleviate fears associated with pregnancy or raising a family.

''(C) IMMUNIZATION.—The Secretary shall support State, local, territorial, and tribal efforts to expand the current vaccination programs to protect every child in the Nation and all susceptible adults, particularly those infected with hepatitis C and high-prevalence ethnic populations and other high-risk groups, from the risks of acute and chronic hepatitis B infection by—

''(i) ensuring continued funding for hepatitis B vaccination for all children 18 years of age or younger through the Vaccines for Children program;

''(ii) ensuring that the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are followed regarding the birth dose of hepatitis B vaccinations for newborns;

''(iii) requiring proof of hepatitis B vaccination for entry into public or private daycare, preschool, elementary school, secondary school, and institutions of higher education;

''(iv) expanding the availability of hepatitis B vaccination for all adults to protect them from becoming acutely or chronically infected, including ethnic and other populations with high prevalence rates of chronic hepatitis B infection;

''(v) expanding the availability of hepatitis B vaccination for all adults, particularly those of reproductive age (women and

men less than 45 years of age), to protect them from the risk of hepatitis B infection;

''(vi) ensuring the vaccination of individuals infected, or at risk for infection, with hepatitis C against hepatitis A, hepatitis B, and other infectious diseases, as appropriate, for which such individuals may be at increased risk; and

''(vii) ensuring the vaccination of individuals infected, or at risk for infection, with hepatitis B against hepatitis A virus and other infectious diseases, as appropriate, for which such individuals may be at increased risk.

''(D) MEDICAL REFERRAL.—The Secretary shall support State, local, territorial, and tribal programs that support—

''(i) referral of persons chronically infected with hepatitis B or hepatitis C—

''(I) for medical evaluation to determine the appropriateness for antiviral treatment to reduce the risk of progression to cirrhosis and liver cancer; and

"(II) for ongoing medical management including regular monitoring of liver function and screening for liver cancer; and

"(ii) referral of persons infected with acute or chronic hepatitis B infection or acute or chronic hepatitis C infection for drug and alcohol abuse treatment where appropriate.

"(4) INCREASED SUPPORT FOR ADULT VIRAL HEPATITIS PREVENTION COORDINATORS.—The Secretary, acting through the CDC Director, shall provide increased support to adult viral hepatitis prevention coordinators in State, local, territorial, and tribal health departments in order to enhance the additional management, networking, and technical expertise needed to ensure successful integration of hepatitis B and hepatitis C prevention and control activities into existing public health programs.

"(c) EPIDEMIOLOGICAL SURVEILLANCE.—

"(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall support the establishment and maintenance of a national chronic and

acute hepatitis B and hepatitis C surveillance program, in order to identify—

''(A) trends in the incidence of acute and chronic hepatitis B and acute and chronic hepatitis C;

''(B) trends in the prevalence of acute and chronic hepatitis B and acute and chronic hepatitis C infection among groups that may be disproportionately affected; and

''(C) trends in liver cancer and end-stage liver disease incidence and deaths, caused by chronic hepatitis B and chronic hepatitis C in the high-risk ethnic populations.

''(2) SEROPREVALENCE AND LIVER CANCER STUDIES.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall prepare a report outlining the population-based seroprevalence studies currently underway, future planned studies, the criteria involved in determining which seroprevalence studies to conduct, defer, or suspend, and the scope of those studies, the economic and clinical impact of hepatitis B and hepatitis C, and the impact of chronic hepatitis B and chronic hepatitis C infections on the quality of life. Not later than one year after the date of the enact-

ment of this part, the Secretary shall submit the report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives.

''(3) CONFIDENTIALITY.—The Secretary shall not disclose any individually identifiable information identified under paragraph (1) or derived through studies under paragraph (2).

''(d) RESEARCH.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, the Director of the National Cancer Institute, and the Director of the National Institutes of Health, shall—

''(1) conduct epidemiologic and community-based research to develop, implement, and evaluate best practices for hepatitis B and hepatitis C prevention especially in the ethnic populations with high rates of chronic hepatitis B and chronic hepatitis C and other high-risk groups;

''(2) conduct research on hepatitis B and hepatitis C natural history, pathophysiology, improved treatments and prevention (such as the hepatitis C vaccine), and noninvasive tests that help to predict the risk of progression to liver cirrhosis and liver cancer;

''(3) conduct research that will lead to better noninvasive or blood tests to screen for liver cancer, and more effective treatments of liver cancer caused by chronic hepatitis B and chronic hepatitis C; and

''(4) conduct research comparing the effectiveness of screening, diagnostic, management, and treatment approaches for chronic hepatitis B, chronic hepatitis C, and liver cancer in the affected communities.

''(e) UNDERSERVED AND DISPROPORTIONATELY AFFECTED POPULATIONS.—In carrying out this section, the Secretary shall provide expanded support for individuals with limited access to health education, testing, and health care services and groups that may be disproportionately affected by hepatitis B and hepatitis C.

''(f) EVALUATION OF PROGRAM.—The Secretary shall develop benchmarks for evaluating the effectiveness of the programs and activities conducted under this section and make determinations as to whether such benchmarks have been achieved.

**''SEC. 399PP–2. GRANTS.**

''(a) IN GENERAL.—The Secretary may award grants to, or enter into contracts or cooperative agreements with, States, political subdivisions of States, territories, Indian tribes, or nonprofit entities that have special expertise re-

lating to hepatitis B, hepatitis C, or both, to carry out activities under this part.

''(b) APPLICATION.—To be eligible for a grant, contract, or cooperative agreement under subsection (a), an entity shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

**''SEC. 399PP–3. AUTHORIZATION OF APPROPRIATIONS.**

''There are authorized to be appropriated to carry out this part $90,000,000 for fiscal year 2021, $90,000,000 for fiscal year 2022, $110,000,000 for fiscal year 2023, $130,000,000 for fiscal year 2024, and $150,000,000 for fiscal year 2025.''.

# Subtitle C—Acquired Bone Marrow Failure Diseases

**SEC. 721. ACQUIRED BONE MARROW FAILURE DISEASES.**

(a) SHORT TITLE.—This subtitle may be cited as the ''Bone Marrow Failure Disease Research and Treatment Act of 2020''.

(b) FINDINGS.—The Congress finds the following:

(1) Between 20,000 and 30,000 people in the United States are diagnosed each year with myelodysplastic syndromes, aplastic anemia, paroxysmal nocturnal hemoglobinuria, and other acquired bone marrow failure diseases.

(2) Acquired bone marrow failure diseases have a debilitating and often fatal impact on those diagnosed with these diseases.

(3) While some treatments for acquired bone marrow failure diseases can prolong and improve the quality of patients' lives, there is no single cure for these diseases.

(4) The prevalence of acquired bone marrow failure diseases in the United States will continue to grow as the general public ages.

(5) Evidence exists suggesting that acquired bone marrow failure diseases occur more often in minority populations, particularly in Asian-American and Latino or Hispanic populations.

(6) The National Heart, Lung, and Blood Institute and the National Cancer Institute have conducted important research into the causes of and treatments for acquired bone marrow failure diseases.

(7) The National Marrow Donor Program Registry has made significant contributions to the fight against bone marrow failure diseases by connecting millions of potential marrow donors with individuals and families suffering from these conditions.

(8) Despite these advances, a more comprehensive Federal strategic effort among numerous Federal agencies is needed to discover a cure for acquired bone marrow failure disorders.

(9) Greater Federal surveillance of acquired bone marrow failure diseases is needed to gain a better understanding of the causes of acquired bone marrow failure diseases.

(10) The Federal Government should increase its research support for and engage with public and private organizations in developing a comprehensive approach to combat and cure acquired bone marrow failure diseases.

(c) NATIONAL ACQUIRED BONE MARROW FAILURE DISEASE REGISTRY.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by inserting after section 317V (as added by section 110) the following:

**"SEC. 317W. NATIONAL ACQUIRED BONE MARROW FAILURE DISEASE REGISTRY.**

"(a) ESTABLISHMENT OF REGISTRY.—

"(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

''(A) develop a system to collect data on acquired bone marrow failure diseases; and

''(B) establish and maintain a national and publicly available registry, to be known as the National Acquired Bone Marrow Failure Disease Registry, in accordance with paragraph (3).

''(2) RECOMMENDATIONS OF ADVISORY COMMITTEE.—In carrying out this subsection, the Secretary shall take into consideration the recommendations of the Advisory Committee on Acquired Bone Marrow Failure Diseases established under subsection (b).

''(3) PURPOSES OF REGISTRY.—The National Acquired Bone Marrow Failure Disease Registry shall—

''(A) identify the incidence and prevalence of acquired bone marrow failure diseases in the United States;

''(B) be used to collect and store data on acquired bone marrow failure diseases, including data concerning—

''(i) the age, race or ethnicity, general geographic location, sex, and family history of individuals who are diagnosed with ac-

quired bone marrow failure diseases, and any other characteristics of such individuals determined appropriate by the Secretary;

''(ii) the genetic and environmental factors that may be associated with developing acquired bone marrow failure diseases;

''(iii) treatment approaches for dealing with acquired bone marrow failure diseases;

''(iv) outcomes for individuals treated for acquired bone marrow failure diseases, including outcomes for recipients of stem cell therapeutic products as contained in the database established pursuant to section 379A; and

''(v) any other factors pertaining to acquired bone marrow failure diseases determined appropriate by the Secretary; and

''(C) be made available—

''(i) to the general public; and

''(ii) to researchers to facilitate further research into the causes of, and treatments for, acquired bone marrow failure

diseases in accordance with standard practices of the Centers for Disease Control and Preventions.

''(b) ADVISORY COMMITTEE.—

''(1) ESTABLISHMENT.—Not later than 6 months after the date of the enactment of this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an advisory committee, to be known as the Advisory Committee on Acquired Bone Marrow Failure Diseases.

''(2) MEMBERS.—The members of the Advisory Committee on Acquired Bone Marrow Failure Diseases shall be appointed by the Secretary, acting through the Director of the Centers for Disease Control and Prevention, and shall include at least one representative from each of the following:

''(A) A national patient advocacy organization with experience advocating on behalf of patients suffering from acquired bone marrow failure diseases.

''(B) The National Institutes of Health, including at least one representative from each of—

''(i) the National Cancer Institute;

''(ii) the National Heart, Lung, and Blood Institute; and

''(iii) the Office of Rare Diseases.

''(C) The Centers for Disease Control and Prevention.

''(D) Clinicians with experience in—

''(i) diagnosing or treating acquired bone marrow failure diseases; or

''(ii) medical data registries.

''(E) Epidemiologists who have experience with data registries.

''(F) Publicly or privately funded researchers who have experience researching acquired bone marrow failure diseases.

''(G) The entity operating the C.W. Bill Young Cell Transplantation Program established pursuant to section 379 and the entity operating the C.W. Bill Young Cell Transplantation Program Outcomes Database.

''(3) RESPONSIBILITIES.—The Advisory Committee on Acquired Bone Marrow Failure Diseases shall provide recommendations to the Secretary on the establishment and maintenance of the National Acquired Bone Marrow Failure Disease Registry, in-

cluding recommendations on the collection, maintenance, and dissemination of data.

''(4) PUBLIC AVAILABILITY.—The Secretary shall make the recommendations of the Advisory Committee on Acquired Bone Marrow Failure Disease publicly available.

''(c) GRANTS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may award grants to, and enter into contracts and cooperative agreements with, public or private nonprofit entities for the management of, as well as the collection, analysis, and reporting of data to be included in, the National Acquired Bone Marrow Failure Disease Registry.

''(d) DEFINITION.—In this section, the term 'acquired bone marrow failure disease' means—

''(1) myelodysplastic syndromes;

''(2) aplastic anemia;

''(3) paroxysmal nocturnal hemoglobinuria;

''(4) pure red cell aplasia;

''(5) acute myeloid leukemia that has progressed from myelodysplastic syndromes; or

''(6) large granular lymphocytic leukemia.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $3,000,000 for each of fiscal years 2021 through 2025.''.

(d) PILOT STUDIES THROUGH THE AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY.—

(1) PILOT STUDIES.—The Secretary of Health and Human Services, acting through the Director of the Agency for Toxic Substances and Disease Registry, shall conduct pilot studies to determine which environmental factors, including exposure to toxins, may cause acquired bone marrow failure diseases.

(2) COLLABORATION WITH THE RADIATION INJURY TREATMENT NETWORK.—In carrying out the directives of this section, the Secretary may collaborate with the Radiation Injury Treatment Network of the C.W. Bill Young Cell Transplantation Program established pursuant to section 379 of the Public Health Service Act (42 U.S.C. 274k) to—

(A) augment data for the pilot studies authorized by this section;

(B) access technical assistance that may be provided by the Radiation Injury Treatment Network; or

(C) perform joint research projects.

(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,000,000 for each of fiscal years 2021 through 2025.

(e) MINORITY-FOCUSED PROGRAMS ON ACQUIRED BONE MARROW FAILURE DISEASES.—Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended by inserting after section 1707A the following:

**"SEC. 1707B. MINORITY-FOCUSED PROGRAMS ON ACQUIRED BONE MARROW FAILURE DISEASE.**

"(a) INFORMATION AND REFERRAL SERVICES.—

"(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this section, the Secretary, acting through the Deputy Assistant Secretary for Minority Health, shall establish and coordinate outreach and informational programs targeted to minority populations affected by acquired bone marrow failure diseases.

"(2) PROGRAM REQUIREMENTS.—Minority-focused outreach and informational programs authorized by this section at the National Minority Health Resource Center supported under section 1707(b)(8) (including by means of the Center's website, through appropriate locations such as the Center's knowledge center, and through appropriate programs such as the Center's resource persons network) and through minority health consultants located at each Department of Health and Human Services regional office—

"(A) shall make information about treatment options and clinical trials for acquired bone marrow failure diseases publicly available; and

"(B) shall provide referral services for treatment options and clinical trials.

"(b) HISPANIC AND ASIAN-AMERICAN AND PACIFIC ISLANDER OUTREACH.—

"(1) IN GENERAL.—The Secretary, acting through the Deputy Assistant Secretary for Minority Health, shall undertake a coordinated outreach effort to connect Hispanic, Asian-American, and Pacific Islander communities with comprehensive services focused on treatment of, and information about, acquired bone marrow failure diseases.

"(2) COLLABORATION.—In carrying out this subsection, the Secretary may collaborate with public health agencies, nonprofit organizations, community groups, and online entities to disseminate information about treatment options and clinical trials for acquired bone marrow failure diseases.

"(c) GRANTS AND COOPERATIVE AGREEMENTS.—

"(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this section, the Secretary, acting through the Deputy Assistant Sec-

retary for Minority Health, shall award grants to, or enter into cooperative agreements with, entities to perform research on acquired bone marrow failure diseases.

''(2) REQUIREMENT.—Grants and cooperative agreements authorized by this subsection shall be awarded or entered into on a competitive, peer-reviewed basis.

''(3) SCOPE OF RESEARCH.—Research funded under this section shall examine factors affecting the incidence of acquired bone marrow failure diseases in minority populations.

''(d) DEFINITION.—In this section, the term 'acquired bone marrow failure disease' has the meaning given to such term in section 317W(d).

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,000,000 for each of fiscal years 2021 through 2025.''.

(f) DIAGNOSIS AND QUALITY OF CARE FOR ACQUIRED BONE MARROW FAILURE DISEASES.—

(1) GRANTS.—The Secretary of Health and Human Services, acting through the Director of the Agency for Healthcare Research and Quality, shall award grants to entities to improve diagnostic prac-

tices and quality of care with respect to patients with acquired bone marrow failure diseases.

(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,000,000 for each of fiscal years 2021 through 2025.

(g) DEFINITION.—In this section, the term ''acquired bone marrow failure disease'' has the meaning given such term in section 317W(d) of the Public Health Service Act, as added by subsection (c).

# Subtitle D—Cardiovascular Disease, Chronic Disease, Obesity, and Other Disease Issues

### SEC. 731. GUIDELINES FOR DISEASE SCREENING FOR MINORITY PATIENTS.

(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall convene a series of meetings to develop guidelines for disease screening for minority patient populations that have a higher than average risk for many chronic diseases and cancers.

(b) PARTICIPANTS.—In convening meetings under subsection (a), the Secretary shall ensure that meeting participants include representatives of—

(1) professional societies and associations;

(2) minority health organizations;

(3) health care researchers and providers, including those with expertise in minority health;

(4) Federal health agencies, including the Office of Minority Health, the National Institute on Minority Health and Health Disparities, and the National Institutes of Health; and

(5) other experts as the Secretary determines appropriate.

(c) DISEASES.—Screening guidelines for minority populations shall be developed as appropriate under subsection (a) for—

(1) hypertension;

(2) hypercholesterolemia;

(3) diabetes;

(4) cardiovascular disease;

(5) cancers, including breast, prostate, colon, cervical, and lung cancer;

(6) other pulmonary problems including sleep apnea;

(7) asthma;

(8) diabetes;

(9) kidney diseases;

(10) eye diseases and disorders, including glaucoma;

(11) HIV/AIDS and sexually transmitted infections;

(12) uterine fibroids;

(13) autoimmune disease;

(14) mental health conditions;

(15) dental health conditions and oral diseases, including oral cancer;

(16) environmental and related health illnesses and conditions;

(17) sickle cell disease and sickle cell trait;

(18) violence and injury prevention and control;

(19) genetic and related conditions;

(20) heart disease and stroke;

(21) tuberculosis;

(22) chronic obstructive pulmonary disease;

(23) musculoskeletal diseases, arthritis, and obesity; and

(24) other diseases determined appropriate by the Secretary.

(d) DISSEMINATION.—Not later than 2 years after the date of enactment of this Act, the Secretary shall publish and disseminate to health care provider organizations the guidelines developed under subsection (a).

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section

such sums as may be necessary for each of fiscal years 2021 through 2025.

**SEC. 732. CDC WISEWOMAN SCREENING PROGRAM.**

Section 1509 of the Public Health Service Act (42 U.S.C. 300n–4a) is amended—

(1) in subsection (a)—

(A) by striking the heading and inserting ''IN GENERAL.—''; and

(B) in the matter preceding paragraph (1), by striking ''may make grants'' and all that follows through ''purpose'' and inserting the following: ''may make grants to such States for the purpose''; and

(2) in subsection (d)(1), by striking ''there are authorized'' and all that follows through the period and inserting ''there are authorized to be appropriated $23,000,000 for fiscal year 2021, $25,300,000 for fiscal year 2022, $27,800,000 for fiscal year 2023, $30,800,000 for fiscal year 2024, and $34,000,000 for fiscal year 2025.''.

**SEC. 733. REPORT ON CARDIOVASCULAR CARE FOR WOMEN AND MINORITIES.**

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 531, is further amended by adding at the end the following:

**''SEC. 399V–8. REPORT ON CARDIOVASCULAR CARE FOR WOMEN AND MINORITIES.**

''Not later than September 30, 2021, and annually thereafter, the Secretary shall prepare and submit to Congress a report on the quality of and access to care for women and minorities with heart disease, stroke, and other cardiovascular diseases. The report shall contain recommendations for eliminating disparities in, and improving the treatment of, heart disease, stroke, and other cardiovascular diseases in women, racial and ethnic minorities, those for whom English is not their primary language, and individuals with disabilities.''.

**SEC. 734. COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES IN MEDICAID AND PRIVATE HEALTH INSURANCE.**

(a) REQUIRING MEDICAID COVERAGE OF COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a)(4)(D), by striking ''by pregnant women''; and

(2) in subsection (bb)—

(A) by striking ''by pregnant women'' each place it appears;

(B) in paragraph (1), in the matter before subparagraph (A), by inserting ''by individuals'' before ''who use tobacco''; and

(C) in paragraph (2)(A), by striking ''with respect to pregnant women''.

(b) EXCEPTION FROM OPTIONAL RESTRICTION UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—Section 1927(d)(2)(F) of the Social Security Act (42 U.S.C. 1396r–8(d)(2)(F)) is amended—

(1) by striking ''in the case of pregnant women''; and

(2) by striking ''under the over-the-counter monograph process''.

(c) STATE MONITORING AND PROMOTING OF COMPREHENSIVE TOBACCO CESSATION SERVICES UNDER MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 462(a), is amended—

(1) by striking ''and'' at the end of paragraph (85);

(2) by striking the period at the end of paragraph (86) and inserting ''; and''; and

(3) by inserting after paragraph (86) the following new paragraph:

''(87) provide for the State to monitor and promote the use of comprehensive tobacco cessation services under the State plan, including conducting an outreach campaign to increase awareness of, and the benefits of using, such services among—

''(A) individuals entitled to medical assistance under the State plan who use tobacco products; and

''(B) clinicians and others who provide services to individuals entitled to medical assistance under the State plan.''.

(d) FEDERAL REIMBURSEMENT FOR MEDICAID OUTREACH CAMPAIGN TO INCREASE AWARENESS.—Section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) is amended—

(1) by striking the period at the end of paragraph (7) and inserting ''; plus''; and

(2) by inserting after paragraph (7) the following new paragraph:

''(8) an amount equal to 90 percent of the sums expended during each quarter which are attributable to the development, implementation, and evaluation of an outreach campaign to—

''(A) increase awareness of comprehensive tobacco cessation services covered in the State plan among—

''(i) individuals who are likely to be eligible for medical assistance under the State plan; and

''(ii) clinicians and others who provide services to individuals who are likely to be eligible for medical assistance under the State plan; and

''(B) increase awareness of the benefits of using comprehensive tobacco cessation services covered in the State plan among—

''(i) individuals who are likely to be eligible for medical assistance under the State plan; and

''(ii) clinicians and others who provide services to individuals who are likely to be eligible for medical assistance under the State plan about the benefits of using comprehensive tobacco cessation services.''.

(e) REMOVAL OF COST SHARING FOR COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE UNDER MEDICAID.—

(1) GENERAL COST SHARING LIMITATIONS.—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended—

(A) in subsections (a)(2)(B) and (b)(2)(B), by striking ''and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb) of this title) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1905(bb)(2)(A)'' each place it appears; and

(B) in each of subsections (a)(2)(B) and (b)(2)(B) by inserting ''and counseling and pharmacotherapy for cessation of tobacco use (as defined in section 1905d(bb) of this title) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to pro-

mote, tobacco cessation in accordance with the Guideline referred to in section 1905(bb)(2)(A)'' after ''(or at the option of the State, any services furnished to pregnant women''.

(2) APPLICATION TO ALTERNATIVE COST SHARING.—Section 1916A(b)(3)(B) of such Act (42 U.S.C. 1396o–1(b)(3)(B)) is amended—

(A) in clause (iii), by striking '', and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb))''; and

(B) by adding at the end the following:

''(xi) Counseling and pharmacotherapy for cessation of tobacco use (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation in accordance with the Guideline referred to in section 1396d (bb)(2)(A) of this title.''.

(f) NO PRIOR AUTHORIZATION FOR TOBACCO CESSATION DRUGS UNDER MEDICAID.—Section 1927(d) of the Social Security Act (42 U.S.C. 1396r–8) is amended—

(1) by striking in paragraph (1)(A) ''A State'' and inserting ''Except as otherwise provided in paragraph (6), a State'';

(2) by redesignating paragraphs (6) and (7) as paragraphs (7) and (8), respectively; and

(3) by inserting after paragraph (5) the following:

''(6) NO PRIOR AUTHORIZATION PROGRAMS FOR TOBACCO CESSATION DRUGS.—A State plan under this title shall not require, as a condition of coverage or payment for a covered outpatient drug for which Federal financial participation is available in accordance with this section, the approval of an agent when used to promote smoking cessation, including agents approved by the Food and Drug Administration for the purposes of promoting, and when used to promote, tobacco cessation.''.

(g) COMPREHENSIVE COVERAGE OF TOBACCO CESSATION COVERAGE IN PRIVATE HEALTH INSURANCE.—Section 2713 of the Public Health Service Act (42 U.S.C. 300gg–3) is amended by adding at the end the following:

''(d) NO PRIOR AUTHORIZATION.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not impose any prior authorization requirement for tobacco cessation counseling and pharmacotherapy that has in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force.''.

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2021.

**SEC. 735. CLINICAL RESEARCH FUNDING FOR ORAL HEALTH.**

(a) IN GENERAL.—The Secretary of Health and Human Services shall expand and intensify the conduct and support of the research activities of the National Institutes of Health and the National Institute of Dental and Craniofacial Research to improve the oral health of the population through the prevention and management of oral diseases and conditions.

(b) INCLUDED RESEARCH ACTIVITIES.—Research activities under subsection (a) shall include—

(1) comparative effectiveness research and clinical disease management research addressing early childhood caries and oral cancer; and

(2) awarding of grants and contracts to support the training and development of health services researchers, comparative effectiveness researchers, and clinical researchers whose research improves the oral health of the population.

**SEC. 736. PARTICIPATION BY MEDICAID BENEFICIARIES IN APPROVED CLINICAL TRIALS.**

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1943 the following new section:

**"SEC. 1944. PARTICIPATION IN AN APPROVED CLINICAL TRIAL.**

''(a) COVERAGE OF ROUTINE PATIENT COSTS ASSOCIATED WITH APPROVED CLINICAL TRIALS.—

''(1) INCLUSION.—Subject to paragraph (2), routine patient costs shall include all items and services consistent with the medical assistance provided under the State plan that would otherwise be provided to the individual under such State plan if such individual was not enrolled in an approved clinical trial, including any items or services related to the prevention, detection, and treatment of any medical complications that arise as a result of participation in the approved clinical trial.

''(2) EXCLUSION.—For purposes of paragraph (1), routine patient costs does not include—

''(A) the investigational item, device, or service itself;

''(B) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

''(C) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

''(3) INFORMATION CONCERNING CLINICAL TRIALS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary, in consultation with relevant stakeholders, shall develop a single standardized electronic form for use by the individual or the referring health care provider to submit to the State agency administering the State plan in order to verify that the clinical trial meets the conditions established for an approved clinical trial (as defined in subsection (c)).

''(B) EXCLUDED INFORMATION.—For purposes of subparagraph (A) or any such request

by the State agency for information regarding a clinical trial, an individual or referring health care provider shall not be required to submit—

"(i) the clinical protocol document for the clinical trial; or

"(ii) subject to subparagraph (C), any additional information other than such information as is required pursuant to the form described in subparagraph (A).

"(C) OPTIONAL INFORMATION.—For purposes of subparagraphs (A) and (B)(ii), the form may include a requirement that the referring health care provider attest that the individual is eligible to participate in the clinical trial pursuant to the trial protocol and that individual participation in such trial would be appropriate.

"(D) REVIEW OF INFORMATION.—

"(i) IN GENERAL.—A State plan under this title shall establish a process for timely review by the State agency of the form and information submitted pursuant to subparagraph (A) and, not later than 48 hours after receipt of such form, confirmation that the information provided in

such form satisfies the requirements established under such subparagraph, with such process to include establishment and operation of a 24-hour, toll-free telephone number and email address to provide for expedited communication.

''(ii) FAILURE TO RESPOND.—If an individual or the referring health care provider does not receive a response or request for additional information from the State agency following the 48-hour period described in clause (i), the information provided in the form may be presumed to satisfy the requirements established under this paragraph.

''(b) ENCOURAGEMENT OF PARTICIPATION IN APPROVED CLINICAL TRIALS.—

''(1) REASONABLY ACCESSIBLE PROVIDER.—For purposes of participation in an approved clinical trial by an individual eligible for medical assistance under this title, the State agency administering the State plan shall make reasonable efforts to ensure that the individual is provided with access to a provider who is—

''(A) participating in the approved clinical trial;

''(B) located not more than 25 miles from the residence of the individual (or, if no such provider is available, as close as possible to the residence of the individual); and

''(C) a participating provider under the State plan or has been deemed to be a participating provider under the State plan for purposes of providing medical assistance to the individual during their participation in the approved clinical trial.

''(2) INFORMATIONAL MATERIALS.—The State agency administering the plan approved under this title shall develop informational materials and programs to encourage participating providers to make appropriate referrals to physicians and other appropriate health care professionals who can provide individuals with access to approved clinical trials.

''(c) DEFINITION OF APPROVED CLINICAL TRIAL.—The term 'approved clinical trial' has the same meaning as provided under subsection (d) of the section 2709 of the Public Health Service Act that relates to coverage for individuals participating in approved clinical trials.''.

(b) CONFORMING AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 734(c), is amended—

(1) by striking ''and'' at the end of paragraph (86);

(2) by striking the period at the end of paragraph (87) and inserting ''; and''; and

(3) by inserting after paragraph (87) the following new paragraph:

''(88) provide that participation in an approved clinical trial and coverage of routine patient costs associated with such trial for an individual eligible for medical assistance under this title is conducted in accordance with the requirements under section 1944.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to calendar quarters beginning on or after October 1, 2020.

(2) DELAY PERMITTED FOR STATE PLAN AMENDMENT.—In the case of a State plan for medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)which the Secretary of Health and Human Services determines requires

State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

**SEC. 737. GUIDE ON EVIDENCE-BASED STRATEGIES FOR PUBLIC HEALTH DEPARTMENT OBESITY PREVENTION PROGRAMS.**

(a) DEVELOPMENT AND DISSEMINATION OF AN EVIDENCE-BASED STRATEGIES GUIDE.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention, not later than 2 years after the date of enactment of this Act, shall—

(1) develop a guide on evidence-based strategies for State, territorial, and local health departments to

use to build and maintain effective obesity prevention and reduction programs, and, in consultation with stakeholders that have expertise in Tribal health, a guide on such evidence-based strategies with respect to Indian Tribes and Tribal organizations for such Indian Tribes and Tribal organizations to use for such purpose, both of which guides shall—

(A) describe an integrated program structure for implementing interventions proven to be effective in preventing and reducing the incidence of obesity; and

(B) recommend—

(i) optimal resources, including staffing and infrastructure, for promoting nutrition and obesity prevention and reduction; and

(ii) strategies for effective obesity prevention programs for State and local health departments, Indian Tribes, and Tribal organizations, including strategies related to—

(I) the application of evidence-based and evidence-informed practices to prevent and reduce obesity rates;

(II) the development, implementation, and evaluation of obesity prevention and reduction strategies for specific communities and populations;

(III) demonstrated knowledge of obesity prevention practices that reduce associated preventable diseases, health conditions, death, and health care costs;

(IV) best practices for the coordination of efforts to prevent and reduce obesity and related chronic diseases;

(V) addressing the underlying risk factors and social determinants of health that impact obesity rates; and

(VI) interdisciplinary coordination between relevant public health officials specializing in fields such as nutrition, physical activity, epidemiology, communications, and policy implementation, and collaboration between public health officials and community-based organizations; and

(2) disseminate the guides and current research, evidence-based practices, tools, and educational materials related to obesity prevention, consistent with the guide, to State and local health departments, Indian Tribes, and Tribal organizations.

(b) TECHNICAL ASSISTANCE.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall provide technical assistance to State and local health departments, Indian Tribes, and Tribal organizations to support such health departments in implementing the guide developed under subsection (a)(1).

(c) INDIAN TRIBES; TRIBAL ORGANIZATIONS.—In this section, the terms ''Indian Tribe'' and ''Tribal organization'' have the meanings given the terms ''Indian tribe'' and ''tribal organization'', respectively, in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304).

# Subtitle E—HIV/AIDS

**SEC. 741. STATEMENT OF POLICY.**

It is the policy of the United States to achieve an AIDS-free generation, and to—

(1) expand access to lifesaving antiretroviral therapy for people living with HIV and immediately link people to continuous and coordinated high-quality care when they learn they are living with HIV;

(2) expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches, including routine HIV screening, and universal access to HIV prevention tools in communities disproportionately impacted by HIV, particularly communities of color;

(3) ensure laws, policies, and regulations do not impede access to prevention, treatment, and care for people living with HIV or disproportionately impacted by HIV;

(4) accelerate research for more efficacious HIV prevention and treatments tools, a cure, and a vaccine; and

(5) respect the human rights and dignity of persons living with HIV.

**SEC. 742. FINDINGS.**

The Congress finds the following:

(1) Over 1,100,000 people are estimated to be living with HIV in the United States according to the Centers for Disease Control and Prevention, 14 percent of whom are unaware they are living with HIV.

(2) Annually there are about 37,600 new HIV infections and 15,800 deaths in people with an HIV

diagnoses in 50 States and 6 dependent areas of the United States.

(3) The Centers for Disease Control and Prevention estimates that, in 2017, there were approximately 38,700 people newly diagnosed with HIV. The estimated number of annual new HIV infections declined 9 percent from 2010 to 2016. However, the number of new infections is increasing among certain populations, such as Latino gay and bisexual men, where annual infections increase 21 percent.

(4) HIV disproportionately affects certain populations in the United States. Though African Americans represent approximately 12 percent of the population, African Americans account for almost half (42 percent) of all people living with HIV in the United States. African-American men who have sex with men account for 26 percent of all new HIV infections and have remained stable from 2010 to 2016.

(5) Disparities continue to exist among Latinos and Hispanics; in 2017, Latinos and Hispanics made up 18 percent of the United States population and 26 percent of new infections.

(6) Though the rate of new infections among American Indians and Alaska Natives (referred to in

this section as ''AI/AN'') is proportional to their population size, from 2010 to 2016, the annual number of HIV diagnoses increased 46 percent among AI/AN overall and 81 percent among AI/AN gay and bisexual men.

(7) Asian Americans account for about 2 percent of new HIV infections, but in 2013, 22 percent were undiagnosed, the highest rate of undiagnosed HIV among any race or ethnicity. Between 2010 and 2016, the number of Asians receiving an HIV diagnosis increased by 42 percent.

(8) The latest data from the Centers for Disease Control and Prevention indicates that new infections among women declined 21 percent between 2010 and 2016.

(9) The history of HIV shows that culturally relevant and gender-responsive supportive services, including psychosocial support, treatment literacy, case management, and transportation are necessary strategies to reach and engage women and girls in medical care.

(10) Among the 3 million HIV testing events reported to the Centers for Disease Control and Prevention in 2017, the percentage of transgender people who received a new HIV diagnosis was 3 times

the national average. A 2019 systematic review and meta-analysis found that an estimated 14 percent of transgender women have HIV. By race/ethnicity, an estimated 44 percent of Black/African-American transgender women, 26 percent of Hispanic/Latina transgender women, and 7 percent of White transgender women have HIV. The limited data available on transgender individuals point to a disproportionate burden of HIV infection.

(11) Stigma and discrimination contribute to such disparities.

(12) The Centers for Disease Control and Prevention has determined that increasing the proportion of people who know their HIV status is an essential component of comprehensive HIV treatment and prevention efforts and that early diagnosis is critical in order for people with HIV to receive life-extending therapy. Additionally, the Centers for Disease Control and Prevention recommend routine HIV screening in health care settings for all patients aged 13 to 64, regardless of risk.

(13) In 1998, Congress created the National Minority AIDS Initiative to provide technical assistance, build capacity, and strengthen outreach efforts among local institutions and community-based orga-

nizations that serve racial and ethnic minorities living with or vulnerable to HIV.

(14) To combat the HIV epidemic in the United States, the National HIV/AIDS Strategy (referred to in this section as ''NHAS'') provides a framework of increasing access to care, reducing new infections, and eliminating HIV-related health disparities. The vision of NHAS is ''The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, gender identity, or socioeconomic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.''.

(15) In January 2019, the Department of Health and Human Services began implementing the ''Ending the HIV Epidemic: A Plan for America''. The initiative seeks to reduce the number of new HIV infections in the United States by 75 percent by 2025, and then by at least 90 percent by 2030, for an estimated 250,000 total HIV infection averted.

(16) At present, many States and United States territories have criminal statutes based on ''exposure'' to HIV. Most of these laws were adopted

before the availability of effective antiretroviral treatment for HIV/AIDS.

(17) Research shows that stable housing leads to better health outcomes for those living with HIV. Inadequate or unstable housing is not only a barrier to effective treatment, but also increases the likelihood of engaging in risky behaviors leading to HIV infection. Insecure housing puts people with HIV/AIDS at risk of premature death from exposure to other diseases, poor nutrition, and lack of medical care.

(18) Due to advances in treatment, many people living with HIV today are living healthy lives and have the ability and desire to fully participate in all aspects of community life, including employment. Research associates being employed with tremendous economic, social, and health benefits for many people living with HIV.

(19) The common benefits associated with employment include income, autonomy, productivity, and status within society, daily structure, making a contribution to one's community, and increased skills and self-esteem. Research also indicates that many people with disabilities, including people living with HIV, report perceiving themselves as being less dis-

abled or not disabled at all, when working. Furthermore, some studies link working with better physical and mental health outcomes for people living with HIV when compared to those who are not working. Preliminary data also suggest that transitioning to employment is associated with reduced HIV-related health risk behavior for many people.

(20) In July 2012, the Food and Drug Administration approved the first drug to be used as pre-exposure prophylaxis (PrEP). PrEP reduces the risk of HIV infection in HIV-negative individuals. Studies have shown that PrEP reduces HIV transmission from sex by about 99 percent when taken consistently. Despite increases in PrEP uptake, PrEP use remains low among gay and bisexual men of color. The Centers for Disease Control and Prevention found that uptake was lower among African-American (26 percent) and Latino (30 percent) men compared with White men (42 percent). Similarly, PrEP awareness was lower among African-American (86 percent) and Latino (87 percent) men compared with White men (95 percent). While clinical research on transgender populations and PrEP is currently limited, the Centers for Disease Control and Prevention recommends PrEP use in transgender popu-

lations. In September 2019, the Food and Drug Administration approved the second drug to be used as PrEP.

(21) Syringe service programs have been associated with lowered HIV infections, lower hepatitis C infections, and increased linkage to substance use treatment.

(22) There is now conclusive scientific evidence that a person living with HIV who is on antiretroviral therapy and is durably virally suppressed (defined as having a consistent viral load of less than <200 copies/ml) does not sexually transmit HIV. The conclusive evidence about the highly effective preventative benefits of antiretroviral therapy provides an unprecedented opportunity to improve the lives of people living with HIV, improve treatment uptake and adherence, and advocate for expanded access to treatment and care.

**SEC. 743. ADDITIONAL FUNDING FOR AIDS DRUG ASSISTANCE PROGRAM TREATMENTS.**

Section 2623 of the Public Health Service Act (42 U.S.C. 300ff–31b) is amended by adding at the end the following:

''(c) ADDITIONAL FUNDING FOR AIDS DRUG ASSISTANCE PROGRAM TREATMENTS.—In addition to

amounts otherwise authorized to be appropriated for carrying out this subpart, there are authorized to be appropriated such sums as may be necessary to carry out sections 2612(b)(3)(B) and 2616 for each of fiscal years 2021 through 2024.''.

**SEC. 744. ENHANCING THE NATIONAL HIV SURVEILLANCE SYSTEM.**

(a) GRANTS.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall make grants to States to support integration of public health surveillance systems into all electronic health records in order to allow rapid communications between the clinical setting and health departments, by means that include—

(1) providing technical assistance and policy guidance to State and local health departments, clinical providers, and other agencies serving individuals with HIV to improve the interoperability of data systems relevant to monitoring HIV care and supportive services;

(2) capturing longitudinal data pertaining to the initiation and ongoing prescription or dispensing of antiretroviral therapy for individuals diagnosed with HIV (such as through pharmacy-based reporting);

(3) obtaining information—

(A) on a voluntary basis, on sexual orientation and gender identity; and

(B) on sources of coverage (or the lack of coverage) for medical treatment (including coverage through the Medicaid program, the Medicare program, the program under title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.); commonly referred to as the ''Ryan White HIV/AIDS Program''), other public funding, private insurance, and health maintenance organizations); and

(4) obtaining and using current geographic markers of residence (such as current address, zip code, partial zip code, and census block).

(b) PRIVACY AND SECURITY SAFEGUARDS.—In carrying out this section, the Secretary of Health and Human Services shall ensure that appropriate privacy and security safeguards are met to prevent unauthorized disclosure of protected health information and compliance with the HIPAA privacy and security law (as defined in section 3009 of the Public Health Service Act (42 U.S.C. 300jj–19)) and other relevant laws and regulations.

(c) PROHIBITION AGAINST IMPROPER USE OF DATA.—No grant under this section may be used to allow

or facilitate the collection or use of surveillance or clinical data or records—

(1) for punitive measures of any kind, civil or criminal, against the subject of such data or records; or

(2) for imposing any requirement or restriction with respect to an individual without the individual's written consent.

(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2021 through 2024.

**SEC. 745. EVIDENCE-BASED STRATEGIES FOR IMPROVING LINKAGE TO AND RETENTION IN APPROPRIATE CARE.**

(a) STRATEGIES.—The Secretary of Health and Human Services, in collaboration with the Director of the Centers for Disease Control and Prevention, the Assistant Secretary for Mental Health and Substance Use, the Director of the Office of AIDS Research, the Administrator of the Health Resources and Services Administration, and the Administrator of the Centers for Medicare & Medicaid Services, shall—

(1) identify evidence-based strategies most effective at addressing the multifaceted issues that im-

pede disease status awareness and linkage to and retention in appropriate care, taking into consideration health care systems issues, clinic and provider issues, and individual psychosocial, environmental, and other contextual factors;

(2) support the wide-scale implementation of the evidence-based strategies identified pursuant to paragraph (1), including through incorporating such strategies into health care coverage supported by the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), the program under title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.; commonly referred to as the ''Ryan White HIV/AIDS Program''), and health plans purchased through an American Health Benefit Exchange established pursuant to section 1311 of the Patient Protection and Affordable Care Act (42 U.S.C. 18031); and

(3) not later than 1 year after the date of the enactment of this Act, submit a report to the Congress on the status of activities under paragraphs (1) and (2).

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated

such sums as may be necessary for fiscal years 2021 through 2024.

**SEC. 746. IMPROVING ENTRY INTO AND RETENTION IN CARE AND ANTIRETROVIRAL ADHERENCE FOR PERSONS WITH HIV.**

(a) SENSE OF CONGRESS.—It is the sense of Congress that AIDS research has led to scientific advancements that have—

(1) saved the lives of millions of people living with HIV;

(2) prevented millions from new diagnoses; and

(3) had broad benefits that extend far beyond helping people at risk for or living with HIV.

(b) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the National Institutes of Health, shall expand, intensify, and coordinate operational and translational research and other activities of the National Institutes of Health regarding methods—

(1) to increase adoption of evidence-based adherence strategies within HIV care and treatment programs;

(2) to increase HIV testing and case detection rates;

(3) to reduce HIV-related health disparities;

(4) to ensure that research to improve adherence to HIV care and treatment programs address the unique concerns of women;

(5) to integrate HIV prevention and care services with mental health and substance use prevention and treatment delivery systems;

(6) to increase knowledge on the implementation of preexposure prophylaxis (referred to in this section as ''PrEP''), including with respect to—

(A) who can benefit most from PrEP;

(B) how to provide PrEP safely and efficiently;

(C) how to integrate PrEP with other essential prevention methods such as condoms; and

(D) how to ensure high levels of adherence; and

(7) to increase knowledge of undetectable and untransmittable when a person living with HIV who is on antiretroviral therapy and is durably virally suppressed (defined as having a consistent viral load of less than <200 copies/ml) cannot sexually transmit HIV.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated

such sums as may be necessary for fiscal years 2021 through 2024.

**SEC. 747. SERVICES TO REDUCE HIV/AIDS IN RACIAL AND ETHNIC MINORITY COMMUNITIES.**

(a) IN GENERAL.—For the purpose of reducing new HIV diagnoses in racial and ethnic minority communities, the Secretary of Health and Human Services, acting through the Deputy Assistant Secretary for Minority Health, may make grants to public health agencies and faith-based organizations to conduct—

(1) outreach activities related to HIV prevention and testing activities;

(2) HIV prevention activities; and

(3) HIV testing activities.

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2021 through 2024.

**SEC. 748. MINORITY AIDS INITIATIVE.**

(a) EXPANDED FUNDING.—The Secretary of Health and Human Services, in collaboration with the Deputy Assistant Secretary for Minority Health, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Resources and Services Administration, and the Assistant Secretary for Mental Health and

Substance Use, shall provide funds and carry out activities to expand the Minority HIV/AIDS Initiative.

(b) USE OF FUNDS.—The additional funds made available under this section may be used, through the Minority AIDS Initiative, to support the following activities:

(1) Providing technical assistance and infrastructure support to reduce HIV/AIDS in minority populations.

(2) Increasing minority populations' access to HIV prevention and care services.

(3) Building strong community programs and partnerships to address HIV prevention and the health care needs of specific racial and ethnic minority populations.

(c) PRIORITY INTERVENTIONS.—Within the racial and ethnic minority populations referred to in subsection (b), priority in conducting intervention services shall be given to—

(1) men who have sex with men;

(2) youth;

(3) persons who engage in intravenous drug abuse;

(4) women;

(5) homeless individuals; and

(6) individuals incarcerated or in the penal system.

(d) AUTHORIZATION OF APPROPRIATIONS.—For carrying out this section, there are authorized to be appropriated $610,000,000 for fiscal year 2021 and such sums as may be necessary for each of fiscal years 2022 through 2025.

**SEC. 749. HEALTH CARE PROFESSIONALS TREATING INDIVIDUALS WITH HIV.**

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, shall expand, intensify, and coordinate workforce initiatives of the Health Resources and Services Administration to increase the capacity of the health workforce focusing primarily on HIV to meet the demand for culturally competent care, and may award grants for any of the following:

(1) Development of curricula for training primary care providers in HIV/AIDS prevention and care, including routine HIV testing.

(2) Support to expand access to culturally and linguistically accessible benefits counselors, trained peer navigators, and mental and behavioral health professionals with expertise in HIV.

(3) Training health care professionals to provide care to individuals living with HIV.

(4) Development by grant recipients under title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.; commonly referred to as the ''Ryan White HIV/AIDS Program'') and other persons, of policies for providing culturally relevant and sensitive treatment to individuals living with HIV, with particular emphasis on treatment to racial and ethnic minorities, men who have sex with men, and women, young people, and children living with HIV.

(5) Development and implementation of programs to increase the use of telehealth to respond to HIV-specific health care needs in rural and minority communities, with particular emphasis given to medically underserved communities and insular areas.

(6) Evaluating interdisciplinary medical provider care team models that promote high-quality care, with particular emphasis on care to racial and ethnic minorities.

(7) Training health care professionals to make them aware of the high rates of chronic hepatitis B and chronic hepatitis C in adult racial and ethnic populations, and the importance of prevention, de-

tection, and medical management of hepatitis B and hepatitis C and of liver cancer screening.

(8) Development of curricula for training primary care providers that HIV and tuberculosis are significant mutual comorbidities, and that a patient who tests positive for one disease should be offered and encouraged to receive testing for the other.

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2021 through 2024.

**SEC. 750. HIV/AIDS PROVIDER LOAN REPAYMENT PROGRAM.**

(a) IN GENERAL.—The Secretary may enter into an agreement with any physician, nurse practitioner, or physician assistant under which—

(1) the physician, nurse practitioner, or physician assistant agrees to serve as a medical provider for a period of not less than 2 years—

(A) at a Ryan White-funded or title X-funded facility with a critical shortage of doctors (as determined by the Secretary); or

(B) in an area with a high incidence of HIV; and

(2) the Secretary agrees to make payments in accordance with subsection (b) on the professional education loans of the physician, nurse practitioner, or physician assistant.

(b) MANNER OF PAYMENTS.—The payments described in subsection (a) shall be made by the Secretary as follows:

(1) Upon completion by the physician, nurse practitioner, or physician assistant for whom the payments are to be made of the first year of the service specified in the agreement entered into with the Secretary under subsection (a), the Secretary shall pay 30 percent of the principal of and the interest on the individual's professional education loans.

(2) Upon completion by the physician, nurse practitioner, or physician assistant of the second year of such service, the Secretary shall pay another 30 percent of the principal of and the interest on such loans.

(3) Upon completion by that individual of a third year of such service, the Secretary shall pay another 25 percent of the principal of and the interest on such loans.

(c) APPLICABILITY OF CERTAIN PROVISIONS.—Subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 254l et seq.) shall, except as inconsistent with this section, apply to the program carried out under this section in the same manner and to the same extent as such provisions apply to the National Health Service Corps loan repayment program.

(d) REPORTS.—Not later than 18 months after the date of the enactment of this Act, and annually thereafter, the Secretary shall prepare and submit to Congress a report describing the program carried out under this section, including statements regarding the following:

(1) The number of physicians, nurse practitioners, and physician assistants enrolled in the program.

(2) The number and amount of loan repayments.

(3) The placement location of loan repayment recipients at facilities described in subsection (a)(1).

(4) The default rate and actions required.

(5) The amount of outstanding default funds.

(6) To the extent that it can be determined, the reason for the default.

(7) The demographics of individuals participating in the program.

(8) An evaluation of the overall costs and benefits of the program.

(e) DEFINITIONS.—In this section:

(1) HIV/AIDS.—The term ''HIV/AIDS'' means human immunodeficiency virus and acquired immune deficiency syndrome.

(2) NURSE PRACTITIONER.—The term ''nurse practitioner'' means a registered nurse who has completed an accredited graduate degree program in advanced nurse practice and has successfully passed a national certification exam.

(3) PHYSICIAN.—The term ''physician'' means a graduate of a school of medicine who has completed postgraduate training in general or pediatric medicine.

(4) PHYSICIAN ASSISTANT.—The term ''physician assistant'' means a medical provider who completed an accredited physician assistant training program and successfully passed the Physician Assistant National Certifying Examination.

(5) PROFESSIONAL EDUCATION LOAN.—The term ''professional education loan''—

(A) means a loan that is incurred for the cost of attendance (including tuition, other reasonable educational expenses, and reasonable

living costs) at a school of medicine, nursing, or physician assistant training program; and

(B) includes only the portion of the loan that is outstanding on the date the physician, nurse practitioner, or physician assistant involved begins the service specified in the agreement under subsection (a).

(6) RYAN WHITE-FUNDED.—The term ''Ryan White-funded'' means, with respect to a facility, receiving funds under title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.).

(7) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(8) SCHOOL OF MEDICINE.—The term ''school of medicine'' has the meaning given to that term in section 799B of the Public Health Service Act (42 U.S.C. 295p).

(9) TITLE X-FUNDED.—The term ''title X-funded'' means, with respect to a facility, receiving funds under title X of the Public Health Service Act (42 U.S.C. 300 et seq.).

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2021 through 2024.

**SEC. 751. DENTAL EDUCATION LOAN REPAYMENT PROGRAM.**

(a) IN GENERAL.—The Secretary may enter into an agreement with any dentist under which—

(1) the dentist agrees to serve as a dentist for a period of not less than 2 years at a facility with a critical shortage of dentists (as determined by the Secretary) in an area with a high incidence of HIV; and

(2) the Secretary agrees to make payments in accordance with subsection (b) on the dental education loans of the dentist.

(b) MANNER OF PAYMENTS.—The payments described in subsection (a) shall be made by the Secretary as follows:

(1) Upon completion by the dentist for whom the payments are to be made of the first year of the service specified in the agreement entered into with the Secretary under subsection (a), the Secretary shall pay 30 percent of the principal of and the interest on the dental education loans of the dentist.

(2) Upon completion by the dentist of the second year of such service, the Secretary shall pay another 30 percent of the principal of and the interest on such loans.

(3) Upon completion by that individual of a third year of such service, the Secretary shall pay another 25 percent of the principal of and the interest on such loans.

(c) APPLICABILITY OF CERTAIN PROVISIONS.—Subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 254l et seq.) shall, except as inconsistent with this section, apply to the program carried out under this section in the same manner and to the same extent as such provisions apply to the National Health Service Corps Loan Repayment Program.

(d) REPORTS.—Not later than 18 months after the date of the enactment of this Act, and annually thereafter, the Secretary shall prepare and submit to the Congress a report describing the program carried out under this section, including statements regarding the following:

(1) The number of dentists enrolled in the program.

(2) The number and amount of loan repayments.

(3) The placement location of loan repayment recipients at facilities described in subsection (a)(1).

(4) The default rate and actions required.

(5) The amount of outstanding default funds.

(6) To the extent that it can be determined, the reason for the default.

(7) The demographics of individuals participating in the program.

(8) An evaluation of the overall costs and benefits of the program.

(e) DEFINITIONS.—In this section:

(1) DENTAL EDUCATION LOAN.—The term ''dental education loan''—

(A) means a loan that is incurred for the cost of attendance (including tuition, other reasonable educational expenses, and reasonable living costs) at a school of dentistry; and

(B) includes only the portion of the loan that is outstanding on the date the dentist involved begins the service specified in the agreement under subsection (a).

(2) DENTIST.—The term ''dentist'' means a graduate of a school of dentistry who has completed postgraduate training in general or pediatric dentistry.

(3) HIV/AIDS.—The term ''HIV/AIDS'' means human immunodeficiency virus and acquired immune deficiency syndrome.

(4) SCHOOL OF DENTISTRY.—The term ''school of dentistry'' has the meaning given to that term in section 799B of the Public Health Service Act (42 U.S.C. 295p).

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2021 through 2024.

**SEC. 752. REDUCING NEW HIV INFECTIONS AMONG INJECTING DRUG USERS.**

(a) SENSE OF CONGRESS.—It is the sense of Congress that providing sterile syringes and sterilized equipment to injecting drug users substantially reduces risk of HIV infection, increases the probability that they will initiate drug treatment, and does not increase drug use.

(b) IN GENERAL.—The Secretary of Health and Human Services may provide grants and technical assistance for the purpose of reducing the rate of HIV infections among injecting drug users through a comprehensive package of services for such users, including the provision of sterile syringes, education and outreach, access to infectious disease testing, overdose prevention, and treatment for drug dependence.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2021 through 2024.

**SEC. 753. REPORT ON IMPACT OF HIV/AIDS IN VULNERABLE POPULATIONS.**

(a) IN GENERAL.—The Secretary shall submit to Congress and the President an annual report on the impact of HIV for racial and ethnic minority communities, women, and youth aged 24 and younger.

(b) CONTENTS.—The report under subsection (a) shall include information on the—

(1) progress that has been made in reducing the impact of HIV/AIDS in such communities;

(2) opportunities that exist to make additional progress in reducing the impact of HIV/AIDS in such communities;

(3) challenges that may impede such additional progress; and

(4) Federal funding necessary to achieve substantial reductions in HIV in racial and ethnic minority communities.

**SEC. 754. NATIONAL HIV/AIDS OBSERVANCE DAYS.**

(a) NATIONAL OBSERVANCE DAYS.—It is the sense of Congress that national observance days highlighting the

impact of HIV on communities of color include the following:

(1) National Black HIV/AIDS Awareness Day.

(2) National Latino AIDS Awareness Day.

(3) National Asian and Pacific Islander HIV/AIDS Awareness Day.

(4) National Native American HIV/AIDS Awareness Day.

(5) National Youth HIV/AIDS Awareness Day.

(b) CALL TO ACTION.—It is the sense of Congress that the President should call on members of communities of color—

(1) to become involved at the local community level in HIV testing, policy, and advocacy;

(2) to become aware, engaged, and empowered on the HIV epidemic within their communities; and

(3) to urge members of their communities to reduce risk factors, practice safe sex and other preventive measures, be tested for HIV, and seek care when appropriate.

**SEC. 755. REVIEW OF ALL FEDERAL AND STATE LAWS, POLICIES, AND REGULATIONS REGARDING THE CRIMINAL PROSECUTION OF INDIVIDUALS FOR HIV-RELATED OFFENSES.**

(a) DEFINITIONS.—In this section:

(1) HIV.—The term ''HIV'' has the meaning given to the term in section 2689 of the Public Health Service Act (42 U.S.C. 300ff–88).

(2) STATE.—The term ''State'' includes the District of Columbia, American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the United States Virgin Islands.

(b) SENSE OF CONGRESS REGARDING LAWS OR REGULATIONS DIRECTED AT PEOPLE LIVING WITH HIV.—It is the sense of Congress that Federal and State laws, policies, and regulations regarding people living with HIV—

(1) should not place unique or additional burdens on such individuals solely as a result of their HIV status; and

(2) should instead demonstrate a public health-oriented, evidence-based, medically accurate, and contemporary understanding of—

(A) the multiple factors that lead to HIV transmission;

(B) the relative risk of HIV transmission routes;

(C) the current health implications of living with HIV;

(D) the associated benefits of treatment and support services for people living with HIV;

(E) the impact of punitive HIV-specific laws and policies on public health, on people living with or affected by HIV, and on their families and communities; and

(F) the current science on HIV prevention and treatment, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and viral suppression.

(c) REVIEW OF ALL FEDERAL AND STATE LAWS, POLICIES, AND REGULATIONS REGARDING THE CRIMINAL PROSECUTION OF INDIVIDUALS FOR HIV–RELATED OFFENSES.—

(1) REVIEW OF FEDERAL AND STATE LAWS.—

(A) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Attorney General, the Secretary of Health and Human Services, and the Secretary of Defense acting jointly (in this paragraph and paragraph (2) referred to as the ''designated officials'') shall initiate a national review of Federal and State laws, policies, regulations, and judicial precedents and decisions regarding criminal and related civil commitment cases involving people

living with HIV, including in regards to the Uniform Code of Military Justice.

(B) CONSULTATION.—In carrying out the review under subparagraph (A), the designated officials shall ensure diverse participation and consultation from each State, including with—

(i) State attorneys general (or their representatives);

(ii) State public health officials (or their representatives);

(iii) State judicial and court system officers, including judges, district attorneys, prosecutors, defense attorneys, law enforcement, and correctional officers;

(iv) members of the United States Armed Forces, including members of other Federal services subject to the Uniform Code of Military Justice;

(v) people living with HIV, particularly those who have been subject to HIV-related prosecution or who are from communities whose members have been disproportionately subject to HIV-specific arrests and prosecutions;

(vi) legal advocacy and HIV service organizations that work with people living with HIV;

(vii) nongovernmental health organizations that work on behalf of people living with HIV; and

(viii) trade organizations or associations representing persons or entities described in clauses (i) through (vii).

(C) RELATION TO OTHER REVIEWS.—In carrying out the review under subparagraph (A), the designated officials may utilize other existing reviews of criminal and related civil commitment cases involving people living with HIV, including any such review conducted by any Federal or State agency or any public health, legal advocacy, or trade organization or association if the designated officials determine that such reviews were conducted in accordance with the principles set forth in subsection (b).

(2) REPORT.—No later than 180 days after initiating the review required by paragraph (1), the Attorney General shall transmit to Congress and make publicly available a report containing the results of the review, which includes the following:

(A) For each State and for the Uniform Code of Military Justice, a summary of the relevant laws, policies, regulations, and judicial precedents and decisions regarding criminal cases involving people living with HIV, including, if applicable, the following:

(i) A determination of whether such laws, policies, regulations, and judicial precedents and decisions place any unique or additional burdens upon people living with HIV.

(ii) A determination of whether such laws, policies, regulations, and judicial precedents and decisions demonstrate a public health-oriented, evidence-based, medically accurate, and contemporary understanding of—

(I) the multiple factors that lead to HIV transmission;

(II) the relative risk of HIV transmission routes;

(III) the current health implications of living with HIV;

(IV) the associated benefits of treatment and support services for people living with HIV;

(V) the impact of punitive HIV-specific laws and policies on public health, on people living with or affected by HIV, and on their families and communities; and

(VI) the current science on HIV prevention and treatment, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and viral suppression.

(iii) An analysis of the public health and legal implications of such laws, policies, regulations, and judicial precedents, including an analysis of the consequences of having a similar penal scheme applied to comparable situations involving other communicable diseases.

(iv) An analysis of the proportionality of punishments imposed under HIV-specific laws, policies, regulations, and judicial precedents, taking into consideration penalties attached to violation of State laws

against similar degrees of endangerment or harm, such as driving while intoxicated or transmission of other communicable diseases, or more serious harms, such as vehicular manslaughter offenses.

(B) An analysis of common elements shared among State laws, policies, regulations, and judicial precedents.

(C) A set of best practice recommendations directed to State governments, including State attorneys general, public health officials, and judicial officers, in order to ensure that laws, policies, regulations, and judicial precedents regarding people living with HIV are in accordance with the principles set forth in subsection (b).

(D) Recommendations for adjustments to the Uniform Code of Military Justice, as may be necessary, in order to ensure that laws, policies, regulations, and judicial precedents regarding people living with HIV are in accordance with the principles set forth in subsection (b).

(3) GUIDANCE.—Within 90 days of the release of the report required by paragraph (2), the Attor-

ney General and the Secretary of Health and Human Services, acting jointly, shall develop and publicly release updated guidance for States based on the set of best practice recommendations required by paragraph (2)(C) in order to assist States dealing with criminal and related civil commitment cases regarding people living with HIV.

(4) MONITORING AND EVALUATION SYSTEM.—Within 60 days of the release of the guidance required by paragraph (3), the Attorney General and the Secretary of Health and Human Services, acting jointly, shall establish an integrated monitoring and evaluation system which includes, where appropriate, objective and quantifiable performance goals and indicators to measure progress toward statewide implementation in each State of the best practice recommendations required in paragraph (2)(C), including to monitor, track, and evaluate the effectiveness of assistance provided pursuant to subsection (d).

(5) ADJUSTMENTS TO FEDERAL LAWS, POLICIES, OR REGULATIONS.—Within 90 days of the release of the report required by paragraph (2), the Attorney General, the Secretary of Health and Human Services, and the Secretary of Defense, acting jointly, shall develop and transmit to the Presi-

dent and the Congress, and make publicly available, such proposals as may be necessary to implement adjustments to Federal laws, policies, or regulations, including to the Uniform Code of Military Justice, based on the recommendations required by paragraph (2)(D), either through Executive order or through changes to statutory law.

(6) AUTHORIZATION OF APPROPRIATIONS.—

(A) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary for the purpose of carrying out this subsection. Amounts authorized to be appropriated by the preceding sentence are in addition to amounts otherwise authorized to be appropriated for such purpose.

(B) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to the authorization of appropriations in subparagraph (A) are authorized to remain available until expended.

(d) AUTHORIZATION TO PROVIDE GRANTS.—

(1) GRANTS BY ATTORNEY GENERAL.—

(A) IN GENERAL.—The Attorney General may provide assistance to eligible State and local entities and eligible nongovernmental organizations for the purpose of incorporating the

best practice recommendations developed under subsection (c)(2)(C) within relevant State laws, policies, regulations, and judicial decisions regarding people living with HIV.

(B) AUTHORIZED ACTIVITIES.—The assistance authorized by subparagraph (A) may include—

(i) direct technical assistance to eligible State and local entities in order to develop, disseminate, or implement State laws, policies, regulations, or judicial decisions that conform with the best practice recommendations developed under subsection (c)(2)(C);

(ii) direct technical assistance to eligible nongovernmental organizations in order to provide education and training, including through classes, conferences, meetings, and other educational activities, to eligible State and local entities; and

(iii) subcontracting authority to allow eligible State and local entities and eligible nongovernmental organizations to seek technical assistance from legal and public health experts with a demonstrated under-

standing of the principles underlying the best practice recommendations developed under subsection (c)(2)(C).

(2) GRANTS BY SECRETARY OF HEALTH AND HUMAN SERVICES.—

(A) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, may provide assistance to State and local public health departments and eligible nongovernmental organizations for the purpose of supporting eligible State and local entities to incorporate the best practice recommendations developed under subsection (c)(2)(C) within relevant State laws, policies, regulations, and judicial decisions regarding people living with HIV.

(B) AUTHORIZED ACTIVITIES.—The assistance authorized by subparagraph (A) may include—

(i) direct technical assistance to State and local public health departments in order to support the development, dissemination, or implementation of State laws, policies, regulations, or judicial decisions that conform with the set of best practice

recommendations developed under subsection (c)(2)(C);

(ii) direct technical assistance to eligible nongovernmental organizations in order to provide education and training, including through classes, conferences, meetings, and other educational activities, to State and local public health departments; and

(iii) subcontracting authority to allow State and local public health departments and eligible nongovernmental organizations to seek technical assistance from legal and public health experts with a demonstrated understanding of the principles underlying the best practice recommendations developed under subsection (c)(2)(C).

(3) LIMITATION.—As a condition of receiving assistance through this subsection, eligible State and local entities, State and local public health departments, and eligible nongovernmental organizations shall agree—

(A) not to place any unique or additional burdens on people living with HIV solely as a result of their HIV status; and

(B) that if the entity, department, or organization promulgates any laws, policies, regulations, or judicial decisions regarding people living with HIV, such actions shall demonstrate a public health-oriented, evidence-based, medically accurate, and contemporary understanding of—

(i) the multiple factors that lead to HIV transmission;

(ii) the relative risk of HIV transmission routes;

(iii) the current health implications of living with HIV;

(iv) the associated benefits of treatment and support services for people living with HIV;

(v) the impact of punitive HIV-specific laws and policies on public health, on people living with or affected by HIV, and on their families and communities; and

(vi) the current science on HIV prevention and treatment, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and viral suppression.

(4) REPORT.—No later than 1 year after the date of the enactment of this Act, and annually

thereafter, the Attorney General and the Secretary of Health and Human Services, acting jointly, shall transmit to Congress and make publicly available a report describing, for each State, the impact and effectiveness of the assistance provided through this section. Each such report shall include—

(A) a detailed description of the progress each State has made, if any, in implementing the best practice recommendations developed under subsection (c)(2)(C) as a result of the assistance provided under this subsection, and based on the performance goals and indicators established as part of the monitoring and evaluation system in subsection (c)(4);

(B) a brief summary of any outreach efforts undertaken during the prior year by the Attorney General and the Secretary of Health and Human Services to encourage States to seek assistance under this subsection in order to implement the best practice recommendations developed under subsection (c)(2)(C);

(C) a summary of how assistance provided through this subsection is being utilized by eligible State and local entities, State and local public health departments, and eligible non-

governmental organizations and, if applicable, any contractors, including with respect to non-governmental organizations, the type of technical assistance provided, and an evaluation of the impact of such assistance on eligible State and local entities; and

(D) a summary and description of eligible State and local entities, State and local public health departments, and eligible nongovernmental organizations receiving assistance through this subsection, including if applicable, a summary and description of any contractors selected to assist in implementing such assistance.

(5) DEFINITIONS.—For the purposes of this subsection:

(A) ELIGIBLE STATE AND LOCAL ENTITIES.—The term ''eligible State and local entities'' means the relevant individuals, offices, or organizations that directly participate in the development, dissemination, or implementation of State laws, policies, regulations, or judicial decisions, including—

(i) State governments, including State attorneys general, State departments of

justice, and State National Guards, or their equivalents;

(ii) State judicial and court systems, including trial courts, appellate courts, State supreme courts and courts of appeal, and State correctional facilities, or their equivalents; and

(iii) local governments, including city and county governments, district attorneys, and local law enforcement departments, or their equivalents.

(B) STATE AND LOCAL PUBLIC HEALTH DEPARTMENTS.—The term ''State and local public health departments'' means the following:

(i) State public health departments, or their equivalents, including the chief officer of such departments and infectious disease and communicable disease specialists within such departments.

(ii) Local public health departments, or their equivalents, including city and county public health departments, the chief officer of such departments, and infectious

disease and communicable disease specialists within such departments.

(iii) Public health departments or officials, or their equivalents, within State or local correctional facilities.

(iv) Public health departments or officials, or their equivalents, within State National Guards.

(v) Any other recognized State or local public health organization or entity charged with carrying out official State or local public health duties.

(C) ELIGIBLE NONGOVERNMENTAL ORGANIZATIONS.—The term ''eligible nongovernmental organizations'' means the following:

(i) Nongovernmental organizations, including trade organizations or associations that represent—

(I) State attorneys general, or their equivalents;

(II) State public health officials, or their equivalents;

(III) State judicial and court officers, including judges, district attorneys, prosecutors, defense attorneys,

law enforcement, and correctional officers;

(IV) State National Guards;

(V) people living with HIV;

(VI) legal advocacy and HIV service organizations that work with people living with HIV; and

(VII) nongovernmental health organizations that work on behalf of people living with HIV.

(ii) Nongovernmental organizations, including trade organizations or associations that demonstrate a public-health oriented, evidence-based, medically accurate, and contemporary understanding of—

(I) the multiple factors that lead to HIV transmission;

(II) the relative risk of HIV transmission routes;

(III) the current health implications of living with HIV;

(IV) the associated benefits of treatment and support services for people living with HIV;

(V) the impact of punitive HIV-specific laws and policies on public health, on people living with or affected by HIV, and on their families and communities; and

(VI) the current science on HIV prevention and treatment, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and viral suppression.

(6) AUTHORIZATION OF APPROPRIATIONS.—

(A) IN GENERAL.—In addition to amounts otherwise made available, there are authorized to be appropriated to the Attorney General and the Secretary of Health and Human Services such sums as may be necessary to carry out this subsection for each of the fiscal years 2021 through 2024.

(B) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to the authorizations of appropriations in subparagraph (A) are authorized to remain available until expended.

**SEC. 756. EXPANDING SUPPORT FOR CONDOMS IN PRISONS.**

(a) DEFINITIONS.—For the purposes of this section:

(1) COMMUNITY ORGANIZATION.—The term ''community organization'' means a public health care facility or a nonprofit organization which provides health- or STI-related services according to established public health standards.

(2) COMPREHENSIVE SEXUALITY EDUCATION.—The term ''comprehensive sexuality education'' means sexuality education—

(A) that includes information about abstinence and about the proper use and disposal of sexual barrier protection devices; and

(B) which is—

(i) evidence-based;

(ii) medically accurate;

(iii) age and developmentally appropriate;

(iv) gender and identity sensitive;

(v) culturally and linguistically appropriate; and

(vi) structured to promote critical thinking, self-esteem, respect for others, and the development of healthy attitudes and relationships.

(3) CORRECTIONAL FACILITY.—The term ''correctional facility'' means any prison, penitentiary,

adult detention facility, juvenile detention facility, jail, or other facility to which persons may be sent after conviction of a crime or act of juvenile delinquency within the United States.

(4) INCARCERATED PERSON.—The term ''incarcerated person'' means any person who is serving a sentence in a correctional facility after conviction of a crime.

(5) SEXUALLY TRANSMITTED INFECTION.—The term ''sexually transmitted infection'' or ''STI'' means any disease or infection that is commonly transmitted through sexual activity, including HIV, gonorrhea, chlamydia, syphilis, genital herpes, viral hepatitis, and human papillomavirus.

(6) SEXUAL BARRIER PROTECTION DEVICE.—The term ''sexual barrier protection device'' means any FDA-approved physical device which has not been tampered with and which reduces the probability of STI transmission or infection between sexual partners, including female condoms, male condoms, and dental dams.

(7) STATE.—The term ''State'' includes the District of Columbia, American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the United States Virgin Islands.

(b) AUTHORITY TO ALLOW COMMUNITY ORGANIZATIONS TO PROVIDE STI COUNSELING, STI PREVENTION EDUCATION, AND SEXUAL BARRIER PROTECTION DEVICES IN FEDERAL CORRECTIONAL FACILITIES.—

(1) DIRECTIVE TO ATTORNEY GENERAL.—Not later than 30 days after the date of enactment of this Act, the Attorney General shall direct the Director of the Bureau of Prisons to allow community organizations to, in accordance with all relevant Federal laws and regulations which govern visitation in correctional facilities—

(A) distribute sexual barrier protection devices in Federal correctional facilities; and

(B) engage in STI counseling and STI prevention education in Federal correctional facilities.

(2) INFORMATION REQUIREMENT.—Any community organization permitted to distribute sexual barrier protection devices under paragraph (1) shall ensure that the persons to whom the devices are distributed are informed about the proper use and disposal of sexual barrier protection devices in accordance with established public health practices. Any community organization conducting STI counseling

or STI prevention education under paragraph (1) shall offer comprehensive sexuality education.

(3) POSSESSION OF DEVICE PROTECTED.—A Federal correctional facility may not, because of the possession or use of a sexual barrier protection device—

(A) take adverse action against an incarcerated person; or

(B) consider possession or use as evidence of prohibited activity for the purpose of any Federal correctional facility administrative proceeding.

(4) IMPLEMENTATION.—The Attorney General and Bureau of Prisons shall implement this section according to established public health practices in a manner that protects the health, safety, and privacy of incarcerated persons and of correctional facility staff.

(c) SENSE OF CONGRESS REGARDING DISTRIBUTION OF SEXUAL BARRIER PROTECTION DEVICES IN STATE PRISON SYSTEMS.—It is the sense of the Congress that States should allow for the legal distribution of sexual barrier protection devices in State correctional facilities to reduce the prevalence and spread of STIs in those facilities.

(d) SURVEY OF AND REPORT ON CORRECTIONAL FACILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF STIS.—

(1) SURVEY.—Not later than 180 days after the date of enactment of this Act, and annually thereafter for 5 years, the Attorney General, after consulting with the Secretary of Health and Human Services, State officials, and community organizations, shall, to the maximum extent practicable, conduct a survey of all Federal and State correctional facilities, to determine the following:

(A) COUNSELING, TREATMENT, AND SUPPORTIVE SERVICES.—Whether the correctional facility—

(i) requires incarcerated persons to participate in counseling, treatment, and supportive services related to STIs or

(ii) offers such programs to incarcerated persons.

(B) ACCESS TO SEXUAL BARRIER PROTECTION DEVICES.—Whether incarcerated persons can—

(i) possess sexual barrier protection devices;

(ii) purchase sexual barrier protection devices;

(iii) purchase sexual barrier protection devices at a reduced cost; or

(iv) obtain sexual barrier protection devices without cost.

(C) INCIDENCE OF SEXUAL VIOLENCE.—The incidence of sexual violence and assault committed by incarcerated persons and by correctional facility staff.

(D) PREVENTION EDUCATION OFFERED.—The type of prevention education, information, or training offered to incarcerated persons and correctional facility staff regarding sexual violence and the spread of STIs, including whether such education, information, or training—

(i) constitutes comprehensive sexuality education;

(ii) is compulsory for new incarcerated persons and for new staff; and

(iii) is offered on an ongoing basis.

(E) STI TESTING.—Whether the correctional facility tests incarcerated persons for STIs or gives them the option to undergo such testing—

(i) at intake;

(ii) on a regular basis; and

(iii) prior to release.

(F) STI TEST RESULTS.—The number of incarcerated persons who are tested for STIs and the outcome of such tests at each correctional facility, disaggregated to include results for—

(i) the type of sexually transmitted infection tested for;

(ii) the race and ethnicity of individuals tested;

(iii) the age of individuals tested; and

(iv) the gender of individuals tested.

(G) PRERELEASE REFERRAL POLICY.—Whether incarcerated persons are informed prior to release about STI-related services or other health services in their communities, including free and low-cost counseling and treatment options.

(H) PRERELEASE REFERRALS MADE.—The number of referrals to community-based organizations or public health facilities offering STI-related or other health services provided to incarcerated persons prior to release, and the

type of counseling or treatment for which the referral was made.

(I) REINSTATEMENT OF MEDICAID BENEFITS.—Whether the correctional facility assists incarcerated persons that were enrolled in the State Medicaid program prior to their incarceration, in reinstating their enrollment upon release and whether such individuals receive referrals as provided by subparagraph (G) to entities that accept the State Medicaid program, including if applicable—

(i) the number of such individuals, including those diagnosed with HIV, that have been reinstated;

(ii) a list of obstacles to reinstating enrollment or to making determinations of eligibility for reinstatement, if any; and

(iii) the number of individuals denied enrollment.

(J) OTHER ACTIONS TAKEN.—Whether the correctional facility has taken any other action, in conjunction with community organizations or otherwise, to reduce the prevalence and spread of STIs in that facility.

(2) PRIVACY.—In conducting the survey under paragraph (1), the Attorney General shall not request or retain the identity of any person who has sought or been offered counseling, treatment, testing, or prevention education information regarding an STI (including information about sexual barrier protection devices), or who has tested positive for an STI.

(3) REPORT.—

(A) IN GENERAL.—The Attorney General shall transmit to Congress and make publicly available the results of the survey required under paragraph (1), both for the United States as a whole and disaggregated as to each State and each correctional facility.

(B) DEADLINES.—To the maximum extent possible, the Attorney General shall—

(i) issue the first report under subparagraph (A) not later than 1 year after the date of enactment of this Act; and

(ii) issue reports under subparagraph (A) annually thereafter for 5 years.

(e) STRATEGY.—

(1) DIRECTIVE TO ATTORNEY GENERAL.—The Attorney General, in consultation with the Secretary

of Health and Human Services, State officials, and community organizations, shall develop and implement a 5-year strategy to reduce the prevalence and spread of STIs in Federal and State correctional facilities. To the maximum extent possible, the strategy shall be developed, transmitted to Congress, and made publicly available no later than 180 days after the transmission of the first report required under subsection (d)(3).

(2) CONTENTS OF STRATEGY.—The strategy developed under paragraph (1) shall include the following:

(A) PREVENTION EDUCATION.—A plan for improving prevention education, information, and training offered to incarcerated persons and correctional facility staff, including information and training on sexual violence and the spread of STIs, and comprehensive sexuality education.

(B) SEXUAL BARRIER PROTECTION DEVICE ACCESS.—A plan for expanding access to sexual barrier protection devices in correctional facilities.

(C) SEXUAL VIOLENCE REDUCTION.—A plan for reducing the incidence of sexual vio-

lence among incarcerated persons and correctional facility staff, developed in consultation with the National Prison Rape Elimination Commission.

(D) COUNSELING AND SUPPORTIVE SERVICES.—A plan for expanding access to counseling and supportive services related to STIs in correctional facilities.

(E) TESTING.—A plan for testing incarcerated persons for STIs during intake, during regular health exams, and prior to release, and that—

(i) is conducted in accordance with guidelines established by the Centers for Disease Control and Prevention;

(ii) includes pretest counseling;

(iii) requires that incarcerated persons are notified of their option to decline testing at any time;

(iv) requires that incarcerated persons are confidentially notified of their test results in a timely manner; and

(v) ensures that incarcerated persons testing positive for STIs receive post-test

counseling, care, treatment, and supportive services.

(F) TREATMENT.—A plan for ensuring that correctional facilities have the necessary medicine and equipment to treat and monitor STIs and for ensuring that incarcerated persons living with or testing positive for STIs receive and have access to care and treatment services.

(G) STRATEGIES FOR DEMOGRAPHIC GROUPS.—A plan for developing and implementing culturally appropriate, sensitive, and specific strategies to reduce the spread of STIs among demographic groups heavily impacted by STIs.

(H) LINKAGES WITH COMMUNITIES AND FACILITIES.—A plan for establishing and strengthening linkages to local communities and health facilities that—

(i) provide counseling, testing, care, and treatment services;

(ii) may receive persons recently released from incarceration who are living with STIs; and

(iii) accept payment through the State Medicaid program.

(I) ENROLLMENT IN STATE MEDICAID PROGRAMS.—Plans to ensure that—

(i) incarcerated persons who were enrolled in their State Medicaid program prior to incarceration in a correctional facility are automatically reenrolled in such program upon their release; and

(ii) incarcerated persons who were not enrolled in their State Medicaid program prior to incarceration, and who are diagnosed with HIV while incarcerated in a correctional facility, are automatically enrolled in such program upon their release.

(J) OTHER PLANS.—Any other plans developed by the Attorney General for reducing the spread of STIs or improving the quality of health care in correctional facilities.

(K) MONITORING SYSTEM.—A monitoring system that establishes performance goals related to reducing the prevalence and spread of STIs in correctional facilities and which, where feasible, expresses such goals in quantifiable form.

(L) MONITORING SYSTEM PERFORMANCE INDICATORS.—Performance indicators that measure or assess the achievement of the performance goals described in subparagraph (K).

(M) COST ESTIMATE.—A detailed estimate of the funding necessary to implement the strategy at the Federal and State levels for all 5 years, including the amount of funds required by community organizations to implement the parts of the strategy in which they take part.

(3) REPORT.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter, the Attorney General shall transmit to Congress and make publicly available an annual progress report regarding the implementation and effectiveness of the strategy described in paragraph (1). The progress report shall include an evaluation of the implementation of the strategy using the monitoring system and performance indicators provided for in subparagraphs (K) and (L) of paragraph (2).

(f) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out this section for each of fiscal years 2021 through 2025.

(2) AVAILABILITY OF FUNDS.—Amounts made available under paragraph (1) are authorized to remain available until expended.

**SEC. 757. AUTOMATIC REINSTATEMENT OR ENROLLMENT IN MEDICAID FOR PEOPLE WHO TEST POSITIVE FOR HIV BEFORE REENTERING COMMUNITIES.**

(a) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

''(16) ENROLLMENT OF EX-OFFENDERS.—

''(A) AUTOMATIC ENROLLMENT OR REINSTATEMENT.—

''(i) IN GENERAL.—The State plan shall provide for the automatic enrollment or reinstatement of enrollment of an eligible individual—

''(I) if such individual is scheduled to be released from a public institution due to the completion of sentence, not less than 30 days prior to the scheduled date of the release; and

''(II) if such individual is to be released from a public institution on parole or on probation, as soon as

possible after the date on which the determination to release such individual was made, and before the date such individual is released.

''(ii) EXCEPTION.—If a State makes a determination that an individual is not eligible to be enrolled under the State plan—

''(I) on or before the date by which the individual would be enrolled under clause (i), such clause shall not apply to such individual; or

''(II) after such date, the State may terminate the enrollment of such individual.

''(B) RELATIONSHIP OF ENROLLMENT TO PAYMENT FOR SERVICES.—

''(i) IN GENERAL.—Subject to subparagraph (A)(ii), an eligible individual who is enrolled, or whose enrollment is reinstated, under subparagraph (A) shall be eligible for all services for which medical assistance is provided under the State plan after the date that the eligible individual is released from the public institution.

"(ii) RELATIONSHIP TO PAYMENT PROHIBITION FOR INMATES.—No provision of this paragraph may be construed to permit payment for care or services for which payment is excluded under subdivision (A) following paragraph (29) of section 1905(a).

"(C) TREATMENT OF CONTINUOUS ELIGIBILITY.—

"(i) SUSPENSION FOR INMATES.—Any period of continuous eligibility under this title shall be suspended on the date an individual enrolled under this title becomes an inmate of a public institution (except as a patient of a medical institution).

"(ii) DETERMINATION OF REMAINING PERIOD.—Notwithstanding any changes to State law related to continuous eligibility during the time that an individual is an inmate of a public institution (except as a patient of a medical institution), subject to clause (iii), with respect to an eligible individual who was subject to a suspension under clause (i), on the date that such individual is released from a public institu-

tion the suspension of continuous eligibility under such clause shall be lifted for a period that is equal to the time remaining in the period of continuous eligibility for such individual on the date that such period was suspended under such clause.

''(iii) EXCEPTION.—If a State makes a determination that an individual is not eligible to be enrolled under the State plan—

''(I) on or before the date that the suspension of continuous eligibility is lifted under clause (ii), such clause shall not apply to such individual; or

''(II) after such date, the State may terminate the enrollment of such individual.

''(D) AUTOMATIC ENROLLMENT OR REINSTATEMENT OF ENROLLMENT DEFINED.—For purposes of this paragraph, the term 'automatic enrollment or reinstatement of enrollment' means that the State determines eligibility for medical assistance under the State plan without a program application from, or on behalf of, the eligible individual, but an individual can only be

automatically enrolled in the State Medicaid plan if the individual affirmatively consents to being enrolled through affirmation in writing, by telephone, orally, through electronic signature, or through any other means specified by the Secretary.

''(E) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this paragraph, the term 'eligible individual' means an individual who is an inmate of a public institution (except as a patient in a medical institution)—

''(i) who was enrolled under the State plan for medical assistance immediately before becoming an inmate of such an institution; or

''(ii) who is diagnosed with human immunodeficiency virus.''.

(b) SUPPLEMENTAL FUNDING FOR STATE IMPLEMENTATION OF AUTOMATIC REINSTATEMENT OF MEDICAID BENEFITS.—

(1) IN GENERAL.—Subject to paragraphs (3), with respect to a State, for each of the first 4 calendar quarters in which the State plan meets the requirements of paragraph (16) of section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) (as

added by subsection (a)), the Federal matching payments (including payments based on the Federal medical assistance percentage) made to such State under section 1903 of the Social Security Act (42 U.S.C. 1396b) for the State expenditures described in paragraph (2) shall be increased by 5 percentage points.

(2) EXPENDITURES.—The expenditures described in this paragraph are the following:

(A) Expenditures for which payment is available under section 1903 of the Social Security Act (42 U.S.C. 1396b) and which are attributable to strengthening the State's enrollment and administrative resources for the purpose of improving processes for enrolling (or reinstating the enrollment of) eligible individuals (as such term is defined in subparagraph (E) of paragraph (16) of section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) (as amended by subsection (a)).

(B) Expenditures for medical assistance (as such term is defined in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a))) provided to such eligible individuals.

(3) REQUIREMENTS; LIMITATION.—

(A) REPORT.—A State is not eligible for an increase in its Federal matching payments under paragraph (1) unless the State agrees to submit to the Secretary of Health and Human Services, and make publicly available, a report that contains the information required under paragraph (4) by the end of the 1-year period during which the State receives increased Federal matching payments in accordance with that paragraph.

(B) MAINTENANCE OF ELIGIBILITY.—

(i) IN GENERAL.—Subject to clause (ii), a State is not eligible for an increase in its Federal matching payments under paragraph (1) if eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or waiver of such a plan, are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan or waiver as in effect on the date of enactment of this Act.

(ii) STATE REINSTATEMENT OF ELIGIBILITY PERMITTED.—A State that has re-

stricted eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or a waiver of such plan, after the date of enactment of this Act, is no longer ineligible under clause (i) beginning with the first calendar quarter in which the State has reinstated eligibility standards, methodologies, or procedures that are no more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on such date.

(C) LIMITATION OF MATCHING PAYMENTS TO 100 PERCENT.—In no case shall an increase in Federal matching payments under paragraph (1) result in Federal matching payments that exceed 100 percent of State expenditures.

(4) REQUIRED REPORT INFORMATION.—The information that is required in the report under paragraph (3)(A) shall include—

(A) the results of an evaluation of the impact of the implementation of the requirements of paragraph (16) of section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) on im-

proving the State's processes for enrolling individuals who are released from public institutions under the State Medicaid plan;

(B) the number of individuals who were automatically enrolled (or whose enrollment was reinstated) under such paragraph during the 1-year period during which the State received increased payments under this subsection; and

(C) any other information that is required by the Secretary of Health and Human Services.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by subsection (a) shall take effect 180 days after the date of the enactment of this Act.

(2) RULE FOR CHANGES REQUIRING STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by subsection (a), the State plan shall not be

regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

**SEC. 758. STOP HIV IN PRISON.**

(a) SHORT TITLE.—This section may be cited as the ''Stop HIV in Prison Act''.

(b) IN GENERAL.—The Director of the Bureau of Prisons (referred to in this section as the ''Director'') shall develop a comprehensive policy to provide HIV testing, treatment, and prevention for inmates within the correctional setting and upon reentry.

(c) PURPOSE.—The purposes of the policy required to be developed under subsection (b) shall be as follows:

(1) To stop the spread of HIV among inmates.

(2) To protect prison guards and other personnel from HIV infection.

(3) To provide comprehensive medical treatment to inmates who are living with HIV.

(4) To promote HIV awareness and prevention among inmates.

(5) To encourage inmates to take personal responsibility for their health.

(6) To reduce the risk that inmates will transmit HIV to other persons in the community following their release from prison.

(d) CONSULTATION.—The Director shall consult with appropriate officials of the Department of Health and Human Services, the Office of National Drug Control Policy, and the Centers for Disease Control and Prevention regarding the development of the policy required under subsection (b).

(e) TIME LIMIT.—Not later than 1 year after the date of enactment of this Act, the Director shall draft appropriate regulations to implement the policy required to be developed under subsection (b).

(f) REQUIREMENTS FOR POLICY.—The policy required to be developed under subsection (b) shall provide for the following:

(1) TESTING AND COUNSELING UPON INTAKE.—

(A) Health care personnel shall provide routine HIV testing to all inmates as a part of a comprehensive medical examination imme-

diately following admission to a facility. Health care personnel need not provide routine HIV testing to an inmate who is transferred to a facility from another facility if the inmate's medical records are transferred with the inmate and indicate that the inmate has been tested previously.

(B) To all inmates admitted to a facility prior to the effective date of this policy, health care personnel shall provide routine HIV testing within no more than 6 months. HIV testing for these inmates may be performed in conjunction with other health services provided to these inmates by health care personnel.

(C) All HIV tests under this paragraph shall comply with the opt-out provision.

(2) PRE-TEST AND POST-TEST COUNSELING.—Health care personnel shall provide confidential pre-test and post-test counseling to all inmates who are tested for HIV. Counseling may be included with other general health counseling provided to inmates by health care personnel.

(3) HIV PREVENTION EDUCATION.—

(A) Health care personnel shall improve HIV awareness through frequent educational

programs for all inmates. HIV educational programs may be provided by community-based organizations, local health departments, and inmate peer educators.

(B) HIV educational materials shall be made available to all inmates at orientation, at health care clinics, at regular educational programs, and prior to release. Both written and audiovisual materials shall be made available to all inmates.

(C)(i) The HIV educational programs and materials under this paragraph shall include information on—

(I) modes of transmission, including transmission through tattooing, sexual contact, and intravenous drug use;

(II) prevention methods;

(III) treatment; and

(IV) disease progression.

(ii) The programs and materials shall be culturally sensitive, written or designed for low-literacy levels, available in a variety of languages, and present scientifically accurate information in a clear and understandable manner.

(4) HIV TESTING UPON REQUEST.—

(A) Health care personnel shall allow inmates to obtain HIV tests upon request once per year or whenever an inmate has a reason to believe the inmate may have been exposed to HIV. Health care personnel shall, both orally and in writing, inform inmates, during orientation and periodically throughout incarceration, of their right to obtain HIV tests.

(B) Health care personnel shall encourage inmates to request HIV tests if the inmate is sexually active, has been raped, uses intravenous drugs, receives a tattoo, or if the inmate is concerned that the inmate may have been exposed to HIV.

(C) An inmate's request for an HIV test shall not be considered an indication that the inmate has put him/herself at risk of infection and/or committed a violation of prison rules.

(5) HIV TESTING OF PREGNANT WOMAN.—

(A) Health care personnel shall provide routine HIV testing to all inmates who become pregnant.

(B) All HIV tests under this paragraph shall comply with the opt-out provision.

(6) COMPREHENSIVE TREATMENT.—

(A) Health care personnel shall provide all inmates who test positive for HIV—

(i) timely, comprehensive medical treatment;

(ii) confidential counseling on managing their medical condition and preventing its transmission to other persons; and

(iii) voluntary partner notification services.

(B) Health care provided under this paragraph shall be consistent with current Department of Health and Human Services guidelines and standard medical practice. Health care personnel shall discuss treatment options, the importance of adherence to antiretroviral therapy, and the side effects of medications with inmates receiving treatment.

(C) Health care personnel and pharmacy personnel shall ensure that the facility formulary contains all Food and Drug Administration-approved medications necessary to provide comprehensive treatment for inmates living with HIV, and that the facility maintains adequate

supplies of such medications to meet inmates' medical needs. Health care personnel and pharmacy personnel shall also develop and implement automatic renewal systems for these medications to prevent interruptions in care.

(D) Correctional staff, health care personnel, and pharmacy personnel shall develop and implement distribution procedures to ensure timely and confidential access to medications.

(7) PROTECTION OF CONFIDENTIALITY.—

(A) Health care personnel shall develop and implement procedures to ensure the confidentiality of inmate tests, diagnoses, and treatment. Health care personnel and correctional staff shall receive regular training on the implementation of these procedures. Penalties for violations of inmate confidentiality by health care personnel or correctional staff shall be specified and strictly enforced.

(B) HIV testing, counseling, and treatment shall be provided in a confidential setting where other routine health services are provided and in a manner that allows the inmate to re-

quest and obtain these services as routine medical services.

(8) TESTING, COUNSELING, AND REFERRAL PRIOR TO REENTRY.—

(A) Health care personnel shall provide routine HIV testing to all inmates not earlier than 3 months prior to their release and reentry into the community. Inmates who are already known to be infected need not be tested again. This requirement may be waived if an inmate's release occurs without sufficient notice to the Bureau to allow health care personnel to perform a routine HIV test and notify the inmate of the results.

(B) All HIV tests under this paragraph shall comply with the opt-out provision.

(C) To all inmates who test positive for HIV and all inmates who already are known to have HIV, health care personnel shall provide—

(i) confidential prerelease counseling on managing their medical condition in the community, accessing appropriate treatment and services in the community, and preventing the transmission of their condi-

tion to family members and other persons in the community;

(ii) referrals to appropriate health care providers and social service agencies in the community that meet the inmate's individual needs, including voluntary partner notification services and prevention counseling services for people living with HIV; and

(iii) a 30-day supply of any medically necessary medications the inmate is currently receiving.

(9) OPT-OUT PROVISION.—Inmates shall have the right to refuse routine HIV testing. Inmates shall be informed both orally and in writing of this right. Oral and written disclosure of this right may be included with other general health information and counseling provided to inmates by health care personnel. If an inmate refuses a routine test for HIV, health care personnel shall make a note of the inmate's refusal in the inmate's confidential medical records. However, the inmate's refusal shall not be considered a violation of prison rules or result in disciplinary action. Any reference in this section to the

''opt-out provision'' shall be deemed a reference to the requirement of this paragraph.

(10) EXCLUSION OF TESTS PERFORMED UNDER SECTION 4014(b) FROM THE DEFINITION OF ROUTINE HIV TESTING.—HIV testing of an inmate under section 4014(b) of title 18, United States Code, is not routine HIV testing for the purposes of the opt-out provision. Health care personnel shall document the reason for testing under section 4014(b) of title 18, United States Code, in the inmate's confidential medical records.

(11) TIMELY NOTIFICATION OF TEST RESULTS.—Health care personnel shall provide timely notification to inmates of the results of HIV tests.

(g) CHANGES IN EXISTING LAW.—

(1) SCREENING IN GENERAL.—Section 4014(a) of title 18, United States Code, is amended—

(A) by striking ''for a period of 6 months or more'';

(B) by striking '', as appropriate,''; and

(C) by striking ''if such individual is determined to be at risk for infection with such virus in accordance with the guidelines issued by the Bureau of Prisons relating to infectious disease management'' and inserting ''unless the indi-

vidual declines. The Attorney General shall also cause such individual to be so tested before release unless the individual declines.''.

(2) INADMISSIBILITY OF HIV TEST RESULTS IN CIVIL AND CRIMINAL PROCEEDINGS.—Section 4014(d) of title 18, United States Code, is amended by inserting ''or under the Stop HIV in Prison Act'' after ''under this section''.

(3) SCREENING AS PART OF ROUTINE SCREENING.—Section 4014(e) of title 18, United States Code, is amended by adding at the end the following: ''Such rules shall also provide that the initial test under this section be performed as part of the routine health screening conducted at intake.''.

(h) REPORTING REQUIREMENTS.—

(1) REPORT ON HEPATITIS, LIVER, AND OTHER DISEASES.—Not later than 1 year after the date of enactment of this Act, the Director shall provide a report to the Congress on the policies and procedures of the Bureau of Prisons to provide testing, treatment, and prevention education programs for hepatitis, liver failure, and other liver-related diseases transmitted through sexual activity, intravenous drug use, or other means. The Director shall consult with appropriate officials of the Department

of Health and Human Services, the Office of National Drug Control Policy, the Office of National AIDS Policy, and the Centers for Disease Control and Prevention regarding the development of this report.

(2) ANNUAL REPORTS.—

(A) GENERALLY.—Not later than 2 years after the date of enactment of this Act, and then annually thereafter, the Director shall report to Congress on the incidence among inmates of diseases transmitted through sexual activity and intravenous drug use.

(B) MATTERS PERTAINING TO VARIOUS DISEASES.—Each report under paragraph (1) shall discuss—

(i) the incidence among inmates of HIV, hepatitis, and other diseases transmitted through sexual activity and intravenous drug use; and

(ii) updates on the testing, treatment, and prevention education programs for these diseases conducted by the Bureau of Prisons.

(C) MATTERS PERTAINING TO HIV ONLY.—Each report under paragraph (1) shall also include—

(i) the number of inmates who tested positive for HIV upon intake;

(ii) the number of inmates who tested positive prior to reentry;

(iii) the number of inmates who were not tested prior to reentry because they were released without sufficient notice;

(iv) the number of inmates who opted-out of taking the test;

(v) the number of inmates who were tested under section 4014(b) of title 18, United States Code; and

(vi) the number of inmates under treatment for HIV.

(D) CONSULTATION.—The Director shall consult with appropriate officials of the Department of Health and Human Services, the Office of National Drug Control Policy, and the Centers for Disease Control and Prevention regarding the development of each report under paragraph (1).

**SEC. 759. SUPPORT DATA SYSTEM REVIEW AND INDICATORS FOR MONITORING HIV CARE.**

The Secretary of Health and Human Services, in collaboration with the Assistant Secretary for Health, the Director of the Office of Infectious Disease and HIV/AIDS Policy, the Director of the Centers for Disease Control and Prevention, the Assistant Secretary for Mental Health and Substance Use, the Director of the Department of Housing and Urban Development, the Director of the Office of AIDS Research, the Administrator of the Health Resources and Services Administration, and the Administrator of the Centers for Medicare & Medicaid Services, shall expand and coordinate efforts to align metrics across agencies and modify Federal data systems, to—

(1) adopt the National Academy of Medicine's clinical HIV care indicators as the core metrics for monitoring the quality of HIV care, mental health, substance abuse, and supportive services;

(2) better enable assessment of the impact of the National HIV/AIDS Strategy and the Patient Protection and Affordable Care Act (Public Law 111–148) on improving HIV care and access to supportive services for individuals with HIV;

(3) expand the demographic data elements to be captured by Federal data systems relevant to HIV care to permit calculation of the indicators for sub-

groups of the population of people with diagnosed HIV infection, including—

(A) age;

(B) race;

(C) ethnicity;

(D) sex (assigned at birth);

(E) gender identity;

(F) sexual orientation;

(G) current geographic marker of residence;

(H) income or poverty level; and

(I) primary means of reimbursement for medical services (including a State Medicaid program, the Medicare program, the Ryan White HIV Program, private insurance, health maintenance organizations, and no coverage); and

(4) streamline data collection and systematically review all existing reporting requirements for federally funded HIV programs to ensure that only essential data are collected.

**SEC. 760. TRANSFER OF FUNDS FOR IMPLEMENTATION OF ENDING THE HIV EPIDEMIC: A PLAN FOR AMERICA.**

Title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by inserting after section 241 the following:

**"SEC. 241A. TRANSFER OF FUNDS FOR IMPLEMENTATION OF NATIONAL HIV/AIDS STRATEGY.**

''(a) TRANSFER AUTHORIZATION.—Of the discretionary appropriations made available to the Department of Health and Human Services for any fiscal year for programs and activities that, as determined by the Secretary, pertain to HIV, the Secretary may transfer up to 1 percent of such appropriations to the Office of the Assistant Secretary for Health for implementation of the Ending the HIV Epidemic: A Plan for America.

''(b) CONGRESSIONAL NOTIFICATION.—Not less than 30 days before making any transfer under this section, the Secretary shall give notice of the transfer to the Congress.

''(c) DEFINITIONS.—In this section, the term 'Ending the HIV Epidemic: A Plan for America' means the initiative that seeks to reduce the number of new HIV infections in the United States by 75 percent by 2025, and then by at least 90 percent by 2030, for an estimated 250,000 total HIV infections averted.''.

# Subtitle F—Diabetes

**SEC. 771. RESEARCH, TREATMENT, AND EDUCATION.**

Subpart 3 of part C of title IV of the Public Health Service Act (42 U.S.C. 285c et seq.) is amended by adding at the end the following new section:

**"SEC. 434B. DIABETES IN MINORITY POPULATIONS.**

''(a) IN GENERAL.—The Director of NIH shall expand, intensify, and support ongoing research and other activities with respect to prediabetes and diabetes, particularly type 2, in minority populations.

''(b) RESEARCH.—

''(1) DESCRIPTION.—Research under subsection (a) shall include investigation into—

''(A) the causes of diabetes, including socioeconomic, geographic, clinical, environmental, genetic, and other factors that may contribute to increased rates of diabetes in minority populations; and

''(B) the causes of increased incidence of diabetes complications in minority populations, and possible interventions to decrease such incidence.

''(2) INCLUSION OF MINORITY PARTICIPANTS.—In conducting and supporting research described in subsection (a), the Director of NIH shall seek to in-

clude minority participants as study subjects in clinical trials.

''(c) REPORT; COMPREHENSIVE PLAN.—

''(1) IN GENERAL.—The Diabetes Mellitus Interagency Coordinating Committee shall—

''(A) prepare and submit to the Congress, not later than 6 months after the date of enactment of this section, a report on Federal research and public health activities with respect to prediabetes and diabetes in minority populations; and

''(B) develop and submit to Congress, not later than 1 year after the date of enactment of this section, an effective and comprehensive Federal plan (including all appropriate Federal health programs) to address prediabetes and diabetes in minority populations.

''(2) CONTENTS.—The report under paragraph (1)(A) shall at minimum address each of the following:

''(A) Research on diabetes and prediabetes in minority populations, including such research on—

''(i) genetic, behavioral, and environmental factors; and

''(ii) prevention and complications among individuals within these populations who have already developed diabetes.

''(B) Surveillance and data collection on diabetes and prediabetes in minority populations, including with respect to—

''(i) efforts to better determine the prevalence of diabetes among Asian-American and Pacific Islander subgroups; and

''(ii) efforts to coordinate data collection on the American Indian population.

''(C) Community-based interventions to address diabetes and prediabetes targeting minority populations, including—

''(i) the evidence base for such interventions;

''(ii) the cultural appropriateness of such interventions; and

''(iii) efforts to educate the public on the causes and consequences of diabetes.

''(D) Education and training programs for health professionals (including community health workers) on the prevention and management of diabetes and its related complications that is supported by the Health Resources and

Services Administration, including such programs supported by—

''(i) the National Health Service Corps; or

''(ii) the community health centers program under section 330.

''(d) EDUCATION.—The Director of NIH shall—

''(1) through the National Institute on Minority Health and Health Disparities and the National Diabetes Education Program—

''(A) make grants to programs funded under section 464z–4 for the purpose of establishing a mentoring program for health care professionals to be more involved in weight counseling, obesity research, and nutrition; and

''(B) provide for the participation of minority health professionals in diabetes-focused research programs; and

''(2) make grants for programs to establish a pipeline from high school to professional school that will increase minority representation in diabetes-focused health fields by expanding Minority Access to Research Careers program internships and mentoring opportunities for recruitment.

''(e) DEFINITIONS.—For purposes of this section:

''(1) DIABETES MELLITUS INTERAGENCY COORDINATING COMMITTEE.—The 'Diabetes Mellitus Interagency Coordinating Committee' means the Diabetes Mellitus Interagency Coordinating Committee established under section 429.

''(2) MINORITY POPULATION.—The term 'minority population' means a racial and ethnic minority group, as defined in section 1707.''.

**SEC. 772. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.), as amended by section 721, is further amended by inserting after section 317W the following section:

**''SEC. 317X. DIABETES IN MINORITY POPULATIONS.**

''(a) RESEARCH AND OTHER ACTIVITIES.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct and support research and public health activities with respect to diabetes in minority populations.

''(2) CERTAIN ACTIVITIES.—Activities under paragraph (1) regarding diabetes in minority populations shall include the following:

''(A) Further enhancing the National Health and Nutrition Examination Survey by

oversampling Asian American, Native Hawaiian, and Pacific Islanders in appropriate geographic areas to better determine the prevalence of diabetes in such populations as well as to improve the data collection of diabetes penetration disaggregated into major ethnic groups within such populations. The Secretary shall ensure that any such oversampling does not reduce the oversampling of other minority populations including African-American and Latino populations.

''(B) Through the Division of Diabetes Translation—

''(i) providing for prevention research to better understand how to influence health care systems changes to improve quality of care being delivered to such populations;

''(ii) carrying out model demonstration projects to design, implement, and evaluate effective diabetes prevention and control interventions for minority populations, including culturally appropriate community-based interventions;

''(iii) developing and implementing a strategic plan to reduce diabetes in minority populations through applied research to reduce disparities and culturally and linguistically appropriate community-based interventions;

''(iv) supporting, through the national diabetes prevention program under section 399V–3, diabetes prevention program sites in underserved regions highly impacted by diabetes; and

''(v) implementing, through the national diabetes prevention program under section 399V–3, a demonstration program developing new metrics measuring health outcomes related to diabetes that can be stratified by specific minority populations.

''(b) EDUCATION.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall direct the Division of Diabetes Translation to conduct and support both programs to educate the public on diabetes in minority populations and programs to educate minority populations about the causes and effects of diabetes.

''(c) DIABETES; HEALTH PROMOTION, PREVENTION ACTIVITIES, AND ACCESS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and the National Diabetes Education Program, shall conduct and support programs to educate specific minority populations through culturally appropriate and linguistically appropriate information campaigns about prevention of, and managing, diabetes.

''(d) DEFINITION.—For purposes of this section, the term 'minority population' means a racial and ethnic minority group, as defined in section 1707.''.

**SEC. 773. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 733, is further amended by adding at the end the following new section:

**''SEC. 399V–9. PROGRAMS TO EDUCATE HEALTH PROVIDERS ON THE CAUSES AND EFFECTS OF DIABETES IN MINORITY POPULATIONS.**

''(a) IN GENERAL.—The Secretary, acting through the Director of the Health Resources and Services Administration, shall conduct and support programs described in subsection (b) to educate health professionals on the causes and effects of diabetes in minority populations.

''(b) PROGRAMS.—Programs described in this subsection, with respect to education on diabetes in minority populations, shall include the following:

''(1) Giving priority, under the primary care training and enhancement program under section 747—

''(A) to awarding grants to focus on or address diabetes; and

''(B) to adding minority populations to the list of vulnerable populations that should be served by such grants.

''(2) Providing additional funds for the Health Careers Opportunity Program, the Centers for Excellence, and the Minority Faculty Fellowship Program to partner with the Office of Minority Health under section 1707 and the National Institutes of Health to strengthen programs for career opportunities focused on diabetes treatment and care within underserved regions highly impacted by diabetes.

''(3) Developing a diabetes focus within, and providing additional funds for, the National Health Service Corps scholarship program—

''(A) to place individuals in areas that are disproportionately affected by diabetes and to

provide diabetes treatment and care in such areas; and

''(B) to provide such individuals continuing medical education specific to diabetes care.''.

**SEC. 774. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.**

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 773, is further amended by adding at the end the following section:

**''SEC. 399V–10. RESEARCH, EDUCATION, AND OTHER ACTIVITIES REGARDING DIABETES IN AMERICAN INDIAN POPULATIONS.**

''In addition to activities under sections 399V–6 and 434B, the Secretary, acting through the Indian Health Service and in collaboration with other appropriate Federal agencies, shall—

''(1) conduct and support research and other activities with respect to diabetes; and

''(2) coordinate the collection of data on clinically and culturally appropriate diabetes treatment, care, prevention, and services by health care professionals to the American Indian population.''.

**SEC. 775. UPDATED REPORT ON HEALTH DISPARITIES.**

The Secretary of Health and Human Services shall seek to enter into an arrangement with the National Academy of Medicine under which the National Academy will—

(1) not later than 1 year after the date of enactment of this Act, submit to Congress an updated version of the 2002 report entitled ''Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care''; and

(2) in such updated version, address how racial and ethnic health disparities have changed since the publication of the original report.

# Subtitle G—Lung Disease

**SEC. 776. EXPANSION OF THE NATIONAL ASTHMA EDUCATION AND PREVENTION PROGRAM.**

(a) FINDINGS.—Congress finds as follows:

(1) The prevalence of asthma has increased since 1980 and affects more than 26,000,000 people in the United States.

(2) Significant disparities in asthma morbidity and mortality exist for both adults and children particularly for low-income and minority populations, particularly African Americans and Puerto Ricans.

(3) African-American children are twice as likely to have asthma as White children.

(4) In 2016, almost 4,500,000 non-Hispanic African Americans reported having asthma. African Americans with asthma are 3 times as likely to visit the emergency department and twice as likely to get hospitalized as White patients with asthma.

(5) Puerto Ricans are 3.4 times as likely to die from asthma compared with all other Hispanic or Latino groups. Overall Hispanic Americans are 30 percent more likely to be hospitalized for asthma than non-Hispanic Whites.

(6) The majority of adults with asthma are women.

(b) IN GENERAL.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall convene a working group comprised of patient groups, nonprofit organizations, medical societies, and other relevant governmental and nongovernmental entities, including those that participate in the National Asthma Education and Prevention Program, to develop a report to Congress that—

(1) catalogs, with respect to asthma prevention, management, and surveillance—

(A) the activities of the Federal Government, including identifying all Federal programs that carry out asthma-related activities,

as well as assessment of the progress of the Federal Government and States, with respect to achieving the goals of Healthy People 2020; and

(B) the activities of other entities that participate in the program, including nonprofit organizations, patient advocacy groups, and medical societies; and

(2) makes recommendations for the future direction of asthma activities, in consultation with researchers from the National Institutes of Health and other member bodies of the National Asthma Education and Prevention Program who are qualified to review and analyze data and evaluate interventions, including—

(A) a description of how the Federal Government may better coordinate and improve its response to asthma including identifying any barriers that may exist;

(B) a description of how the Federal Government may continue, expand, and improve its private-public partnerships with respect to asthma including identifying any barriers that may exist;

(C) identification of steps that may be taken to reduce the—

(i) morbidity, mortality, and overall prevalence of asthma;

(ii) financial burden of asthma on society;

(iii) burden of asthma on disproportionately affected areas, particularly those in medically underserved populations (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))); and

(iv) burden of asthma as a chronic disease;

(D) identification of programs and policies that have achieved the steps described in subparagraph (C), and steps that may be taken to expand such programs and policies to benefit larger populations; and

(E) recommendations for future research and interventions.

(c) REPORT TO CONGRESS.—At the end of the 5-year period following the submission of the report under this section, the National Asthma Education and Prevention Program shall evaluate the analyses and recommendations

under such report and determine whether a new report to the Congress is necessary, and make appropriate recommendations to the Congress.

**SEC. 777. ASTHMA-RELATED ACTIVITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.**

Section 317I of the Public Health Service Act (42 U.S.C. 247b–10) is amended to read as follows:

**"SEC. 317I. ASTHMA-RELATED ACTIVITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.**

''(a) PROGRAM FOR PROVIDING INFORMATION AND EDUCATION TO THE PUBLIC.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall collaborate with State and local health departments to conduct activities, including the provision of information and education to the public regarding asthma including—

''(1) deterring the harmful consequences of uncontrolled asthma; and

''(2) disseminating health education and information regarding prevention of asthma episodes and strategies for managing asthma.

''(b) DEVELOPMENT OF STATE ASTHMA PLANS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall collaborate with State and local health departments to develop State plans

incorporating public health responses to reduce the burden of asthma, particularly regarding disproportionately affected populations.

''(c) COMPILATION OF DATA.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall, in cooperation with State and local public health officials—

''(1) conduct asthma surveillance activities to collect data on the prevalence and severity of asthma, the effectiveness of public health asthma interventions, and the quality of asthma management, including—

''(A) collection of household data on the local burden of asthma;

''(B) surveillance of health care facilities; and

''(C) collection of data not containing individually identifiable information from electronic health records or other electronic communications;

''(2) compile and annually publish data regarding the prevalence and incidence of childhood asthma, the child mortality rate, and the number of hospital admissions and emergency department visits by children associated with asthma nationally and in

each State and at the county level by age, sex, race, and ethnicity, as well as lifetime and current prevalence; and

''(3) compile and annually publish data regarding the prevalence and incidence of adult asthma, the adult mortality rate, and the number of hospital admissions and emergency department visits by adults associated with asthma nationally and in each State and at the county level by age, sex, race, ethnicity, industry, and occupation, as well as lifetime and current prevalence.

''(d) COORDINATION OF DATA COLLECTION.—The Director of the Centers for Disease Control and Prevention, in conjunction with State and local health departments, shall coordinate data collection activities under subsection (c)(2) so as to maximize comparability of results.

''(e) COLLABORATION.—The Centers for Disease Control and Prevention are encouraged to collaborate with national, State, and local nonprofit organizations to provide information and education about asthma, and to strengthen such collaborations when possible.

''(f) ADDITIONAL FUNDING.—In addition to any other authorization of appropriations that is available to the Centers for Disease Control and Prevention for the

purpose of carrying out this section, there are authorized to be appropriated to such Centers such sums as may be necessary for each of fiscal years 2021 through 2025 for the purpose of carrying out this section.''.

**SEC. 778. INFLUENZA AND PNEUMONIA VACCINATION CAMPAIGN.**

(a) IN GENERAL.—The Secretary of Health and Human Services shall—

(1) enhance the annual campaign by the Department of Health and Human Services to increase the number of people vaccinated each year for influenza and pneumonia; and

(2) include in such campaign the use of written educational materials, public service announcements, physician education, and any other means which the Secretary deems effective.

(b) MATERIALS AND ANNOUNCEMENTS.—In carrying out the annual campaign described in subsection (a), the Secretary of Health and Human Services shall ensure that—

(1) educational materials and public service announcements are readily and widely available in communities experiencing disparities in the incidence and mortality rates of influenza and pneumonia; and

(2) the campaign uses targeted, culturally appropriate messages and messengers to reach underserved communities.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

**SEC. 779. CHRONIC OBSTRUCTIVE PULMONARY DISEASE ACTION PLAN.**

(a) FINDINGS.—Congress finds as follows:

(1) Chronic obstructive pulmonary disease (referred to in this subsection as ''COPD'') refers to chronic bronchitis and emphysema, incurable diseases that make it difficult to exhale all the air from one's lungs, and that can cause persistent coughing, shortness of breath, and sputum.

(2) COPD exacerbations—episodes of acute difficulty breathing and moderate to severe fatigue—are dangerous, and their treatment often requires hospitalization.

(3) While smoking is the primary risk factor for COPD, other risk factors include air pollution, occupational exposures, heredity, a history of childhood respiratory infections, and socioeconomic status.

(4) It is estimated that over 13,500,000 adults in the United States have COPD.

(5) COPD is the third-leading cause of death in the United States, claiming over 134,000 lives in 2010.

(6) Since 2000, deaths for women with COPD have exceeded deaths in men.

(7) Although African Americans have a lower prevalence of COPD in the United States, researchers have shown that African Americans may be underdiagnosed. Furthermore, research has shown that African Americans develop COPD with less cumulative smoke exposure and at a younger age.

(b) IN GENERAL.—The Director of the Centers for Disease Control and Prevention shall conduct, support, and expand public health strategies, prevention, diagnosis, surveillance, and public and professional awareness activities regarding chronic obstructive pulmonary disease.

(c) NATIONAL ACTION PLAN.—

(1) DEVELOPMENT.—Not later than 2 years after the date of the enactment of this Act, the Director of the National Heart, Lung, and Blood Institute, in consultation with the Director of the Centers for Disease Control and Prevention, shall develop a national action plan to address chronic obstructive

pulmonary disease in the United States with participation from patients, caregivers, health professionals, patient advocacy organizations, researchers, providers, public health professionals, and other stakeholders.

(2) CONTENTS.—At a minimum, such plan shall include recommendations for—

(A) public health interventions for the purpose of implementation of the national plan;

(B) biomedical, health services, and public health research on chronic obstructive pulmonary disease; and

(C) inclusion of chronic obstructive pulmonary disease in the health data collections of all Federal agencies.

(3) CONSIDERATION.—In developing such plan, the Director of the National Heart, Lung, and Blood Institute shall consider the recommendations and findings of the National Academy of Medicine in the report entitled ''A Nationwide Framework for Surveillance of Cardiovascular and Chronic Lung Diseases'' (July 22, 2011).

(d) CHRONIC DISEASE PREVENTION PROGRAMS.—The Director of the National Heart, Lung, and Blood Institute shall carry out the following:

(1) Conduct public education and awareness activities with patient and professional organizations to stimulate earlier diagnosis and improve patient outcomes from treatment of chronic obstructive pulmonary disease. To the extent known and relevant, such public education and awareness activities shall reflect differences in chronic obstructive pulmonary disease by cause (tobacco, environmental, occupational, biological, and genetic) and include a focus on outreach to undiagnosed and, as appropriate, minority populations.

(2) Supplement and expand upon the activities of the National Heart, Lung, and Blood Institute by making grants to nonprofit organizations, State and local jurisdictions, and Indian tribes for the purpose of reducing the burden of chronic obstructive pulmonary disease, especially in disproportionately impacted communities, through public health interventions and related activities.

(3) Coordinate with the Centers for Disease Control and Prevention, the Indian Health Service, the Health Resources and Services Administration, and the Department of Veterans Affairs to develop pilot programs to demonstrate best practices for the

diagnosis and management of chronic obstructive pulmonary disease.

(4) Develop improved techniques and identify best practices, in coordination with the Secretary of Veterans Affairs, for assisting chronic obstructive pulmonary disease patients to successfully stop smoking, including identification of subpopulations with different needs. Initiatives under this paragraph may include research to determine whether successful smoking cessation strategies are different for chronic obstructive pulmonary disease patients compared to such strategies for patients with other chronic diseases.

(e) ENVIRONMENTAL AND OCCUPATIONAL HEALTH PROGRAMS.—The Director of the Centers for Disease Control and Prevention shall—

(1) support research into the environmental and occupational causes and biological mechanisms that contribute to chronic obstructive pulmonary disease; and

(2) develop and disseminate public health interventions that will lessen the impact of environmental and occupational causes of chronic obstructive pulmonary disease.

(f) DATA COLLECTION.—Not later than 180 days after the enactment of this Act, the Director of the National Heart, Lung, and Blood Institute and the Director of the Centers for Disease Control and Prevention, acting jointly, shall assess the depth and quality of information on chronic obstructive pulmonary disease that is collected in surveys and population studies conducted by the Centers for Disease Control and Prevention, including whether there are additional opportunities for information to be collected in the National Health and Nutrition Examination Survey, the National Health Interview Survey, and the Behavioral Risk Factors Surveillance System surveys. The Director of the National Heart, Lung, and Blood Institute shall include the results of such assessment in the national action plan under subsection (c).

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

# Subtitle H—Tuberculosis

**SEC. 781. ELIMINATION OF ALL FORMS OF TUBERCULOSIS.**

(a) SHORT TITLE.—This subtitle may be cited as the ''End Tuberculosis Act''.

(b) FINDINGS.—Congress makes the following findings:

(1) In the United States, 9,025 people were diagnosed with tuberculosis (referred to in this section as ''TB'') in 2018.

(2) Disparities in TB exist and significantly impact minority communities in the United States. The Centers for Disease Control and Prevention (referred to in this section as ''CDC'') finds that 70 percent of people diagnosed with TB in 2018 self-identified as racial and ethnic minorities.

(3) African Americans comprised 20 percent of people diagnosed with TB during 2018. The population-adjusted rate of TB among African Americans is 1.7 times higher than the national total, and 8.0 times higher than among Whites.

(4) Asian Americans, Native Hawaiians, and other Pacific Islanders comprised 37 percent of people diagnosed with TB during 2018. The population-adjusted rate of TB among Asian Americans is 6.2 times higher than the national total, and 31 times higher than among Whites. The population-adjusted rate of TB among Native Hawaiians and other Pacific Islanders is 4.8 times higher than the national total, and 23.2 times higher than among Whites.

(5) Hispanics and Latinos comprised 26 percent of people diagnosed with TB during 2018. The

population-adjusted rate of TB among Hispanics and Latinos is 1.6 times higher than the national total, and 8.0 times higher than among Whites.

(6) TB is both preventable and curable, but the current rate of decline of TB in the United States remains too slow to achieve TB elimination in this century.

(7) TB is transmitted through the air when a person who has TB disease in their lungs coughs or sneezes. People who are in close proximity to the person with TB can breathe in the TB bacteria, and the bacteria will initially settle in their lungs. Without proper and timely diagnosis and access to treatment, the TB bacteria may grow and spread to other parts of their body.

(8) As many as 13,000,000 people in the United States may have latent TB Infection (referred to in this section as ''LTBI''). People with LTBI have TB bacteria in their bodies, but their immune system is containing the bacteria, and they are not sick, nor do they have any current risk of spreading TB to others. LTBI can activate into infectious, life-threatening TB if not treated. Modeling has shown that eliminating TB is not possible without addressing LTBI.

(9) Comorbidities associated with TB include cancer, diabetes mellitus, and HIV. People with these medical conditions and compromised immune systems are more likely to develop active TB disease and to have worse outcomes from TB.

(10) Forms of active TB that do not show drug resistance are classified as drug-susceptible TB (referred to in this section as ''DS–TB''). Drug-resistant TB (referred to in this section as ''DR–TB'') is a rising threat to the public health of the United States. DR–TB that exhibits resistance to two or more first-line drugs is referred to as multi-drug resistant TB (referred to in this section as ''MDR–TB''). MDR–TB that also is resistant to at least one injectable second-line medication and at least one fluoroquinolone is classified as extensively drug-resistant TB (referred to in this section as ''XDR–TB'').

(11) Approximately 97 people in the United States were diagnosed with MDR–TB in 2018. One person was diagnosed with XDR–TB in the same year.

(12) In the United States, $480 million was spent in 2018 to treat TB; direct treatment costs average $19,000 to treat a patient with DS–TB,

$175,000 to treat a patient with MDR–TB, and $544,000 to treat a patient with XDR–TB. When factoring in productivity losses during treatment, DS–TB averages $46,000, MDR–TB averages $294,000 and XDR–TB averages $694,000. Treatment is often difficult, with daily complex multi-pill regimens and injections, with side-effects ranging from hearing and vision loss to mental health issues.

(13) Recognizing the public health, economic and societal costs to the threat of MDR–TB, the National Action Plan to Combat MDR–TB was developed by the White House to provide the United States with a comprehensive three-pronged strategy to address MDR–TB by strengthening domestic capacity to combat MDR–TB; improve international capacity and cooperation to combat MDR–TB; accelerate basic and applied research and development for new therapies, diagnostics and prevention strategies to combat MDR–TB.

(14) Additional Federal support is necessary to expand TB control efforts in case finding and treatment to address LTBI in a national prevention initiative. Key policy and research breakthroughs increase the success of a TB prevention initiative: the U.S. Preventative Services Task Force recommenda-

tion's ''B'' rating, screening for LTBI among high-risk adults as a covered service increases the likelihood that impacted racial and ethnic minority groups can get tested for TB; a new, shorter course treatment regimen reduces the length of treatment for LTBI from every day for 6 to 9 months to one dose per week for 12 weeks, increasing likelihood of treatment completion; and the use of blood-based diagnostic tests, Interferon-gamma release assays or IGRAs, increases ability to detect LTBI among patients in affected communities.

(15) The right to health, and the right to science as a necessary human right to help achieve the right to health, is enshrined in Articles 25 and 27 of the Universal Declaration of Human Rights. These fundamental human rights cannot be achieved when anyone lacks access to TB prevention or treatment, and when the benefits of scientific innovation are not extended to people with all forms of TB.

**SEC. 782. ADDITIONAL FUNDING FOR STATES IN COMBATING AND ELIMINATING TUBERCULOSIS.**

Section 317E(h) of the Public Health Act (42 U.S.C. 247b–6(h)) is amended by adding at the end the following:

''(3) ADDITIONAL FUNDING FOR STATES IN COMBATING AND ELIMINATING TUBERCULOSIS.—In

addition to amounts otherwise authorized to be appropriated to carry out this section, there are authorized to be appropriated such sums as may be necessary to carry out section 317 for each of fiscal years 2020 through 2021.''.

**SEC. 783. STRENGTHENING CLINICAL RESEARCH FUNDING FOR TUBERCULOSIS.**

(a) IN GENERAL.—The Secretary of Health and Human Services shall expand and intensify support for current and prospective research activities of the National Institutes of Health, the Biomedical Advanced Research and Development Authority, and the Centers for Disease Control and Prevention Division of Tuberculosis Elimination to develop new therapeutics, diagnostics, vaccines, and other prevention modalities in addressing all forms of tuberculosis (referred to in this section as ''TB'').

(b) INCLUDED RESEARCH ACTIVITIES.—Research activities under subsection (a) shall include—

(1) research and development, and pathways to approval, for novel, safe drugs and drug regimens for the treatment of TB, including in adolescent and pediatric populations and in pregnant and lactating women;

(2) research to develop rapid diagnostic tests for all forms of TB, including diagnostics that can

be used for pediatric populations and people living with HIV, diagnostics that can detect extra pulmonary TB and drug resistance, and diagnostics that can be used at the point of care;

(3) research to advance basic knowledge of the pathogenesis of TB and its major comorbidities, including HIV and diabetes mellitus;

(4) research to improve knowledge and understandings of the role of latency in TB and the factors that increase the risk of latent TB infection progressing to active, symptomatic TB disease;

(5) awarding grants and contracts to specifically develop new and needed vaccines to address TB;

(6) awarding grants and contracts to support the training and development of clinical researchers whose research improves the landscape of tools to combat TB; and

(7) awarding grants and contracts to support capacity-building and develop clinical trial site infrastructure in the United States and in TB endemic countries to support the aforementioned research activities.

# Subtitle I—Osteoarthritis and Musculoskeletal Diseases

**SEC. 785. FINDINGS.**

Congress finds as follows:

(1) Eighty percent of African-American women and nearly 74 percent of Hispanic men are either overweight or obese, speeding the onset and progression of arthritis.

(2) Arthritis affects 46,000,000 people in the United States, and that number will rise to 67,000,000 by the year 2030.

(3) Twenty-seven million people in the United States suffer from osteoarthritis, the most common form of arthritis, making it the leading cause of disability in the United States. Osteoarthritis is sometimes referred to as degenerative joint disease.

(4) Obesity accelerates the onset of arthritis: 70 percent of obese adults with mild osteoarthritis of the knee at age 60 will develop advanced end-stage disease by age 80. In contrast, just 43 percent of non-obese adults will have end-stage disease over the same time period.

(5) Arthritis affects 1 in 5 people in the United States and is the single greatest cause of chronic pain and disability in the United States.

(6) Women, African Americans, and Hispanics have more severe arthritis and functional limitations. These same individuals are more likely to be obese, diabetic, and have higher incidence of heart disease—medical conditions that can be improved with physical activity. Instead of moving; however, these groups have an inactivity rate of 40 to 50 percent, which continues to increase.

(7) Arthritis costs $128,000,000,000 a year, including $81,000,000,000 in direct costs (medical) and $47,000,000,000 in indirect costs (lost earnings). Each year, $309,000,000,000 in direct and indirect costs is lost due to disparities in osteoarthritis and musculoskeletal diseases.

(8) Obesity and other chronic health conditions exacerbate the debilitating impact of arthritis, leading to inactivity, loss of independence, and a perpetual cycle of comorbid chronic conditions.

(9) Sixty-one percent of arthritis sufferers are women, and women represent 64 percent of an estimated 43,000,000 annual visits to physicians' offices and outpatient clinics where arthritis was the primary diagnosis. Women also represented 60 percent of approximately 1,000,000 hospitalizations that oc-

curred in 2003 for which arthritis was the primary diagnosis.

(10) Women ages 65 and older have up to 2½ times more disabilities than men of the same age. Higher rates of obesity and arthritis among this group explained up to 48 percent of the gender gap in disability, above all other common chronic health conditions.

(11) The primary indication for total knee arthroplasty (referred to in this section as ''TKA''), also known as knee replacement, is relief of significant, disabling pain caused by severe arthritis.

(12) Knee replacement is surgery for people with severe knee damage. Knee replacement can relieve pain and allow you to be more active. When you have a total knee replacement, the surgeon removes damaged cartilage and bone from the surface of your knee joint and replaces them with a man-made surface of metal and plastic. In a partial knee replacement, the surgeon only replaces one part of your knee joint.

(13) Total hip replacement, also called total hip arthroplasty (referred to in this section as ''THA''), is used if your hip pain interferes with daily activities and more conservative treatments have not

helped. Arthritis damage is the most common reason to need hip replacement.

(14) The odds of a family practice physician recommending TKA to a male patient with moderate arthritis are twice that of a female patient, while the odds of an orthopaedic surgeon recommending TKA to a male patient with moderate arthritis are 22 times that of a female patient.

(15) African Americans with doctor-diagnosed arthritis have a higher prevalence of severe pain attributable to arthritis, compared with Whites (34.0 percent versus 22.6 percent). African Americans, compared to Whites, report a higher proportion of work limitations (39.5 percent versus 28.0 percent) and a higher prevalence of arthritis-attributable work limitation (6.6 percent versus 4.6 percent).

(16) Hispanics are 50 percent more likely than non-Hispanic Whites to report needing assistance with at least one instrumental activity of daily living and to have difficulty walking.

(17) African Americans and Hispanics were 1.3 times more likely to have activity limitation, 1.6 times more likely to have work limitations, and 1.9 times more likely to have severe joint pain than Whites.

(18) In 2003, the National Academy of Medicine reported that the rates of TKA and THA among African-American and Hispanic patients are significantly lower than for Whites—even for those with equitable health care coverage such as through Medicare or the Department of Veterans Affairs.

(19) According to the Centers for Disease Control and Prevention, in 2000, African-American Medicare enrollees were 37 percent less likely than White Medicare enrollees to undergo total knee replacements. In 2006, the disparity increased to 39 percent.

(20) Even after adjusting for insurance and health access, Hispanics and African Americans are almost 50 percent less likely to undergo total knee replacement than Whites.

**SEC. 786. OSTEOARTHRITIS AND OTHER MUSCULOSKELETAL HEALTH-RELATED ACTIVITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.**

(a) EDUCATION AND AWARENESS ACTIVITIES.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall direct the National Center for Chronic Disease Prevention and Health Promotion to conduct and ex-

pand the Health Community Program and Arthritis Program to educate the public on—

(1) the causes of, preventive health actions for, and effects of arthritis and other musculoskeletal conditions in minority patient populations; and

(2) the effects of such conditions on other comorbidities including obesity, hypertension, and cardiovascular disease.

(b) PROGRAMS ON ARTHRITIS AND MUSCULOSKELETAL CONDITIONS.—Education and awareness programs of the Centers for Disease Control and Prevention on arthritis and other musculoskeletal conditions in minority communities shall—

(1) be culturally and linguistically appropriate to minority patients, targeting musculoskeletal health promotion and prevention programs of each major ethnic group, including—

(A) Native Americans and Alaska Natives;

(B) Asian Americans;

(C) African Americans and Blacks;

(D) Hispanic and Latino Americans; and

(E) Native Hawaiians and Pacific Islanders; and

(2) include public awareness campaigns directed toward these patient populations that emphasize the

importance of musculoskeletal health, physical activity, diet and healthy lifestyle, and weight reduction for overweight and obese patients.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as are necessary for fiscal year 2021 and each subsequent fiscal year.

**SEC. 787. GRANTS FOR COMPREHENSIVE OSTEOARTHRITIS AND MUSCULOSKELETAL DISEASE HEALTH EDUCATION WITHIN HEALTH PROFESSIONS SCHOOLS.**

(a) PROGRAM AUTHORIZED.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), in coordination with the Secretary of Education, shall award grants, on a competitive basis, to academic health science centers, health professions schools, and other institutions of higher education to enable such institutions to provide people with comprehensive education on arthritis and musculoskeletal health, particularly—

(1) obesity-related musculoskeletal diseases;

(2) arthritis and osteoarthritis;

(3) arthritis and musculoskeletal health disparities; and

(4) the relationship between arthritis and musculoskeletal diseases and metabolic activity, psychological health, and comorbidities such as diabetes, cardiovascular disease, and hypertension.

(b) DURATION.—Grants awarded under this section shall be for a period of 5 years.

(c) APPLICATIONS.—An academic health science center, health professions school, or other institution of higher education seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(d) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to an institution of higher education that—

(1) has an enrollment of needy students, as defined in section 318(b) of the Higher Education Act of 1965 (20 U.S.C. 1059e(b));

(2) is a Hispanic-serving institution, as defined in section 502(a) of such Act (20 U.S.C. 1101a(a));

(3) is a Tribal College or University, as defined in section 316(b) of such Act (20 U.S.C. 1059c(b));

(4) is an Alaska Native-serving institution, as defined in section 317(b) of such Act (20 U.S.C. 1059d(b));

(5) is a Native Hawaiian-serving institution, as defined in section 317(b) of such Act (20 U.S.C. 1059d(b));

(6) is a Predominately Black Institution, as defined in section 318(b) of such Act (20 U.S.C. 1059e(b));

(7) is a Native American-serving, non-Tribal institution, as defined in section 319(b) of such Act (20 U.S.C. 1059f(b));

(8) is an Asian-American and Native American Pacific Islander-serving institution, as defined in section 320(b) of such Act (20 U.S.C. 1059g(b)); or

(9) is a minority institution, as defined in section 365 of such Act (20 U.S.C. 1067k), with an enrollment of needy students, as defined in section 312 of such Act (20 U.S.C. 1058).

(e) USES OF FUNDS.—An institution of higher education receiving a grant under this section may use grant funds to integrate issues relating to comprehensive arthritis and musculoskeletal health into the academic or support sectors of the institution in order to reach a large number of students, by carrying out 1 or more of the following activities:

(1) Developing educational content for issues relating to comprehensive arthritis and musculo-

skeletal health education that will be incorporated into first-year orientation or core courses.

(2) Creating innovative technology-based approaches to deliver arthritis and musculoskeletal health education to students, faculty, and staff.

(3) Developing and employing peer-outreach and education programs to generate discussion, educate, and raise awareness among students about issues relating to arthritis and musculoskeletal health disorders, and their relationship to diabetes, hypertension, cardiovascular disease, psychological health, and other comorbid conditions.

(f) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter for a period of 5 years, the Secretary shall prepare and submit to the appropriate committees of Congress a report on the activities to provide health professions students with comprehensive arthritis and musculoskeletal health education funded under this section.

(2) REPORT ELEMENTS.—The report described in paragraph (1) shall include information about—

(A) the number of entities that are receiving grant funds;

(B) the specific activities supported by grant funds;

(C) the number of students served by grant programs; and

(D) the status of program evaluations.

# Subtitle J—Sleep and Circadian Rhythm Disorders

**SEC. 791. SHORT TITLE; FINDINGS.**

(a) SHORT TITLE.—This subtitle may be cited as the ''Sleep and Circadian Rhythm Disorders Health Disparities Act''.

(b) FINDINGS.—Congress finds the following:

(1) Decrements in sleep health such as sleep apnea, insufficient sleep time, and insomnia, affect 50,000,000 to 70,000,000 adults in the United States. Twelve to eighteen million United States adults have sleep apnea, a chronic disorder characterized by one or more pauses in breathing which can last from a few seconds to minutes. They may occur 30 times or more an hour, disrupting sleep and resulting in excessive daytime sleepiness and loss in productivity.

(2) Seventy percent of high school students are not getting enough sleep on school nights, while 33 percent of people in the United States get fewer

than 7 hours of sleep per night, and roughly 6,000 fatal motor vehicle crashes are caused by drowsy drivers.

(3) Insufficient sleep and insomnia are more prevalent in women. Women who are pregnant and have sleep apnea are at an increased risk of cardiovascular complications during pregnancy. The impact of disparities in sleep health is associated with a growing number of health problems, including the following:

(A) Hypertension.

(B) Cancer.

(C) Stroke.

(D) Cardiac arrhythmia.

(E) Chronic heart failure and heart disease.

(F) Diabetes.

(G) Cognitive functioning and behavior.

(H) Depression and bipolar disorder.

(I) Substance abuse.

(4) A sleep disparity exists in that poor sleep quality is strongly associated with poverty and race. Factors such as employment, education, and health status, amongst others, significantly mediated this effect only in poor subjects, suggesting a differential

vulnerability to these factors in poor relative to nonpoor individuals in the context of sleep quality.

(5) African Americans sleep worse than Caucasian Americans. African Americans take longer to fall asleep, report poorer sleep quality, have more light and less deep sleep, and nap more often and longer.

(6) African Americans and individuals in lower socioeconomic status groups may be at an increased risk for sleep disturbances and associated health consequences.

(7) Among young African Americans, the likelihood of having sleep disordered breathing and exhibiting risk factors for poor sleep is twice that in young Caucasians. Frequent snoring is more common among African-American and Hispanic women and Hispanic men compared to non-Hispanic Caucasians, independent of other factors including obesity.

(8) African Americans with sleep-disordered breathing develop symptoms at a younger age than Caucasians but appear less likely to be diagnosed and treated in a timely manner. This delay may at least in part be due to reduced access to care.

(9) Sleep loss contributes to increased risk for chronic conditions such as obesity, diabetes, and hy-

pertension, all of which have increased prevalence in underserved, underrepresented minorities. Racial and ethnic disparities related to obesity may also contribute to disparities in health outcomes related to sleep-disordered breathing.

(10) Non-Caucasian adults report an insomnia rate of 12.9 percent compared to only 6.6 percent for Caucasians.

(11) African-American women have a higher incidence of insomnia than African-American men, perhaps related in part to higher risk for chronic persisting symptoms.

**SEC. 792. SLEEP AND CIRCADIAN RHYTHM DISORDERS RESEARCH ACTIVITIES OF THE NATIONAL INSTITUTES OF HEALTH.**

(a) IN GENERAL.—The Director of the National Institutes of Health, acting through the Director of the National Heart, Lung, and Blood Institute, shall—

(1) continue to expand research activities addressing sleep health disparities; and

(2) continue implementation of the NIH Sleep Disorders Research Plan across all institutes and centers of the National Institutes of Health to improve treatment and prevention of sleep health disparities.

(b) REQUIRED RESEARCH ACTIVITIES.—In conducting or supporting research relating to sleep and circadian rhythm, the Director of the National Heart, Lung, and Blood Institute shall—

(1) advance epidemiology and clinical research to achieve a more complete understanding of disparities in domains of sleep health and across population subgroups for which cardiovascular and metabolic health disparities exist, including—

(A) prevalence and severity of sleep apnea;

(B) habitual sleep duration;

(C) sleep timing and regularity; and

(D) insomnia;

(2) develop study designs and analytical approaches to explain and predict multilevel and life-course determinants of sleep health and to elucidate the sleep-related causes of cardiovascular and metabolic health disparities across the age spectrum, including such determinants and causes that are—

(A) environmental;

(B) biological or genetic;

(C) psychosocial;

(D) societal;

(E) political; or

(F) economic;

(3) determine the contribution of sleep impairments such as sleep apnea, insufficient sleep duration, irregular sleep schedules, and insomnia to unexplained disparities in cardiovascular and metabolic risk and disease outcomes;

(4) develop study designs, data sampling and collection tools, and analytical approaches to optimize understanding of mediating and moderating factors, and feedback mechanisms coupling sleep to cardiovascular and metabolic health disparities;

(5) advance research to understand cultural and linguistic barriers (on the person, provider, or system level) to access to care, medical diagnosis, and treatment of sleep disorders in diverse population groups;

(6) develop and test multilevel interventions (including sleep health education in diverse communities) to reduce disparities in sleep health that will impact ability to improve disparities in cardiovascular and metabolic risk or disease;

(7) create opportunities to integrate sleep and health disparity science by strategically utilizing resources (existing or anticipated cohorts), exchanging scientific data and ideas (cross-over into scientific

meetings), and develop multidisciplinary investigator-initiated grant applications; and

(8) enhance the diversity and foster career development of young investigators involved in sleep and health disparities science.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal year 2021 and each subsequent fiscal year.

**SEC. 793. SLEEP AND CIRCADIAN RHYTHM HEALTH DISPARITIES-RELATED ACTIVITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.**

(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention shall conduct, support, and expand public health strategies and prevention, diagnosis, surveillance, and public and professional awareness activities regarding sleep and circadian rhythm disorders.

(b) FINDINGS.—Congress finds as follows:

(1) Sleep disorders and sleep deficiency unrelated to a primary sleep disorder are underdiagnosed and are increasingly detrimental to health status.

(2) The consequences to society include additional diseases, motor vehicle accidents, decreased longevity, elevated direct medical costs, and indirect

costs related to work absenteeism and property damage.

(c) REQUIRED SURVEILLANCE AND EDUCATION AWARENESS ACTIVITIES.—In conducting or supporting research relating to sleep and circadian rhythm disorders surveillance and education awareness activities, the Director of the Centers for Disease Control and Prevention shall—

(1) ensure that such activities are culturally and linguistically appropriate to minority patients, targeting sleep and circadian rhythm health promotion and prevention programs of each major ethnic group, including—

(A) Native Americans and Alaska Natives;

(B) Asian Americans;

(C) African Americans and Blacks;

(D) Hispanic and Latino-Americans; and

(E) Native Hawaiians and Pacific Islanders;

(2) collect and compile national and State surveillance data on sleep disorders health disparities;

(3) continue to develop and implement new sleep questions in public health surveillance systems to increase public awareness of sleep health and sleep disorders and their impact on health;

(4) publish monthly reports highlighting geographic, racial, and ethnic disparities in sleep health, as well as relationships between insufficient sleep and chronic disease, health risk behaviors, and other outcomes as determined necessary by the Director; and

(5) include public awareness campaigns that inform patient populations from major ethnic groups about the prevalence of sleep and circadian rhythm disorders and emphasize the importance of sleep health.

(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal year 2021 and each subsequent fiscal year.

**SEC. 794. GRANTS FOR COMPREHENSIVE SLEEP AND CIRCADIAN HEALTH EDUCATION WITHIN HEALTH PROFESSIONS SCHOOLS.**

(a) PROGRAM AUTHORIZED.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), in coordination with the Secretary of Education, shall award grants, on a competitive basis, to academic health science centers, health professions schools, and other institutions of higher education to enable such institutions to provide people with comprehen-

sive education on sleep and circadian health, particularly—

(1) poor sleep health;

(2) sleep disorders;

(3) sleep health disparities; and

(4) the relationship between sleep and circadian health on metabolic activity, neurological activity, comorbidities, and other diseases.

(b) DURATION.—Grants awarded under this section shall be for a period of 5 years.

(c) APPLICATIONS.—Any academic health science center, health professions school, or other institutions of higher education seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(d) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to an institution that—

(1) has an enrollment of needy students, as defined in section 318(b) of the Higher Education Act of 1965 (20 U.S.C. 1059e(b));

(2) is a Hispanic-serving institution, as defined in section 502(a) of such Act (20 U.S.C. 1101a(a));

(3) is a Tribal College or University, as defined in section 316(b) of such Act (20 U.S.C. 1059c(b));

(4) is an Alaska Native-serving institution, as defined in section 317(b) of such Act (20 U.S.C. 1059d(b));

(5) is a Native Hawaiian-serving institution, as defined in section 317(b) of such Act (20 U.S.C. 1059d(b));

(6) is a Predominately Black Institution, as defined in section 318(b) of such Act (20 U.S.C. 1059e(b));

(7) is a Native American-serving, nontribal institution, as defined in section 319(b) of such Act (20 U.S.C. 1059f(b));

(8) is an Asian-American and Native American Pacific Islander-serving institution, as defined in section 320(b) of such Act (20 U.S.C. 1059g(b)); or

(9) is a minority institution, as defined in section 365 of such Act (20 U.S.C. 1067k), with an enrollment of needy students, as defined in section 312 of such Act (20 U.S.C. 1058).

(e) USES OF FUNDS.—An institution of higher education receiving a grant under this section may use grant funds to integrate issues relating to comprehensive sleep and circadian health into the academic or support sectors

of the institution in order to reach a large number of students, by carrying out 1 or more of the following activities:

(1) Developing educational content for issues relating to comprehensive sleep and circadian health education that will be incorporated into first-year orientation or core courses.

(2) Creating innovative technology-based approaches to deliver sleep health education to students, faculty, and staff.

(3) Developing and employing peer-outreach and education programs to generate discussion, educate, and raise awareness among students about issues relating to poor quality sleep, sleep and circadian disorders, and the role sleep health plays in other diseases and comorbidities.

(f) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter for a period of 5 years, the Secretary shall prepare and submit to the appropriate committees of Congress a report on the activities to provide health professions students with comprehensive sleep and circadian health education funded under this section.

(2) REPORT ELEMENTS.—The report described in paragraph (1) shall include information about—

(A) the number of eligible entities and institutions of higher education that are receiving grant funds;

(B) the specific activities supported by grant funds;

(C) the number of students served by grant programs; and

(D) the status of program evaluations.

**SEC. 795. REPORT ON IMPACT OF SLEEP AND CIRCADIAN HEALTH DISORDERS IN VULNERABLE AND RACIAL/ETHNIC POPULATIONS.**

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress and the President a report on the impact of sleep and circadian health disorders for racial and ethnic minority communities and other vulnerable populations.

(b) CONTENTS.—The report under subsection (a) shall include information on the—

(1) progress that has been made in reducing the impact of sleep and circadian health disorders in such communities and populations;

(2) opportunities that exist to make additional progress in reducing the impact of sleep and circa-

dian health disorders in such communities and populations;

(3) challenges that may impede such additional progress; and

(4) Federal funding necessary to achieve substantial reductions in sleep and circadian health disorders in racial and ethnic minority communities.

# Subtitle K—Kidney Disease Research, Surveillance, Prevention, and Treatment

### SEC. 797. KIDNEY DISEASE, RESEARCH, SURVEILLANCE, PREVENTION, AND TREATMENT.

(a) SHORT TITLE.—This section may be cited as the ''Kidney Disease Research, Surveillance, Prevention and Treatment Improvement Act of 2020''.

(b) FINDINGS.—Congress makes the following findings:

(1) Kidney diseases impact 37 million Americans.

(2) African Americans comprise just 13 percent of the United States population, but 33 percent of the United States dialysis patient population. Compared to Caucasians, kidney failure prevalence is about 3.7 times greater in African Americans, 1.4

times greater in Native Americans, and 1.5 times greater in Asian Americans.

(3) Peritoneal dialysis and home hemodialysis use is 40–50 percent lower among African Americans and Hispanics.

(4) Every racial/ethnic minority group in the United States is significantly less likely to be treated with home dialysis than whites, and demographic and clinical characteristics are insufficient to explain this differential use.

(5) African Americans on dialysis, irrespective of dialysis modality, and Hispanics undergoing PD or in-center HD, are significantly less likely than their white counterparts to receive a kidney transplant.

(6) African Americans, Hispanics, and Asian Americans are less likely to receive living donor kidney transplants than Whites. Efforts to reduce disparities in live donor kidney transplantation for African-American, Hispanic, and Asian patients with kidney failure have been unsuccessful.

(7) Medicare and Medicaid patients are less likely to receive a preemptive transplant from a deceased donor compared to private insurance patients (5 percent and 11 percent versus 24 percent), and

Black and Hispanic patients are less likely to receive a preemptive transplant from a deceased donor compared with White patients even after changes to the kidney allocation system (5 percent of Black patients and 5 percent of Hispanic patients compared with 18 percent of White patients).

(8) Low-income populations are significantly more likely to progress to kidney failure.

(9) Low socioeconomic status is associated with increased incidence of chronic kidney disease, progression to kidney failure, inadequate dialysis treatment, and reduced access to kidney transplantation.

(10) The three goals of the recent Executive Order on Advancing American Kidney Health recognizes the need for more transplants, better prevention and education and improved access to treatment modalities.

**SEC. 798. KIDNEY DISEASE RESEARCH IN MINORITY POPULATIONS.**

(a) IN GENERAL.—The Director of the National Institutes of Health shall expand, intensify, and support ongoing research and other activities with respect to kidney disease in minority populations.

(b) RESEARCH.—

(1) DESCRIPTION.—Research under subsection (a) shall include investigation into—

(A) the causes of kidney disease, including socioeconomic, geographic, clinical, environmental, genetic, and other factors that may contribute to increased rates of kidney disease in minority populations; and

(B) the causes of increased incidence of kidney disease complications in minority populations, and possible interventions to decrease such incidence.

(2) INCLUSION OF MINORITY PARTICIPANTS.—In conducting and supporting research described in subsection (a), the Director of the National Institutes of Health shall seek to include minority participants as study subjects in clinical trials.

(c) REPORT; COMPREHENSIVE PLAN.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall—

(A) prepare and submit to the Congress, not later than 6 months after the date of enactment of this section, a report on Federal research and public health activities with respect to kidney disease in minority populations; and

(B) develop and submit to Congress, not later than 1 year after the date of enactment of this section, an effective and comprehensive Federal plan (including all appropriate Federal health programs) to address kidney disease in minority populations.

(2) CONTENTS.—The report under paragraph (1)(A) shall at minimum address each of the following:

(A) Research on kidney disease in minority populations, including such research on—

(i) genetic, behavioral, and environmental factors; and

(ii) prevention and complications among individuals within these populations who have already developed kidney disease.

(B) Surveillance and data collection on kidney disease in minority populations, including with respect to—

(i) efforts to better determine the prevalence of kidney disease among Asian-American and Pacific Islander subgroups; and

(ii) efforts to coordinate data collection on the American Indian population.

(C) Community-based interventions to address kidney disease targeting minority populations, including—

(i) the evidence base for such interventions;

(ii) the cultural appropriateness of such interventions; and

(iii) efforts to educate the public on the causes and consequences of kidney disease.

(D) Education and training programs for health professionals (including community health workers) on the prevention and management of kidney disease and its related complications that are supported by the Health Resources and Services Administration, including such programs supported by he Bureau of Health Workforce, the Bureau of Primary Health Care, and the Healthcare Systems Bureau.

**SEC. 799. KIDNEY DISEASE ACTION PLAN.**

(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention shall conduct, support, and expand public health strategies, prevention, diagnosis,

surveillance, and public and professional awareness activities regarding kidney disease.

(b) NATIONAL ACTION PLAN.—

(1) DEVELOPMENT.—Not later than 2 years after the date of the enactment of this Act, the Director of the National Institute of Diabetes and Digestive and Kidney Disease, in consultation with the Director of the Centers for Disease Control and Prevention, shall develop a national action plan to address kidney disease in the United States with participation from patients, caregivers, health professionals, patient advocacy organizations, researchers, providers, public health professionals, and other stakeholders.

(2) CONTENTS.—At a minimum, such plan shall include recommendations for—

(A) public health interventions for the purpose of implementation of the national plan;

(B) biomedical, health services, and public health research on kidney disease; and

(C) inclusion of kidney disease in the health data collections of all Federal agencies.

(c) KIDNEY DISEASE PREVENTION PROGRAMS.—The Director of the National Institute of Diabetes and Digestive and Kidney Disease shall carry out the following:

(1) Conduct public education and awareness activities with patient and professional organizations to stimulate earlier diagnosis and improve patient outcomes from treatment of kidney disease. To the extent known and relevant, such public education and awareness activities shall reflect differences in kidney disease by cause (such as hypertension, diabetes, and polycystic kidney disease) and include a focus on outreach to undiagnosed and, as appropriate, minority populations.

(2) Supplement and expand upon the activities of the National Institute of Diabetes and Digestive and Kidney Disease by making grants to nonprofit organizations, State and local jurisdictions, and Indian tribes for the purpose of reducing the burden of kidney disease, especially in disproportionately impacted communities, through public health interventions and related activities.

(3) Coordinate with the Centers for Disease Control and Prevention, the Indian Health Service, the Health Resources and Services Administration, and the Department of Veterans Affairs to develop pilot programs to demonstrate best practices for the diagnosis and management of kidney disease.

(4) Develop improved techniques and identify best practices, in coordination with the Secretary of Veterans Affairs, for assisting kidney disease patients.

(d) DATA COLLECTION.—Not later than 180 days after the date of enactment of this Act, the Director of the National Institute of Diabetes and Digestive and Kidney Disease and the Director of the Centers for Disease Control and Prevention, acting jointly, shall assess the depth and quality of information on kidney disease that is collected in surveys and population studies conducted by the Centers for Disease Control and Prevention, including whether there are additional opportunities for information to be collected in the National Health and Nutrition Examination Survey, the National Health Interview Survey, and the Behavioral Risk Factors Surveillance System surveys. The Director of the National Institute of Diabetes and Digestive and Kidney Disease shall include the results of such assessment in the national action plan under subsection (b).

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $1,000,000 for fiscal year 2021, $1,000,000 for fiscal year 2022, $1,000,000 for fiscal year 2023, $1,000,000 for fiscal year 2024, and $1,000,000 for fiscal year 2025.

**SEC. 799A. HOME DIALYSIS AND INCREASING END-STAGE RENAL DISEASE TREATMENT MODALITIES IN MINORITY COMMUNITIES ACTION PLAN.**

(a) NATIONAL ACTION PLAN.—

(1) DEVELOPMENT.—Not later than 2 years after the date of the enactment of this Act, the Director of the National Institute of Diabetes and Digestive and Kidney Disease, in consultation with the Director of the Centers for Disease Control and Prevention, shall develop a national action plan to increase the number of home dialyzers and choice in dialysis treatment modality in the United States with participation from patients, caregivers, health professionals, patient advocacy organizations, researchers, providers, public health professionals, and other stakeholders in the minority community.

(2) CONTENTS.—At a minimum, such plan shall include recommendations for—

(A) public health officials for the purpose of implementation of the national plan;

(B) biomedical, health services, and public health research on home dialysis and modalities in minority communities; and

(C) inclusion of dialysis location and modality in the health data collections of all Federal agencies.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $1,000,000 for fiscal year 2021, $1,000,000 for fiscal year 2022, $1,000,000 for fiscal year 2023, $1,000,000 for fiscal year 2024, and $1,000,000 for fiscal year 2025.

**SEC. 799B. INCREASING KIDNEY TRANSPLANTS IN MINORITY COMMUNITIES.**

(a) IN GENERAL.—The Director of the National Institutes of Health shall expand, intensify, and support ongoing research and other activities with respect to kidney transplants in minority populations.

(b) RESEARCH.—Research under subsection (a) shall include investigation into—

(1) the causes of lower rates of kidney transplants in minority communities, including socioeconomic, geographic, clinical, environmental, genetic, and other factors that may contribute to lower rates of kidney transplants in minority populations; and

(2) possible interventions to increase kidney transplants.

(c) REPORT; COMPREHENSIVE PLAN.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall—

(A) prepare and submit to the Congress, not later than 6 months after the date of enactment of this section, a report on Federal research and public health activities with respect to kidney transplants as a treatment for end-stage renal disease in minority populations; and

(B) develop and submit to the Congress, not later than 1 year after the date of enactment of this section, an effective and comprehensive Federal plan (including all appropriate Federal health programs) to increase the number of kidney transplants in minority populations.

(2) CONTENTS.—The report under paragraph (1)(A) shall at a minimum address each of the following:

(A) Research on kidney transplants in minority populations, including such research on financial, insurance coverage, genetic, behavioral, and environmental factors.

(B) Surveillance and data collection on kidney transplants in minority populations, including with respect to—

(i) efforts to increase kidney transplants disease among Asian-American and

Pacific Islander subgroups with end-stage renal disease; and

(ii) efforts to increase kidney transplants in the American Indian population.

(C) Community-based efforts to increase kidney transplants targeting minority populations, including—

(i) the evidence base for such increases;

(ii) the cultural appropriateness of such increases; and

(iii) efforts to educate the public on the kidney transplants.

(D) Education and training programs for health professionals (including community health workers) on the kidney transplants that are supported by the Health Resources and Services Administration, including such programs supported by the Bureau of Health Workforce, the Bureau of Primary Health Care, and the Healthcare Systems Bureau.

**SEC. 799C. ENVIRONMENTAL AND OCCUPATIONAL HEALTH PROGRAMS.**

The Director of the Centers for Disease Control and Prevention shall—

(1) support research into the environmental and occupational causes and biological mechanisms that contribute to kidney disease; and

(2) develop and disseminate public health interventions that will lessen the impact of environmental and occupational causes of kidney disease.

**SEC. 799D. UNDERSTANDING THE TREATMENT PATTERNS ASSOCIATED WITH PROVIDING CARE AND TREATMENT OF KIDNEY FAILURE IN MINORITY POPULATIONS.**

(a) STUDY.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study on treatment patterns associated with providing care, under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.), and through private health insurance, to minority populations that are disproportionately affected by kidney failure.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a), together with such recommendations as the Secretary determines to be appropriate.

**SEC. 799E. IMPROVING ACCESS IN UNDERSERVED AREAS.**

(a) DEFINITION OF PRIMARY CARE SERVICES.—Section 331(a)(3)(D) of the Public Health Service Act (42 U.S.C. 254d(a)(3)(D)) is amended by inserting ''renal dialysis,'' after ''dentistry,''.

(b) NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM.—Section 338A(a)(2) of the Public Health Service Act (42 U.S.C. 254l(a)(2)) is amended by inserting '', which may include nephrology health professionals'' before the period at the end.

(c) NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM.—Section 338B(a)(2) of the Public Health Service Act (42 U.S.C. 254l–1(a)(2)) is amended by inserting '', which may include nephrology health professionals'' before the period at the end.

# TITLE VIII—HEALTH INFORMATION TECHNOLOGY

**SEC. 800. DEFINITIONS.**

In this title:

(1) CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY.—The term ''certified EHR technology'' has the meaning given such term in section 3000 of the Public Health Service Act (42 U.S.C. 300jj).

(2) EHR.—The term ''EHR'' means an electronic health record.

(3) INTEROPERABILITY.—The term ''interoperability'' has the meaning given such term in section 3000 of the Public Health Service Act (42 U.S.C. 300jj). Evaluation and measurement of interoperability shall consider exchange of electronic health information, usability of exchanged electronic health information, effective application and use of the exchanged electronic health information, and impact an outcomes of interoperability.

(4) ACCESS.—The term ''access'' has the meaning given such term within the definition of ''interoperability'' in section 3000 of the Public Health Service Act (42 U.S.C. 300jj) and within HIPAA's Privacy Rule, 45 C.F.R. 164.524.

(5) CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY; EHR.—The term ''certified electronic health record technology'' and the term ''EHR'' both include the health information infrastructure for interoperability, access, exchange, and use of electronic health information required by sections 4003 and 4006 of the 21 st Century Cures Act, and are not limited solely to doctors' electronic health records.

# Subtitle A—Reducing Health Disparities Through Health IT

### SEC. 801. HRSA ASSISTANCE TO HEALTH CENTERS FOR PROMOTION OF HEALTH IT.

The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, shall expand and intensify the programs and activities of the Administration (directly or through grants or contracts) to provide technical assistance and resources to health centers (as defined in section 330(a) of the Public Health Service Act (42 U.S.C. 254b(a))) to adopt and meaningfully use certified EHR technology for the management of chronic diseases and health conditions and reduction of health disparities.

### SEC. 802. ASSESSMENT OF IMPACT OF HEALTH IT ON RACIAL AND ETHNIC MINORITY COMMUNITIES; OUTREACH AND ADOPTION OF HEALTH IT IN SUCH COMMUNITIES.

(a) NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY.—Not later than 18 months after the date of enactment of this Act, the National Coordinator for Health Information Technology (referred to in this section as the ''National Coordinator'') shall—

(1) conduct an evaluation of the level of interoperability, access, use, and accessibility of electronic

health records in racial and ethnic minority communities, focusing on whether patients in such communities have providers who use electronic health records, and the degree to which patients in such communities can access, exchange, and use without special effort their health information in those electronic health records, and indicating whether such providers—

(A) are participating in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan);

(B) have received incentive payments or incentive payment adjustments under Medicare and Medicaid Electronic Health Records Incentive Programs (as defined in subsection (c)(2));

(C) are MIPS eligible professionals, as defined in paragraph (1)(C) of section 1848(q) of the Social Security Act (42 U.S.C. 1395w–4(q)), for purposes of the Merit-Based Incentive Payment System under such section; or

(D) have been recruited by any of the Health Information Technology Regional Extension Centers established under section 3012

of the Public Health Service Act (42 U.S.C. 300jj–32);

(2) publish the results of such evaluation including the race and ethnicity of such providers and the populations served by such providers; and

(3) not later than 12 months after the enactment of this Act, shall promulgate a certification criterion and module of certified EHR technology that stratifies quality measures by disparity characteristics, including race, ethnicity, language, gender, gender identity, sexual orientation, socio-economic status, and disability status, as those characteristics are defined in certified EHR technology; and reports to Centers for Medicare & Medicaid Services the quality measures stratified by race and at least two other disparity characteristics.

The term ''quality measures'' refers to the quality measures specified in MIPS.

(b) NATIONAL CENTER FOR HEALTH STATISTICS.—As soon as practicable after the date of enactment of this Act, the Director of the National Center for Health Statistics shall provide to Congress a more detailed analysis of the data presented in National Center for Health Statistics data brief entitled ''Adoption of Certified Electronic Health Record Systems and Electronic Information Shar-

ing in Physician Offices: United States, 2013 and 2014'' (NCHS Data Brief No. 236).

(c) CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) IN GENERAL.—As part of the process of collecting information, with respect to a provider, at registration and attestation for purposes of Medicare and Medicaid Electronic Health Records Incentive Programs (as defined in paragraph (2)) or the Merit-Based Incentive Payment System under section 1848(q) of the Social Security Act (42 U.S.C. 1395w–4(q)), the Secretary of Health and Human Services shall collect the race and ethnicity of such provider.

(2) MEDICARE AND MEDICAID ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAMS DEFINED.—For purposes of paragraph (1), the term ''Medicare and Medicaid Electronic Health Records Incentive Programs'' means the incentive programs under section 1814(l)(3), subsections (a)(7) and (o) of section 1848, subsections (l) and (m) of section 1853, subsections (b)(3)(B)(ix)(I) and (n) of section 1886, and subsections (a)(3)(F) and (t) of section 1903 of the Social Security Act (42 U.S.C.

1395f(l)(3), 1395w–4, 1395w–23, 1395ww, and 1396b).

(d) NATIONAL COORDINATOR'S ASSESSMENT OF IMPACT OF HIT.—Section 3001(c)(6)(C) of the Public Health Service Act (42 U.S.C. 300jj–11(c)(6)(C)) is amended—

(1) in the heading by inserting ", RACIAL AND ETHNIC MINORITY COMMUNITIES," after "HEALTH DISPARITIES";

(2) by inserting ", in communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)), including people with disabilities in these groups," after "communities with health disparities";

(3) by striking "The National Coordinator" and inserting the following:

"(i) IN GENERAL.—The National Coordinator"; and

(4) by adding at the end the following:

"(ii) CRITERIA.—In any publication under clause (i), the National Coordinator shall include best practices for encouraging partnerships between the Federal Government, States, and private entities to expand outreach for and the adoption of cer-

tified EHR technology in communities with a high proportion of individuals from racial and ethnic minority groups (as so defined), while also maintaining the accessibility requirements of section 508 of the Rehabilitation Act of 1973 to encourage patient involvement in patient health care. The National Coordinator shall—

''(I) not later than 6 months after the submission of the report required under section 822 of the Health Equity and Accountability Act of 2020, establish criteria for evaluating the impact of health information technology on communities with a high proportion of individuals from racial and ethnic minority groups (as so defined) taking into account the findings in such report; and

''(II) not later than 1 year after the submission of such report, conduct and publish the results of an evaluation of such impact.''.

**SEC. 803. NONDISCRIMINATION AND HEALTH EQUITY IN HEALTH INFORMATION TECHNOLOGY.**

Covered entities shall ensure that electronic and information technology in their health programs or activities does not exclude individuals from participation in, deny them the benefits of, or subject them to discrimination under any health program or activity on the basis of race, color, national origin, sex, age, or disability. The term ''covered entity'' means—

(1) an entity that operates a health program or activity, any part of which receives Federal financial assistance;

(2) an entity established under title I of the Patient Protection and Affordable Care Act that administers a health program or activity; and

(3) the U.S. Department of Health and Human Services.

**SEC. 804. LANGUAGE ACCESS IN HEALTH INFORMATION TECHNOLOGY.**

The National Coordinator shall—

(1) not later than 18 months following enactment of this Act, require the Office of the National Coordinator to provide access to certified EHR technology to provide patients access to their personal health information in a computable format, including using patient portals or third-party applications

(as described in 21 st Century Cures Act), in the ten (10) most common non-English languages;

(2) hold a public hearing to identify best practices for such a requirement listed in paragraph (1); and

(3) not later than 6 months after the public hearing, promulgate a regulation and subsequent proposed rulemaking.

# Subtitle B—Modifications To Achieve Parity in Existing Programs

**SEC. 811. EXTENDING FUNDING TO STRENGTHEN THE HEALTH IT INFRASTRUCTURE IN RACIAL AND ETHNIC MINORITY COMMUNITIES.**

Section 3011 of the Public Health Service Act (42 U.S.C. 300jj–31) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by inserting ", including with respect to communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g))" before the colon; and

(2) by adding at the end the following new subsection:

''(e) ANNUAL REPORT ON EXPENDITURES.—The National Coordinator shall report annually to Congress on activities and expenditures under this section.''.

**SEC. 812. EXTENDING COMPETITIVE GRANTS FOR THE DEVELOPMENT OF LOAN PROGRAMS TO FACILITATE ADOPTION OF CERTIFIED EHR TECHNOLOGY BY PROVIDERS SERVING RACIAL AND ETHNIC MINORITY GROUPS.**

Section 3014(e) of the Public Health Service Act (42 U.S.C. 300jj–34(e)) is amended, in the matter preceding paragraph (1), by inserting '', including with respect to communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g))'' after ''health care provider to''.

**SEC. 813. AUTHORIZATION OF APPROPRIATIONS.**

Section 3018 of the Public Health Service Act (42 U.S.C. 300jj–38) is amended by striking ''fiscal years 2009 through 2013'' and inserting ''fiscal years 2021 through 2026''.

# Subtitle C—Additional Research and Studies

**SEC. 821. DATA COLLECTION AND ASSESSMENTS CONDUCTED IN COORDINATION WITH MINORITY-SERVING INSTITUTIONS.**

Section 3001(c)(6) of the Public Health Service Act (42 U.S.C. 300jj–11(c)(6)) is amended by adding at the end the following new subparagraph:

"(F) DATA COLLECTION AND ASSESSMENTS CONDUCTED IN COORDINATION WITH MINORITY-SERVING INSTITUTIONS.—

"(i) IN GENERAL.—In carrying out subparagraph (C) with respect to communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)), the National Coordinator shall, to the greatest extent possible, coordinate with an entity described in clause (ii).

"(ii) MINORITY-SERVING INSTITUTIONS.—For purposes of clause (i), an entity described in this clause is a historically black college or university, a Hispanic-serving institution, a tribal college or university, or an Asian-American-, Native Amer-

ican-, or Pacific Islander-serving institution with an accredited public health, health policy, or health services research program.''.

**SEC. 822. STUDY OF HEALTH INFORMATION TECHNOLOGY IN MEDICALLY UNDERSERVED COMMUNITIES.**

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) enter into an agreement with the National Academies of Sciences, Engineering, and Medicine to conduct a study on the development, implementation, and effectiveness of health information technology within medically underserved areas (as described in subsection (c)); and

(2) submit a report to Congress describing the results of such study, including any recommendations for legislative or administrative action.

(b) STUDY.—The study described in subsection (a)(1) shall—

(1) identify barriers to successful implementation of health information technology in medically underserved areas;

(2) survey a cross-section of individuals in medically underserved areas and report their opinions about the various topics of study;

(3) examine the degree of interoperability among health information technology and users of health information technology in medically underserved areas, including patients, providers, and community services;

(4) examine the impact of health information technology on providing quality care and reducing the cost of care to individuals in such areas, including the impact of such technology on improved health outcomes for individuals, including which technology worked for which population and how it improved health outcomes for that population;

(5) examine the impact of health information technology on improving health care-related decisions by both patients and providers in such areas;

(6) identify specific best practices for using health information technology to foster the consistent provision of physical accessibility and reasonable policy accommodations in health care to individuals with disabilities in such areas;

(7) assess the feasibility and costs associated with the use of health information technology in such areas;

(8) evaluate whether the adoption and use of qualified electronic health records (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 300jj)) is effective in reducing health disparities, including analysis of clinical quality measures reported by providers who are participating in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan), pursuant to programs to encourage the adoption and use of certified EHR technology;

(9) identify providers in medically underserved areas that are not electing to adopt and use electronic health records and determine what barriers are preventing those providers from adopting and using such records; and

(10) examine urban and rural community health systems and determine the impact that health information technology may have on the capacity of primary health providers in those systems.

(c) MEDICALLY UNDERSERVED AREA.—The term ''medically underserved area'' means—

(1) a population that has been designated as a medically underserved population under section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3));

(2) an area that has been designated as a health professional shortage area under section 332 of the Public Health Service Act (42 U.S.C. 254e);

(3) an area or population that has been designated as a medically underserved community under section 799B of the Public Health Service Act (42 U.S.C. 295p); or

(4) another area or population that—

(A) experiences significant barriers to accessing quality health services; and

(B) has a high prevalence of diseases or conditions described in title VII, with such diseases or conditions having a disproportionate impact on racial and ethnic minority groups (as defined in section 1707(g) of the Public Health Service Act (42 U.S.C. 300u–6(g))) or a subgroup of people with disabilities who have specific functional impairments.

**SEC. 823. ASSESSMENT OF USE AND MISUSE OF DE-IDENTIFIED HEALTH DATA.**

(a) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) enter into an agreement with the Office of the National Coordinator to conduct a study on the impact of digital health technology on medically underserved areas (as described in section 822(c) of the Health Equity and Accountability Act of 2020) in consultation with relevant stakeholders; and

(2) submit a report to Congress describing the results of such study, including any recommendations for legislative or administrative action.

(b) STUDY.—The study described in subsection (a)(1) shall—

(1) examine the overall prevalence, and historical and existing practices and their respective prevalence, of use and misuse of de-identified protected health information, as it is defined in section 160.103, title 45, Code of Federal Regulations, to discriminate against or benefit medically underserved areas;

(2) identify best practices and tools to leverage the benefits and prevent misuse of de-identified pro-

tected health information to discriminate against medically underserved areas;

(3) examine the overall prevalence, and historical and existing practices and their respective prevalence, of use and misuse of de-identified personal health information other than protected health information, as it is defined in section 160.103, title 45, Code of Federal Regulations, to discriminate against or benefit medically underserved areas; and

(4) identify best practices and tools to leverage the benefits and prevent misuse of de-identified personal health information other than protected health information to discriminate against medically underserved areas.

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

**SEC. 831. EXTENDING MEDICAID EHR INCENTIVE PAYMENTS TO REHABILITATION FACILITIES, LONG-TERM CARE FACILITIES, AND HOME HEALTH AGENCIES.**

(a) IN GENERAL.—Section 1903(t)(2)(B) of the Social Security Act (42 U.S.C. 1396b(t)(2)(B)) is amended—

(1) in clause (i), by striking ", or" and inserting a semicolon;

(2) in clause (ii), by striking the period at the end and inserting a semicolon; and

(3) by inserting after clause (ii) the following new clauses:

''(iii) a rehabilitation facility (as defined in section 1886(j)(1)) that furnishes acute or subacute rehabilitation services;

''(iv) a long-term care hospital (as defined in section 1886(d)(1)(B)(iv)); or

''(v) a home health agency (as defined in section 1861(o)).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to amounts expended under section 1903(a)(3)(F) of the Social Security Act (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters beginning on or after the date of the enactment of this Act.

**SEC. 832. EXTENDING PHYSICIAN ASSISTANT ELIGIBILITY FOR MEDICAID ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS.**

(a) IN GENERAL.—Section 1903(t)(3)(B)(v) of the Social Security Act (42 U.S.C. 1396b(t)(3)(B)(v)) is amended to read as follows:

''(v) physician assistant.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to amounts ex-

pended under section 1903(a)(3)(F) of the Social Security Act (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters beginning on or after the date of the enactment of this Act.

# TITLE IX—ACCOUNTABILITY AND EVALUATION

**SEC. 901. PROHIBITION ON DISCRIMINATION IN FEDERAL ASSISTED HEALTH CARE SERVICES AND RESEARCH PROGRAMS ON THE BASIS OF SEX (INCLUDING SEX ORIENTATION, GENDER IDENTITY, AND PREGNANCY, INCLUDING TERMINATION OF PREGNANCY), RACE, COLOR, NATIONAL ORIGIN, MARITAL STATUS, FAMILIAL STATUS, SEXUAL ORIENTATION, GENDER IDENTITY, OR DISABILITY STATUS.**

(a) IN GENERAL.—No person in the United States shall, on the basis of sex (including sex orientation, gender identity, and pregnancy, including termination of pregnancy), race, color, national origin, marital status, familial status, sexual orientation, gender identity, or disability status, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity, including any health research program or activity, receiving Federal financial assistance, including credits, subsidies, or contracts of insurance or

any health program or activity that is administered by an executive agency.

(b) DEFINITION.—In this section, the term ''familial status'' means, with respect to one or more individuals—

(1) being domiciled with any individual related by blood or affinity whose close association with the individual is the equivalent of a family relationship;

(2) being in the process of securing legal custody of any individual; or

(3) being pregnant.

**SEC. 902. TREATMENT OF MEDICARE PAYMENTS UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964.**

A payment to a provider of services, physician, or other supplier under part B, C, or D of title XVIII of the Social Security Act shall be deemed a grant, and not a contract of insurance or guaranty, for the purposes of title VI of the Civil Rights Act of 1964.

**SEC. 903. ACCOUNTABILITY AND TRANSPARENCY WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.**

Title XXXIV of the Public Health Service Act, as amended by titles I, II, and III of this Act, is further amended by inserting after subtitle C the following:

# "Subtitle D—Strengthening Accountability

**"SEC. 3441. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.**

''(a) IN GENERAL.—The Secretary shall establish within the Office for Civil Rights an Office of Health Disparities, which shall be headed by a director to be appointed by the Secretary.

''(b) PURPOSE.—The Office of Health Disparities shall ensure that the health programs, activities, and operations of health entities that receive Federal financial assistance are in compliance with title VI of the Civil Rights Act, including through the following activities:

''(1) The development and implementation of an action plan to address racial and ethnic health care disparities, which shall address concerns relating to the Office for Civil Rights as released by the United States Commission on Civil Rights in the report entitled 'Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equity' (September 1999) in conjunction with the reports by the National Academy of Sciences (formerly known as the Institute of Medicine) entitled 'Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care', 'Crossing the Quality Chasm: A New Health System for the 21st

Century', 'In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce', 'The National Partnership for Action to End Health Disparities', and 'The Health of Lesbian, Gay, Bisexual, and Transgender People', and other related reports by the National Academy of Sciences. This plan shall be publicly disclosed for review and comment and the final plan shall address any comments or concerns that are received by the Office.

''(2) Investigative and enforcement actions against intentional discrimination and policies and practices that have a disparate impact on minorities.

''(3) The review of racial, ethnic, gender identity, sexual orientation, sex, disability status, socioeconomic status, and primary language health data collected by Federal health agencies to assess health care disparities related to intentional discrimination and policies and practices that have a disparate impact on minorities. Such review shall include an assessment of health disparities in communities with a combination of these classes.

''(4) Outreach and education activities relating to compliance with title VI of the Civil Rights Act.

''(5) The provision of technical assistance for health entities to facilitate compliance with title VI of the Civil Rights Act.

''(6) Coordination and oversight of activities of the civil rights compliance offices established under section 3442.

''(7) Ensuring—

''(A) at a minimum, compliance with the most recent version of the Office of Management and Budget statistical policy directive entitled 'Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity'; and

''(B) consideration of available data and language standards such as—

''(i) the standards for collecting and reporting data under section 3101; and

''(ii) the National Standards on Culturally and Linguistically Appropriate Services of the Office of Minority Health.

''(c) FUNDING AND STAFF.—The Secretary shall ensure the effectiveness of the Office of Health Disparities by ensuring that the Office is provided with—

''(1) adequate funding to enable the Office to carry out its duties under this section; and

''(2) staff with expertise in—

''(A) epidemiology;

''(B) statistics;

''(C) health quality assurance;

''(D) minority health and health disparities;

''(E) cultural and linguistic competency;

''(F) civil rights; and

''(G) social, behavioral, and economic determinants of health.

''(d) REPORT.—Not later than December 31, 2021, and annually thereafter, the Secretary, in collaboration with the Director of the Office for Civil Rights and the Deputy Assistant Secretary for Minority Health, shall submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives that includes—

''(1) the number of cases filed, broken down by category;

''(2) the number of cases investigated and closed by the office;

''(3) the outcomes of cases investigated;

''(4) the staffing levels of the office including staff credentials;

''(5) the number of other lingering and emerging cases in which civil rights inequities can be demonstrated; and

''(6) the number of cases remaining open and an explanation for their open status.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2026.

**''SEC. 3442. ESTABLISHMENT OF HEALTH PROGRAM OFFICES FOR CIVIL RIGHTS WITHIN FEDERAL HEALTH AND HUMAN SERVICES AGENCIES.**

''(a) IN GENERAL.—The Secretary shall establish civil rights compliance offices in each agency within the Department of Health and Human Services that administers health programs.

''(b) PURPOSE OF OFFICES.—Each office established under subsection (a) shall ensure that recipients of Federal financial assistance under Federal health programs administer programs, services, and activities in a manner that—

''(1) does not discriminate, either intentionally or in effect, on the basis of race, national origin, language, ethnicity, sex, age, disability, sexual orientation, and gender identity; and

''(2) promotes the reduction and elimination of disparities in health and health care based on race, national origin, language, ethnicity, sex, age, disability, sexual orientation, and gender identity.

''(c) POWERS AND DUTIES.—The offices established in subsection (a) shall have the following powers and duties:

''(1) The establishment of compliance and program participation standards for recipients of Federal financial assistance under each program administered by the applicable agency, including the establishment of disparity reduction standards to encompass disparities in health and health care related to race, national origin, language, ethnicity, sex, age, disability, sexual orientation, and gender identity.

''(2) The development and implementation of program-specific guidelines that interpret and apply Department of Health and Human Services guidance under title VI of the Civil Rights Act of 1964 and section 1557 of the Patient Protection and Affordable Care Act to each Federal health program administered by the agency.

''(3) The development of a disparity-reduction impact analysis methodology that shall be applied to every rule issued by the agency and published as

part of the formal rulemaking process under sections 555, 556, and 557 of title 5, United States Code.

''(4) Oversight of data collection, analysis, and publication requirements for all recipients of Federal financial assistance under each Federal health program administered by the agency; compliance with, at a minimum, the most recent version of the Office of Management and Budget statistical policy directive entitled 'Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity'; and consideration of available data and language standards such as—

''(A) the standards for collecting and reporting data under section 3101; and

''(B) the National Standards on Culturally and Linguistically Appropriate Services of the Office of Minority Health.

''(5) The conduct of publicly available studies regarding discrimination within Federal health programs administered by the agency as well as disparity reduction initiatives by recipients of Federal financial assistance under Federal health programs.

''(6) Annual reports to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Com-

mittee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives on the progress in reducing disparities in health and health care through the Federal programs administered by the agency.

''(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS IN THE DEPARTMENT OF JUSTICE.—

''(1) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Office for Civil Rights of the Department of Health and Human Services shall provide standard-setting and compliance review investigation support services to the Civil Rights Compliance Office for each agency described in subsection (a), subject to paragraph (2).

''(2) DEPARTMENT OF JUSTICE.—The Office for Civil Rights of the Department of Justice may, as appropriate, institute formal proceedings when a civil rights compliance office established under subsection (a) determines that a recipient of Federal financial assistance is not in compliance with the disparity reduction standards of the applicable agency.

''(e) DEFINITION.—In this section, the term 'Federal health programs' mean programs—

''(1) under the Social Security Act (42 U.S.C. 301 et seq.) that pay for health care and services; and

''(2) under this Act that provide Federal financial assistance for health care, biomedical research, health services research, and programs designed to improve the public's health, including health service programs.''.

**SEC. 904. UNITED STATES COMMISSION ON CIVIL RIGHTS.**

(a) COORDINATION WITHIN DEPARTMENT OF JUSTICE OF ACTIVITIES REGARDING HEALTH DISPARITIES.—Section 3(a) of the Civil Rights Commission Act of 1983 (42 U.S.C. 1975a(a)) is amended—

(1) in paragraph (1), by striking ''and'' at the end;

(2) in paragraph (2), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(3) shall, with respect to activities carried out in health care and correctional facilities toward the goal of eliminating health disparities between the general population and members of minority groups based on race or color, promote coordination of such activities of—

''(A) the Office for Civil Rights within the Office of Justice Programs of the Department of Justice;

''(B) the Office of Justice Programs within the Department of Justice;

''(C) the Office for Civil Rights within the Department of Health and Human Services; and

''(D) the Office of Minority Health within the Department of Health and Human Services (headed by the Deputy Assistant Secretary for Minority Health).''.

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 5 of the Civil Rights Commission Act of 1983 (42 U.S.C. 1975c) is amended by striking the first sentence and inserting the following: ''For the purpose of carrying out this Act, there are authorized to be appropriated $30,000,000 for fiscal year 2021, and such sums as may be necessary for each of the fiscal years 2022 through 2026.''.

**SEC. 905. SENSE OF CONGRESS CONCERNING FULL FUNDING OF ACTIVITIES TO ELIMINATE RACIAL AND ETHNIC HEALTH DISPARITIES.**

(a) FINDINGS.—Congress makes the following findings:

(1) The health status of the population of the United States is declining and the United States currently ranks below most industrialized nations in health status measured by longevity, sickness, and mortality.

(2) Racial and ethnic minority populations tend to have the poorest health status and face substantial cultural, social, and economic barriers to obtaining quality health care.

(3) Lesbian, gay, bisexual, transgender, queer, and questioning populations experience significant personal and structural barriers to obtaining high-quality health care.

(4) Efforts to improve minority health have been limited by inadequate resources (funding, staffing, and stewardship) and lack of accountability.

(b) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) health disparities negatively impact outcomes for health and human security of the Nation;

(2) reducing racial, ethnic, sexual, and gender disparities in prevention and treatment are unique civil and human rights challenges and, as such, Federal agencies and health care entities and systems

receiving Federal funds should be accountable for their role in causing disparities and inequity;

(3) funding for the National Institute on Minority Health and Health Disparities, the Office of Civil Rights in the Department of Health and Human Services, the National Institute of Nursing Research, and the Office of Minority Health should be doubled by fiscal year 2022;

(4) adequate funding by fiscal year 2022, and subsequent funding increases, should be provided for health and human service professions training programs, the Racial and Ethnic Approaches to Community Health Initiative at the Centers for Disease Control and Prevention, the Minority HIV/AIDS Initiative, and the Excellence Centers to Eliminate Ethnic/Racial Disparities Program at the Agency for Healthcare Research and Quality;

(5) funding should be fully restored to the Racial and Ethnic Approaches to Community Health Initiative at the Centers for Disease Control and Prevention, which has been a successful program at the community health level, and efforts should continue to place a strong emphasis on building community capacity to secure financial resources and technical assistance to eliminate health disparities;

(6) adequate funding for fiscal year 2022 and increased funding for future years should be provided for the Racial and Ethnic Approaches to Community Health Initiative's United States Risk Factor Survey to ensure adequate data collection to track health disparities, and there should be appropriate avenues provided to disseminate findings to the general public;

(7) current and newly created health disparity elimination incentives, programs, agencies, and departments under this Act (and the amendments made by this Act) should receive adequate staffing and funding by fiscal year 2022; and

(8) stewardship and accountability should be provided to the Congress and the President for measurable and sustainable progress toward health disparity elimination.

**SEC. 906. GAO AND NIH REPORTS.**

(a) GAO REPORT ON NIH GRANT RACIAL AND ETHNIC DIVERSITY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on the racial and ethnic diversity among the following groups:

(A) All applicants for grants, contracts, and cooperative agreements awarded by the Na-

tional Institutes of Health during the period beginning on January 1, 2009, and ending December 31, 2019.

(B) All recipients of such grants, contracts, and cooperative agreements during such period.

(C) All members of the peer review panels of such applicants and recipients, respectively.

(2) REPORT.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General shall complete the study under paragraph (1) and submit to Congress a report containing the results of such study.

(b) NIH REPORT ON CERTAIN AUTHORITY OF NATIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH DISPARITIES.—Not later than 6 months after the date of the enactment of this Act, and biennially thereafter, the Director of the National Institutes of Health, in collaboration with the Director of the National Institute on Minority Health and Health Disparities, shall submit to Congress a report that details and evaluates—

(1) the steps taken during the applicable report period by the Director of the National Institutes of Health to enforce the expanded planning, coordination, review, and evaluation authority provided the

National Institute on Minority Health and Health Disparities under section 464z–3(h) of the Public Health Service Act (42 U.S.C. 285(h)) over all minority health and health disparity research that is conducted or supported by the Institutes and Centers at the National Institutes of Health; and

(2) the outcomes of such steps.

(c) GAO REPORT RELATED TO RECIPIENTS OF PPACA FUNDING.—Not later than one year after the date of the enactment of this Act and biennially thereafter until 2024, the Comptroller General of the United States shall submit to Congress a report that identifies—

(1) the racial and ethnic diversity of community-based organizations that applied for Federal enrollment funding provided pursuant to the Patient Protection and Affordable Care Act (Public Law 111–148) (including the amendments made by such Act);

(2) the percentage of such organizations that were awarded such funding; and

(3) the impact of such community-based organizations' enrollment efforts on the insurance status of their communities.

(d) ANNUAL REPORT ON ACTIVITIES OF NATIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH DIS-

PARITIES.—The Director of the National Institute on Minority Health and Health Disparities shall prepare an annual report on the activities carried out or to be carried out by such institute, and shall submit each such report to the Committee on Health, Education, Labor, and Pensions of the Senate, the Committee on Energy and Commerce of the House of Representatives, the Secretary of Health and Human Services, and the Director of the National Institutes of Health. With respect to the fiscal year involved, the report shall—

(1) describe and evaluate the progress made in health disparities research conducted or supported by institutes and centers of the National Institutes of Health;

(2) summarize and analyze expenditures made for activities with respect to health disparities research conducted or supported by the National Institutes of Health;

(3) include a separate statement applying the requirements of paragraphs (1) and (2) specifically to minority health disparities research; and

(4) contain such recommendations as the Director of the Institute considers appropriate.

# TITLE X—ADDRESSING SOCIAL DETERMINANTS AND IMPROVING ENVIRONMENTAL JUSTICE

## Subtitle A—In General

**SEC. 1001. DEFINITIONS.**

In this title:

(1) DETERMINANTS OF HEALTH.—The term ''determinants of health''—

(A) means the range of personal, social, economic, and environmental factors that influence health status; and

(B) includes social determinants of health (which are sometimes referred to as ''social and economic determinants of health'', ''socioeconomic determinants of health'', ''environmental determinants of health'', ''social drivers of inequality'', and ''personal determinants of health'').

(2) ENVIRONMENTAL DETERMINANTS OF HEALTH.—The term ''environmental determinants of health'' means the broad physical (including man-made and natural environments), psychological, social, spiritual, cultural and aesthetic environment.

(3) BUILT ENVIRONMENT.—The term ''built environment'' means the components of the environment, and the location of these components in a geographically defined space, that are created or modified by individuals to form the physical and social characteristics of a community or enhance quality of human life, including—

(A) homes, schools, and places of work and worship;

(B) parks, recreation areas, and greenways;

(C) transportation systems;

(D) business, industry, and agriculture; and

(E) land-use plans, projects, and policies that impact the physical or social characteristics of a community, including access to services and amenities.

(4) PERSONAL DETERMINANTS OF HEALTH.—The term ''personal determinants of health'' means an individual's behavior, biology, and genetics.

(5) SOCIAL DETERMINANTS OF HEALTH.—The term ''social determinants of health'' means a subset of determinants of the health of individuals and environments (such as communities, neighborhoods,

and societies) that describe an individual's or group of people's social identity, describe the social and economic resources to which such individual or group has access, and describe the conditions in which an individual or group of people works, lives, and plays.

(6) ECONOMIC DETERMINANTS OF HEALTH.—The term ''economic determinants of health'' refers to income and social status. Higher income and socioeconomic status (SES) are linked to decreased rates of morbidity and mortality. The higher your SES, the healthier you are the longer you'll live. Low SES leads to an increased risk of illness and death.

**SEC. 1002. FINDINGS.**

Congress finds as follows:

(1) Social determinants of health are the largest predictors of health outcomes.

(2) Social determinants of health, including health-related behaviors, social and economic factors, and physical environment factors account for 80 percent of health outcomes, whereas clinical care accounts for 20 percent of improved health outcomes. Yet, in 2017, public health spending only rep-

resented 2.5 percent of all health spending in the United States.

(3) There are more opportunities to improve health for everyone when we understand that health starts, first, not in a medical setting, but in our families, in our schools and workplaces, in our neighborhoods, in the air we breathe, and in the water we drink.

(4)(A) Healthy People 2020 identifies health and health care quality as a function of not only access to health care, but also the social determinants of health, categorized into the following: neighborhoods and the built environment; social and community context; education; and economic stability.

(B) The following examples illustrate the nexus between the unequal distribution of the social determinants of health and health disparities:

(i) The built environment influences residents' level of physical activity. Neighborhoods with high levels of poverty are significantly less likely to have places where children can be physically active, such as parks, green spaces, and bike paths and lanes. Neighborhoods and communities can provide opportunities for physical activity and support active lifestyles

through accessible and safe parks and open spaces and through land use policy, zoning, and healthy community design.

(ii) Emotional and physical health and well-being are directly impacted by perceived levels of safety, such as unlit streets at night. Community members have expressed that safety is not only a barrier to accessing programs and services that increase quality of life but they are also not able to access physical activity in their community through the built environment.

(iii) In many workplace environments.

(iv) Historical and institutional racism in the United States has shaped the way in which social and economic resources and exposure to health promoting environments are distributed. Income, education, occupation, neighborhood conditions, schools, workplaces, the use of health and social services, and experiences with the criminal justice system are all highly patterned by race, with people of color experiencing more that is health harming. Finding ways to uncouple the link between race and access to resources and healthy environments is a principal means of reducing health disparities. Addition-

ally, the anticipation of racism itself causes higher psychological and cardiovascular stress levels that are linked to poor health outcomes. Remedying discriminatory practices at the individual and systemic levels will likely reduce health disparities caused by this unequal distribution of stress.

(v) Poor health among Native Americans has largely been driven by post-colonial oppression and historical trauma. The expropriation of native lands and territories to the American state had severe consequences on Native American health. This resulted in the deprivation of traditional food sources—and nutrients—for Native Americans and also the destruction of traditional economies and community organization. Today, Native Americans have twice the rate of diabetes of non-Hispanic Whites. Recognition of the origins of the diabetes as having a social and community context, rather than just individual responsibility and genetic predisposition, will shape better policy to provide food security.

(vi) In the context of prisons, overcrowding has led to the deterioration of the physical and

mental health of individuals after they leave prison. In particular, the mass incarceration of African-American males as a result of unequal contact with and treatment in the criminal justice system has contributed to an overburdening of certain infectious diseases within the African-American community. As a social institution, incarceration amplifies existing adverse health conditions by concentrating diseases and harmful health behaviors such as tobacco use, drug use, and violence.

(vii) Educational attainment is the strongest predictor of adult mortality. It is a basic component of socioeconomic status that shapes earning potential to access resources that promote health. People with more education are less likely to report that they are in poor health, and are also less likely to have diabetes and other chronic diseases.

(viii) Individuals with lower levels of educational attainment are much more likely to report to be current smokers. In 2017, smoking prevalence was 36.8 percent among adults with a GED diploma, 23.1 percent with less than a high school diploma, and 18.7 percent with a

high school diploma, while dropping significantly to 7.1 percent among adults with an undergraduate college degree and 4.1 percent with a postgraduate college degree.

(ix) Income inequality differences account for a large part of health disparities.. For example, children living in poverty experience poorer housing conditions, increased exposure to indoor allergens and toxins (such as pesticides, lead, mercury, radon, air pollution, and carcinogens), increased food insecurity, and more psychological stress. These experiences culminate in worse adult health as compared with children with higher socioeconomic status. Specifically, children living in lower socioeconomic neighborhoods have higher rates of asthma due to higher rates of psychological stress resulting from higher rates of violence. Food insecurity is associated with obesity and racial and ethnic minorities have higher rates of food insecurity.

(x) Lesbian, gay, bisexual, transgender, queer, questioning, questioning and intersex (LGBTQIA) individuals face health disparities linked to societal stigma, discrimination, and

denial of their civil and human rights. Discrimination against LGBTQIA individuals has been associated with high rates of psychiatric disorders, substance abuse, and suicide. Experiences of violence and victimization are frequent for LGBTQIA individuals, and have long-lasting effects on the individual and the community. Personal, family, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBTQIA individuals.

(xi) Individuals in older and cheaper housing are at higher risks to be exposed to lead, particularly in housing built prior to 1960. The threat of lead poisoning disproportionally affects vulnerable populations, with children living in poverty (5.6 percent) and Black children (5.6) experiencing the highest rates. According to the Department of Housing and Urban Development, about 3,600,000 homes nationwide that house young children have lead hazards such as contaminated drinking water, peeling paint, contaminated dust, or toxic soil. The combined cost of medical treatment and special education for lead poisoned children averages

about $5,600 per child per year, and lead poisoning costs the United States an estimated $50,000,000,000 annually.

(xii) Individuals with disabilities, as a group, experience health disparities in routine public health arenas such as health behaviors, clinical preventive services, and chronic conditions. Compared with individuals without disabilities, individuals with disabilities are—

(I) less likely to receive recommended preventive health care services, such as routine teeth cleanings and cancer screenings;

(II) at a high risk for poor health outcomes such as obesity, hypertension, falls-related injuries, and mood disorders such as depression; and

(III) more likely to engage in unhealthy behaviors that put their health at risk, such as cigarette smoking and inadequate physical activity (from Healthy People 2020).

(5) Laws and regulations that improve opportunities to live in safe neighborhoods, with more social cohesion, attain higher education, sustain stable em-

ployment, and bridge class differences help foster the health and safety of individuals.

(6) The global public health community has reached consensus through the Rio Political Declaration of Social Determinants of Health adopted by the World Health Organisation in October 2011 that ''[c]ollaboration in coordinated and intersectoral policy actions has proven to be effective. Health in All Policies, an initiative of the American Public Health Association, together with intersectoral cooperation and action, is one promising approach to enhance accountability in other sectors of health, as well as the promotion of health equity and more inclusive and productive societies.''.

**SEC. 1003. HEALTH IMPACT ASSESSMENTS.**

(a) FINDINGS.—Congress makes the following findings:

(1) Health Impact Assessment is a tool to help planners, health officials, decisionmakers, and the public make more informed decisions about the potential health effects of proposed plans, policies, programs, and projects in order to maximize health benefits and minimize harms.

(2) Health Impact Assessments fosters community leadership, ownership and participation in decision-making processes.

(3) Health Impact Assessments can build community support and reduce opposition to a project or policy, thereby facilitating economic growth by aiding the development of consensus regarding new development proposals.

(4) Health Impact Assessments facilitate collaboration across sectors.

(b) PURPOSES.—It is the purpose of this section to—

(1) provide more information about the potential human health effects of policy decisions and the distribution of those effects;

(2) improve how health is considered in planning and decisionmaking processes; and

(3) build stronger, healthier communities through the use of Health Impact Assessment.

(c) HEALTH IMPACT ASSESSMENTS.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 796A, is further amended by adding at the end the following:

**"SEC. 399V–12. HEALTH IMPACT ASSESSMENTS.**

''(a) DEFINITIONS.—In this section:

''(1) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Environmental Protection Agency.

''(2) DIRECTOR.—The term 'Director' means the Director of the Centers for Disease Control and Prevention.

''(3) HEALTH IMPACT ASSESSMENT.—The term 'health impact assessment' means a systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a population and the distribution of those effects within the population. Such term includes identifying and recommending appropriate actions on monitoring and maximizing potential benefits and minimizing the potential harms.

''(4) HEALTH DISPARITY.—The term 'health disparity' means a particular type of health difference that is closely linked with social, economic, or environmental disadvantage and that adversely affects groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or

physical disability; sexual orientation or gender identity; geographic location; citizenship status; or other characteristics historically linked to discrimination or exclusion.

''(b) ESTABLISHMENT.—The Secretary, acting through the Director and in collaboration with the Administrator, shall—

''(1) in consultation with the Director of the National Center for Chronic Disease Prevention and Health Promotion and relevant offices within the Department of Housing and Urban Development, the Department of Transportation, and the Department of Agriculture, establish a program at the National Center for Environmental Health at the Centers for Disease Control and Prevention focused on advancing the field of health impact assessment that includes—

''(A) collecting and disseminating best practices;

''(B) administering capacity building grants to States to support grantees in initiating health impact assessments, in accordance with subsection (d);

''(C) providing technical assistance;

"(D) developing training tools and providing training on conducting health impact assessment and the implementation of built environment and health indicators;

"(E) making information available, as appropriate, regarding the existence of other community healthy living tools, checklists, and indices that help connect public health to other sectors, and tools to help examine the effect of the indoor built environment and building codes on population health;

"(F) conducting research and evaluations of health impact assessments; and

"(G) awarding competitive extramural research grants;

"(2) develop guidance and guidelines to conduct health impact assessments in accordance with subsection (c); and

"(3) establish a grant program to allow States to fund eligible entities to conduct health impact assessments.

"(c) GUIDANCE.—

"(1) IN GENERAL.—Not later than 1 year after the date of enactment of the Health Equity and Accountability Act of 2020, the Secretary, acting

through the Director, shall issue final guidance for conducting the health impact assessments. In developing such guidance the Secretary shall—

''(A) consult with the Director of the National Center for Environmental Health and, the Director of the National Center for Chronic Disease Prevention and Health Promotion, and relevant offices within the Department of Housing and Urban Development, the Department of Transportation, and the Department of Agriculture; and

''(B) consider available international health impact assessment guidance, North American health impact assessment practice standards, and recommendations from the National Academy of Science.

''(2) CONTENT.—The guidance under this subsection shall include—

''(A) background on national and international efforts to bridge urban planning, climate forecasting, and public health institutions and disciplines, including a review of health impact assessment best practices internationally;

''(B) evidence-based direct and indirect pathways that link land-use planning, transpor-

tation, and housing policy and objectives to human health outcomes;

''(C) data resources and quantitative and qualitative forecasting methods to evaluate both the status of health determinants and health effects, including identification of existing programs that can disseminate these resources;

''(D) best practices for inclusive public involvement in conducting health impact assessments; and

''(E) technical assistance for other agencies seeking to develop their own guidelines and procedures for health impact assessment.

''(d) GRANT PROGRAM.—

''(1) IN GENERAL.—The Secretary, acting through the Director and in collaboration with the Administrator, shall—

''(A) award grants to States to fund eligible entities for capacity building or to prepare health impact assessments; and

''(B) ensure that States receiving a grant under this subsection further support training and technical assistance for grantees under the program by funding and overseeing appropriate local, State, Tribal, Federal, institution of high-

er education, or nonprofit health impact assessment experts to provide such technical assistance.

''(2) APPLICATIONS.—

''(A) IN GENERAL.—To be eligible to receive a grant under this section, an eligible entity shall—

''(i) be a State, Indian tribe, or tribal organization that includes individuals or populations the health of which are, or will be, affected by an activity or a proposed activity; and

''(ii) submit to the Secretary an application in accordance with this subsection, at such time, in such manner, and containing such additional information as the Secretary may require.

''(B) INCLUSION.—An application under this subsection shall include a list of proposed activities that require or would benefit from conducting a health impact assessment within six months of awarding funds. The list should be accompanied by supporting documentation, including letters of support, from potential conductors of health impact assessments for the

listed proposed activities. Each application should also include an assessment by the eligible entity of the health of the population of its jurisdiction and describe potential adverse or positive effects on health that the proposed activities may create.

''(C) PREFERENCE.—Preference in awarding funds under this section may be given to eligible entities that demonstrate the potential to significantly improve population health or lower health care costs as a result of potential health impact assessment work.

''(3) USE OF FUNDS.—

''(A) IN GENERAL.—An entity receiving a grant under this section shall use such grant funds to conduct health impact assessment capacity building or to fund subgrantees in conducting a health impact assessment for a proposed activity in accordance with this subsection.

''(B) PURPOSES.—The purposes of a health impact assessment under this subsection are—

''(i) to facilitate the involvement of tribal, State, and local public health offi-

cials in community planning, transportation, housing, and land use decisions and other decisions affecting the built environment to identify any potential health concern or health benefit relating to an activity or proposed activity;

''(ii) to provide for an investigation of any health-related issue of concern raised in a planning process, an environmental impact assessment process, or policy appraisal relating to a proposed activity;

''(iii) to describe and compare alternatives (including no-action alternatives) to a proposed activity to provide clarification with respect to the potential health outcomes associated with the proposed activity and, where appropriate, to the related benefit-cost or cost-effectiveness of the proposed activity and alternatives;

''(iv) to contribute, when applicable, to the findings of a planning process, policy appraisal, or an environmental impact statement with respect to the terms and conditions of implementing a proposed ac-

tivity or related mitigation recommendations, as necessary;

''(v) to ensure that the disproportionate distribution of negative impacts among vulnerable populations is minimized as much as possible;

''(vi) to engage affected community members and ensure adequate opportunity for public comment on all stages of the health impact assessment;

''(vii) where appropriate, to consult with 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; and

''(viii) to inspect homes, water systems, and other elements that pose risks to lead exposure, with an emphasis on areas that pose a higher risk to children.

''(4) ASSESSMENTS.—Health impact assessments carried out using grant funds under this section shall—

''(A) take appropriate health factors into consideration as early as practicable during the planning, review, or decisionmaking processes;

''(B) assess the effect on the health of individuals and populations of proposed policies, projects, or plans that result in modifications to the built environment; and

''(C) assess the distribution of health effects across various factors, such as race, income, ethnicity, age, disability status, gender, and geography.

''(5) ELIGIBLE ACTIVITIES.—

''(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 (B).

''(B) CRITERIA.—The criteria described in this subparagraph include, as applicable to the proposed activity, the following:

''(i) Any substantial adverse effect or significant health benefit on health out-

comes or factors known to influence health, including the following:

''(I) Physical activity.

''(II) Injury.

''(III) Mental health.

''(IV) Accessibility to health-promoting goods and services.

''(V) Respiratory health.

''(VI) Chronic disease.

''(VII) Nutrition.

''(VIII) Land use changes that promote local, sustainable food sources.

''(IX) Infectious disease.

''(X) Health disparities.

''(XI) Existing air quality, ground or surface water quality or quantity, or noise levels.

''(XII) Lead exposure.

''(XIII) Drinking water quality and accessibility.

''(ii) Other factors that may be considered, including—

''(I) the potential for a proposed activity to result in systems failure

that leads to a public health emergency;

''(II) the probability that the proposed activity will result in a significant increase in tourism, economic development, or employment in the jurisdiction of the eligible entity;

''(III) any other significant potential hazard or enhancement to human health, as determined by the eligible entity; or

''(IV) whether the evaluation of a proposed activity would duplicate another analysis or study being undertaken in conjunction with the proposed activity.

''(C) FACTORS FOR CONSIDERATION.—In evaluating a proposed activity under subparagraph (A), an eligible entity may take into consideration any reasonable, direct, indirect, or cumulative effect that can be clearly related to potential health effects and that is related to the proposed activity, including the effect of any action that is—

''(i) included in the long-range plan relating to the proposed activity;

''(ii) likely to be carried out in coordination with the proposed activity;

''(iii) dependent on the occurrence of the proposed activity; or

''(iv) likely to have a disproportionate impact on high-risk or vulnerable populations.

''(6) REQUIREMENTS.—A health impact assessment prepared with funds awarded under this subsection shall incorporate the following, after conducting the screening phase (identifying projects or policies for which a health impact assessment would be valuable and feasible) through the application process:

''(A) SCOPING.—Identifying which health effects to consider and the research methods to be utilized.

''(B) ASSESSING RISKS AND BENEFITS.—Assessing the baseline health status and factors known to influence the health status in the affected community, which may include aggregating and synthesizing existing health assessment evidence and data from the community.

"(C) DEVELOPING RECOMMENDATIONS.—Suggesting changes to proposals to promote positive or mitigate adverse health effects.

"(D) REPORTING.—Synthesizing the assessment and recommendations and communicating the results to decisionmakers.

"(E) MONITORING AND EVALUATING.—Tracking the decision and implementation effect on health determinants and health status.

"(7) PLAN.—An eligible entity that is awarded a grant under this section shall develop and implement a plan, to be approved by the Director, for meaningful and inclusive stakeholder involvement in all phases of the health impact assessment. Stakeholders may include community leaders, community-based organizations, youth-serving organizations, planners, public health experts, State and local public health departments and officials, health care experts or officials, housing experts or officials, and transportation experts or officials.

"(8) SUBMISSION OF FINDINGS.—An eligible entity that is awarded a grant under this section shall submit the findings of any funded health impact assessment activities to the Secretary and make these findings publicly available.

''(9) ASSESSMENT OF IMPACTS.—An eligible entity that is awarded a grant under this section shall ensure the assessment of the distribution of health impacts (related to the proposed activity) across race, ethnicity, income, age, gender, disability status, and geography.

''(10) CONDUCT OF ASSESSMENT.—To the greatest extent feasible, a health impact assessment shall be conducted under this section in a manner that respects the needs and timing of the decision-making process it evaluates.

''(11) METHODOLOGY.—In preparing a health impact assessment under this subsection, an eligible entity or partner shall follow the guidance published under subsection (c).

''(e) HEALTH IMPACT ASSESSMENT DATABASE.—The Secretary, acting through the Director and in collaboration with the Administrator, shall establish, maintain, and make publicly available a health impact assessment database, including—

''(1) a catalog of health impact assessments received under this section;

''(2) an inventory of tools used by eligible entities to conduct health impact assessments; and

''(3) guidance for eligible entities with respect to the selection of appropriate tools described in paragraph (2).

''(f) EVALUATION OF GRANTEE ACTIVITIES.—The Secretary shall award competitive grants to Prevention Research Centers, or nonprofit organizations or academic institutions with expertise in health impact assessments to—

''(1) assist grantees with the provision of training and technical assistance in the conducting of health impact assessments;

''(2) evaluate the activities carried out with grants under subsection (d); and

''(3) assist the Secretary in disseminating evidence, best practices, and lessons learned from grantees.

''(g) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of the Health Equity and Accountability Act of 2020, the Secretary shall submit to Congress a report concerning the evaluation of the programs under this section, including recommendations as to how lessons learned from such programs can be incorporated into future guidance documents developed and provided by the Secretary and other Federal agencies, as appropriate.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

**"SEC. 399V–13. IMPLEMENTATION OF RESEARCH FINDINGS TO IMPROVE HEALTH OUTCOMES THROUGH THE BUILT ENVIRONMENT.**

''(a) RESEARCH GRANT PROGRAM.—The Secretary, in collaboration with the Administrator of the Environmental Protection Agency (referred to in this section as the 'Administrator'), shall award grants to public agencies or private nonprofit institutions to implement evidence-based programming to improve human health through improvements to the built environment and subsequently human health, by addressing—

''(1) levels of physical activity;

''(2) consumption of nutritional foods;

''(3) rates of crime;

''(4) air, water, and soil quality;

''(5) risk or rate of injury;

''(6) accessibility to health-promoting goods and services;

''(7) chronic disease rates;

''(8) community design;

''(9) housing; or transportation options; and

''(10) other factors, as the Secretary determines appropriate.

''(b) APPLICATIONS.—A public agency or private nonprofit institution desiring a grant under this section shall submit to the Secretary an application at such time, in such manner, and containing such agreements, assurances, and information as the Secretary, in consultation with the Administrator, may require.

''(c) RESEARCH.—The Secretary, in consultation with the Administrator, shall support, through grants awarded under this section, research that—

''(1) uses evidence-based research to improve the built environment and human health;

''(2) examines—

''(A) the scope and intensity of the impact that the built environment (including the various characteristics of the built environment) has on the human health; or

''(B) the distribution of such impacts by—

''(i) location; and

''(ii) population subgroup;

''(3) is used to develop—

''(A) measures and indicators to address health impacts and the connection of health to the built environment;

''(B) efforts to link the measures to transportation, land use, and health databases; and

''(C) efforts to enhance the collection of built environment surveillance data;

''(4) distinguishes carefully between personal attitudes and choices and external influences on behavior to determine how much the association between the built environment and the health of residents, versus the lifestyle preferences of the people that choose to live in the neighborhood, reflects the physical characteristics of the neighborhood; and

''(5)(A) identifies or develops effective intervention strategies focusing on enhancements to the built environment that promote increased use physical activity, access to nutritious foods, or other health-promoting activities by residents; and

''(B) in developing the intervention strategies under subparagraph (A), ensures that the intervention strategies will reach out to high-risk or vulnerable populations, including low-income urban and rural communities and aging populations, in addition to the general population.

''(d) SURVEYS.—The Secretary may allow recipients of grants under this section to use such grant funds to support the expansion of national surveys and data track-

ing systems to provide more detailed information about the connection between the built environment and health.

''(e) PRIORITY.—In awarding grants under this section, the Secretary and the Administrator shall give priority to entities with programming that incorporates—

''(1) interdisciplinary approaches; or

''(2) the expertise of the public health, physical activity, urban planning, land use, and transportation research communities in the United States and abroad.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section. The Secretary may allocate not more than 20 percent of the amount so appropriated for a fiscal year for purposes of conducting research under subsection (c).''.

**SEC. 1004. IMPLEMENTATION OF RECOMMENDATIONS BY ENVIRONMENTAL PROTECTION AGENCY.**

(a) INSPECTOR GENERAL RECOMMENDATIONS.—The Administrator of the Environmental Protection Agency (referred to in this section as the ''Administrator'') shall, as promptly as practicable, carry out each of the following recommendations of the Inspector General of the Environmental Protection Agency as described in the report entitled ''EPA needs to conduct environmental justice reviews

of its programs, policies and activities'' (Report No. 2006–P–00034):

(1) The recommendation that the program and regional offices of the Environmental Protection Agency identify which programs, policies, and activities need environmental justice reviews and the Administrator require those offices to establish a plan to complete the necessary reviews.

(2) The recommendation that the Administrator ensure that the reviews described in paragraph (1) determine whether the programs, policies, and activities may have a disproportionately high and adverse health or environmental impact on minority and low-income populations.

(3) The recommendation that each program and regional office of the Environmental Protection Agency develop specific environmental justice review guidance for conducting environmental justice reviews.

(4) The recommendation that the Administrator designate a responsible office to compile results of environmental justice reviews and recommend appropriate actions.

(b) GAO RECOMMENDATIONS.—In promulgating regulations of the Environmental Protection Agency, the Ad-

ministrator shall, as promptly as practicable, carry out each of the following recommendations of the Comptroller General of the United States as described in the report entitled ''EPA Should Devote More Attention to Environmental Justice when Developing Clean Air Rules'' (GAO–05–289):

(1) The recommendation that the Administrator ensure that workgroups involved in developing a rule devote attention to environmental justice while drafting and finalizing the rule.

(2) The recommendation that the Administrator enhance the ability of the workgroups described in paragraph (1) to identify potential environmental justice issues through steps such as—

(A) providing workgroup members with guidance and training to help those members identify potential environmental justice problems; and

(B) involving environmental justice coordinators in the workgroups if appropriate.

(3) The recommendation that the Administrator improve assessments of potential environmental justice impacts in economic reviews by identifying the data and developing the modeling techniques needed to assess those impacts.

(4) The recommendation that the Administrator direct appropriate officers and employees of the Environmental Protection Agency, if feasible, to respond fully to public comments on environmental justice, including by—

(A) improving the explanation by the Administrator of the basis for any conclusions relating to environmental justice; and

(B) including in an explanation under subparagraph (A) supporting data.

(c) 2004 INSPECTOR GENERAL REPORT.—

(1) IN GENERAL.—The Administrator shall, as promptly as practicable, carry out each of the following recommendations of the Inspector General of the Environmental Protection Agency as described in the report entitled ''EPA Needs to Consistently Implement the Intent of the Executive Order on Environmental Justice'' (Report No. 2004–P–00007):

(A) The recommendation that the Administrator clearly define the mission of the Office of Environmental Justice and provide Environmental Protection Agency staff with an understanding of the roles and responsibilities of that Office.

(B) The recommendation that the Administrator—

(i) establish, through the issuance of guidance or a policy statement, specific timeframes for the development of definitions, goals, and measurements regarding environmental justice; and

(ii) provide the regions and program offices a standard and consistent definition for a minority and low-income community, with instructions on how the Environmental Protection Agency will implement and put into operation environmental justice in the daily activities of the Environmental Protection Agency.

(C) The recommendation that the Administrator ensure that the comprehensive training program under development (as of the date of enactment of this Act) includes standard and consistent definitions of the key environmental justice concepts, such as ''low-income'', ''minority'', and ''disproportionately impacted'', and instructions for implementation of those concepts.

(2) REPORTS.—

(A) INITIAL REPORT.—Not later than 180 days after the date of enactment of this Act, the Administrator shall submit to Congress an initial report on the strategy of the Administrator for implementing the recommendations described in subparagraphs (A), (B), and (C) of paragraph (1).

(B) SUBSEQUENT REPORTS.—After submitting the initial report under subparagraph (A), the Administrator shall submit to Congress semiannual reports on the progress of the Administrator in—

(i) implementing the recommendations referred to in subparagraph (A); and

(ii) modifying the emergency management procedures of the Administrator to incorporate environmental justice in the Incident Command Structure of the Environmental Protection Agency, in accordance with the December 18, 2006, letter from the Deputy Administrator to the Acting Inspector General of the Environmental Protection Agency.

(d) FEDERAL ACTION PLAN FOR SAVING LIVES, PROTECTING PEOPLE AND THEIR FAMILIES FROM RADON.—

(1) FINDINGS.—Congress finds that radon is a naturally occurring radioactive gas that is—

(A) recognized as the leading cause of lung cancer among nonsmokers; and

(B) a particular environmental threat for low-income and minority individuals because of the lack of information about radon levels in the homes of those individuals.

(2) IMPLEMENTATION.—Not later than 180 days after the date of the enactment of this Act, the Administrator shall implement the action plan entitled ''Protecting People and Families from Radon: A Federal Action Plan for Saving Lives'' (June 20, 2011), in consultation with the Director of the Centers for Disease Control and Prevention and any other Federal agencies referred to in the action plan.

(3) SPECIFIC STEPS.—In carrying out paragraph (2), the Administrator shall ensure that—

(A) the workgroup comprised of the Federal agencies participating in the development of the action plan referred to in paragraph (2) implements specific steps within the existing

authority and activities of each Federal agency to reduce exposure to radon; and

(B) not later than the date that is 1 year after the date on which the Administrator begins implementation of the action plan described in paragraph (2), the workgroup described in subparagraph (A) meets to assess and recognize achievements of the plan.

(4) REPORT.—After the progress meeting of the workgroup under paragraph (3)(B), the Administrator shall submit to Congress a report on the implementation of the action plan described in paragraph (2), including the challenges remaining and the progress in reducing radon exposure, particularly for low-income and minority families.

(e) FEDERAL ACTION PLAN FOR PREVENTING CHILDHOOD LEAD POISONING.—

(1) FINDINGS.—Congress finds that—

(A) the effects of lead poisoning are irreversible and cost the United States millions annually in medical and education costs;

(B) the cognitive effects suffered by children exposed to lead result in a lifetime of health and behavioral problems, which makes prevention efforts more critical; and

(C) the risk is especially high for vulnerable minority populations who are more likely to live in older homes, where lead-based paint is more likely to be present.

(2) ACTION PLAN.—Not later than 180 days after the date of enactment of this Act, the Administrator, in consultation with the Director of the Centers for Disease Control and Prevention and other relevant Federal agencies, shall develop an action plan to reduce exposure to lead.

(3) SPECIFIC STEPS.—In carrying out paragraph (2), the Administrator shall—

(A) establish a working group, comprised of representatives of the Federal agencies participating in the development of the action plan described in paragraph (2), to make recommendations for the implementation of specific steps within the existing authority and activities of each Federal agency to reduce exposure to lead; and

(B) assist other Federal agencies in the development of materials on the hazards of lead-based paint for the purpose of educating tenants and landlords, how to recognize potential

sources of exposure, and how to remediate those sources.

**SEC. 1005. GRANT PROGRAM TO CONDUCT ENVIRONMENTAL HEALTH IMPROVEMENT ACTIVITIES AND TO IMPROVE SOCIAL DETERMINANTS OF HEALTH.**

(a) DEFINITIONS.—In this section:

(1) DIRECTOR.—The term ''Director'' means the Director of the Centers for Disease Control and Prevention, acting in collaboration with the Administrator of the Environmental Protection Agency and the Director of the National Institute of Environmental Health Sciences.

(2) ELIGIBLE ENTITY.—The term ''eligible entity'' means a State or local community that—

(A) bears a disproportionate burden of exposure to environmental health hazards;

(B) bears a disproportionate burden of exposure to unhealthy living conditions, low standard housing conditions, low socioeconomic status, poor nutrition, less opportunity for educational attainment, disproportionately high unemployment rates, or lower literacy levels and access to information;

(C) has established a coalition—

(i) with not less than 1 community-based organization or demonstration program; and

(ii) with not less than 1—

(I) public health entity;

(II) health care provider organization;

(III) academic institution, including any minority-serving institution (including a Hispanic-serving institution, a historically black college or university, or a tribal college or university);

(IV) child-serving institution; or

(V) landlord or housing provider working on lead remediation;

(D) ensures planned activities and funding streams are coordinated to improve community health; and

(E) submits an application in accordance with subsection (c).

(b) ESTABLISHMENT.—The Director shall establish a grant program under which eligible entities shall receive grants to conduct environmental health improvement activities and to improve social determinants of health.

(c) APPLICATION.—To receive a grant under this section, an eligible entity shall submit an application to the Director at such time, in such manner, and accompanied by such information as the Director may require.

(d) USE OF GRANT FUNDS.—An eligible entity may use a grant under this section—

(1) to promote environmental health;

(2) to address environmental health disparities among all populations, including children; and

(3) to address racial and ethnic disparities in social determinants of health.

(e) AMOUNT OF COOPERATIVE AGREEMENT.—The Director shall award grants to eligible entities at the following 3 funding levels:

(1) LEVEL 1 COOPERATIVE AGREEMENTS.—

(A) IN GENERAL.—An eligible entity awarded a grant under this paragraph shall use the funds to identify environmental health problems and solutions by—

(i) establishing a planning and prioritizing council in accordance with subparagraph (B); and

(ii) conducting an environmental health assessment in accordance with subparagraph (C).

(B) PLANNING AND PRIORITIZING COUNCIL.—

(i) IN GENERAL.—A prioritizing and planning council established under subparagraph (A)(i) (referred to in this paragraph as a ''PPC'') shall assist the environmental health assessment process and environmental health promotion activities of the eligible entity.

(ii) MEMBERSHIP.—Membership of a PPC shall consist of representatives from various organizations within public health, planning, development, and environmental services and shall include stakeholders from vulnerable groups such as children, the elderly, disabled, and minority ethnic groups that are often not actively involved in democratic or decisionmaking processes.

(iii) DUTIES.—A PPC shall—

(I) identify key stakeholders and engage and coordinate potential partners in the planning process;

(II) establish a formal advisory group to plan for the establishment of services;

(III) conduct an in-depth review of the nature and extent of the need for an environmental health assessment, including a local epidemiological profile, an evaluation of the service provider capacity of the community, and a profile of any target populations; and

(IV) define the components of care and form essential programmatic linkages with related providers in the community.

(C) ENVIRONMENTAL HEALTH ASSESSMENT.—

(i) IN GENERAL.—A PPC shall carry out an environmental health assessment to identify environmental health concerns.

(ii) ASSESSMENT PROCESS.—The PPC shall—

(I) define the goals of the assessment;

(II) generate the environmental health issue list;

(III) analyze issues with a systems framework;

(IV) develop appropriate community environmental health indicators;

(V) rank the environmental health issues;

(VI) set priorities for action;

(VII) develop an action plan;

(VIII) implement the plan; and

(IX) evaluate progress and planning for the future.

(D) EVALUATION.—Each eligible entity that receives a grant under this paragraph shall evaluate, report, and disseminate program findings and outcomes.

(E) TECHNICAL ASSISTANCE.—The Director may provide such technical and other nonfinancial assistance to eligible entities as the Director determines to be necessary.

(2) LEVEL 2 COOPERATIVE AGREEMENTS.—

(A) ELIGIBILITY.—

(i) IN GENERAL.—The Director shall award grants under this paragraph to eligible entities that have already—

(I) established broad-based collaborative partnerships; and

(II) completed environmental assessments.

(ii) NO LEVEL 1 REQUIREMENT.—To be eligible to receive a grant under this paragraph, an eligible entity is not required to have successfully completed a Level 1 Cooperative Agreement (as described in paragraph (1)).

(B) USE OF GRANT FUNDS.—An eligible entity awarded a grant under this paragraph shall use the funds to further activities to carry out environmental health improvement activities, including—

(i) addressing community environmental health priorities in accordance with paragraph (1)(C)(ii), including—

(I) geography;

(II) the built environment;

(III) air quality;

(IV) water quality;

(V) land use;

(VI) solid waste;

(VII) housing;

(VIII) violence;

(IX) socioeconomic status;

(X) ethnicity, social construct and language preference;

(XI) educational attainment;

(XII) employment;

(XIII) food safety, accessibility, and affordability;

(XIV) nutrition;

(XV) health care services; and

(XVI) injuries;

(ii) building partnerships between planning, public health, and other sectors, including child-serving institutions, to address how the built environment impacts food availability and access and physical activity to promote healthy behaviors and lifestyles and reduce overweight and obesity, musculoskeletal diseases, respiratory conditions, dental, oral and mental health conditions, poverty, and related co-morbidities;

(iii) establishing programs to address—

(I) how environmental and social conditions of work and living choices

influence physical activity and dietary intake; or

(II) how the conditions described in subclause (I) influence the concerns and needs of people who have impaired mobility and use assistance devices, including wheelchairs, lower limb prostheses, and hip, knee, and other joint replacements; and

(iv) convening intervention and demonstration programs that examine the role of the social environment in connection with the physical and chemical environment in—

(I) determining access to nutritional food;

(II) improving physical activity to reduce overweight, obesity, and comorbidities and increase quality of life; and

(III) location and access to medical facilities.

(3) LEVEL 3 COOPERATIVE AGREEMENTS.—

(A) IN GENERAL.—An eligible entity awarded a grant under this paragraph shall use

the funds to identify and address racial and ethnic disparities in social determinants of health by creating demonstration programs that assess the feasibility of establishing a federally funded comprehensive program and describe key outcomes that address racial and ethnic disparities in social determinants of health.

(B) PROGRAM DESIGN.—

(i) EVALUATION.—No later than 1 year after enactment of this Act, the Director shall evaluate the best practices of existing programs from the private, public, community based, and academically supported initiatives focused on reducing disparities in the social determinants of health for racial and ethnic populations.

(ii) DEMONSTRATION PROJECTS.—Not later than two years after the date of enactment of this Act, the Director shall implement at least ten demonstration projects including at least one project for each major racial and ethnic minority group, each of which is unique to the cultural and linguistic needs of each of the following groups:

(I) Native Americans and Alaska Natives.

(II) Asian Americans.

(III) African Americans/Blacks.

(IV) Hispanic/Latino-Americans.

(V) Native Hawaiians and Pacific Islanders.

(iii) REPORT TO CONGRESS.—No later than 2 years after the implementation of the initial demonstration projects, the Director shall submit to Congress a report which includes—

(I) a description of each demonstration project and design;

(II) an evaluation of the cost-effectiveness of each project's prevention and treatment efforts;

(III) an evaluation of the cultural and linguistic appropriateness of each project by racial and ethnic group; and

(IV) an evaluation of the beneficiary's health status improvement under the demonstration project.

(iv) ANY OTHER INFORMATION DEEMED APPROPRIATE BY THE DIRECTOR.—The Director shall require eligible entities awarded a grant under this paragraph to report any other information the Director determines appropriate to be shared by or developed by such entity, including the following:

(I) Developing models and evaluating methods that improve the cultural and linguistically appropriate services provided through the Centers for Disease Control and Prevention to target individuals impacted by health disparities based on their race, ethnicity, and gender.

(II) Promoting the collaboration between primary and specialty care health care providers and patients, to ensure patients impacted by health disparities based on race, ethnicity, and gender are receiving comprehensive and organized treatment and care.

(III) Educating health care professionals on the causes and effects of disparities in the social determinants of health as it relates to minority and racial and ethnic communities and the need for culturally and linguistically appropriate care in the prevention and treatment of high-impact diseases.

(IV) Encouraging collaboration among community and patient-based organizations which work to address disparities in the social determinants of health as it relates to high-impact diseases in minority and racial and ethnic populations.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) $25,000,000 for fiscal year 2021; and

(2) such sums as may be necessary for fiscal years 2022 through 2024.

**SEC. 1006. ADDITIONAL RESEARCH ON THE RELATIONSHIP BETWEEN THE BUILT ENVIRONMENT AND THE HEALTH OF COMMUNITY RESIDENTS.**

(a) DEFINITION OF ELIGIBLE INSTITUTION.—In this section, the term ''eligible institution'' means a public or private nonprofit institution that submits to the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') and the Administrator of the Environmental Protection Agency (in this section referred to as the ''Administrator'') an application for a grant under the grant program authorized under subsection (b)(2) at such time, in such manner, and containing such agreements, assurances, and information as the Secretary and Administrator may require.

(b) RESEARCH GRANT PROGRAM.—

(1) DEFINITION OF HEALTH.—In this section, the term ''health'' includes—

(A) levels of physical activity;

(B) degree of mobility due to factors such as musculoskeletal diseases, arthritis, and obesity;

(C) consumption of nutritional foods;

(D) rates of crime;

(E) air, water, and soil quality;

(F) risk of injury;

(G) accessibility to health care services;

(H) levels of educational attainment; and

(I) other indicators as determined appropriate by the Secretary.

(2) GRANTS.—The Secretary, in collaboration with the Administrator, shall provide grants to eligible institutions to conduct and coordinate research on the built environment and its influence on individual and population-based health.

(3) RESEARCH.—The Secretary shall support research that—

(A) investigates and defines the causal links between all aspects of the built environment and the health of residents;

(B) examines—

(i) the extent of the impact of the built environment (including the various characteristics of the built environment) on the health of residents;

(ii) the variance in the health of residents by—

(I) location (such as inner cities, inner suburbs, and outer suburbs); and

(II) population subgroup (including children, the elderly, the disadvantaged); or

(iii) the importance of the built environment to the total health of residents, which is the primary variable of interest from a public health perspective;

(C) is used to develop—

(i) measures to address health and the connection of health to the built environment; and

(ii) efforts to link the measures to travel and health databases;

(D) distinguishes carefully between personal attitudes and choices and external influences on observed behavior to determine how much an observed association between the built environment and the health of residents, versus the lifestyle preferences of the people that choose to live in the neighborhood, reflects the physical characteristics of the neighborhood; and

(E)(i) identifies or develops effective intervention strategies to promote better health among residents with a focus on behavioral

interventions and enhancements of the built environment that promote increased use by residents; and

(ii) in developing the intervention strategies under clause (i), ensures that the intervention strategies will reach out to high-risk populations, including racial and ethnic minorities, low-income urban and rural communities, and children.

(4) PRIORITY.—In providing assistance under the grant program authorized under paragraph (2), the Secretary and the Administrator shall give priority to research that incorporates—

(A) minority-serving institutions as grantees;

(B) interdisciplinary approaches; or

(C) the expertise of the public health, physical activity, nutrition and health care (including child health), urban planning, and transportation research communities in the United States and abroad.

**SEC. 1007. ENVIRONMENT AND PUBLIC HEALTH RESTORATION.**

(a) FINDINGS.—

(1) GENERAL FINDINGS.—Congress finds that—

(A) humans share an environment with a wide variety of habitats and ecosystems that nurture and sustain a diversity of species;

(B) the abundance of natural resources in the environment forms the basis for the economy and has greatly contributed to human development throughout history;

(C) the accelerated pace of human development over the last several hundred years has significantly impacted—

(i) the natural environment and its resources;

(ii) the health and diversity of plant and animal life;

(iii) the availability of critical habitats;

(iv) the quality of the air and water; and

(v) the global climate;

(D) the intervention of the Federal Government is necessary to minimize and mitigate human impact on the environment—

(i) for the benefit of public health;

(ii) to maintain air quality and water quality;

(iii) to sustain the diversity of plants and animals;

(iv) to combat global climate change; and

(v) to protect the environment;

(E) laws and regulations in the United States have been enacted and promulgated to minimize and mitigate human impact on the environment for the benefit of public health, to maintain air quality and water quality, to sustain wildlife, and to protect the environment, including—

(i) chapter 3203 of title 54, United States Code (commonly known as the ''Antiquities Act of 1906''), which was initiated by President Theodore Roosevelt to create the National Park System;

(ii) the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.);

(iii) the Clean Air Act (42 U.S.C. 7401 et seq.);

(iv) the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.);

(v) the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9601 et seq.);

(vi) the Endangered Species Act of 1973 (16 U.S.C. 1531 et seq.); and

(vii) the National Forest Management Act of 1976 (Public Law 94–588; 90 Stat. 2949) and the amendments made by that Act; and

(F) attempts to repeal or weaken key environmental safeguards pose dangers to the public health, air quality, water quality, wildlife, and the environment.

(2) FINDINGS ON CHANGES AND PROPOSED CHANGES IN LAW.—Congress finds that, since 2001, the following changes and proposed changes to existing law or regulations have negatively impacted or will negatively impact the environment and public health:

(A) CLEAN WATER.—

(i) FILL MATERIAL.—

(I) On May 9, 2002, the Environmental Protection Agency and the Corps of Engineers issued a final rule, entitled ''Final Revisions to the Clean

Water Act Regulatory Definitions of 'Fill Material' and 'Discharge of Fill Material'" (67 Fed. Reg. 31129), that reconciled regulations implementing section 404 of the Federal Water Pollution Control Act (33 U.S.C. 1344) by redefining the term ''fill material'' and amending the definition of the term ''discharge of fill material'', reversing a 25-year-old regulation.

(II) The rule described in subclause (I)—

(aa) fails to restrict the dumping of hardrock mining waste, construction debris, and other industrial wastes into rivers, streams, lakes, and wetlands; and

(bb) allows destructive mountaintop removal coal mining companies to dump waste into streams and lakes, polluting the surrounding natural habitat and poisoning plants and animals

that depend on those water sources.

(ii) LIVESTOCK WASTE REGULATIONS.—

(I) On February 12, 2003, the Environmental Protection Agency published the rule entitled ''National Pollutant Discharge Elimination System Permit Regulation and Effluent Limitation Guidelines and Standards for Concentrated Animal Feeding Operations (CAFOs)'' (68 Fed. Reg. 7176), new livestock waste regulations that aimed to control factory farm pollution but which would severely undermine then-existing protections under the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.).

(II) The regulation described in subclause (I) allows large-scale animal factories to foul waters in the United States with animal waste, allows livestock owners to draft their own pollution-management plans and avoid ground water monitoring, legalizes the

discharge of contaminated runoff water rich in nitrogen, phosphorus, bacteria, and metals, and ensures that large factory farms are not held liable for the environmental damage they cause.

(III) In a 2005 Federal court decision, Waterkeeper Alliance, et al. v. Environmental Protection Agency, 399 F.3d 486 (2nd Cir. 2005), major parts of the rule were upheld, others vacated, and still others remanded back to the Environmental Protection Agency.

(IV) On November 20, 2008, the Environmental Protection Agency published a revised final rule, entitled ''Revised National Pollutant Discharge Elimination System Permit Regulation and Effluent Limitations Guidelines for Concentrated Animal Feeding Operations in Response to the Waterkeeper Decision'' (73 Fed. Reg. 70418), that undermines environmental protection provisions by re-

moving mandatory permitting requirements and allowing large animal farms to self-certify the absence of pollutant discharge activity.

(iii) TOTAL MAXIMUM DAILY LOAD.—

(I) On March 19, 2003, the Environmental Protection Agency published a new rule regarding the total maximum daily load program under section 303(d) of the Federal Water Pollution Control Act (33 U.S.C. 1313(d)), entitled ''Withdrawal of Revisions to the Water Quality Planning and Management Regulation and Revisions to the National Pollutant Discharge Elimination System Program in Support of Revisions to the Water Quality Planning and Management Regulation'' (68 Fed. Reg. 13608), that regulates the maximum amount of a particular pollutant that can be present in a body of water and still meet water quality standards.

(II) The new rule described in subclause (I) withdrew the then-exist-

ing regulation issued on July 13, 2000, and entitled ''Revisions to the Water Quality Planning and Management Regulation and Revisions to the National Pollutant Discharge Elimination System Program in Support of Revisions to the Water Quality Planning and Management Regulation'' (65 Fed. Reg. 43586) and halted momentum in cleaning up polluted waterways throughout the United States.

(III) By abandoning the then-existing rule, the Environmental Protection Agency is undermining the effectiveness of cleanup plans and is allowing States to avoid cleaning polluted waters entirely by dropping them from their cleanup lists.

(IV) Waterways play a crucial role in the lives of the people of the United States and are critical to the livelihood of fish and wildlife.

(V) The result of dropping the rule described in subclause (II) is that the restoration of polluted rivers,

shorelines, and lakes will be delayed, harming more fish and wildlife and worsening the quality of drinking water.

(iv) WATERS OF THE UNITED STATES.—

(I) On December 2, 2008, the Environmental Protection Agency and the Corps of Engineers jointly issued a guidance document, entitled ''Clean Water Act Jurisdiction Following the U.S. Supreme Court's Decision in Rapanos v. United States & Carabell v. United States''.

(II) The guidance described in subclause (I) dictates enforcement actions under the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.) and calls for a complicated ''case-by-case'' analysis to determine jurisdiction for waterways that do not flow all year.

(III) Enforcement actions described in subclause (II) endanger small streams and wetlands that serve

as important habitats for aquatic life, which play a fundamental role in safeguarding sources of clean drinking water and mitigate the risks and effects of floods and droughts.

(IV) The definition provided in the guidance described in subclause (I) for ''waters of the United States'' is applicable to the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.) as a whole, potentially affecting programs that control industrial pollution and sewage levels, prevent oil spills, and set water quality standards for all waters in the United States protected under that Act.

(B) FORESTS AND LAND MANAGEMENT.—

(i) HEALTHY FORESTS RESTORATION ACT OF 2003.—

(I) On December 3, 2003, the President signed into law the Healthy Forests Restoration Act of 2003 (16 U.S.C. 6501 et seq.) (referred to in this clause as the ''law'').

(II) Although the law attempts to reduce the risk of catastrophic forest fires, the law provides a boon to timber companies by accelerating the aggressive thinning of backcountry forests that are located far from at-risk communities.

(III) The law allows for increased logging of large, fire-resistant trees that are not in close proximity to homes and communities.

(IV) The law undermines critical protections for endangered species by exempting Federal land management agencies from consulting with the United States Fish and Wildlife Service before approving any action that could harm endangered plants or wildlife.

(V) The law limits public participation by reducing the number of environmental reviews for projects carried out under the law.

(ii) NFS LAND MANAGEMENT PLANNING FINAL PLANNING RULE AND RECORD OF DECISION.—

(I) On April 21, 2008, the Secretary of Agriculture issued a final rule entitled ''National Forest System Land Management Planning'' (73 Fed. Reg. 21486 (April 21, 2008)) (referred to in this clause as the ''revised rule'').

(II) The revised rule is a revision of a similar final rule entitled ''National Forest System Land Management Planning'' (70 Fed Reg. 1022 (January 5, 2005)), which the United States District Court for the Northern District of California remanded to the Secretary of Agriculture in the case styled Citizens for Better Forestry v. United States Department of Agriculture (481 F. Supp. 2d 1059 (N.D. Cal. 2007)) for violating—

(aa) the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.);

(bb) the Endangered Species Act of 1973 (16 U.S.C. 1531 et seq.); and

(cc) subchapter II of chapter 5, and chapter 7, of title 5, United States Code (commonly known as the ''Administrative Procedure Act'').

(III) The revised rule eliminates strict forest planning standards established in 1982.

(IV) The revised rule opens millions of acres of public land to damaging and invasive logging, mining, and drilling operations.

(V) The revised rule would reverse more than 20 years of protections for wildlife and national forests by—

(aa) removing the overall goal of ensuring ecological sustainability in managing the National Forest System;

(bb) weakening the effect of the National Forest Management

Act of 1976 (Public Law 94–588; 90 Stat. 2949) and the amendments made by that Act; and

(cc) effectively ending the review of forest management plans under the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.).

(iii) INVENTORIED ROADLESS AREA RULES.—

(I) On September 20, 2006, the United States District Court for the Northern District of California vacated the final rule entitled ''Special Areas; State Petitions for Inventoried Roadless Area Management'' (70 Fed. Reg. 25654 (May 13, 2005)) (referred to in this clause as the ''2005 rule''), which gave each Governor of a State 18 months to petition the Federal Government—

(aa) to restore the inventoried roadless area rules applicable to the State of the Governor before the effective date of the

final rule entitled ''Special Areas; Roadless Area Conservation'' (66 Fed. Reg. 3244 (January 12, 2001)) (referred to in this clause as the ''2001 rule''); or

(bb) to submit a new management and development plan for National Forest System inventoried roadless areas within the State.

(II) Despite the enjoinment of the 2005 rule and the subsequent restoration of the 2001 rule, the Forest Service has continued to allow States to petition for a special rule under the authority of section 553(e) of title 5, United States Code, and has issued a final rule entitled ''Special Areas; Roadless Area Conservation; Applicability to the National Forests in Idaho'' (73 Fed. Reg. 61456 (October 16, 2008)).

(III) As a result, 58,500,000 acres of wild National Forest System land are still vulnerable to logging,

road building, and other developments that may fragment natural habitats and negatively impact fish and wildlife.

(iv) BLM RESOURCE MANAGEMENT PLANS.—

(I) On November 28, 2008, the Bureau of Land Management announced the record of decision entitled ''Record of Decision for Oil Shale and Tar Sands Resources to Address Land Use Allocations in Colorado, Utah, and Wyoming'' (73 Fed. Reg. 72519 (November 28, 2008)), which amended 12 resource management plans in the States of Colorado, Utah, and Wyoming, opening 2,000,000 acres of public land to commercial tar sands and oil shale exploration and development.

(II) On November 18, 2008, the Bureau of Land Management issued the final rule entitled ''Oil Shale Management—General'' (73 Fed. Reg. 69414 (November 18, 2008)), setting

the policies and procedures for a commercial leasing program for the management of federally owned oil shale in the States referred to in subclause (I).

(III) Previously barred by a congressional moratorium on the commercial leasing regulations for oil shale until September 30, 2008, the development of oil shale on public land poses a serious threat to land conservation, endangered and threatened species, and critical habitat.

(IV) Domestic shale oil production authorized by the final rules described in subclauses (I) and (II)—

(aa) is water- and energy-intensive; and

(bb) will intensify existing water scarcity in the arid Western United States and potentially degrade air and water quality for surrounding populations.

(C) SCIENTIFIC REVIEW.—

(i) On December 16, 2008, the United States Fish and Wildlife Service and the National Marine Fisheries Service jointly issued a new rule, entitled ''Interagency Cooperation Under the Endangered Species Act'' (73 Fed. Reg. 76272) amending regulations governing interagency cooperation under section 7 of the Endangered Species Act of 1973 (16 U.S.C. 1536).

(ii) The rule described in clause (i) undermines the intention of the Endangered Species Act (16 U.S.C. 1531 et seq.) to protect species and the ecosystems on which those species depend by allowing Federal agencies to carry out, permit, or fund an action without proper environmental review and expert third-party consultation from Federal wildlife experts.

(iii) Under the rule described in clause (i), Federal agencies can unilaterally circumvent the formal review process, eliminating longstanding and scientifically grounded safeguards that serve to protect the biodiversity of ecosystems in the United States and avert harm to thou-

sands of endangered and threatened species.

(b) STATEMENT OF POLICY.—It is the policy of the Federal Government to work in conjunction with States, territories, Tribal governments, international organizations, and foreign governments as a steward of the environment for the benefit of public health, to maintain air quality and water quality, to sustain the diversity of plant and animal species, to combat global climate change, and to protect the environment for future generations.

(c) STUDY AND REPORT ON PUBLIC HEALTH OR ENVIRONMENTAL IMPACT OF REVISED RULES, REGULATIONS, LAWS, OR PROPOSED LAWS.—

(1) STUDY.—Not later than 30 days after the date of enactment of this Act, the President shall enter into an arrangement under which the National Academy of Sciences shall conduct a study to determine the impact on public health, air quality, water quality, wildlife, and the environment of the following regulations, laws, and proposed laws:

(A) CLEAN WATER.—

(i) The final rule of the Environmental Protection Agency and the Corps of Engineers entitled ''Final Revisions to the Clean Water Act Regulatory Definitions of

'Fill Material' and 'Discharge of Fill Material'" (67 Fed. Reg. 31129 (May 9, 2002)).

(ii) The final rule of the Environmental Protection Agency entitled "Revised National Pollutant Discharge Elimination System Permit Regulation and Effluent Limitations Guidelines for Concentrated Animal Feeding Operations in Response to the Waterkeeper Decision" (73 Fed. Reg. 70418 (November 20, 2008)).

(iii) The final rule entitled "Withdrawal of Revisions to the Water Quality Planning and Management Regulation and Revisions to the National Pollutant Discharge Elimination System Program in Support of Revisions to the Water Quality Planning and Management Regulation" (68 Fed. Reg. 13608 (March 19, 2003)).

(iv) The guidance document of the Environmental Protection Agency and the Corps of Engineers entitled "Clean Water Act Jurisdiction Following the U.S. Supreme Court's Decision in Rapanos v.

United States & Carabell v. United States'' (December 2, 2008).

(B) FORESTS AND LAND MANAGEMENT.—

(i) The Healthy Forests Restoration Act of 2003 (16 U.S.C. 6501 et seq.).

(ii) The application of section 553(e) of title 5, United States Code, such that a State may petition for a special rule for the National Forest System inventoried roadless areas within the State.

(iii) The final rule entitled ''National Forest System Land Management Planning'' (73 Fed. Reg. 21486 (April 21, 2008)).

(iv) The final rule entitled ''Oil Shale Management—General'' (73 Fed. Reg. 69414 (November 18, 2008)).

(v) The record of decision entitled ''Record of Decision for Oil Shale and Tar Sands Resources To Address Land Use Allocations in Colorado, Utah, and Wyoming'' (73 Fed. Reg. 72519 (November 28, 2008)).

(C) SCIENTIFIC REVIEW.—The final rule of the United States Fish and Wildlife Service

and the National Marine Fisheries Service entitled ''Interagency Cooperation Under the Endangered Species Act'' (73 Fed. Reg. 76272 (December 16, 2008)).

(2) METHOD.—In conducting the study under paragraph (1), the National Academy of Sciences may use and compare existing scientific studies regarding the regulations, laws, and proposed laws described in paragraph (1).

(3) REPORT.—Not later than 270 days after the date on which the President enters into the arrangement under paragraph (1), the National Academy of Sciences shall make publicly available and shall submit to the Congress and to the head of each department and agency of the Federal Government that issued, implements, or would implement a regulation, law, or proposed law described in paragraph (1), a report that includes—

(A) a description of the impact of each regulation, law, or proposed law described in paragraph (1) on public health, air quality, water quality, wildlife, and the environment, compared to the impact of preexisting regulations, or laws in effect, as applicable, including—

(i) any negative impacts to air quality or water quality;

(ii) any negative impacts to wildlife;

(iii) any delays in hazardous waste cleanup that are projected to be hazardous to public health; and

(iv) any other negative impact on public health or the environment; and

(B) any recommendations that the National Academy of Sciences considers appropriate to maintain, restore, or improve in whole or in part protections for public health, air quality, water quality, wildlife, and the environment for each of the regulations, laws, and proposed laws described in paragraph (1), which may include recommendations for the adoption of any regulation or law in place or proposed prior to January 1, 2001.

(d) DEPARTMENT AND AGENCY REVISION OF EXISTING RULES, REGULATIONS, OR LAWS.—Not later than 180 days after the date on which the report is submitted pursuant to subsection (c)(3), the head of each department or agency that has issued or implemented a regulation or law described in subsection (c)(1) shall submit to Congress a plan describing the steps the department or

agency will take, or has taken, to restore or improve protections for public health and the environment in whole or in part that were in existence prior to the issuance of the applicable regulation or law.

**SEC. 1008. GAO REPORT ON HEALTH EFFECTS OF DEEPWATER HORIZON OIL RIG EXPLOSION IN THE GULF COAST.**

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the type and scope of health care services administered through the Department of Health and Human Services addressing the provision of health care to racial and ethnic minorities, including residents, cleanup workers, and volunteers, affected by the blowout and explosion of the mobile offshore drilling unit Deepwater Horizon that occurred on April 20, 2010, and resulting hydrocarbon releases into the environment.

(b) SPECIFIC COMPONENTS.—In carrying out subsection (a), the Comptroller General shall—

(1) assess the type, size, and scope of programs administered by the Secretary of Health and Human Services that focus on the provision of health care to communities on the Gulf Coast;

(2) identify the merits and disadvantages associated with each of the programs;

(3) perform an analysis of the costs and benefits of the programs; and

(4) determine whether there is any duplication of programs.

(c) REPORT.—Not later than 180 days after the date of enactment of this Act, the Comptroller General shall submit to Congress a report that includes—

(1) the findings of the study conducted under subsection (a); and

(2) recommendations for improving access to health care for racial and ethnic minorities.

**SEC. 1009. ESTABLISH AN INTERAGENCY COUNSEL AND GRANT PROGRAMS ON SOCIAL DETERMINANTS OF HEALTH.**

(a) SHORT TITLE.—This section may be cited as the ''Social Determinants Accelerator Act of 2020''.

(b) FINDINGS; PURPOSES.—

(1) FINDINGS.—Congress finds the following:

(A) There is a significant body of evidence showing that economic and social conditions have a powerful impact on individual and population health outcomes and well-being, as well as medical costs.

(B) State, local, and Tribal governments and the service delivery partners of such gov-

ernments face significant challenges in coordinating benefits and services delivered through the Medicaid program and other social services programs because of the fragmented and complex nature of Federal and State funding and administrative requirements.

(C) The Federal Government should prioritize and proactively assist State and local governments to strengthen the capacity of State and local governments to improve health and social outcomes for individuals, thereby improving cost-effectiveness and return on investment.

(2) PURPOSES.—The purposes of this Act are as follows:

(A) To establish effective, coordinated Federal technical assistance to help State and local governments to improve outcomes and cost-effectiveness of, and return on investment from, health and social services programs.

(B) To build a pipeline of State and locally designed, cross-sector interventions and strategies that generate rigorous evidence about how to improve health and social outcomes, and increase the cost-effectiveness of, and return on

investment from, Federal, State, local, and Tribal health and social services programs.

(C) To enlist State and local governments and the service providers of such governments as partners in identifying Federal statutory, regulatory, and administrative challenges in improving the health and social outcomes of, cost-effectiveness of, and return on investment from, Federal spending on individuals enrolled in Medicaid.

(D) To develop strategies to improve health and social outcomes without denying services to, or restricting the eligibility of, vulnerable populations.

(c) SOCIAL DETERMINANTS ACCELERATOR COUNCIL.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services (referred to in this Act as the ''Secretary''), in coordination with the Administrator of the Centers for Medicare & Medicaid Services (referred to in this Act as the ''Administrator''), shall establish an interagency council, to be known as the Social Determinants Accelerator Interagency Council (referred to in this Act as the ''Council'') to achieve the purposes listed in subsection (b)(1).

(2) MEMBERSHIP.—

(A) FEDERAL COMPOSITION.—The Council shall be composed of at least one designee from each of the following Federal agencies:

(i) The Office of Management and Budget.

(ii) The Department of Agriculture.

(iii) The Department of Education.

(iv) The Indian Health Service.

(v) The Department of Housing and Urban Development.

(vi) The Department of Labor.

(vii) The Department of Transportation.

(viii) Any other Federal agency the Chair of the Council determines necessary.

(B) DESIGNATION.—

(i) IN GENERAL.—The head of each agency specified in subparagraph (A) shall designate at least one employee to serve as a member of the Council.

(ii) RESPONSIBILITIES.—An employee described in this clause shall be a senior employee of the agency—

(I) whose responsibilities relate to authorities, policies, and procedures with respect to the health and well-being of individuals receiving medical assistance under a State plan (or a waiver of such plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.); or

(II) who has authority to implement and evaluate transformative initiatives that harness data or conducts rigorous evaluation to improve the impact and cost-effectiveness of federally funded services and benefits.

(C) HHS REPRESENTATION.—In addition to the designees under subparagraph (A), the Council shall include designees from at least three agencies within the Department of Health and Human Services, including the Centers for Medicare & Medicaid Services, at least one of whom shall meet the criteria under this section.

(D) OMB ROLE.—The Director of the Office of Management and Budget shall facilitate the timely resolution of Governmentwide and multiagency issues to help the Council achieve

consensus recommendations described under this section.

(E) NON-FEDERAL COMPOSITION.—The Comptroller General of the United States may designate up to 6 Council designees—

(i) who have relevant subject matter expertise, including expertise implementing and evaluating transformative initiatives that harness data and conduct evaluations to improve the impact and cost-effectiveness of Federal Government services; and

(ii) that each represent—

(I) State, local, and Tribal health and human services agencies;

(II) public housing authorities or State housing finance agencies;

(III) State and local government budget offices;

(IV) State Medicaid agencies; or

(V) national consumer advocacy organizations.

(F) CHAIR.—

(i) IN GENERAL.—The Secretary shall select the Chair of the Council from among the members of the Council.

(ii) INITIATING GUIDANCE.—The Chair, on behalf of the Council, shall identify and invite individuals from diverse entities to provide the Council with advice and information pertaining to addressing social determinants of health, including—

(I) individuals from State and local government health and human services agencies;

(II) individuals from State Medicaid agencies;

(III) individuals from State and local government budget offices;

(IV) individuals from public housing authorities or State housing finance agencies;

(V) individuals from nonprofit organizations, small businesses, and philanthropic organizations;

(VI) advocates;

(VII) researchers; and

(VIII) any other individuals the Chair determines to be appropriate.

(3) DUTIES.—The duties of the Council are—

(A) to make recommendations to the Secretary and the Administrator regarding the criteria for making awards under this section;

(B) to identify Federal authorities and opportunities for use by States or local governments to improve coordination of funding and administration of Federal programs, the beneficiaries of whom include individuals, and which may be unknown or underutilized and to make information on such authorities and opportunities publicly available;

(C) to provide targeted technical assistance to States developing a social determinants accelerator plan under this section, including identifying potential statutory or regulatory pathways for implementation of the plan and assisting in identifying potential sources of funding to implement the plan;

(D) to report to Congress annually on the subjects set forth in this section;

(E) to develop and disseminate evaluation guidelines and standards that can be used to reliably assess the impact of an intervention or approach that may be implemented pursuant to this Act on outcomes, cost-effectiveness of, and

return on investment from Federal, State, local, and Tribal governments, and to facilitate technical assistance, where needed, to help to improve State and local evaluation designs and implementation;

(F) to seek feedback from State, local, and Tribal governments, including through an annual survey by an independent third party, on how to improve the technical assistance the Council provides to better equip State, local, and Tribal governments to coordinate health and social service programs;

(G) to solicit applications for grants under this section; and

(H) to coordinate with other cross-agency initiatives focused on improving the health and well-being of low-income and at-risk populations in order to prevent unnecessary duplication between agency initiatives.

(4) SCHEDULE.—Not later than 60 days after the date of the enactment of this Act, the Council shall convene to develop a schedule and plan for carrying out the duties described in this section, including solicitation of applications for the grants under this section.

(5) REPORT TO CONGRESS.—The Council shall submit an annual report to Congress, which shall include—

(A) a list of the Council members;

(B) activities and expenditures of the Council;

(C) summaries of the interventions and approaches that will be supported by State, local, and Tribal governments that received a grant under this section, including—

(i) the best practices and evidence-based approaches such governments plan to employ to achieve the purposes listed in this section; and

(ii) a description of how the practices and approaches will impact the outcomes, cost-effectiveness of, and return on investment from, Federal, State, local, and Tribal governments with respect to such purposes;

(D) the feedback received from State and local governments on ways to improve the technical assistance of the Council, including findings from a third-party survey and actions the

Council plans to take in response to such feedback; and

(E) the major statutory, regulatory, and administrative challenges identified by State, local, and Tribal governments that received a grant under subsection (d), and the actions that Federal agencies are taking to address such challenges.

(6) FACA APPLICABILITY.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Council.

(7) COUNCIL PROCEDURES.—The Secretary, in consultation with the Comptroller General of the United States and the Director of the Office of Management and Budget, shall establish procedures for the Council to—

(A) ensure that adequate resources are available to effectively execute the responsibilities of the Council;

(B) effectively coordinate with other relevant advisory bodies and working groups to avoid unnecessary duplication;

(C) create transparency to the public and Congress with regard to Council membership, costs, and activities, including through use of

modern technology and social media to disseminate information; and

(D) avoid conflicts of interest that would jeopardize the ability of the Council to make decisions and provide recommendations.

(d) SOCIAL DETERMINANTS ACCELERATOR GRANTS TO STATES OR LOCAL GOVERNMENTS.—

(1) GRANTS TO STATES, LOCAL GOVERNMENTS, AND TRIBES.—Not later than 180 days after the date of the enactment of this Act, the Administrator, in consultation with the Secretary and the Council, shall award on a competitive basis not more than 25 grants to eligible applicants described in this section, for the development of social determinants accelerator plans, as described in this section.

(2) ELIGIBLE APPLICANT.—An eligible applicant described in this section is a State, local, or Tribal health or human services agency that—

(A) demonstrates the support of relevant parties across relevant State, local, or Tribal jurisdictions; and

(B) in the case of an applicant that is a local government agency, provides to the Secretary a letter of support from the lead State

health or human services agency for the State in which the local government is located.

(3) AMOUNT OF GRANT.—The Administrator, in coordination with the Council, shall determine the total amount that the Administrator will make available to each grantee under this section.

(4) APPLICATION.—An eligible applicant seeking a grant under this section shall include in the application the following information:

(A) The target population (or populations) that would benefit from implementation of the social determinants accelerator plan proposed to be developed by the applicant.

(B) A description of the objective or objectives and outcome goals of such proposed plan, which shall include at least one health outcome and at least one other important social outcome.

(C) The sources and scope of inefficiencies that, if addressed by the plan, could result in improved cost-effectiveness of or return on investment from Federal, State, local, and Tribal governments.

(D) A description of potential interventions that could be designed or enabled using such proposed plan.

(E) The State, local, Tribal, academic, nonprofit, community-based organizations, and other private sector partners that would participate in the development of the proposed plan and subsequent implementation of programs or initiatives included in such proposed plan.

(F) Such other information as the Administrator, in consultation with the Secretary and the Council, determines necessary to achieve the purposes of this Act.

(5) USE OF FUNDS.—A recipient of a grant under this section may use funds received through the grant for the following purposes:

(A) To convene and coordinate with relevant government entities and other stakeholders across sectors to assist in the development of a social determinant accelerator plan.

(B) To identify populations of individuals receiving medical assistance under a State plan (or a waiver of such plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) who may benefit from the proposed ap-

proaches to improving the health and well-being of such individuals through the implementation of the proposed social determinants accelerator plan.

(C) To engage qualified research experts to advise on relevant research and to design a proposed evaluation plan, in accordance with the standards and guidelines issued by the Administrator.

(D) To collaborate with the Council to support the development of social determinants accelerator plans.

(E) To prepare and submit a final social determinants accelerator plan to the Council.

(6) CONTENTS OF PLANS.—A social determinant accelerator plan developed under this section shall include the following:

(A) A description of the target population (or populations) that would benefit from implementation of the social determinants accelerator plan, including an analysis describing the projected impact on the well-being of individuals described in paragraph (5)(B).

(B) A description of the interventions or approaches designed under the social deter-

minants accelerator plan and the evidence for selecting such interventions or approaches.

(C) The objectives and outcome goals of such interventions or approaches, including at least one health outcome and at least one other important social outcome.

(D) A plan for accessing and linking relevant data to enable coordinated benefits and services for the jurisdictions described in this section and an evaluation of the proposed interventions and approaches.

(E) A description of the State, local, Tribal, academic, nonprofit, or community-based organizations, or any other private sector organizations that would participate in implementing the proposed interventions or approaches, and the role each would play to contribute to the success of the proposed interventions or approaches.

(F) The identification of the funding sources that would be used to finance the proposed interventions or approaches.

(G) A description of any financial incentives that may be provided, including outcome-focused contracting approaches to encourage

service providers and other partners to improve outcomes of, cost-effectiveness of, and return on investment from, Federal, State, local, or Tribal government spending.

(H) The identification of the applicable Federal, State, local, or Tribal statutory and regulatory authorities, including waiver authorities, to be leveraged to implement the proposed interventions or approaches.

(I) A description of potential considerations that would enhance the impact, scalability, or sustainability of the proposed interventions or approaches and the actions the grant awardee would take to address such considerations.

(J) A proposed evaluation plan, to be carried out by an independent evaluator, to measure the impact of the proposed interventions or approaches on the outcomes of, cost-effectiveness of, and return on investment from, Federal, State, local, and Tribal governments.

(K) Precautions for ensuring that vulnerable populations will not be denied access to Medicaid or other essential services as a result of implementing the proposed plan.

(e) FUNDING.—

(1) IN GENERAL.—Out of any money in the Treasury not otherwise appropriated, there is appropriated to carry out this Act $25,000,000, of which up to $5,000,000 may be used to carry out this Act, to remain available for obligation until the date that is 5 years after the date of enactment of this Act.

(2) RESERVATION OF FUNDS.—

(A) IN GENERAL.—Of the funds made available under paragraph (1), the Secretary shall reserve not less than 20 percent to award grants to eligible applicants for the development of social determinants accelerator plans under this section intended to serve rural populations.

(B) EXCEPTION.—In the case of a fiscal year for which the Secretary determines that there are not sufficient eligible applicants to award up to 25 grants under section 4 that are intended to serve rural populations and the Secretary cannot satisfy the 20-percent requirement, the Secretary may reserve an amount that is less than 20 percent of amounts made available under paragraph (1) to award grants for such purpose.

(3) RULE OF CONSTRUCTION.—Nothing in this Act shall prevent Federal agencies represented on the Council from contributing additional funding from other sources to support activities to improve the effectiveness of the Council.

**SEC. 1010. CORRECTING HURTFUL AND ALIENATING NAMES IN GOVERNMENT EXPRESSION (CHANGE).**

(a) SHORT TITLE.—This section may be cited as the ''Correcting Hurtful and Alienating Names in Government Expression (CHANGE) Act''.

(b) MODERNIZATION OF LANGUAGE REFERRING TO INDIVIDUALS WHO ARE NOT CITIZENS OR NATIONALS OF THE UNITED STATES.—An Executive agency (as defined in section 105 of title 5, United States Code) shall not use the following terms in any proposed or final rule, regulation, interpretation, publication, other document, display, or sign issued by the agency after the date of the enactment of this Act, except to the extent that the term is used in quoting or reproducing text written by a source other than an officer (as defined in section 2104 of title 5, United States Code) or employee (as defined in section 2105 of title 5, United States Code) of the agency:

(1) The term ''alien'', when used to refer to an individual who is not a citizen or national of the United States.

(2) The term ''illegal alien'' when used to refer to an individual who is unlawfully present in the United States or who lacks a lawful immigration status in the United States.

(c) UNIFORM DEFINITION.—

(1) IN GENERAL.—Chapter 1 of title 1, United States Code, is amended by adding at the end the following:

**''§ 9. Definition of 'foreign national'**

''In determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of various administrative bureaus and agencies of the United States, the term 'foreign national' means any individual other than an individual—

''(1) who is a citizen of the United States; or

''(2) though not a citizen of the United States, who owes permanent allegiance to the United States.''.

(2) TECHNICAL AMENDMENT.—The table of sections for chapter 1 of title 1, United States Code, is amended by adding at the end the following:

''9. Definition of 'foreign national'.''.

(d) REFERENCES.—

(1) IN GENERAL.—Any reference in any Federal statute, rule, regulation, Executive order, publication, or other document of the United States—

(A) to the term ''alien'', when used to refer to an individual who is not a citizen or national of the United States, is deemed to refer to the term ''foreign national''; and

(B) to the term ''illegal alien'', when used to refer to an individual who is unlawfully present in the United States or who lacks a lawful immigration status in the United States, is deemed to refer to the term ''undocumented foreign national''.

(2) CONFORMING AMENDMENTS.—

(A) Section 421(5)(A)(ii)(II) of the Congressional Budget and Impoundment Control Act of 1974 (2 U.S.C. 658(5)(A)(ii)(II)) is amended by striking ''illegal aliens'' and inserting ''undocumented foreign nationals''.

(B) Section 432(e) of the Homeland Security Act of 2002 (6 U.S.C. 240(e)) is amended by striking ''illegal alien'' and inserting ''undocumented foreign national''.

(C) Section 439 of the Antiterrorism and Effective Death Penalty Act of 1996 (8 U.S.C.

1252c) is amended in the section heading by striking ''**ILLEGAL ALIENS**'' and inserting ''**UNDOCUMENTED FOREIGN NATIONALS**''.

(D) Section 280(b)(3)(A)(iii) of the Immigration and Nationality Act (8 U.S.C. 1330(b)(3)(A)(iii)) is amended by striking ''illegal aliens'' and inserting ''undocumented foreign nationals''.

(E) Section 286(r)(3)(ii) of the Immigration and Nationality Act (8 U.S.C. 1356(r)(3)(ii)) is amended by striking ''illegal aliens'' and inserting ''undocumented foreign nationals''.

(F) Section 501 of the Immigration Reform and Control Act of 1986 (8 U.S.C. 1365) is amended—

(i) in the section heading, by striking ''**ILLEGAL ALIENS**'' and inserting ''**UNDOCUMENTED FOREIGN NATIONALS**'';

(ii) in the subsection heading for subsection (b), by striking ''ILLEGAL ALIENS'' and inserting ''UNDOCUMENTED FOREIGN NATIONALS''; and

(iii) by striking ''illegal alien'' each place such term appears and inserting ''undocumented foreign national''.

(G) Section 332 of the Omnibus Consolidated Appropriations Act, 1997 (8 U.S.C. 1366) is amended by striking ''illegal aliens'' each place such term appears and inserting ''undocumented foreign nationals''.

(H) Section 411(d) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1621(d)) is amended in the subsection heading by striking ''ILLEGAL ALIENS'' and inserting ''UNDOCUMENTED FOREIGN NATIONALS''.

(I) Section 106(e) of the Public Works Employment Act of 1976 (42 U.S.C. 6705(e)) is amended in the subsection heading by striking ''ILLEGAL ALIENS'' and inserting ''UNDOCUMENTED FOREIGN NATIONALS''.

(J) Section 40125(a)(2) of title 49, United States Code, is amended by striking ''illegal aliens'' and inserting ''undocumented foreign nationals''.

# Subtitle B—Gun Violence

**SEC. 1011. FINDINGS.**

Congress finds as follows:

(1) On average, 86 Americans are killed by guns each day.

(2) An estimated 39,773 people were killed by guns in 2017, of which two-thirds committed suicide.

(3) Gun violence disproportionately affects communities of color, especially African Americans (who comprise around 14 percent of the United States population but account for more than half the country's gun homicide victims).

(4) On average, there is more than one mass shooting each day in the United States.

**SEC. 1012. REAFFIRMING RESEARCH AUTHORITY OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.**

(a) IN GENERAL.—Section 391 of the Public Health Service Act (42 U.S.C. 280b) is amended—

(1) in subsection (a)(1), by striking ''research relating to the causes, mechanisms, prevention, diagnosis, treatment of injuries, and rehabilitation from injuries;'' and inserting: ''research, including data collection, relating to—

''(A) the causes, mechanisms, prevention, diagnosis, and treatment of injuries, including with respect to gun violence; and

''(B) rehabilitation from such injuries;''; and

(2) by adding at the end the following new subsection:

''(c) NO ADVOCACY OR PROMOTION OF GUN CONTROL.—Nothing in this section shall be construed to—

''(1) authorize the Secretary to give assistance, make grants, or enter into cooperative agreements or contracts for the purpose of advocating or promoting gun control; or

''(2) permit a recipient of any assistance, grant, cooperative agreement, or contract under this section to use such assistance, grant, agreement, or contract for the purpose of advocating or promoting gun control.''.

**SEC. 1013. NATIONAL VIOLENT DEATH REPORTING SYSTEM.**

The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall improve, particularly through the inclusion of additional States, the National Violent Death Reporting System, as authorized by sections 301(a) and 391(a) of the Public Service Health Act (42 U.S.C.

241(a), 280(b)). Participation in the system by the States shall be voluntary.

**SEC. 1014. REPORT ON EFFECTS OF GUN VIOLENCE ON PUBLIC HEALTH.**

Not later than one year after the date of the enactment of this Act, and annually thereafter, the Surgeon General shall submit to Congress a report on the effects on public health, including mental health, of gun violence in the United States during the preceding year, and the status of actions taken to address such effects.

**SEC. 1015. REPORT ON EFFECTS OF GUN VIOLENCE ON MENTAL HEALTH IN MINORITY COMMUNITIES.**

Not later than one year after the date of the enactment of this Act, the Deputy Assistant Secretary for Minority Health in the Office of the Secretary of Health and Human Services shall submit to the Congress a report on the effects of gun violence on public health, including mental health, in minority communities in the United States, and the status of actions taken to address such effects.