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112TH CONGRESS
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S. 2474

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

IN THE SENATE OF THE UNITED STATES

APRIL 26, 2012

Mr. AKAKA (for himself and Mr. INOUYE) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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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 2012''.

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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) By 2020, the Nation will face a shortage of health care providers and allied health workers and this shortage disproportionately affects health professional shortage areas where many racial and ethnic minority populations reside.

(4) All efforts to reduce health disparities and barriers to quality health services require better and more consistent 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, two strategic plans that represent the country's first coordinated roadmap to reducing health disparities. Along with the National Prevention Strategy and the National Health Care Quality Strategy, these comprehensive plans will work to increase the number of Americans who are healthy at every stage of life.

(9) The Department of Health and Human Services also developed other strategic planning documents to combat disease disparities with a high impact on minority populations including the National HIV/AIDS Strategy, and the Action Plan for the Prevention, Care and Treatment of Viral Hepatitis.

(10) The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, represents the biggest advancement for minority health in the last 40 years.

TITLE I—DATA COLLECTION AND REPORTING

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

(a) PURPOSE.—It is the purpose of this section to promote data collection, analysis, and reporting by race, ethnicity, sex, primary language, sexual orientation, disability status, gender identity, and socioeconomic status among federally supported health programs.

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

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

"SEC. 3431. HEALTH DISPARITY DATA.

''(a) REQUIREMENTS.—

''(1) IN GENERAL.—Each health-related program operated by or that receives funding or reim-

bursement, in whole or in part, either directly or indirectly from the Department of Health and Human Services 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, and socioeconomic status of each applicant for and recipient of health-related assistance under such program—

"(i) using, at a minimum, the standards for data collection on race, ethnicity, sex, primary language, sexual orientation, disability status, gender identity, and socioeconomic status developed under section 3101;

"(ii) collecting data for additional population groups if such groups can be aggregated into the minimum race and ethnicity categories;

"(iii) additionally referring, where practicable, to the standards developed by the Institute of Medicine in 'Race, Ethnicity, and Language Data: Standardiza-

tion for Health Care Quality Improvement'; and

''(iv) where practicable, 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, 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, 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; and

''(B) diminish existing or future requirements on health care providers to collect data.

''(b) PROTECTION OF DATA.—The Secretary shall ensure (through the promulgation of regulations or other-

wise) 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 (Public Law 104–191; 110 Stat. 2033) 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 appropriate and competent manner, to improve the collection, analysis, and reporting of racial, ethnic, sex, primary language, sexual orientation, disability status, gender identity, 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 the

standards developed under section 3101. The Data Council of the Department of Health and Human Services, in consultation with the National Committee 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 awareness among Federal agencies, States, territories, Indian tribes, health providers, health plans, health insurance issuers, and the general public that data collection, analysis, and reporting by race, ethnicity, primary language, sexual orientation, disability status, gender identity, and socioeconomic status is legal and necessary to assure equity and nondiscrimination in the quality of health care services;

''(3) ensure that future patient record systems have data code sets for racial, ethnic, primary language, sexual orientation, disability status, gender identity, and socioeconomic status identifiers and

that such identifiers can be retrieved from clinical records, including records transmitted electronically;

''(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 for racial and ethnic groups that comprise a significant proportion of the population of the State;

''(5) provide researchers with greater access to racial, ethnic, primary language, sexual orientation, disability status, gender identity, and socioeconomic status data, subject to privacy and confidentiality regulations; 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 the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (at a minimum).

''(e) TECHNICAL ASSISTANCE FOR THE COLLECTION AND REPORTING OF DATA.—

''(1) IN GENERAL.—The Secretary may, either directly or through grant or contract, provide technical assistance to enable a health care program or an entity operating under such program to comply with the requirements of this section.

''(2) TYPES OF ASSISTANCE.—Assistance provided under this subsection may include assistance to—

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

''(B) improve methods for health data collection and analysis including additional population groups beyond the Office of Management and Budget categories if such groups can be aggregated into the minimum race and ethnicity categories;

''(C) develop mechanisms for submitting collected data subject to existing privacy and confidentiality regulations; and

''(D) develop educational programs to inform health insurance issuers, health plans, health providers, health-related agencies, and

the general public that data collection and reporting by race, ethnicity, primary language, sexual orientation, disability status, gender identity, and socioeconomic status are legal and essential for eliminating health and health care disparities.

''(f) ANALYSIS OF HEALTH DISPARITY DATA.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and in coordination with the Administrator of the Centers for Medicare & Medicaid Services, 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 and ethnic disparities in health and health care in public programs 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.

''(g) DEFINITION.—In this section, the term 'health-related program' mean a program—

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

''(2) under this Act that provides Federal financial assistance for health care, biomedical research, or health services research and or is designed to improve the public's health.

''SEC. 3432. PROVISIONS RELATING TO NATIVE AMERICANS.

''(a) ESTABLISHMENT OF EPIDEMIOLOGY CENTERS.—The Secretary shall establish an epidemiology center in each service area to carry out the functions described in subsection (b). Any new center established after the date of the enactment of the Health Equity and Accountability Act of 2012 may be operated under a grant authorized by subsection (d), but funding under such a grant shall not be divisible.

''(b) FUNCTIONS OF CENTERS.—In consultation with and upon the request of Indian tribes, tribal organizations, and urban indian organizations, each service area epidemiology center established under this subsection shall, with respect to such service area—

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

''(2) evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

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

''(4) make recommendations for the targeting of services needed by the populations served;

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

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

''(7) provide disease surveillance and assist Indian tribes, tribal organizations, and urban Indian organizations to promote public health.

''(c) TECHNICAL ASSISTANCE.—The Director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out the requirements of this subsection.

''(d) GRANTS FOR STUDIES.—

''(1) IN GENERAL.—The Secretary may make grants to Indian tribes, tribal organizations, urban indian organizations, and eligible intertribal consortia to conduct epidemiological studies of Indian communities.

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

''(A) the intertribal consortium is incorporated for the primary purpose of improving Indian health; and

''(B) the intertribal consortium is representative of the Indian tribes or urban Indian communities in which the intertribal consortium is located.

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

''(4) REQUIREMENTS.—An applicant for a grant under this subsection shall—

''(A) demonstrate the technical, administrative, and financial expertise necessary to carry out the functions described in paragraph (5);

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

''(C) demonstrate cooperation from Indian tribes or urban Indian organizations in the area to be served.

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

''(A) to carry out the functions described in subsection (b);

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

''(C) in collaboration with Indian tribes, tribal organizations, and urban Indian communities, to provide the service with information regarding ways to improve the health status of Indians.

''(e) ACCESS TO INFORMATION.—An epidemiology center operated by a grantee pursuant to a grant awarded under subsection (d) shall be treated as a public health authority for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033), as such entities are defined in part 164.501 of title 45, Code of Federal Regulations (or a successor regulation). The Secretary shall grant such grantees access to and use of data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary.''.

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 RACE AND ETHNICITY DATA BY THE SOCIAL SECURITY ADMINISTRATION.

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:

"SEC. 1150C. COLLECTION OF RACE AND ETHNICITY DATA BY THE SOCIAL SECURITY ADMINISTRATION.

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

''(1) require the collection of data on the race, ethnicity, primary language, sex, and disability status of all applicants for Social Security account numbers or benefits under title II or part A of title XVIII and all individuals with respect to whom the Commissioner maintains records of wages and self-employment income in accordance with reports received by the Commissioner or the Secretary of the Treasury—

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

''(B) where practicable, collecting data for additional population groups if such groups can be aggregated into the minimum race and ethnicity categories; and

''(C) additionally referring, where practicable, to the standards developed by the Institute of Medicine in 'Race, Ethnicity, and Lan-

guage Data: Standardization for Health Care Quality Improvement' (released August 31, 2009);

''(2) with respect to the collection of the data described in paragraph (1) for applicants who are under 18 years of age or otherwise legally incapacitated, 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;

''(3) require that such data be uniformly analyzed and reported at least annually to the Commissioner of Social Security;

''(4) be responsible for storing the data reported under paragraph (3);

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

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

''(7) ensure that the provision of assistance to an applicant is not denied or otherwise adversely affected because of the failure of the applicant to pro-

vide race, ethnicity, primary language, sex, and disability status data.

''(b) 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) are protected—

''(1) 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 (Public Law 104–191; 110 Stat. 2033) 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) 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.

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

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 the standards for data collection on race, ethnicity, primary language, disability, and sex developed under section 3101 of the Public Health Service Act (42 U.S.C. 300kk); and

(2) the designation of the racial, ethnic, primary language, disability, and sex 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 health 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 health 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 ''2016'';

(2) in paragraph (2), in the first sentence, by striking ''2003'' and inserting ''2016''; and

(3) in paragraph (3), by striking ''2002'' and inserting ''2016''.

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

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

"SEC. 317U. OVERSAMPLING OF ASIAN-AMERICANS, NATIVE HAWAIIANS, OR PACIFIC ISLANDERS AND OTHER UNDERREPRESENTED GROUPS IN FEDERAL HEALTH SURVEYS.

''(a) NATIONAL STRATEGY.—

''(1) IN GENERAL.—The Secretary of Health and Human Services, 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 oversampling Asian-Americans, Native Hawaiians, or Pacific Islanders, and other underrepresented populations as determined appropriate by the Secretary in Federal health surveys.

''(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 the this section, the Secretary—

''(A) shall consult with representatives of community groups, nonprofit organizations, nongovernmental organizations, and government agencies working with Asian-Americans,

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

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

''(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).''.

SEC. 107. GEO-ACCESS STUDY.

The Administrator of the Substance Abuse and Mental Health Services Administration 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 the Congress on the results of such study.

SEC. 108. RACIAL, ETHNIC, AND LINGUISTIC DATA COLLECTED BY THE FEDERAL GOVERNMENT.

(a) COLLECTION; SUBMISSION.—Not later than 90 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 racial, ethnic, or linguistic data during the preceding calendar year shall submit such data to the Secretary of Health and Human Services.

(b) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—Not later than April 30, 2012, and each April 30 thereafter, 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—

(1) collect and analyze the racial, ethnic, and linguistic data, including by stratifying such data by sex, submitted under subsection (a) for the preceding calendar year;

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

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

SEC. 109. DATA COLLECTION AND ANALYSIS GRANTS TO MINORITY-SERVING INSTITUTIONS.

(a) AUTHORITY.—The Secretary of Health and Human Services, acting through the National Institute on Minority Health and Health Disparities and the Office of Minority Health, may award grants to access and analyze racial and ethnic, and where possible other health disparity data, to monitor and report on progress to reduce and eliminate disparities in health and health care. Such analysis under the preceding sentence shall include stratifying such data by sex.

(b) ELIGIBLE ENTITY.—In this section, the term ''eligible entity'' means a historically Black college or university, an Hispanic-serving institution, a tribal college or university, or an Asian-American, Native American, or Pacific Islander-serving institution with an accredited public health, health policy, or health services research program.

SEC. 110. STANDARDS FOR MEASURING SEXUAL ORIENTATION AND GENDER IDENTITY 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,'' before ''and disability status'';

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

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

SEC. 111. OPTIONAL COLLECTION OF HEALTH DATA ON IMMIGRANTS AND INDIVIDUALS IN THEIR HOUSEHOLDS.

Section 3101(a) of the Public Health Service Act (42 U.S.C. 300k(a)) is amended by adding at the end the following:

''(4) OPTIONAL UNIFORM CATEGORIES.—Not later than 12 months after the date of the enactment of this paragraph, the Secretary shall—

''(A) enter into an arrangement with the Institute of Medicine of the National Academies (or, if the Institute of Medicine declines to enter into such an arrangement, another appropriate entity) to—

''(i) conduct a study and develop recommended standards for the optional collection of data in major health surveys and research on citizens, noncitizens, and citizens living in noncitizen households, in-

cluding standards protecting the confidentiality and security of personal information of respondents and research subjects, to the full extent permitted by law, in order to measure disparities in health coverage, health care access and quality, and health status among these populations;

''(ii) in carrying out clause (i), address how the protection of confidentiality and security of personal information under such clause interacts with immigration laws; and

''(iii) include ensuing study results and recommended standards in a report to the Secretary;

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

''(C) provide clear guidance that such data categories are optional uniform categories and, if collected, the entity and any person conducting the survey or research shall—

''(i) adhere to the standards under subparagraph (B);

''(ii) use the information only for the purposes of measuring disparities in health coverage, health care access and quality, and health status among these populations;

''(iii) comply with all applicable laws and policies regarding privacy, confidentiality and security of the personal information of the respondent or research subject and of the family members of the respondent or research subject; and

''(iv) not share that information with other individuals or entities without the express consent of the respondent or research subject.''.

SEC. 112. GAO STUDY ON COMPLIANCE WITH EXISTING FDA REQUIREMENTS TO PRESENT DRUG AND DEVICE SAFETY AND EFFECTIVENESS DATA BY SEX, AGE, AND RACIAL AND ETHNIC SUBGROUPS.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study investigating the extent to which sponsors of clinical studies of investigational drugs, biologics, and devices and sponsors of applications for approval or licensure of new drugs, biologics, and devices comply with Food and Drug Administration require-

ments and follow guidance for presentation of clinical study safety and effectiveness data by sex, age, and racial and ethnic subgroups.

(b) REPORT BY GAO.—

(1) SUBMISSION.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall complete the study under subsection (a) and submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report on the results of such study.

(2) CONTENTS.—The report required by paragraph (1) shall include each of the following:

(A) An assessment of the extent to which the Food and Drug Administration assists sponsors in complying with the requirements and following the guidance referred to in subsection (a).

(B) An assessment of the effectiveness of the Food and Drug Administration's enforcement of compliance with such requirements.

(C) An analysis of the extent to which females, racial and ethnic minorities, and adults of all ages are adequately represented in Food

and Drug Administration-approved clinical studies (at all phases) so that product safety and effectiveness data can be evaluated by sex, age, and racial and ethnic subgroup.

(D) An analysis of the extent to which a summary of product safety and effectiveness data disaggregated by sex, age, and racial and ethnic subgroup is readily available to the public in a timely manner by means of the product label or the Food and Drug Administration's Web site.

(E) Recommendations for—

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

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

(c) REPORT BY HHS.—Not later than 6 months after the submission by the Comptroller General of the report required under subsection (b), the Secretary of Health and Human Services shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a response to that re-

port, including a corrective action plan as needed to respond to the recommendations in that report.

(d) DEFINITIONS.—In this section:

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

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

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

SEC. 113. 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, as added, the following:

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

''(a) FINDINGS.—Congress makes the following findings:

''(1) Native Hawaiians and Other Pacific Islanders (referred to in this subsection as 'NHOPI') are identified as 1 of 6 specific racial or ethnic categories in the United States Census. The other cat-

egories are African Americans, American Indians/Alaska Natives, Asians, Caucasians, and Latinos/Hispanics.

''(2) Native Hawaiians and the Pacific Jurisdictions have a special legal relationship with the United States, which requires careful consideration of consultation rights and expectations that are based upon formal United States policy, special treaties with the United States, and international law.

''(3) The NHOPI population is unique in that its peoples have homelands in the Pacific yet many have moved to reside in the continental United States and today are living in every state of the United States. Yet, NHOPI are often 'invisible' in current Federal data collection, analysis, and reporting, particularly those identifying health status.

''(b) DEFINITIONS.—In this section:

''(1) COMMUNITY GROUPS.—The term 'community groups' means groups of people which are organized at the community level and are specific to NHOPI populations such as church groups, social service groups, and cultural groups.

''(2) DESIGNATED ORGANIZATIONS.—The term 'designated organizations' means organizations which are constituted to represent NHOPI popu-

lations and which have statutory responsibilities or community support for aspects of health and health care.

''(3) GOVERNMENT REPRESENTATIVES.—The term 'government representatives' mean government representatives from Pacific Island Jurisdictions including American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Republic of Belau, and Republic of the Marshall Islands.

''(4) NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER; NHOPI.—The terms 'Native Hawaiian and Other Pacific Islander' and 'NHOPI' mean people having origins in any of the original peoples of American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Hawai`i, Republic of the Marshall Islands, Republic of Belau, or any other Pacific Islands.

''(c) REPORT.—

''(1) IN GENERAL.—The Secretary shall submit to Congress a report that describes factors that affect NHOPI health. Such report shall describe—

''(A) the health disparities that affect such population;

''(B) an assessment of the needs of such population; and

''(C) an evaluation of the impact of such disparities, and of efforts to address such disparities, on the health of such population.

''(2) RESOURCES; PARTNERSHIP.—In compiling the report under paragraph (1), the Secretary shall use data available from the National Center for Health Statistics. The report shall be complied in partnership with the Native Hawaiian Epidemiology Center.

''(d) NATIONAL STRATEGY.—

''(1) IN GENERAL.—Not later than 10 months after the date of enactment of the Health Equity and Accountability Act of 2012, the Secretary, in consultation with representatives from community groups, designated organizations, government representatives of NHOPI populations, and other Federal department representatives as determined appropriate by the Secretary, shall develop, implement, and make public an ongoing and sustainable national strategy for identifying and evaluating the health status and health care needs of NHOPI living on the continental United States, in Hawai`i, and in the various Pacific Island Jurisdictions.

''(2) CONTENT.—The national strategy developed under paragraph (1) shall—

''(A) address gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures and data aggregation techniques; and

''(B) enhance the use of health care data to improve quality, efficiency, transparency, and outcomes.

''(e) IMPLEMENTATION.—The Secretary shall ask the National Center for Health Statistics, in partnership with the Native Hawaiian Epidemiology Center, to develop and implement the national strategy developed under subsection (d). The Secretary shall require other agencies within the Department of Health and Human Services to assist the National Center for Health Statistics in carrying out the preceding sentence.

''(f) REPORT.—Not later than 2 years after the date of enactment of the Health Equity and Accountability Act of 2012, the Secretary shall submit to Congress a progress report on the activities conducted under this section, including the national strategy for identifying and evaluating the health status and health care needs of NHOPI populations.''.

SEC. 114. SIMPLIFIED ADMINISTRATIVE REPORTING REQUIREMENT FOR NUTRITION ASSISTANCE.

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) ADMINISTRATIVE REPORTING REQUIREMENT RELATING TO THE INDIGENCE EXCEPTION FOR ALIENS.—In satisfaction of the administrative reporting requirement under section 421(e)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1631(e)(2)), the Secretary shall accept from the Attorney General for each fiscal year an aggregate report that describes the quantity of exceptions granted in that fiscal year under that section.''.

TITLE II—CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE

SEC. 201. DEFINITIONS.

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

SEC. 202. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

(a) 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 languages barriers that result in increased risk of misdiagnosis, ineffective treatment plans and poor health outcomes for limited-English-proficient individuals and individuals with communication disabilities such as 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 limited-English-proficient individuals and individuals with communication disabilities such as hearing, vision, or print impairments is a societal one that cannot fairly be visited solely upon the health care, public health or social services community.

(5) Title VI of the Civil Rights Act of 1964 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 Department must take adequate steps to ensure that their policies and procedures do not deny or have the effect of denying limited-English-proficient individuals with equal access to benefits and services for which such persons qualify.

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

(7) 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 limited-English-proficient individuals and individuals with communication disabilities such as hearing, vision, or print impairments.

(8) Access to English as a second language and sign language instructions is an important mechanism for ensuring effective communication and elimi-

nating the language barriers that impede access to health care.

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

(b) AMENDMENT.—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.

''In this title:

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

''(2) COMMUNITY HEALTH WORKER.—The term 'community health worker' means an individual who promotes health or nutrition within the community in which the individual resides.

''(3) COMPETENT INTERPRETER SERVICES.—The term 'competent interpreter services' means a translanguage rendition of a spoken or signed message in which the interpreter comprehends the source language and can communicate comprehensively in the target language to convey the meaning

intended in the source language. The interpreter knows health and health-related terminology and provides accurate interpretations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source message.

''(4) COMPETENT TRANSLATION SERVICES.—The term 'competent translation services' means a translanguage rendition of a written document in which the translator comprehends the source language and can write or sign comprehensively in the target language to convey the meaning intended in the source language. The translator knows health and health-related terminology and provides accurate translations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source document.

''(5) CULTURAL COMPETENCE.—The term 'cultural competence' means a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. In the preceding sentence—

"(A) the term 'cultural' refers 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 and intersex individuals, and individuals with physical and mental disabilities; and

"(B) the term 'competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

"(6) 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, or learning impairment, that enables access, understanding, and benefit from health care or health-care-related services, and full participation in the development of their treatment plan.

"(7) GRIEVANCE RESOLUTION PROCESS.—The term 'grievance resolution process' means all aspects

of dispute resolution including filing complaints, grievance and appeal procedures, and court action.

''(8) HEALTH CARE GROUP.—The term 'health care group' means a group of physicians organized, at least in part, for the purposes of providing physicians' services under the Medicaid, SCHIP, or Medicare programs and may include a hospital and any other individual or entity furnishing services covered under the Medicaid, SCHIP, or Medicare programs that is affiliated with the health care group.

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

''(10) 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.

''(11) INDIAN TRIBE.—The term 'Indian tribe' means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) (43 U.S.C. 1601 et seq.), which is recognized as eli-

gible for the special programs and services provided by the United States to Indians because of their status as Indians.

''(12) 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 and related disciplines to improve the health outcomes of an individual. Providers may include but are not limited to hospitals, health, mental health or substance use clinics and providers, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation centers, and employed, independent or contracted physicians.

''(13) 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.

''(14) LANGUAGE ACCESS.—The term 'language access' means the provision of language services to an LEP individual or individual with communication disabilities designed to enhance that individual's ac-

cess to, understanding of or benefit from health care or health-care-related services.

''(15) LANGUAGE OR LANGUAGE ACCESS SERVICES.—The term 'language or language access services' means provision of health care services directly in a non-English language, interpretation, translation, signage, video recording, and English or non-English alternative formats.

''(16) LEP.—The term 'LEP' means limited-English proficient.

''(17) LEP RELATED DATA COLLECTION ACTIVITIES.—The term 'LEP related 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 limited-English-proficient individuals.

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

''(19) 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.

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

"(21) RACIAL AND ETHNIC MINORITY GROUP.—The term 'racial and ethnic minority group' means American 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.

"(22) ON-SITE INTERPRETING/INTERPRETATION.—The term 'on-site interpreting/interpretation' means a method of interpreting or interpretation for which the interpreter is in the physical presence of 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 hearing, vision, or learning.

"(23) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(24) 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.

''(25) STATE.—The term 'State' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Indian tribes, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

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

''(27) 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.

''(28) VIDEO INTERPRETATION.—The term 'video interpretation' means a method of inter-

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

''(29) VITAL DOCUMENT.—The term 'vital document' includes but is not limited to 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 benefits, notices of the right to appeal such actions, and notices advising limited-English-proficient individuals and individuals with communication disabilities of the availability of free language services, alternative formats, and other outreach materials.

"SEC. 3401. IMPROVING ACCESS TO SERVICES FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY.

''(a) PURPOSE.—As provided in Executive Order 13166, 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 who are limited in their English proficiency;

''(2) to require each Federal agency to examine the services it provides and develop and implement a system by which limited-English-proficient individuals can obtain cultural competence 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 cultural competence and meaningful access to their limited-English-proficient applicants and beneficiaries;

''(4) to ensure that recipients of Federal financial assistance take reasonable steps, consistent with the guidelines set forth in the Limited English Proficient Guidance of the Department of Justice (as issued on June 12, 2002), to ensure cultural competence and meaningful access to their programs

and activities by limited-English-proficient individuals; and

''(5) to ensure compliance with title VI of the Civil Rights Act of 1964 and 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 title, each Federal agency that carries out health-care-related activities shall prepare a plan to improve access cultural competence to the federally conducted, health-are-related programs and activities of the agency by limited-English-proficient individuals. Each Federal agency must ensure that such plan is fully implemented not later than one year after the date of enactment of this Act.

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

''(A) the steps the agency will take to ensure that limited-English-proficient individuals have access to the agency's federally conducted health care and health-care-related programs and activities;

"(B) the policies and procedures for identifying, assessing, and meeting the language needs and cultural competence needs of its limited-English-proficient beneficiaries served by federally conducted programs and activities;

"(C) the steps the agency will take for its federally conducted programs and activities to improve cultural competence to provide a range of language assistance options, notice to limited-English-proficient individuals 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 to ensure that applications, forms, and other relevant documents for its federally conducted programs and activities are competently translated into the primary language of a limited-English-proficient client where such materials are needed to improve access to federally conducted and federally assisted programs and activities for such a limited-English-proficient individual; and

''(E) the resources the agency will provide to improve cultural competence to assist recipients of Federal funds to improve access to health care or health-care-related programs and activities for limited-English-proficient individuals.

Each agency shall send a copy of such plan to the Department of Justice, which shall serve as the central repository of the Agency's plans.

''(c) FEDERALLY ASSISTED PROGRAMS AND ACTIVITIES.—

''(1) IN GENERAL.—Not later than 120 days after the date of enactment of this title, each Federal agency providing health-care-related Federal financial assistance shall ensure that the guidance for recipients of Federal financial assistance developed by the agency to ensure compliance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) is specifically tailored to the recipients of such assistance. Each agency shall send a copy of such guidance to the Department of Justice which shall serve as the central repository of the Agency's plans. After approval by the Department of Justice, each agency shall publish its guidance document in the Federal Register for public comment.

''(2) REQUIREMENTS.—The agency-specific guidance developed under paragraph (1) shall take into account the types of health care services provided by the recipients, the individuals served by the recipients, and other factors set out in such standards.

''(3) EXISTING GUIDANCES.—A Federal agency that has developed a guidance for purposes of title VI of the Civil Rights Act of 1964 shall examine such existing guidance, as well as the programs and activities to which such guidance applies, to determine if modification of such guidance is necessary to comply with this subsection.

''(4) CONSULTATION.—Each Federal agency shall consult with the Department of Justice in establishing the guidances under this subsection.

''(d) CONSULTATIONS.—

''(1) IN GENERAL.—In carrying out this section, each Federal agency that carriers out health care and health-care-related activities shall ensure that stakeholders, such as limited-English-proficient individuals and their representative organizations, recipients of Federal assistance, and other appropriate individuals or entities, have an adequate op-

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

''(2) EVALUATION.—Each Federal agency described in paragraph (1) shall evaluate the—

''(A) particular needs of the limited-English-proficient individuals served by the agency;

''(B) particular needs of the limited-English-proficient individuals served by the agency's recipients of Federal financial assistance; and

''(C) burdens of compliance with the agency guidance and this section for the agency and its recipients.

"SEC. 3402. NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE.

''Recipients of Federal financial assistance from the Secretary shall, to the extent reasonable and practicable after applying the 4-factor analysis described in title V of the Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited-English Proficient Persons (June 12, 2002)—

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

''(2) ensure that staff at all levels and across all disciplines of the organization receive ongoing education and training in culturally and linguistically appropriate service delivery;

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

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

''(5) ensure the competence of language assistance provided to limited-English-proficient patients by interpreters and bilingual staff, and ensure that family, particularly minor children, and friends are not used to provide interpretation services—

''(A) except in case of emergency; or

''(B) except on request of the patient, who has been informed in his or her preferred language of the availability of free interpretation services;

''(6) make available easily understood patient-related materials, if such materials exist for non-limited-English-proficient patients, including information or notices about termination of benefits and post signage in the languages of the commonly encountered groups or groups represented in the service area of the organization;

''(7) develop and implement clear goals, policies, operational plans, and management accountability and oversight mechanisms to provide culturally and linguistically appropriate services;

''(8) conduct initial and ongoing organizational assessments of culturally and linguistically appropriate services-related activities and integrate valid linguistic, competence-related measures into the internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations of the organization;

''(9) ensure that, consistent with the privacy protections provided for under the regulations promulgated under section 264(c) of the Health Insur-

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

"(A) data on the individual patient's race, ethnicity, primary language, alternative format preferences, and policy modification needs are collected in health records, integrated into the organization's management information systems, and periodically updated; and

"(B) if the patient is a minor or is incapacitated, the primary language of the parent or legal guardian is collected;

"(10) maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area of the organization;

"(11) develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient involvement in designing and implementing culturally and linguistically appropriate services-related activities;

"(12) ensure that conflict and grievance resolution processes are culturally and linguistically sen-

sitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients;

''(13) 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

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

''SEC. 3403. ROBERT T. MATSUI CENTER FOR CULTURAL AND LINGUISTIC COMPETENCE IN 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 Cultural and Linguistic Competence in Health Care' (referred to in this section as the 'Center') to carry out 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) The Center shall provide, directly or through contract, vital documents from competent translation services for providers of health care and health-care-related services at no cost to such providers. Materials may be submitted for translation into non-English languages. Translation services shall be provided in a timely and reasonable manner and in accordance with the guidelines and standards set forth in subsection (c) when such standards become available. The quality of such translation services shall be monitored and reported publicly.

''(B) For each form developed or revised by the Secretary that will be used by LEP individuals 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 Commu-

nity Survey or its replacement. The translation must be completed within 45 days of the Secretary receiving final approval of the form from the Office of Management and Budget.

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

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

''(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 and health-care-related services to reduce medical errors, improve medical outcomes, to improve cultural competence, reduce health care costs caused by

miscommunication with individuals with limited-English proficiency, and reduce or eliminate the duplication of effort to translate materials. The clearinghouse shall make such information available on the Internet and in print. Such information shall include the information described in the succeeding provisions of this paragraph.

''(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 the following:

''(i) Administrative and legal documents, including—

''(I) intake forms;

''(II) Medicare, Medicaid, and SCHIP forms, including eligibility information;

''(III) forms informing patient of HIPAA compliance and consent; 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.—The operating the clearinghouse, the Center shall—

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

''(ii) allow public review of the documents before dissemination in order to ensure that the documents are understandable and culturally 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 LEP individuals, including case studies using de-identified patient information, program summaries, and program evaluations.

"(E) CULTURAL AND LINGUISTIC COMPETENCE MATERIALS.—The Center shall provide information relating to culturally and linguistically competent 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 competent care;

"(ii) cultural and linguistic competence self-assessment tools;

"(iii) cultural and linguistic competence training tools;

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

"(v) cultural and linguistic competence information for educators, practitioners, and researchers.

"(F) INFORMATION ABOUT PROGRESS.—The Center shall regularly collect and make publicly available information about the progress of entities receiving grants under section 3404 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) INTERPRETATION AND TRANSLATION GUIDELINES AND STANDARDS.—The Center shall convene a working group to develop and adopt interpretation and translation quality guidelines and standards for use by the Center. The guidelines and standards must be sufficient to ensure that LEP individuals have the equal opportunity to benefit from health care services to the same extent as non-LEP individuals. The guidelines and standards shall address the training, assessment, and certification of individuals to provide competent interpreter and translator services to work in health care and health-care-related settings and of bilingual staff who provide services directly in non-English languages. The working group may develop different guidelines and standards for bilingual staff, interpreters, and translators.

''(d) MEMBERSHIP.—

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

"(A) Four members from organizations that advocate on behalf of LEP individuals.

"(B) One member who represents a professional interpreter association (that is not the National Council on Interpreting in Health Care) or translator association.

"(C) One member from a nonprofit community-based organization that provides language services.

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

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

"(F) One member who works in or has extensive knowledge of issues related to health care risk management.

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

urban and rural representatives, including representatives of the United States territories.

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

''(4) VACANCIES.—Any vacancies in the Working Group shall not affect the power and duties of the Working Group but shall be filled in the same manner as the original appointment.

''(5) SUBCOMMITTEES.—The Working Group may establish subcommittees if doing so increases the efficiency of the Working Group in completing its tasks, including subcommittees to develop different guidelines and standards for interpreters, translators, and bilingual staff.

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

''(A) representatives from the American Translators Association, Association of Language Companies, the National Center for State Courts, and States which have developed interpreter standards such as California, Mas-

sachusetts, and Oregon who have experience in the development or implementation of their organizations' interpreter and translator certification programs;

"(B) Federal agencies including the Office for Civil Rights, the Office of Minority Health, the Centers for Medicare & Medicaid Services, and the National Institute on Minority Health and Health Disparities; and

"(C) other individuals or entities determined appropriate by the Secretary who have specific expertise that will be useful to the Working Group.

"(7) PUBLICATION.—

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

"(i) prepare and make available to the public through the Internet, the Federal Register, and other appropriate public channels, a proposed set of interpretation and translation guidelines and standards for training, assessment, and certification; and

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

"(B) FINAL STANDARDS.—Not later than 120 days after the expiration of the public comment period described in subparagraph (A), the Director of the Agency for Healthcare Research and Quality shall publish, after consultation with and the approval of the Working Group, final guidelines and standards in the Federal Register and on the Internet.

"(C) TESTING DEVELOPMENT.—Not later than 120 days after the publication of the final recommendations described in subparagraph (B), the Director of the Agency for Healthcare Research and Quality shall, if deemed necessary by the Working Group, enter into a contract with an entity experienced in the development of designing certification tests in language related fields to develop such tests as may be necessary to implement the guidelines and standards.

"(D) PILOT PROJECT.—

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

scribed in subparagraph (C) or after publication of the final guidelines and standards, whichever is later, the Secretary shall design, fund, and implement a pilot project in up to 50 geographically and demographically diverse sites, two of which must be in the United States territories, to test and evaluate implementation of the recommendations.

''(ii) The Secretary shall consult with the Working Group and the Advisory Panel in development of the pilot project and report progress to the Working Group on an ongoing basis.

''(iii) The pilot project shall include interpreters and translators working with various provider types, including small group practices, hospitals, mental health and substance use clinics, and community health clinics, and shall include broad geographic representation including both urban and rural representatives.

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

''(v) If the Working Group determines that any revisions to guidelines and standards are necessary as a result of the pilot project, it shall revise such guidelines and standards and the Director of the Agency for Healthcare Research and Quality shall publish the revisions in the Federal Register for notice and comment. Not later than 120 days after the expiration of the public comment period on such revisions, the Director of the Agency for Healthcare Research and Quality shall publish, after consultation with and the approval of the Working Group, final revisions to the guidelines and standards in the Federal Register and on the Internet.

''(8) ADMINISTRATION.—

''(A) CHAIRPERSON.—Not later than 15 days after the date on which all members of the Working Group have been appointed under subsection (d), the Working Group shall designate its chairperson.

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

or the Advisory Panel shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the chairperson of the Working Group. For purposes of pay and employment benefits, rights, and privileges, all personnel of the Working Group shall be treated as if they were employees of the House of Representatives.

''(C) INFORMATION FROM FEDERAL AGENCIES.—The Working Group may secure directly from any Federal department or agency such information as the Working Group considers necessary to carry out this section. Upon request of the Working Group, the head of such department or agency shall furnish such information. Any information that contains individually identifiable information received by the Working Group shall not be disseminated or disclosed outside of the Working Group and shall not be used except by the Working Group.

''(D) DETAIL.—Not more than 10 Federal Government employees employed by the Department of Health and Human Services may be detailed to staff the Working Group under this section without further reimbursement. Any detail of an employee shall be without interruption or loss of civil service status or privilege.

''(E) TEMPORARY AND INTERMITTENT SERVICES.—The Working Group may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

''(9) DEEMED STATUS.—

''(A) CERTIFICATION BY PRIVATE ORGANIZATION.—If a private accreditation organization establishes training, assessment, or certification standards for interpreters or translators in health care which the Secretary determines are at least equivalent to the training, assessment, or certification standards promulgated by the Secretary as described in subsection (c), the Secretary shall find that all organizations or in-

dividuals accredited by such organization comply also with the standard described in subsection (c) if—

"(i) such organization or individual authorizes the organization to release to the Secretary upon the Secretary's request (or such State agency as the Secretary may designate) a copy of the most current accreditation survey of such organization or individual made by the organization, together with any other information directly related to the survey as the Secretary may require (including corrective action plans); and

"(ii) such organization releases such a copy and any such information to the Secretary.

"(B) CERTIFICATION BY A STATE OR LOCALITY.—If a State or locality has or establishes training, assessment, or certification standards for interpreters or translators in health care which the Secretary determines are at least equivalent to the training, assessment, or certification standards promulgated by the Secretary as described in subsection (c), the

Secretary shall find that all organizations or individuals accredited by such State or locality comply also with the standard described in subsection (c) if—

''(i) such organization or individual authorizes the State or locality to release to the Secretary upon his request (or such State agency as the Secretary may designate) a copy of the most current accreditation survey of such organization or individual made by such State or locality, together with any other information directly related to the survey as the Secretary may require (including corrective action plans); and

''(ii) such State or locality releases such a copy and any such information to the Secretary.

''(C) TIMELY ACTION ON APPLICATION.—The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization, State, or locality whether the process of the private accrediting organization, State, or locality meets the requirements with respect to training,

assessment, or certification standards for interpreters or translators with respect to which standards the application is made. The Secretary may not deny an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, training, assessment, or certification standards for interpreters or translators.

''(D) DISCLOSURE OF ACCREDITATION SURVEY.—The Secretary may not disclose any accreditation survey made and released to him by the National Council on Interpreting in Health Care or any State or locality of an accredited organization or individual, except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.

''(E) DEFICIENCIES.—If the Secretary finds that an accredited organization or individual has significant deficiencies (as defined in regulations pertaining to the training, assessment, or certification standards), the organization or individual shall, after the date of notice of such finding to the organization and for such

period as may be prescribed in regulations, be deemed not to meet the conditions or requirements the organization or individual has been treated as meeting pursuant to subparagraph (A).

''(e) AVAILABILITY OF LANGUAGE ACCESS.—The Director shall collaborate with the Administrator of the Office of 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.

''(f) EDUCATION.—The Secretary, directly or through contract, shall undertake a national education campaign to inform providers, LEP individuals, 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 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.

''SEC. 3404. INNOVATIONS IN CULTURAL AND LINGUISTIC COMPETENCE GRANTS.

''(a) IN GENERAL.—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 cultural competence and language access in health care for individuals with limited-English proficiency. The Director of the Agency for Healthcare Research and Quality shall coordinate with, and ensure the participation of, other agencies including but not limited to the Health Resources and Services Administration, the Center 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, territory or subdivision thereof;

"(B) an organization described in section 501(c)(3) of the Internal Revenue Code of 1986;

"(C) a community health, mental health, or substance use 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) other entity designated by the Secretary; and

"(2) 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.

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

"(1) develop, implement, and evaluate models of providing competent interpretation services through on-site interpretation, telephonic interpretation, or video interpretation;

"(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 organization;

''(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 service area of the organization;

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

''(5) develop participatory, collaborative partnerships with communities encompassing the LEP patient populations being served to gain input in designing and implementing language services;

''(6) develop and implement grievance resolution processes that are culturally and linguistically sensitive and capable of identifying, preventing, and resolving complaints by LEP individuals; or

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

''(8) develop formal training programs, including continued professional development and education programs as well as supervision, for individ-

uals interested in becoming dedicated health care interpreters and culturally competent providers;

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

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

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

''(12) develop, implement, and evaluate models of improving cultural competence; 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 (42 U.S.C. 1320d–2 note), 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 pri-

marily engage in providing direct care and that have developed partnerships with community organizations or with agencies with experience language access.

''(e) EVALUATION.—

''(1) 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 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 Cultural and Linguistic Competence in Health Care established under section 3403. 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) The Director of the Agency for Healthcare Research and Quality shall evaluate or arrange with other individuals or organizations to evaluate projects funded under this section.

"SEC. 3405. 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.

''(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 do so.

''(c) USE OF FUNDS.—Research 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 LEP individuals.

''(2) To identify health care providers' and health administrators' attitudes, knowledge, and awareness of the barriers to quality health care services that are faced by LEP individuals.

''(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 and health-care-related services of data on the race, ethnicity, and primary language of recipients of such services, taking into account ex-

isting 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 Department can create or coordinate, and then subsidize or otherwise fund telephonic interpretation providers 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.''.

SEC. 203. 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 (in this section referred to as the ''Secretary''), acting through the Centers for Medicare & Medicaid Services and in consultation with the Center for Medicare and Medicaid Innovation, shall establish demonstration program under which the Secretary shall award grants to eligible Medicare service providers to improve communication between such providers and limited-English-proficient Medicare beneficiaries, 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.

(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;

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

(iii) a Medicare Advantage organization offering a Medicare Advantage plan under part C of such title; or

(iv) a PDP sponsor offering a prescription drug plan under part D of such title.

(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 limited-English proficient individuals, 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, 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 limited-English proficient.

(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

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

(aa) on-site 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—

(i) to a Medicare beneficiary who is limited-English-proficient who has been informed, in the beneficiary's primary language, of the availability of free interpreter and translation services and who, instead, requests that a family member, friend, or other person provide such services, if 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.

Subparagraph (C)(ii) shall not be construed to exempt emergency rooms or similar entities that regularly provide health care services in medical emergencies to limited-English-proficient patients from any applicable legal or regulatory requirements related to providing com-

petent interpreter and translation services without undue delay.

(D) MA ORGANIZATIONS AND PDP SPONSORS.—If a grantee is a Medicare Advantage organization or a PDP sponsor, 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 physicians and pharmacies) for the purpose of providing support for such providers to provide competent language services to Medicare beneficiaries who are limited-English proficient.

(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 limited-English-

proficient Medicare beneficiaries in a grantee's service area utilizing—

(i) data on the numbers of limited-English-proficient individuals 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 limited-English-proficient individuals 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 sub-

paragraph (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—

(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 with limited-English proficiency 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 is collected for recipients of language services and such data is 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 is collected on the parent or legal guardian of such recipient.

(8) NO COST SHARING.—Limited-English-proficient Medicare beneficiaries 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 demonstration 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 limited-English-proficient Medicare beneficiaries participating in the project as compared to such outcomes and costs for limited-English-proficient 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 subsection (c) of section 1907 of this Act.

(D) Recommendations, if any, regarding the extension of such project to the entire Medicare program, subject the to provision of section 1115A(c) of the Social Security Act.

(b) LANGUAGE SERVICES UNDER THE MEDICARE PROGRAM.—

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

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

(B) in subparagraph (C), by inserting ''and'' after the comma at the end; and

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

''(D) language services as defined in subsection (iii),''.

(2) 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 redesignating paragraph (9) as paragraph (10); and

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

''(9) in the case of language services described in section 1861(iii), 100 percent of the reasonable charges for such services, as determined in consultation with the Medicare Payment Advisory Commission; and''.

(3) Section 1832(a)(2) of such 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 services (as defined in section 1861(iii)) furnished by a interpreter or translator.''.

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

''Language Services and Related Terms

''(iii)(1) LANGUAGE SERVICES DEFINED.—The term 'language services' has the same meaning given 'language or language access services' in section 3400 of the Public Health Service Act.

''(2) INTERPRETER SERVICES DEFINED.—For purposes of this subsection, the term 'interpreter services' has the meaning given 'competent interpreter services' under section 3400(3) of the Public Health Service Act.

''(3) INTERPRETER DEFINED.—The term 'interpreter'—

''(A) means an individual—

''(i) who faithfully, accurately, and objectively transmits a spoken message from one language into another language; and

''(ii) who knows health and health-related terminology in both languages; and

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

''(4) TRANSLATION DEFINED.—The term 'translation' means the transmission of a written message in one language into a written message in another language that retains the intended meaning of the original message.

''(5) LIMITED-ENGLISH-PROFICIENT AND LEP DEFINED.—The terms 'Limited-English-proficient' and 'LEP' have the meaning given the term 'limited english proficient' under section 9101(25) of the Elementary and Secondary Education Act of 1965, except that subparagraphs (A), (B), and (D) of such section shall not apply.''.

(5) 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 to language services (as such term is defined in section 1861(iii) of such Act, as added by paragraph (4)).

(c) MEDICARE PART C AND PART D.—

(1) MEDICARE PART C.—Section 1852 of the Social Security Act (42 U.S.C. 1395ww–22) is amended by adding at the end the following new subsection:

''(m) PROVISION OF EFFECTIVE LANGUAGE SERVICES.—

''(1) IN GENERAL.—Each Medicare Advantage organization that offers a Medicare Advantage plan under this part shall provide effective language services to enrollees in such plan.

''(2) REPORTING REQUIREMENTS.—A Medicare Advantage organization shall annually submit to the Secretary a report that contains information on the internal policies and procedures of Medicare Advantage plans offered by the organization 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 2012, 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 plan's language services programs and services with respect to the plan's 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 plan's enrollee population.

''(E) The periodic provision of educational information to plan enrollees on the plan's language services and programs.''.

(2) MEDICARE PART D.—Section 1860D–4 of the Social Security Act (42 U.S.C. 1395w–104) is amended by adding at the end the following new subsection:

''(m) PROVISION OF EFFECTIVE LANGUAGE SERVICES.—The provisions of section 1852(m) shall apply to a PDP sponsor (and a prescription drug plan offered by such sponsor) in the same manner as such provisions apply to a Medicare Advantage organization (and a Medicare Advantage plan offered by such organization.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to plan years beginning on or after the date of enactment of this Act.

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

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

(A) striking ''75'' and inserting ''90'';

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

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

(2) Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)) is amended, in the matter preceding clause (i), by striking ''and (28)'' and inserting ''(28), and (29)''.

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

(A) in paragraph (28), by striking ''and'' at the end;

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

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

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

(4) Section 1916(a)(2) of the Social Security Act (42 U.S.C. 1396o(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 services described in section 1905(a)(29); and''.

(5) 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 (9)''; and

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

''(9) LANGUAGE SERVICES.—The child health assistance provided to a targeted low-income child shall include coverage of language services, as such term is defined in section 1861(iii), provided in a timely manner to limited-English-proficient individuals who need such services.''; and

(C) in subsection (e)(2)—

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

(ii) by inserting '', subsection (c)(9),'' after ''subsection (c)(1)(C)''.

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

(7) 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; and

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

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

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

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

(e) FUNDING LANGUAGE 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 shall make payments (on a quarterly basis) directly to eligible entities to support the provision of language services to limited-English-proficient individuals in an amount equal to an entity's eligible costs (as defined under paragraph (3)) for 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 2012 through 2016.

(C) RELATION TO MEDICAID DSH.—Payments under this subsection shall not offset or reduce payments under section 1923 of the Social Security Act, nor shall payments under such section be considered when determining uncompensated costs associated with the provision of language services.

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

(A) be 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)));

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

(C) prepare and submit 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.

(3) ELIGIBLE COSTS DEFINED.—

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

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

(ii) the number of limited-English-proficient individuals who are provided language 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) METHODOLOGY.—

(i) IN GENERAL.—The Secretary shall establish a methodology to determine the

average per person cost of language services.

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

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

(4) 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.

(5) REPORTING REQUIREMENTS.—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 (4)

and shall otherwise be in a form and manner determined by the Secretary.

(6) LANGUAGE SERVICES.—For purposes of this subsection, the term ''language services'' has the meaning given such term in section 1861(iii) of the Social Security Act.

(7) GUIDELINES AND REPORT.—

(A) ESTABLISHMENT.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall establish and distribute guidelines concerning the implementation of this subsection.

(B) REPORT.—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.

(f) APPLICATION OF CIVIL RIGHTS ACT OF 1964 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. 2000(d) et seq.) 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, 2013.

(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—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 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. 204. INCREASING UNDERSTANDING OF AND IMPROVING HEALTH LITERACY.

(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and the Administrator of the Health Resources and Services Administration, in consultation with the Director of the National Institute on Minority Health and Health Disparities and the Office of 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 containing such information as the Secretary may require.

(c) USE OF FUNDS.—

(1) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.—Grants awarded under subsection (a) through 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 of the Agency.

(2) HEALTH RESOURCES AND SERVICES ADMINISTRATION.—Grants awarded under subsection (a) through 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 existing 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; and

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

(d) DEFINITIONS.—In this section, the term ''low health literacy'' means the inability of an individual to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

SEC. 205. ASSURANCES FOR RECEIVING FEDERAL FUNDS.

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

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

(2) offer and provide appropriate language services at no additional charge to each patient 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 competent interpreter or translation services which—

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

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

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

(1) When a patient (who has been informed in his or her primary language of the availability of free interpreter and translation services) requests the use of family, friends, or other persons untrained in interpretation or translation if the following conditions are met:

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

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

(C) The recipient informs the patient that the recipient may not require an LEP person to use a family member or friend as an interpreter.

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

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

(F) The recipient 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 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; however, nothing in this subsection shall exempt emergency rooms or similar entities that regularly provide health care services in medical emergencies from having in place systems to provide competent interpreter and translation services without undue delay.

SEC. 206. REPORT ON FEDERAL EFFORTS TO PROVIDE CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE SERVICES.

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 Institute 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 culturally competent to health care and health-care-related services. 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 and health-care-related services for limited-English-proficient individuals;

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

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

SEC. 207. 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 (hereafter referred to as ''ESL'') instruction and shall determine, after consultation with appropriate stakeholders, the mechanism for administering and distributing such grants.

(b) ELIGIBLE ENTITY DEFINED.—For purposes of 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 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 them 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 the additional funds to supplement rather than supplant any funds expended for ESL instruction in the State as of January 1, 2006.

(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 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) within 1 year of 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.

SEC. 208. IMPLEMENTATION.

(a) GENERAL PROVISIONS.—

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

(2) In a suit against a State for a violation of this title, remedies (including remedies at 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 the 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. 2000(d) et seq.) or any other statute.

SEC. 209. 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.—Section 36B(c)(2)(C) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(v) COVERAGE MUST INCLUDE LANGUAGE ACCESS AND SERVICES.—Except as provided in clause (iii), 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 lan-

guage access services, including oral interpretation and written translations.''.

(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 54.9815–2719T(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 written translations of notices, to apply a threshold that 5 percent of the population or at least 500 individuals per service area are literate only in the same non–English language in lieu of 10 percent or more residing in a county.

SEC. 210. ASSISTANT SECRETARY OF THE INDIAN HEALTH SERVICE.

(a) IN GENERAL.—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''.

(b) CONFORMING AMENDMENTS.—

(1) POSITIONS AT LEVEL V.—Section 5316 of title 5, United States Code, is amended by striking

''Director, Indian Health Service, Department of Health and Human Services.''.

(2) 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.

SEC. 211. 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''.

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 202, is amended by adding at the end the following:

"Subtitle A—Diversifying the Health Care Workplace

"SEC. 3411. REPORT ON WORKFORCE DIVERSITY.

''(a) IN GENERAL.—Not later than July 1, 2012, and biannually thereafter, the Secretary, acting through the director of each entity within the Department of Health and Human Services, shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on health workforce diversity.

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

''(1) A description of any grant support that is provided by each entity for workforce diversity initiatives with the following information—

''(A) the number of grants made;

''(B) the purpose of the grants;

''(C) the populations served through the grants;

''(D) the organizations and institutions receiving the grants; and

''(E) the tracking efforts that were used to follow the progress of participants.

''(2) A description of the entity's plan to achieve workforce diversity goals that includes, to the extent relevant to such entity—

''(A) the number of underrepresented minority health professionals that will be needed in various disciplines over the next 10 years to achieve population parity;

''(B) the level of funding needed to fully expand and adequately support health professions pipeline programs;

''(C) the impact such programs have had on the admissions practices and policies of health professions schools;

''(D) the management strategy necessary to effectively administer and institutionalize health profession pipeline programs; and

''(E) the impact that the Government Performance and Results Act (GPRA) has had on evaluating the performance of grantees and

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

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

''(c) PUBLIC AVAILABILITY.—The report under subsection (a) shall be made available for public review and comment.

''SEC. 3412. NATIONAL WORKING GROUP ON WORKFORCE DIVERSITY.

''(a) IN GENERAL.—The Secretary, acting through the Bureau of Health Professions within 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 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.

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

''(E) The Public Health Practice Program Office—Office of Workforce Policy and Planning.

''(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) Minority-serving academic institutions.

''(K) Consumer organizations.

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

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

''(N) Health workforce accreditation entities.

''(O) Private foundations that have sponsored workforce diversity initiatives.

''(2) The grantee shall ensure that, in addition to the representatives under paragraph (1), the 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 current 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 curriculum guidelines for diversity training.

''(8) Develop a strategy for the inclusion of community members on admissions committees for health profession schools.

''(9) 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 prepare 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.

''SEC. 3413. TECHNICAL CLEARINGHOUSE FOR HEALTH WORKFORCE DIVERSITY.

''(a) IN GENERAL.—The Secretary, acting through the Office of Minority Health, and in collaboration with the Agency for Healthcare Research and Quality, the Bureau of Health Professions 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.

''(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.

''(4) Admissions policies that promote health workforce diversity and are in compliance with Federal and State laws.

''(5) Lists of scholarship, loan repayment, and loan cancellation grants as well as fellowship information for underserved populations for health professions schools.

''(6) 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 to ensure the adequacy and accuracy of information.

"SEC. 3414. SUPPORT FOR INSTITUTIONS COMMITTED TO WORKFORCE DIVERSITY.

"(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) historically Black colleges and universities;

"(B) Hispanic-serving health professions schools;

"(C) Hispanic-serving institutions;

"(D) tribal colleges and universities;

"(E) Asian-American, Native American, and Pacific Islander-serving institutions;

"(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—

''(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) 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) DEFINITION.—In this section, the term 'Asian-American, Native American, and Pacific Islander-serving institutions' has the same meaning as the term 'Asian

American and Native American Pacific Islander-serving institution' as defined in section 371(c) of the Higher Education Act of 1965 (20 U.S.C. 1067q(c)).

"SEC. 3415. 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, and the Director of the Agency for Healthcare Research and Quality, shall award grants that expand existing opportunities for scientists and researchers and promote the inclusion of underrepresented minorities in the health professions.

''(b) RESEARCH FUNDING.—The head of each entity within the Department of Health and Human Services 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 entity within the Department of Health and Human Services 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.

''SEC. 3416. CAREER SUPPORT FOR NON-RESEARCH HEALTH PROFESSIONALS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Pre-

vention, the Administrator of the Substance Abuse and Mental Health Services Administration, the Administrator of the Health Resources and Services Administration, and the Administrator of the Centers for Medicare and Medicaid Services shall establish a program to award grants to eligible individuals for career support in non-research-related health care.

''(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, 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 for individuals who are health pro-

fessionals 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 non-research-related health care' 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.

''SEC. 3417. 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 entities 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.

''SEC. 3418. HEALTH DISPARITIES EDUCATION PROGRAM.

''(a) ESTABLISHMENT.—The Secretary, acting through the National Institute on Minority Health and Health Disparities and in collaboration with the Office of Minority Health, the Office of the Surgeon General, 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 cam-

paigns 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 people 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; and

''(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.''.

SEC. 302. HISPANIC-SERVING HEALTH PROFESSIONS SCHOOLS.

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 HEALTH PROFESSIONS SCHOOLS.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall award grants to Hispanic-serving health professions schools for the purpose of carrying out programs to recruit Hispanic individuals to enroll in and

graduate from such schools, which may include providing scholarships and other financial assistance as appropriate.

''(b) ELIGIBILITY.—In subsection (a), the term 'Hispanic-serving health professions school' means an entity that—

''(1) is a school or program under section 799B;

''(2) has an enrollment of full-time equivalent students that is made up of at least 9 percent Hispanic students;

''(3) has been effective in carrying out programs to recruit Hispanic individuals to enroll in and graduate from the school;

''(4) has been effective in recruiting and retaining Hispanic faculty members;

''(5) has a significant number of graduates who are providing health services to medically underserved populations or to individuals in health professional shortage areas; and

''(6) Regional Hispanic Centers of Excellence.''.

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

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

(1) by striking ''and'' after ''1994,''; and

(2) by inserting before the period the following: ''$750,000 for fiscal year 2012, and such sums as may be necessary for each of the fiscal years 2013 through 2017.''.

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 award cooperative agreements to schools of public health and schools of allied health to design and implement online degree programs.

''(b) PRIORITY.—In awarding 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.—Awardees must design and implement an online degree program, that meet the following restrictions:

''(1) Enrolling individuals who have obtained a secondary school diploma or its recognized equivalent.

''(2) Maintaining a significant enrollment of underrepresented minority or disadvantaged students.''.

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 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 and transgender populations, and individuals who are members of multiple minority or special population groups.

SEC. 306. SCHOLARSHIP AND FELLOWSHIP PROGRAMS.

Subtitle A of title XXXIV of the Public Health Service Act, as amended by section 301, is further amended by inserting after section 3418 the following:

"SEC. 3419. DAVID SATCHER PUBLIC HEALTH AND HEALTH SERVICES CORPS.

''(a) IN GENERAL.—The Administrator of the Health Resources and Services Administration and the Director of the Centers for Disease Control and Prevention, in collaboration with the Deputy Assistant Secretary for Minority Health, shall award grants to eligible entities to increase awareness among postprimary 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 and 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) Other professions deemed 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.—The Secretary may approve stipends under this section for individuals for any period of education in student-enhancement programs (other than regular courses) at health professions schools, programs, or entities, except that such a stipend may not be provided to an individual for more than 6 months, and such a stipend may not exceed $20 per day (notwithstanding any other provision of law regarding the amount of stipends).

"SEC. 3420. 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 postsecondary students who seek a career in public health.

''(b) ELIGIBILITY.—To be eligible to receive a scholarship under subsection (a) an individual shall—

''(1) have experience 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) have expressed an interest in public health;

''(4) demonstrate promise for becoming a leader in public health;

''(5) secure admission to a 4-year institution of higher education;

''(6) comply with subsection (f); and

''(7) 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 undergraduate tenure, except that such a scholarship may not be provided to an individual for more than 4 years, and such scholarships may not exceed $10,000 per academic year (notwithstanding any other provision of law regarding the amount of scholarship).

''SEC. 3420A. 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 Administrator of the Substance Abuse and Mental Health Services Administration, the Director of the Indian Health Service, the Director of the National Institutes of Health, and the Director of the Agency for Healthcare Research and Quality, shall award research fellowships to post-baccalaureate students 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 determined by the Secretary;

''(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;

''(6) comply with subsection (f); and

''(7) 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 researchers and advance the research base on the intersection between gender and health.

''(d) PRIORITY.—In awarding grants 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 graduate 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 (notwith-

standing any other provision of law regarding the amount of fellowship).

"SEC. 3420B. 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 college students or recent graduates 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 four-year higher education institution;

''(5) comply with subsection (f); 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.—Amounts received under an award under subsection (a) shall be used to support opportunities for students to become health professionals and to advance their knowledge about international issues relating to health care access and quality.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director shall give priority to those applicants 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.—The Secretary shall approve fellowships for college seniors or recent graduates, except that such a fellowship may not be provided to an individual for more than 6 months, may not be awarded to a graduate that has not been enrolled in school for more than 1 year, and may not exceed $4,000 per academic year

(notwithstanding any other provision of law regarding the amount of fellowship).

"SEC. 3420C. EDWARD R. ROYBAL HEALTH CARE SCHOLAR PROGRAM.

"(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, the Director of the Centers for Medicaid & Medicare, and the Administrator for 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 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 determined by the Secretary;

"(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.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director of the Agency for Healthcare Research and Quality 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 such individuals in successfully completing their education at the postsecondary level.

''(e) STIPENDS.—The Secretary may approve the payment of stipends for individuals under this section for

any period of education in student-enhancement programs (other than regular courses) at health professions schools or entities, except that such a stipend may not be provided to an individual for more than 2 months, and such a stipend may not exceed $100 per day (notwithstanding any other provision of law regarding the amount of stipends).''.

SEC. 307. ADVISORY COMMITTEE ON HEALTH PROFESSIONS TRAINING FOR DIVERSITY.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish an advisory committee to be known as the Advisory Committee on Health Professions Training for Diversity (in this section referred to as the ''Advisory Committee'').

(b) COMPOSITION.—

(1) IN GENERAL.—The Secretary shall determine the appropriate number of individuals to serve on the Advisory Committee. Such individuals shall not be officers or employees of the Federal Government.

(2) APPOINTMENT.—Not later than 60 days after the date of enactment of this section, the Secretary shall appoint the members of the Advisory Committee from among individuals who are health

professionals. In making such appointments, the Secretary shall ensure a fair balance between the health professions, that at least 75 percent of the members of the Advisory Committee are health professionals, a broad geographic representation of members and a balance between urban and rural members. Members shall be appointed based on their competence, interest, and knowledge of the mission of the profession involved.

(3) MINORITY REPRESENTATION.—In appointing the members of the Advisory Committee under paragraph (2), the Secretary shall ensure the adequate representation of women and minorities.

(c) TERMS.—

(1) IN GENERAL.—A member of the Advisory Committee shall be appointed for a term of 3 years, except that of the members first appointed—

(A) ⅓ of such members shall serve for a term of 1 year;

(B) ⅓ of such members shall serve for a term of 2 years; and

(C) ⅓ of such members shall serve for a term of 3 years.

(2) VACANCIES.—

(A) IN GENERAL.—A vacancy on the Advisory Committee shall be filled in the manner in which the original appointment was made and shall be subject to any conditions which applied with respect to the original appointment.

(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

(d) DUTIES.—

(1) IN GENERAL.—The Advisory Committee shall—

(A) provide advice and recommendations to the Secretary concerning policy and program development and other matters of significance concerning activities under this part; and

(B) not later than 2 years after the date of enactment of this section, and annually thereafter, prepare and submit to the Secretary, and the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Energy and Commerce of the House of Representatives, a report describing the activities of the Committee.

(2) CONSULTATION WITH STUDENTS.—In carrying out duties under paragraph (1), the Advisory Committee shall consult with individuals who are attending health professions schools with which this part is concerned.

(e) MEETINGS AND DOCUMENTS.—

(1) MEETINGS.—The Advisory Committee shall meet not less than 2 times each year. Such meetings shall be held jointly with other related entities established under this title where appropriate.

(2) DOCUMENTS.—Not later than 14 days prior to the convening of a meeting under paragraph (1), the Advisory Committee shall prepare and make available an agenda of the matters to be considered by the Advisory Committee at such meeting. At any such meeting, the Advisory Committee shall distribute materials with respect to the issues to be addressed at the meeting. Not later than 30 days after the adjourning of such a meeting, the Advisory Committee shall prepare and make available a summary of the meeting and any actions taken by the Committee based upon the meeting.

(f) COMPENSATION AND EXPENSES.—

(1) COMPENSATION.—Each member of the Advisory Committee shall be compensated at a rate

equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Committee.

(2) EXPENSES.—The members of the Advisory Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Committee.

(g) FACA.—The Federal Advisory Committee Act shall apply to the Advisory Committee under this section only to the extent that the provisions of such Act do not conflict with the requirements of this section.

SEC. 308. 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 Serv-

ices 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 participants in programs under this section to consider health profession careers.''.

SEC. 309. 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(d)(5)(B)) is amended—

(1) in subparagraph (E), by striking ''Subject to subparagraphs (J) and (K), such rules'' and inserting ''Subject to subparagraphs (J), (K), and (L), such rules'';

(2) in subparagraph (J), by striking ''Such rules'' and inserting ''Subject to subparagraph (L), such rules'';

(3) in subparagraph (K), by striking ''In determining'' and inserting ''Subject to subparagraph (L), in determining''; and

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

"(L) For purposes of cost-reporting periods beginning on or after the date of enactment of the Health Equity and Accountability Act of 2012, in determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program shall be counted toward the determination 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) of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended—

(1) by redesignating clause (x), as added by section 5505(b) of Public Law 111–148, as clause (xi); and

(2) in clause (xi), as redesignated by paragraph (1)—

(A) in subclause (II), by striking ''In determining'' and inserting ''Subject to subclause (IV), in determining'';

(B) in subclause (III), by striking ''In determining'' and inserting ''Subject to subclause (IV), in determining''; and

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

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

SEC. 310. DEVELOPING AND IMPLEMENTING STRATEGIES FOR LOCAL HEALTH EQUITY.

(a) GRANTS.—The Secretaries of Health and Human Services, Education, and Labor, acting jointly, shall make grants to academic institutions 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 academic 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 academic institution 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 institutionwide health workforce goals that can serve as models for increasing health equity in communities across the country ;

(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 academic institution 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 the ''birth to career'' pipeline in the biomedical sciences and health professions, including by developing partnerships between institu-

tions of higher education and elementary and secondary schools to recruit the next generation of health professionals earlier in the pipeline to a health care career.

SEC. 311. 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 new subsection:

''(q) REPAYMENT PLAN FOR MENTAL AND BEHAVIORAL HEALTH SOCIAL WORKERS.—

''(1) IN GENERAL.—The Secretary shall cancel the balance of interest and principal due 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, 2012, 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) 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.''.

TITLE IV—IMPROVEMENT OF HEALTH CARE SERVICES

Subtitle A—Health Empowerment Zones

SEC. 401. SHORT TITLE.

This subtitle may be cited as the ''Health Empowerment Zone Act of 2012''.

SEC. 402. FINDINGS.

The Congress finds the following:

(1) Numerous studies and reports, including the National Healthcare Disparities Report and Unequal Treatment, the 2002 Institute of Medicine Report, 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, 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, employment, race, ethnicity, 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 is 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, but not limited to local businesses, local departments of commerce, education, labor, urban planning, and transportation, and community-based and other nonprofit organizations—to find areas of common ground around health disparity elimination and collaborate to im-

prove the overall health and wellness of a community and its residents.

SEC. 403. DESIGNATION OF HEALTH EMPOWERMENT ZONES.

(a) IN GENERAL.—At the request of an eligible community partnership, the Secretary may designate an eligible area as a health empowerment zone.

(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 State and local governments, nonprofit organizations, 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 the data collected by the Department of Health and Human Services focusing on the following areas:

(A) Access to affordable high-quality health services.

(B) Arthritis, osteoporosis, and chronic back conditions.

(C) Cancer.

(D) Chronic kidney disease.

(E) Diabetes.

(F) Injury and violence prevention.

(G) Maternal, infant, and child health.

(H) Medical product safety.

(I) Mental health and mental disorders.

(J) Nutrition and overweight.

(K) Disability and secondary conditions.

(L) Educational and community-based health programs.

(M) Environmental health.

(N) Family planning.

(O) Food safety.

(P) Health communication.

(Q) Health disease and stroke.

(R) HIV/AIDS.

(S) Immunization and infectious diseases.

(T) Occupational safety and health.

(U) Oral health.

(V) Physical activity and fitness.

(W) Public health infrastructure.

(X) Respiratory diseases.

(Y) Sexually transmitted diseases.

(Z) Substance abuse.

(AA) Tobacco use.

(BB) Vision and hearing.

(CC) The degree to which those who have disabilities have access to health services, including physical activity and fitness, including the ability to physically access the locations where such services are provided.

(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 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. 404. ASSISTANCE TO THOSE SEEKING DESIGNATION.

At the request of any organization or entity seeking to submit a request under section 403(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 403(b)(1);

(2) to complete a health assessment, including an assessment of health disparities under section 403(c)(1)(D); or

(3) to prepare and submit a request, including a strategic plan, in accordance with section 403.

SEC. 405. BENEFITS OF DESIGNATION.

(a) PRIORITY.—In awarding any competitive grant, 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 403.

(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 404.

(4) REPORTING.—The Secretary shall require each recipient of a grant under this subsection 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. 406. DEFINITION.

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 for Minority Health and Health Disparities.

Subtitle B—Other Improvements of Health Care Services

CHAPTER 1—EXPANSION OF COVERAGE

SEC. 411. 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 C the following:

"Subtitle D—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 unin-

sured, are receiving assistance under a State program under title XIX of the Social Security Act, 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 minorities; or

''(ii) that—

''(I) serves a disproportionate percentage of local, minority racial and ethnic patients, or that has a patient population, at least 50 percent of which is limited-English proficient; 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 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;

''(C) living with illness or disability; and

''(D) coping with end-of-life issues.

''(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.

"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.

"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.

''(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, re-

ceiving assistance under a State program under a title XVIII of the Social Security Act, or a State program under title XIX of such Act, or who are members of a vulnerable population, as determined by the Secretary; or

''(B) serves a disproportionate percentage of local, minority racial and ethnic patients.

''(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 described in subsection (b);

''(2) include all amounts of Federal assistance received by each entity in the preceding fiscal year;

''(3) review the total unmet needs of each jurisdiction for health care facilities, including needs for renovation and expansion of existing facilities; and

''(4) include a strategic plan for addressing the needs of each jurisdiction identified in the report.''.

SEC. 412. REMOVING BARRIERS TO UNSUBSIDIZED PURCHASE OF PRIVATE INSURANCE IN AMERICAN HEALTH BENEFIT EXCHANGES.

(a) IN GENERAL.—Section 1312(f) of the Patient Protection and Affordable Care Act (42 U.S.C.18032(f)) is amended—

(1) in the subsection heading, by striking the semicolon and all that follows through ''RESIDENTS''; and

(2) by striking paragraph (3).

(b) CONFORMING AMENDMENT.—Section 1411(a)(1) of such Act (42 U.S.C. 18081(a)(1)) is amended by striking ''1312(f)(3),''.

SEC. 413. STUDY ON THE UNINSURED.

(a) IN GENERAL.—The Secretary of Health and Human Services shall—

(1) conduct a study on the demographic characteristics of the population of individuals who do not have health insurance coverage; and

(2) predict, based on such study, the demographic characteristics of the population of individuals who will not have health insurance coverage after January 1, 2014.

(b) REPORTING REQUIREMENTS.—

(1) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act, the Sec-

retary 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 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, and citizenship and immigration status, in a manner consistent with title I of this Act.

SEC. 414. MEDICAID PAYMENT PARITY FOR THE TERRITORIES.

(a) ELIMINATION OF FUNDING LIMITATIONS FOR PUERTO RICO, THE UNITED STATES VIRGIN ISLANDS, GUAM, THE COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA.—

(1) IN GENERAL.—Section 1108 of the Social Security Act (42 U.S.C. 1308) is amended—

(A) in subsection (f), in the matter before paragraph (1), by striking ''subsection (g)'' and inserting ''subsections (g) and (h)'';

(B) in subsection (g)(2), in the matter before subparagraph (A), by inserting ''and subsection (h) of this Act'' after ''paragraphs (3) and (5)''; and

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

''(h) SUNSET OF FUNDING LIMITATIONS FOR PUERTO RICO, THE UNITED STATES VIRGIN ISLANDS, GUAM, THE COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA.—Subsections (f) and (g) shall not apply to Puerto Rico, the United States Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa for any fiscal year after fiscal year 2011.''.

(2) CONFORMING AMENDMENT.—Section 1903(u) of such Act (42 U.S.C. 1396c(u)) is amended by striking paragraph (4).

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply beginning with fiscal year 2012.

(b) PARITY IN FMAP.—

(1) IN GENERAL.—The first sentence of section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by inserting after ''shall be 50 per centum'' the following: ''(except that, beginning with fiscal year

2014, the Federal medical assistance percentage for Puerto Rico, the United States Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa shall be the Federal medical assistance percentage determined by the Secretary in consultation (for the United States Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa) with the Secretary of the Interior)''.

(2) 2-FISCAL-YEAR TRANSITION.—Notwithstanding any other provision of law, during fiscal years 2012 and 2013, the Federal medical assistance percentage established under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) for Puerto Rico, the United States Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa shall be the highest such Federal medical assistance percentage applicable to any of the 50 States or the District of Columbia for the fiscal year involved, taking into account the application of subsections (a) and (b)(1) of 5001 of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) to such States and District of Columbia for calendar quar-

ters during such fiscal years for which such subsections apply respectively.

(3) PER CAPITA INCOME DATA.—

(A) REPORT TO CONGRESS.—Not later than October 1, 2012, the Secretary of Health and Human Services shall submit to Congress a report that describes the per capita income data used to promulgate the Federal medical assistance percentage in the territories and how such data differ from the per capita income data used to promulgate Federal medical assistance percentages for the 50 States and the District of Columbia. The report should include recommendations on how the Federal medical assistance percentages can be calculated for the territories to ensure parity with the 50 States and the District of Columbia.

(B) APPLICATION.—Section 1101(a)(8)(B) of the Social Security Act (42 U.S.C. 1308(a)(8)(B)) is amended—

(i) by striking ''(other than Puerto Rico, the United States Virgin Islands, and Guam)'' and inserting ''(including Puerto Rico, the United States Virgin Islands, Guam, the Commonwealth of the Northern

Mariana Islands, and American Samoa)''; and

(ii) by inserting ''(or, if such satisfactory data are not available in the case of the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa, satisfactory data available from the Department of the Interior for the same period, or if such satisfactory data are not available in the case of Puerto Rico, satisfactory data available from the government of the Commonwealth of Puerto Rico for the same period)'' after ''Department of Commerce''.

(4) RELATION TO AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009.—For any period and territory in which the provisions of this subsection apply to a territory, the provisions of section 5001(b)(2) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) shall not apply (except as otherwise specifically provided in paragraph (2)).

SEC. 415. MEDICAID ELIGIBILITY 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:

''(G) MEDICAID EXCEPTION FOR CITIZENS OF FREELY ASSOCIATED STATES.—With respect to eligibility for benefits for the program defined in paragraph (3)(C) (relating to Medicaid), paragraph (1) shall not apply to any individual who lawfully resides in the United States (including territories and possessions of the United States) in accordance with—

''(i) section 141 of the Compact of Free Association between the Government of the United States and the Government of the Federated States of Micronesia, approved by Congress in the Compact of Free Association Amendments Act of 2003;

''(ii) section 141 of the Compact of Free Association between the Government of the United States and the Government of the Republic of the Marshall Islands, approved by Congress in the Compact of

Free Association Amendments Act of 2003; or

"(iii) section 141 of the Compact of Free Association between the Government of the United States and the Government of Palau, approved by Congress in Public Law 99–658 (100 Stat. 3672).".

(b) EXCEPTION TO 5-YEAR LIMITED ELIGIBILITY.—Section 403(d) of such Act (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 defined 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;

(2) in paragraph (7), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following:

''(8) an individual who lawfully resides in the United States (including territories and possessions of the United States) in accordance with a Compact of Free Association referred to in section 402(b)(2)(G).''.

(d) CONFORMING AMENDMENTS.—Section 1108 of the Social Security Act (42 U.S.C. 1308) is amended—

(1) in subsection (f), in the matter preceding paragraph (1), by striking ''subsection (g)'' and inserting ''subsections (g) and (h)''; and

(2) by adding at the end the following:

''(h) The limitations of subsections (f) and (g) shall not apply with respect to medical assistance provided to an individual described in section 431(b)(8) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.''.

(e) EFFECTIVE DATE.—The amendments made by this section take effect on the date of enactment of this Act and apply to benefits for items and services furnished on or after that date.

SEC. 416. 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, 2013" 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, 2013 (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 in the first sentence.".

(b) EFFECTIVE DATE.—The amendments made by this subsection 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 paragraph (1), 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 paragraph (1)(B).

SEC. 417. BORDER HEALTH GRANTS.

(a) ELIGIBLE ENTITY DEFINED.—In this section, the term ''eligible entity'' means a State, public institution of higher education, local government, tribal government, nonprofit health organization, community health center, or community clinic receiving assistance under section 330 of the Public Health Service Act (42 U.S.C. 254b), that is located in the border area.

(b) AUTHORIZATION.—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) health education and promotion;

(E) oral health;

(F) mental and behavioral health;

(G) substance abuse;

(H) health conditions that have a high prevalence in the border area;

(I) medical and health services research;

(J) workforce training and development;

(K) community health workers or promotoras;

(L) health care infrastructure problems in the border area (including planning and construction grants);

(M) health disparities in the border area;

(N) environmental health; and

(O) 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 and 1397aa)); 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) PRIMARY CARE DEFINITION.—In this Act, the term ''primary care'' includes obstetrical and gynecological care and psychiatric and mental health care.

SEC. 418. REMOVING MEDICARE BARRIERS 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 ''(B) an alien'' and all that follows through the comma and inserting ''(B) 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 ''(B) an alien'' and all that follows through the comma and inserting ''(B) an individual who is lawfully present in the United States,''.

SEC. 419. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED BY URBAN INDIAN HEALTH CENTERS.

(a) IN GENERAL.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396(b)), as amended by section 414(b)(1), is amended by striking ''or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act)'' and inserting '', by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act), or are received through a program operated by an urban Indian organization through a grant or contract under section 502 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. 420. 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 419, is amended by inserting ''; 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'' before the period.

(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.

CHAPTER 2—EXPANSION OF ACCESS

SEC. 421. GRANTS FOR RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH.

(a) PURPOSE.—It is the purpose of this section to provide for the awarding of 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, acting through the Centers for Disease Control and Prevention, 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) American Indian tribal organizations, national American Indian organizations, Indian Health Service, or organizations serving Alaska Natives; and

(V) interested public or private health care providers or organizations

as deemed 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, cardiovascular disease, diabetes, child and adult immunization levels, 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.—Funds provided through this grant program should supplement, not supplant, existing Federal funding, and the funds should not be used to duplicate the activities of the other health disparity grant programs in 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 grantees to share best practices, evaluation results, and reports with communities not affiliated with grantees using the Internet, conferences, and other pertinent information regarding the projects funded by this

section, including the outreach efforts of the Office of Minority Health and Health Disparity Elimination 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 grantees.

SEC. 422. 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, 2013.

(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. 423. 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 203(b)(1)(A), is amended by adding at the end of the following new subsection:

''Rural Community Hospital; Rural Community Hospital Services

''(jjj)(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 other-

wise 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(jjj)(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:

''(p) 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(jjj)(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 REDUCTION IN REIMBURSEMENT FOR BAD DEBT.—Section 1861(v)(1) of such Act (42 U.S.C. 1395x(v)(1)) is amended—

(A) in subparagraph (T), in the matter preceding clause (i), by inserting ''(other than for a rural community hospital)'' after ''In determining such reasonable costs for hospitals''; and

(B) in subparagraph (W)(ii), as added by section 3201(c) of the Middle Class Tax Relief and Job Creation Act of 2012 (Public Law

112–96), by inserting ''(other than a rural community hospital)'' after ''(V)''.

(c) BENEFICIARY COPAYMENT FOR OUTPATIENT SERVICES.—Section 1834(p) 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 ''(p)''; 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 provided by a hospital, the amount of copayment 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 or supplier, no copayment shall apply.

''(C) For all other items and services, the amount of copayment 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, 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 203(b)(2), 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 (9);

(C) by striking the period at the end of paragraph (10) and inserting ''; and''; and

(D) by adding at the end the following:

''(11) in the case of outpatient services furnished by a rural community hospital, the amounts described in section 1834(p).''.

(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), (mm)(1), and (jjj)(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(p)(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, 2012.

SEC. 424. 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 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 after the date of the implementation of the projects.

(c) INCENTIVES.—

(1) PERFORMANCE TARGETS.—The Secretary shall establish for each home health agency partici-

pating 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 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 savings 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 (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 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, 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. 425. 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 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 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 Health care Quality and Research, or the Centers for Medicare & Med-

icaid 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 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 Academies 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 report-

ing, 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.); 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 Nation.

(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.

SEC. 426. 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 dis-

parities 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 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 (which includes obstetrical and gynecological care and psychiatric and mental health 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 mi-

grant 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, 2014, 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) DEFINITIONS.—In this section:

''(1) 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).

''(2) The term 'Director' means the Director of the Office of Rural Health Policy of the Health Resources and Services Administration.''.

SEC. 427. COMMUNITY HEALTH CENTER COLLABORATIVE ACCESS EXPANSION.

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

''(t) MISCELLANEOUS PROVISIONS.—

''(1) RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINICS.—

''(A) IN GENERAL.—Nothing in this section shall be construed to prevent a community health center from contracting with a federally certified rural health clinic (as defined by section 1861(aa)(2) of the Social Security Act) for the delivery of primary health care services that are available at the rural health clinic to individuals who would otherwise be eligible for free or reduced cost care if that individual were able to obtain that care at the community health center. Such services may be limited in scope to those primary health care services available in that rural health clinic.

''(B) ASSURANCES.—In order for a rural health clinic to receive funds under this section through a contract with a community health center under paragraph (1), such rural health clinic shall establish policies to ensure—

''(i) nondiscrimination based upon the ability of a patient to pay; and

''(ii) the establishment of a sliding fee scale for low-income patients.''.

SEC. 428. 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 Secretary 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. 429. 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 new subsection:

''(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 '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; and

"(B) 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.".

SEC. 430. SENSE OF CONGRESS.

It is the sense of the Congress that—

(1) the maintenance of effort (MOE) provisions added to sections 1902 and 2105(d) of the Social Security Act by sections 2001(b) and 2101(b) of the Patient Protection and Affordable Care Act were written to maintain the eligibility standards for the Medicaid program and Children's Health Insurance Program until the American Health Benefit Exchanges in the States are fully operational;

(2) it is imperative that the MOE provisions are enforced to the strict standard intended by the Congress;

(3) waiving the MOE provisions should not be permitted, except in the case of a request for a waiver that meets the explicit nonapplication requirements;

(4) the MOE provisions ensure the continued success of the Medicaid program and CHIP and were written deliberately to specifically protect vulnerable and disabled individuals, children, and senior citizens, many of whom are also members of communities of color; and

(5) the MOE provisions must be strictly enforced and proposals to weaken the MOE provisions must not be considered in this time of recession.

SEC. 431. 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), as added by section 6036 of the Deficit Reduction Act of 2005, are each repealed.

(b) CONFORMING AMENDMENTS.—

(1) Section 1902(a)(46)(B) of the Social Security Act (42 U.S.C. 1396a(a)(46)(B)) is amended by striking ''requirements of'' and all that follows through ''subsection (ee);'' and inserting ''requirements of subsection (ee);''.

(2) Subsection (c) of section 6036 of the Deficit Reduction Act of 2005 is repealed.

(c) EFFECTIVE DATE.—The repeals and amendments made by this section shall take effect as if included in the enactment of the Deficit Reduction Act of 2005.

SEC. 432. 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:

"§ 7309. 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 of 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 of 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 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.''.

SEC. 433. ACCESS FOR NATIVE AMERICANS UNDER PPACA.

(a) IN GENERAL.—Title I of the Patient Protection and Affordable Care Act is amended—

(1) in section 1311(c)(6)(D), by striking ''(as defined in section 4 of the Indian Health Care Improvement Act)'' and inserting ''(as defined in sec-

tion 447.50(b)(1) of title 42 of the Code of Federal Regulations, as in effect on July 1, 2010)''; and

(2) in section 1402(d)(1), by striking ''(as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d)))'' and inserting (f) ''(as defined in section 447.50(b)(1) of title 42 of the Code of Federal Regulations, as in effect on July 1, 2010)''.

(b) INDIVIDUAL MANDATE.—In section 5000A(e)(3) of the Internal Revenue Code of 1986, by striking ''(as defined in section 45A(c)(6))'' and inserting ''(as defined in section 447.50(b)(1) of title 42 of the Code of Federal Regulations, as in effect on July 1, 2010)''.

SEC. 434. STUDY OF DSH PAYMENTS TO ENSURE HOSPITAL ACCESS FOR LOW-INCOME PATIENTS.

(a) IN GENERAL.—Not later than January 1, 2016, the Comptroller General of the United States shall—

(1) evaluate and examine the continued 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) to ensure timely access to health care services for low-income patients after the expansion of coverage under the Medicaid program pursuant to the Patient Protection and Af-

fordable Care Act (Public Law 111-148) in 2014, as well as how such funding should be allocated among such hospitals; and

(2) provide recommendations—

(A) to the Secretary of Health and Human Services for purposes of assisting in development of the methodology for reduction of payments to disproportionate share hospitals, as required pursuant to sections 2551 and 3133 of the Patient Protection and Affordable Care Act; and

(B) to Congress for any legislative changes to the payment levels provided for disproportionate share hospitals that are needed to ensure access to health services for low-income patients, as based on the number of individuals without health insurance, the amount of uncompensated care provided by such hospitals, and the impact of reduced payments levels on low-income communities.

(b) ADDITIONAL CONSIDERATIONS.—For purposes of the study and recommendations described in subsection (a), the Comptroller General shall take into account—

(1) the impact of the expansion of coverage under the Medicaid program pursuant to the Patient Protection and Affordable Care Act on—

(A) the number of individuals in the United States who are without health insurance, as well as 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 their resulting fiscal sustainability;

(2) the role played by disproportionate share hospitals in providing critical access to emergency, inpatient, and outpatient health services, as well as their location in relation to medically underserved areas;

(3) the appropriate level and distribution of payments to disproportionate share hospitals in order to—

(A) sufficiently account for the level of uncompensated care provided by such hospitals to low-income patients; and

(B) provide timely access to health services for individuals in medically underserved areas;

(4) the extent to which disproportionate share hospitals satisfy the requirements established for charitable hospital organizations under section 501(r) of the Internal Revenue Code of 1986 in regard to community health needs assessments, financial assistance policy requirements, limitations on charges, and billing and collection requirements; and

(5) any reports submitted by the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to Congressional committees in regard to the costs incurred by charitable hospital organizations for charity care, bad debt, and non-reimbursed expenses for services provided to individuals under the Medicare and Medicaid programs, as well as any community benefit activities provided by such organizations.

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

SEC. 501. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS IN WOMEN AND CHILDREN.

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–6. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS IN WOMEN AND CHILDREN.

''(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 to promote positive health behaviors for women and children in target populations, especially racial and ethnic minority women and children in medically underserved communities and in underserved rural communities.

''(b) USE OF FUNDS.—Grants awarded pursuant to subsection (a) may be used to support the activities of community health workers, including those 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, guide, and provide outreach in a community setting regarding health problems prevalent among women and children and especially among racial and ethnic minority women and children;

''(3) to educate, guide, and provide experiential learning opportunities that target behavioral risk factors including—

''(A) poor nutrition;

''(B) physical inactivity;

''(C) being overweight or obese;

''(D) tobacco use;

''(E) alcohol and substance use;

''(F) injury and violence;

''(G) risky sexual behavior;

''(H) mental health problems;

''(I) musculoskeletal health;

''(J) dental and oral health problems; and

''(K) understanding informed consent;

''(4) to educate and guide regarding effective strategies to promote positive health behaviors within the family;

''(5) to promote community wellness and awareness; and

''(6) 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 training and supervision to community health workers to enable such workers to provide authorized program services;

''(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 services in the cultural context most appropriate for the individuals served by the program;

''(E) contain a plan to document and disseminate project description 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, that 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—

''(A) with a high percentage of residents who are eligible for health insurance but are uninsured or underinsured; and

''(B) with a high percentage of families for whom English is not their primary language;

''(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 assuring the quality of the training and supervision of community health workers under the programs funded under this section and for assuring 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 the project 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, including by—

"(A) serving as a liaison between communities and health care agencies;

"(B) providing guidance and social assistance to community residents;

"(C) enhancing community residents' ability to effectively communicate with health care providers;

"(D) providing culturally and linguistically appropriate health or nutrition education;

"(E) advocating for individual and community health, including dental, oral, mental, and environmental health, or nutrition needs; and

"(F) 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); and

''(B) a significant portion of which is a health professional shortage area as designated under section 332.

''(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.

''(6) TARGET POPULATION.—The term 'target population' means women of reproductive age, regardless of their current childbearing status and children under 21 years of age.''.

SEC. 502. REMOVING BARRIERS TO HEALTH CARE AND NUTRITION ASSISTANCE FOR CHILDREN, PREGNANT WOMEN, AND LAWFULLY PRESENT INDIVIDUALS.

(a) MEDICAID.—Paragraph (4) of section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)) is amended to read as follows:

"(4)(A) Notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, payment shall be made under this section for care and services that are furnished to aliens, including those described in paragraph (1), if they otherwise meet the eligibility requirements for medical assistance under the State plan approved under this subchapter (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), and are—

"(i) lawfully present in the United States;

"(ii) children under 21 years of age, including any optional targeted low-income child (as such term is defined in section 1905(u)(2)(B)); or

"(iii) pregnant women during pregnancy and during the 60-day period beginning on the last day of the pregnancy.

"(B) No debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such alien under this paragraph and the cost of such assistance shall not be considered as an unreimbursed cost.".

(b) SCHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended by amending subparagraph (J) to read as follows:

"(J) Paragraph (4) of section 1903(v) (relating to individuals who, but for sections 401(a), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, would be eligible for medical assistance under title XXI).".

(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 of the 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 paragraph (2);

(2) in subsection (b) by striking paragraph (2); and

(3) in subsection (e) by striking paragraph (2).

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) 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 re-

garding 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, or lifestyle 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, Web sites, fact sheets, telephonic or electronic communication, community outreach efforts, or other appropriate means.

(2) 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 or had a pregnancy and breastfeeding information service in place on or after January 1, 2006.

(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;

(3) modifying risk behaviors; or

(4) other outcome measures as determined appropriate by the Secretary.

SEC. 505. UNIFORM STATE MATERNAL MORTALITY REVIEW COMMITTEES ON PREGNANCY-RELATED DEATHS.

(a) CONDITION OF RECEIPT OF PAYMENTS FROM ALLOTMENT UNDER MATERNAL AND CHILD HEALTH SERVICE BLOCK GRANT.—Title V of the Social Security Act (42 U.S.C. 701 et seq.) is amended by adding at the end the following new section:

"SEC. 514. UNIFORM STATE MATERNAL MORTALITY REVIEW COMMITTEES ON PREGNANCY-RELATED DEATHS.

''(a) GRANTS.—

''(1) IN GENERAL.—Notwithstanding any other provision of this title, for each of fiscal years 2012 through 2018, in addition to payments from allotments for States under section 502 for such year, the Secretary shall, subject to paragraph (3) and in

accordance with the criteria established under paragraph (2), award grants to States to—

"(A) carry out the activities described in subsection (b)(1);

"(B) establish a State maternal mortality review committee, in accordance with subsection (b)(2), to carry out the activities described in subsection (b)(2)(A), and to establish the processes described in subsection (b)(1);

"(C) ensure the State department of health carries out the applicable activities described in subsection (b)(3), with respect to pregnancy-related deaths occurring within the State during such fiscal year;

"(D) implement and use the comprehensive case abstraction form developed under subsection (c), in accordance with such subsection; and

"(E) provide for public disclosure of information, in accordance with subsection (e).

"(2) CRITERIA.—The Secretary shall establish criteria for determining eligibility for and the amount of a grant awarded to a State under paragraph (1). Such criteria shall provide that in the case of a State that receives such a grant for a fiscal

year and is determined by the Secretary to have not used such grant in accordance with this section, such State shall not be eligible for such a grant for any subsequent fiscal year.

''(b) PREGNANCY-RELATED DEATH REVIEW.—

''(1) REVIEW OF PREGNANCY-RELATED DEATH AND PREGNANCY-ASSOCIATED DEATH CASES.—For purposes of subsection (a), with respect to a State that receives a grant under subsection (a), the following shall apply:

''(A) MANDATORY REPORTING OF PREGNANCY-RELATED DEATHS.—

''(i) IN GENERAL.—The State shall, through the State maternal mortality review committee, develop a process, separate from any reporting process established by the State department of health prior to the date of the enactment of this section, that provides for mandatory and confidential case reporting by individuals and entities described in clause (ii) of pregnancy-related deaths to the State department of health.

''(ii) INDIVIDUALS AND ENTITIES DESCRIBED.—Individuals and entities de-

scribed in this clause include each of the following:

"(I) Health care providers.

"(II) Medical examiners.

"(III) Medical coroners.

"(IV) Hospitals.

"(V) Free-standing birth centers.

"(VI) Other health care facilities.

"(VII) Any other individuals responsible for completing death certificates.

"(VIII) Any other appropriate individuals or entities specified by the Secretary.

"(B) VOLUNTARY REPORTING OF PREGNANCY-RELATED AND PREGNANCY-ASSOCIATED DEATHS.—

"(i) The State shall, through the State maternal mortality review committee, develop a process for and encourage, separate from any reporting process established by the State department of health prior to the date of the enactment of this section, voluntary and confidential case reporting by individuals described in clause (ii) of

pregnancy-associated deaths to the State department of health.

''(ii) The State shall, through the State maternal mortality review committee, develop a process for voluntary and confidential reporting by family members of the deceased and by other individuals on possible pregnancy-related and pregnancy-associated deaths to the State department of health. Such process shall include—

''(I) making publicly available on the Internet Web site of the State department of health a telephone number, Internet Web link, and email address for such reporting; and

''(II) publicizing to local professional organizations, community organizations, and social services agencies the availability of the telephone number, Internet Web link, and email address made available under subclause (I).

''(C) DEVELOPMENT OF CASE-FINDING.—The State, through the vital statistics unit of the State, shall annually identify pregnancy-re-

lated and pregnancy-associated deaths occurring in such State during the year involved by—

''(i) matching all death records, with respect to such year, for women of childbearing age to live birth certificates and infant death certificates to identify deaths of women that occurred during pregnancy and within one year after the end of a pregnancy;

''(ii) identifying deaths reported during such year as having an underlying or contributing cause of death related to pregnancy, regardless of the time that has passed between the end of the pregnancy and the death;

''(iii) collecting data from medical examiner and coroner reports; and

''(iv) any other methods the States may devise to identify maternal deaths, such as through review of a random sample of reported deaths of women of childbearing age to ascertain cases of pregnancy-related and pregnancy-associated

deaths that are not discernable from a review of death certificates alone.

When feasible and for purposes of effectively collecting and obtaining data on pregnancy-related and pregnancy-associated deaths, the State shall adopt the most recent standardized birth and death certificates, as issued by the National Center for Vital Health Statistics, including the recommended checkbox section for pregnancy on the death certificates.

''(D) CASE INVESTIGATION AND DEVELOPMENT OF CASE SUMMARIES.—Following receipt of reports by the State department of health pursuant to subparagraph (A) or (B) and collection by the vital statistics unit of the State of possible cases of pregnancy-related and pregnancy-associated deaths pursuant to subparagraph (C), the State, through the State maternal mortality review committee established under subsection (a), shall investigate each case, utilizing the case abstraction form described in subsection (c), and prepare de-identified case summaries, which shall be reviewed by the committee and included in applicable reports. For purposes of subsection (a), under the

processes established under subparagraphs (A), (B), and (C), a State department of health or vital statistics unit of a State shall provide to the State maternal mortality review committee access to information collected pursuant to such subparagraphs as necessary to carry out this subparagraph. Data and information collected for the case summary and review are for purposes of public health activities, in accordance with HIPAA privacy and security law (as defined in section 3009(a)(2) of the Public Health Service Act). Such case investigations shall include data and information obtained through—

''(i) medical examiner and autopsy reports of the woman involved;

''(ii) medical records of the woman, including such records related to health care prior to pregnancy, prenatal and postnatal care, labor and delivery care, emergency room care, hospital discharge records, and any care delivered up until the time of death of the woman for purposes of public health activities, in accordance with HIPAA privacy and security law

(as defined in section 3009(a)(2) of the Public Health Service Act);

''(iii) oral and written interviews of individuals directly involved in the maternal care of the woman during and immediately following the pregnancy of the woman, including health care, mental health, and social service providers, as applicable;

''(iv) optional oral or written interviews of the family of the woman;

''(v) socioeconomic and other relevant background information about the woman;

''(vi) information collected in subparagraph (C)(i); and

''(vii) other information on the cause of death of the woman, such as social services and child welfare reports.

''(2) STATE MATERNAL MORTALITY REVIEW COMMITTEES.—

''(A) DUTIES.—

''(i) REQUIRED COMMITTEE ACTIVITIES.—For purposes of subsection (a), a maternal mortality review committee established by a State pursuant to a grant under such subsection shall carry out the

following pregnancy-related death and pregnancy-associated death review activities and shall include all information relevant to the death involved on the case abstraction form developed under subsection (d):

"(I) With respect to a case of pregnancy-related or pregnancy-associated death of a woman, review the case summaries prepared under subparagraphs (A), (B), (C), and (D) of paragraph (1).

"(II) Review aggregate statistical reports developed by the vital statistics unit of the State under paragraph (1)(C) regarding pregnancy-related and pregnancy-associated deaths to identify trends, patterns, and disparities in adverse outcomes and address medical, non-medical, and system-related factors that may have contributed to such pregnancy-related and pregnancy-associated deaths and disparities.

''(III) Develop recommendations, based on the review of the case summaries under paragraph (1)(D) and aggregate statistical reports under subclause (II), to improve maternal care, social and health services, and public health policy and institutions, including with respect to improving access to maternal care, improving the availability of social services, and eliminating disparities in maternal care and outcomes.

''(ii) OPTIONAL COMMITTEE ACTIVITIES.—For purposes of subsection (a), a maternal mortality review committee established by a State under such subsection may present findings and recommendations regarding a specific case or set of circumstances directly to a health care facility or its local or State professional organization for the purpose of instituting policy changes, educational activities, or otherwise improving the quality of care provided by the facilities.

"(B) COMPOSITION OF MATERNAL MORTALITY REVIEW COMMITTEES.—

"(i) IN GENERAL.—Each State maternal mortality review committee established pursuant to a grant under subsection (a) shall be multi-disciplinary, consisting of health care and social service providers, public health officials, other persons with professional expertise on maternal health and mortality, and patient and community advocates who represent those communities within such State that are the most affected by maternal mortality. Membership on such a committee of a State shall be reviewed annually by the State department of health to ensure that membership representation requirements are being fulfilled in accordance with this paragraph.

"(ii) REQUIRED MEMBERSHIP.—Each such review committee shall include—

"(I) representatives from medical specialities providing care to pregnant and postpartum patients, including obstetricians (including generalists

and maternal fetal medicine specialists), and family practice physicians;

''(II) certified nurse midwives, certified midwives, and advanced practice nurses;

''(III) hospital-based nurses;

''(IV) representatives of the State department of health maternal and child health department;

''(V) social service providers or social workers;

''(VI) the chief medical examiners or designees;

''(VII) facility representatives, such as from hospitals or free-standing birth centers; and

''(VIII) community or patient advocates who represent those communities within the State that are the most affected by maternal mortality.

''(iii) ADDITIONAL MEMBERS.—Each such review committee may also include representatives from other relevant academic, health, social service, or policy professions, or community organizations, on

an ongoing basis, or as needed, as determined beneficial by the review committee, including—

''(I) anesthesiologists;

''(II) emergency physicians;

''(III) pathologists;

''(IV) epidemiologists or biostatisticians;

''(V) intensivists;

''(VI) vital statistics officers;

''(VII) nutritionists;

''(VIII) mental health professionals;

''(IX) substance abuse treatment specialists;

''(X) representatives of relevant advocacy groups;

''(XI) academics;

''(XII) representatives of beneficiaries of the State plan under the Medicaid program under title XIX;

''(XIII) paramedics;

''(XIV) lawyers;

''(XV) risk management specialists;

''(XVI) representatives of the departments of health or public health of major cities in the State involved; and

''(XVII) policy makers.

''(iv) DIVERSE COMMUNITY MEMBERSHIP.—The composition of such a committee, with respect to a State, shall include—

''(I) representatives from diverse communities, particularly those communities within such State most severely affected by pregnancy-related deaths or pregnancy-associated deaths and by a lack of access to relevant maternal care services, from community maternal child health organizations, and from minority advocacy groups;

''(II) members, including health care providers, from different geographic regions in the State, including any rural, urban, and tribal areas; and

''(III) health care and social service providers who work in communities that are diverse with regard to race, ethnicity, immigration status, Indigenous status, and English proficiency.

''(v) MATERNAL MORTALITY REVIEW STAFF.—Staff of each such review committee shall include—

''(I) vital health statisticians, maternal child health statisticians, or epidemiologists;

''(II) a coordinator of the State maternal mortality review committee, to be designated by the State; and

''(III) administrative staff.

''(C) OPTION FOR STATES TO FORM REGIONAL MATERNAL MORTALITY REVIEWS.—States with a low rate of occurrence of pregnancy-associated or pregnancy-related deaths may choose to partner with one or more neighboring States to fulfill the activities described in paragraph (1)(C). In such a case, with respect to States in such a partnership, any requirement under this section relating to the report-

ing of information related to such activities shall be deemed to be fulfilled by each such State if a single such report is submitted for the partnership.

''(3) STATE DEPARTMENT OF HEALTH ACTIVITIES.—For purposes of subsection (a), a State department of health of a State receiving a grant under such subsection shall—

''(A) in consultation with the maternal mortality review committee of the State and in conjunction with relevant professional organizations, develop a plan for ongoing health care provider education, based on the findings and recommendations of the committee, in order to improve the quality of maternal care; and

''(B) take steps to widely disseminate the findings and recommendations of the State maternal mortality review committees of the State and to implement the recommendations of such committee.

''(c) CASE ABSTRACTION FORM.—

''(1) DEVELOPMENT.—The Director of the Centers for Disease Control and Prevention shall develop a uniform, comprehensive case abstraction form and make such form available to States for

State maternal mortality review committees for use by such committees in order to—

"(A) ensure that the cases and information collected and reviewed by such committees can be pooled for review by the Department of Health and Human Services and its agencies; and

"(B) preserve the uniformity of the information and its use for Federal public health purposes.

"(2) PERMISSIBLE STATE MODIFICATION.—Each State may modify the form developed under paragraph (1) for implementation and use by such State or by the State maternal mortality review committee of such State by including on such form additional information to be collected, but may not alter the standard questions on such form, in order to ensure that the information can be collected and reviewed centrally at the Federal level.

"(d) TREATMENT AS PUBLIC HEALTH AUTHORITY FOR PURPOSES OF HIPAA.—For purposes of applying HIPAA privacy and security law (as defined in section 3009(a)(2) of the Public Health Service Act), a State maternal mortality review committee of a State established pursuant to this section to carry out activities described

in subsection (b)(2)(A) shall be deemed to be a public health authority described in section 164.501 (and referenced in section 164.512(b)(1)(i)) of title 45, Code of Federal Regulations (or any successor regulation), carrying out public health activities and purposes described in such section 164.512(b)(1)(i) (or any such successor regulation).

''(e) PUBLIC DISCLOSURE OF INFORMATION.—

''(1) IN GENERAL.—For fiscal year 2012 or a subsequent fiscal year, each State receiving a grant under this section for such year shall, subject to paragraph (3), provide for the public disclosure, and submission to the information clearinghouse established under paragraph (2), of the information included in the report of the State under section 506(a)(2)(F) for such year (relating to the findings for such year of the State maternal mortality review committee established by the State under this section).

''(2) INFORMATION CLEARINGHOUSE.—The Secretary of Health and Human Services shall establish an information clearinghouse, that shall be administered by the Director of the Centers for Disease Control and Prevention, that will maintain findings and recommendations submitted pursuant to

paragraph (1) and provide such findings and recommendations for public review and research purposes by State health departments, maternal mortality review committees, and health providers and institutions.

''(3) CONFIDENTIALITY OF INFORMATION.—In no case shall any individually identifiable health information be provided to the public, or submitted to the information clearinghouse, under paragraph (1).

''(f) CONFIDENTIALITY OF REVIEW COMMITTEE PROCEEDINGS.—

''(1) IN GENERAL.—All proceedings and activities of a State maternal mortality review committee under this section, opinions of members of such a committee formed as a result of such proceedings and activities, and records obtained, created, or maintained pursuant to this section, including records of interviews, written reports, and statements procured by the Department of Health and Human Services or by any other person, agency, or organization acting jointly with the Department, in connection with morbidity and mortality reviews under this section, shall be confidential, and not subject to discovery, subpoena, or introduction into evidence in any civil, criminal, legislative, or other pro-

ceeding. Such records shall not be open to public inspection.

"(2) TESTIMONY OF MEMBERS OF COMMITTEE.—

"(A) IN GENERAL.—Members of a State maternal mortality review committee under this section may not be questioned in any civil, criminal, legislative, or other proceeding regarding information presented in, or opinions formed as a result of, a meeting or communication of the committee.

"(B) CLARIFICATION.—Nothing in this subsection shall be construed to prevent a member of such a committee from testifying regarding information that was obtained independent of such member's participation on the committee, or that is public information.

"(3) AVAILABILITY OF INFORMATION FOR RESEARCH PURPOSES.—Nothing in this subsection shall prohibit the publishing by such a committee or the Department of Health and Human Services of statistical compilations and research reports that—

"(A) are based on confidential information, relating to morbidity and mortality review; and

"(B) do not contain identifying information or any other information that could be used to ultimately identify the individuals concerned.

"(g) DEFINITIONS.—For purposes of this section:

"(1) The term 'pregnancy-associated death' means the death of a woman while pregnant or during the one-year period following the date of the end of pregnancy, irrespective of the cause of such death.

"(2) The term 'pregnancy-related death' means the death of a woman while pregnant or during the one-year period following the date of the end of pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from any accidental or incidental cause.

"(3) The term 'woman of childbearing age' means a woman who is at least 10 years of age and not more than 54 years of age.".

(b) INCLUSION OF FINDINGS OF REVIEW COMMITTEES IN REQUIRED REPORTS.—

(1) STATE TRIENNIAL REPORTS.—Paragraph (2) of section 506(a) of such Act (42 U.S.C. 706(a)) is amended by inserting after subparagraph (E) the following new subparagraph:

''(F) In the case of a State receiving a grant under section 514, beginning for the first fiscal year beginning after 3 years after the date of establishment of the State maternal mortality review committee established by the State pursuant to such grant and once every 3 years thereafter, information containing the findings and recommendations of such committee and information on the implementation of such recommendations during the period involved.''.

(2) ANNUAL REPORTS TO CONGRESS.—Paragraph (3) of such section is amended—

(A) in subparagraph (D), at the end, by striking ''and'';

(B) in subparagraph (E), at the end, by striking the period and inserting ''; and''; and

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

''(F) For fiscal year 2012 and each subsequent fiscal year, taking into account the findings, recommendations, and implementation information submitted by States pursuant to paragraph (2)(F), on the status of pregnancy-related deaths and pregnancy-associated deaths

in the United States and including recommendations on methods to prevent such deaths in the United States.''.

SEC. 506. ELIMINATING DISPARITIES IN MATERNITY HEALTH OUTCOMES.

Part B of title III of the Public Health Service Act is amended by inserting after section 317V, as added, the following new section:

''SEC. 317W. ELIMINATING DISPARITIES IN MATERNITY HEALTH OUTCOMES.

''(a) IN GENERAL.—The Secretary shall, in consultation with relevant national stakeholder organizations, such as national medical specialty organizations, national maternal child health organizations, and national health disparity organizations, carry out the following activities to eliminate disparities in maternal health outcomes:

''(1) Conduct research into the determinants and the distribution of disparities in maternal care, health risks, and health outcomes, and improve the capacity of the performance measurement infrastructure to measure such disparities.

''(2) Expand access to services that have been demonstrated to improve the quality and outcomes of maternity care for vulnerable populations.

''(3) Establish a demonstration project to compare the effectiveness of interventions to reduce disparities in maternity services and outcomes, and implement and assess effective interventions.

''(b) SCOPE AND SELECTION OF STATES FOR DEMONSTRATION PROJECT.—The demonstration project under subsection (a)(3) shall be conducted in no more than 8 States, which shall be selected by the Secretary based on—

''(1) applications submitted by States, which specify which regions and populations the State involved will serve under the demonstration project;

''(2) criteria designed by the Secretary to ensure that, as a whole, the demonstration project is, to the greatest extent possible, representative of the demographic and geographic composition of communities most affected by disparities;

''(3) criteria designed by the Secretary to ensure that a variety of type of models are tested through the demonstration project and that such models include interventions that have an existing evidence base for effectiveness; and

''(4) criteria designed by the Secretary to assure that the demonstration projects and models will be carried out in consultation with local and regional

provider organizations, such as community health centers, hospital systems, and medical societies representing providers of maternity services.

''(c) DURATION OF DEMONSTRATION PROJECT.—The demonstration project under subsection (a)(3) shall begin on January 1, 2012, and end on December 31, 2016.

''(d) GRANTS FOR EVALUATION AND MONITORING.—The Secretary may make grants to States and health care providers participating in the demonstration project under subsection (a)(3) for the purpose of collecting data necessary for the evaluation and monitoring of such project.

''(e) REPORTS.—

''(1) STATE REPORTS.—Each State that participates in the demonstration project under subsection (a)(3) shall report to the Secretary, in a time, form, and manner specified by the Secretary, the data necessary to—

''(A) monitor the—

''(i) outcomes of the project;

''(ii) costs of the project; and

''(iii) quality of maternity care provided under the project; and

''(B) evaluate the rationale for the selection of the items and services included in any

bundled payment made by the State under the project.

''(2) FINAL REPORT.—Not later than December 31, 2017, the Secretary shall submit to Congress a report on the results of the demonstration project under subsection (a)(3).''.

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 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 dispari-

ties 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 and women's, infants, and children nutrition professionals, 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.

SEC. 508. REDUCING 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 new part:

"PART W—YOUTH PREGNANCY PREVENTION PROGRAMS

"SEC. 399OO. PURPOSE.

''It is the purpose of this part to develop and carry out research and demonstration projects on new and existing program interventions to provide youth in racial or ethnic minority or immigrant communities the information and skills needed to reduce teenage pregnancies, build healthy relationships, and improve overall health and well-being.

"SEC. 399OO–1. DEMONSTRATION GRANTS TO REDUCE TEENAGE PREGNANCIES.

''(a) IN GENERAL.—The Secretary shall award competitive grants to eligible entities for establishing or expanding programs to provide youth in racial or ethnic minority or immigrant communities the information and skills needed to avoid teenage pregnancy and develop healthy relationships.

''(b) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to applicants—

''(1) proposing to carry out projects in racial or ethnic minority or immigrant communities;

''(2) that have a demonstrated history of effectively working with such targeted communities; or

''(3) that have a demonstrated history of engaging in a meaningful and significant partnership with such targeted communities.

''(c) PROGRAM SETTINGS.—Programs funded through a grant under subsection (a) shall be provided—

''(1) through classroom-based settings, such as school health education, humanities, language arts, or family and consumer science education; after-school programs; community-based programs; workforce development programs; and health care settings; or

''(2) in collaboration with systems that serve large numbers of at-risk youth such as juvenile justice or foster care systems.

''(d) PROJECT REQUIREMENTS.—As a condition of receipt of a grant under this section, an entity shall agree that, with respect to information and skills provided through the grant—

''(1) such information and skills will be—

''(A) age-appropriate;

''(B) evidence-based or evidence-informed;

''(C) provided in accordance with section 399OO–5(b); and

''(D) culturally sensitive and relevant to the target populations; and

''(2) any information provided about contraceptives shall include the health benefits and side effects of all contraceptives and barrier methods.

''(e) EVALUATION.—Of the total amount made available to carry out this section for a fiscal year, the Secretary, acting through the Director of the Centers for Disease Control and Prevention and other agencies as appropriate, shall allot up to 10 percent of such amount to carry out a rigorous, independent evaluation to determine the extent and the effectiveness of activities funded through this section during such fiscal year in changing attitudes and behavior of teenagers with respect to healthy relationships and childbearing.

''(f) GRANTS FOR INDIAN TRIBES OR TRIBAL ORGANIZATIONS.—Of the total amount made available to carry out this section for a fiscal year, the Secretary shall reserve 5 percent of such amount to award grants under this section to Indian tribes and tribal organizations in such manner, and subject to such requirements, as the

Secretary, in consultation with Indian tribes and tribal organizations, determines appropriate.

''(g) ELIGIBLE ENTITY DEFINED.—

''(1) IN GENERAL.—In this section, the term 'eligible entity' means a State, local, or tribal agency; a school or postsecondary institution; an after-school program; a nonprofit organization; or a community or faith-based organization.

''(2) PREVENTING EXCLUSION OF SMALLER COMMUNITY-BASED ORGANIZATIONS.—In carrying out this section, the Secretary shall ensure that the amounts and requirements of grants provided under this section do not preclude receipt of such grants by community-based organizations with a demonstrated history of effectively working with adolescents in racial or ethnic minority or immigrant communities or engaged in meaningful and significant partnership with such communities.

''SEC. 399OO–2. MULTIMEDIA CAMPAIGNS TO REDUCE TEENAGE PREGNANCIES.

''(a) IN GENERAL.—The Secretary shall award competitive grants to public and private entities to carry out multimedia campaigns to provide public education and increase public awareness regarding teenage pregnancy and

related social and emotional issues, such as violence prevention.

''(b) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to applicants proposing to carry out campaigns developed for racial or ethnic minority or immigrant communities.

''(c) INFORMATION TO BE PROVIDED.—As a condition of receipt of a grant under this section, an entity shall agree to use the grant to carry out multimedia campaigns described in subsection (a) that—

''(1) at a minimum, shall provide information on—

''(A) the prevention of teenage pregnancy; and

''(B) healthy relationship development; and

''(2) may provide information on the prevention of dating violence.

''SEC. 399OO–3. RESEARCH ON REDUCING TEENAGE PREGNANCIES AND TEENAGE DATING VIOLENCE AND IMPROVING HEALTHY RELATIONSHIPS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall make grants to public and private entities to conduct, support, or coordinate research on teenage pregnancy, dating violence, and healthy relationships

among racial or ethnic minority or immigrant communities that—

"(1) improves data collection on—

"(A) sexual and reproductive health, including teenage pregnancies and births, among all minority communities and subpopulations in which such data are not collected, including American Indian and Alaska Native youth;

"(B) sexual behavior, reproductive and sexual coercion, and teenage contraceptive use patterns at the State level, as appropriate; and

"(C) teenage pregnancies among youth in and aging out of foster care or juvenile justice systems and the underlying factors that lead to teenage pregnancy among youth in foster care or juvenile justice systems;

"(2) investigates—

"(A) the variance in the rates of teenage pregnancy by—

"(i) racial and ethnic group (such as Hispanic, Asian-American, African-American, Pacific Islander, American Indian, and Alaska Native); and

"(ii) socioeconomic status, including as based on the income of the family and education attainment;

"(B) factors affecting the risk for youth of teenage pregnancy or dating abuse, including the physical and social environment, level of acculturation, access to health care, aspirations for the future, and history of physical or sexual violence or abuse;

"(C) the role that violence and abuse play in teenage sex, pregnancy, and childbearing;

"(D) strategies to address the disproportionate rates of teenage pregnancies and dating violence in racial or ethnic minority or immigrant communities;

"(E) how effective interventions can be replicated or adapted in other settings to serve racial or ethnic minority or immigrant communities; and

"(F) the effectiveness of media campaigns in addressing healthy relationship development, dating violence prevention, and teenage pregnancy; and

"(3) tests research-based strategies for addressing high rates of unintended teenage pregnancy

through programs that emphasize healthy relationships and violence prevention.

''(b) PRIORITY.—In carrying out this section, the Secretary shall give priority to research that incorporates—

''(1) interdisciplinary approaches;

''(2) a strong emphasis on community-based participatory research; or

''(3) translational research.

''SEC. 399OO–4. HHS ADOLESCENT HEALTH WORK GROUP.

''(a) PURPOSE.—Not later than 30 days after the date of the enactment of this part, the Secretary shall direct the interagency adolescent health workgroup within the Office of Adolescent Health of the Department of Health and Human Services to—

''(1) include in the work of the group strategies for teenage dating violence prevention and healthy teenage relationships with a particular focus among racial or ethnic minority or immigrant communities; and

''(2) with respect to including such strategies, consult, to the greatest extent possible, with the Federal Interagency Workgroup on Teen Dating Violence formed under the leadership of the National Institute of Justice of the Department of Justice.

''(b) REPORT REQUIREMENT.—The Secretary, through the Office of Adolescent Health, shall periodically submit to Congress a report that—

''(1) includes a review of the evidence-based programs on preventing teenage pregnancy, which are carried out and identified by the Office; and

''(2) identifies the programs of the Department of Health and Human Services that include teenage dating violence prevention and the promotion of healthy teenage relationships as part of a strategy to prevent teenage pregnancy.

''SEC. 399OO–5. GENERAL GRANT PROVISIONS.

''(a) APPLICATIONS.—To seek a grant under this part, an entity shall submit an application to the Secretary in such form, in such manner, and containing such agreements, assurances, and information as the Secretary may require.

''(b) ADDITIONAL REQUIREMENTS.—A grant may be made under this part only if the applicant involved agrees that information, activities, and services provided under the grant—

''(1) will be evidence-based or evidence informed;

''(2) will be factually and medically accurate and complete; and

''(3) if directed to a particular population group, will be provided in an appropriate language and cultural context.

''(c) TRAINING AND TECHNICAL ASSISTANCE.—

''(1) IN GENERAL.—Of the total amount made available to carry out this part for a fiscal year, the Secretary shall use 10 percent to provide, directly or through a competitive grant process, training and technical assistance to the grant recipients under this part, including by disseminating research and information regarding effective and promising practices, providing consultation and resources on a broad array of teenage and unintended pregnancy and violence prevention strategies, and developing resources and materials.

''(2) COLLABORATION.—In carrying out this subsection, the Secretary shall collaborate with entities that have expertise in the prevention of teenage pregnancy, healthy relationship development, minority health and health disparities, and violence prevention.

''SEC. 399OO–6. DEFINITIONS.

''In this part:

''(1) MEDICALLY ACCURATE AND COMPLETE.—The term 'medically accurate and complete' means,

with respect to information, activities, or services, verified or supported by the weight of research conducted in compliance with accepted scientific methods and—

"(A) published in peer-reviewed journals, where applicable; or

"(B) comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete.

"(2) RACIAL OR ETHNIC MINORITY OR IMMIGRANT COMMUNITIES.—The term 'racial or ethnic minority or immigrant communities' means communities with a substantial number of residents who are members of racial or ethnic minority groups or who are immigrants.

"(3) REPRODUCTIVE AND SEXUAL COERCION.—The term 'reproductive and sexual coercion'—

"(A) means, with respect to a person, coercive behavior that interferes with the ability of such person to control the reproductive decisionmaking of such person, such as intentionally exposing such person to sexually transmitted infections; in the case such person is a female, attempting to impregnate such person

against her will; intentionally interfering with the person's birth control; or threatening or acting violent if the person does not comply with the perpetrator's wishes regarding contraception or the decision whether to terminate or continue a pregnancy; and

''(B) includes a range of behaviors that a partner may use related to sexual decision-making to pressure or coerce a person to have sex without using physical force, such as repeatedly pressuring a partner to have sex when he or she does not want to; threatening to end a relationship if a person does not have sex; and threatening retaliation if notified of a positive sexually transmitted disease test result.

''(4) YOUTH.—The term 'youth' means individuals who are 11 to 19 years of age.

"SEC. 399OO–7. REPORTS.

''(a) REPORT ON USE OF FUNDS.—Not later than 1 year after the date of the enactment of this part, the Secretary shall submit to Congress a report on the use of funds provided pursuant to this part.

''(b) REPORT ON IMPACT OF PROGRAMS.—Not later than March 1, 2016, the Secretary shall submit to Con-

gress a report on the impact that the programs under this part had on reducing teenage pregnancies.''.

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 develop 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 women 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 women; 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.—The Secretary shall expand and intensify public health research regarding gestational diabetes. Such research may include—

''(1) developing and testing novel approaches for improving postpartum diabetes testing or screening and for preventing type 2 diabetes in women with a history of gestational diabetes; and

''(2) 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 women with a history of gestational diabetes.

''(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 diabetes in women 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 women who have 1 or more risk factors for developing gestational diabetes;

''(B) working with women with a history of gestational diabetes during a previous pregnancy;

''(C) providing postpartum care for women with gestational diabetes;

''(D) tracking cases where women 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 women 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 women 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 women 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 women with, and at risk for, gestational diabetes, the recurrence of gestational diabetes in subsequent pregnancies, and, for women 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 ges-

tational diabetes in subsequent pregnancies; and

"(ii) to prevent the development of type 2 diabetes in women with a history of gestational 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.

"(d) POSTPARTUM FOLLOW-UP 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 follow-up 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 women 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 information on emergency contraception.

(2) DISSEMINATION.—The Secretary may disseminate information under paragraph (1) directly or through arrangements with nonprofit organizations, consumer groups, institutions of higher education, clinics, the media, and Federal, State, and local agencies.

(3) INFORMATION.—The information disseminated under paragraph (1) shall include, at a minimum, a description of emergency contraception and an explanation of the use, safety, efficacy, and availability of such contraception.

(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 information on emergency contraception.

(2) INFORMATION.—The information disseminated under paragraph (1) shall include, at a minimum—

(A) information describing the use, safety, efficacy, and availability of emergency contraception;

(B) a recommendation regarding the use of such contraception in appropriate cases; 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) EMERGENCY CONTRACEPTION.—The term ''emergency contraception'' means a drug or device (as the terms are defined in section 201 of the Fed-

eral Food, Drug, and Cosmetic Act (21 U.S.C. 321)) or a drug regimen that—

(A) is used postcoitally;

(B) prevents pregnancy primarily by preventing or delaying ovulation, and does not terminate an established pregnancy; and

(C) is approved by the Food and Drug Administration.

(2) 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.

(3) 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)).

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 511. SUPPORTING HEALTHY ADOLESCENT DEVELOPMENT.

(a) IN GENERAL.—The Secretary may award a grant to each eligible State to conduct programs of sex education described in subsection (b), including education on both

abstinence and contraception for the prevention of teenage pregnancy and sexually transmitted diseases, including HIV/AIDS.

(b) REQUIREMENTS FOR SEX EDUCATION PROGRAMS.—A program of sex education described in this subsection is a program that—

(1) is age appropriate and medically accurate;

(2) stresses the value of abstinence while not ignoring those young people who have been or are sexually active;

(3) provides information about the health benefits and side effects of contraceptive and barrier methods used—

(A) as a means to prevent pregnancy; and

(B) to reduce the risk of contracting sexually transmitted disease, including HIV/AIDS;

(4) encourages family communication between parent and child about sexuality;

(5) cultivates a respectful dialogue about sexuality, including sexual orientation and gender identity, and embraces the principles of nondiscrimination based on sexual orientation and gender identity;

(6) counters the perpetuation of narrow gender roles, including the sexualization of female children, adolescents, and adults;

(7) teaches young people the skills to make responsible decisions about sexuality, including how to avoid unwanted verbal, physical, and sexual advances and how to avoid making verbal, physical, and sexual advances that are not wanted by the other party;

(8) develops healthy relationships, including the prevention of dating and sexual violence;

(9) teaches young people how alcohol and drug use can affect responsible decisionmaking; and

(10) does not teach or promote religion.

(c) ADDITIONAL ACTIVITIES.—In carrying out a program of sex education, a State may expend grant funds awarded under subsection (a) to carry out educational and motivational activities that help young people—

(1) gain knowledge about the physical, emotional, biological, and hormonal changes of adolescence and subsequent stages of human maturation;

(2) develop the knowledge and skills necessary to ensure and protect their sexual and reproductive health from unintended pregnancy and sexually transmitted disease, including HIV/AIDS, throughout their lifespan;

(3) gain knowledge about the specific involvement and responsibility of each individual in sexual decisionmaking;

(4) develop healthy attitudes and values about adolescent growth and development, body image, gender roles, racial and ethnic diversity, sexual orientation and gender identity, and other subjects;

(5) develop and practice healthy life skills including goal-setting, decisionmaking, negotiation, communication, and stress management; and

(6) promote self-esteem and positive interpersonal skills focusing on relationship dynamics, including friendships, dating, romantic involvement, marriage, and family interactions.

(d) MATCHING FUNDS.—The Secretary may not make payments to a State under this section in an amount exceeding Federal medical assistance percentage for such State (as such term is defined in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b))) of the costs of the programs conducted by the State under this section.

(e) EVALUATION OF PROGRAMS.—

(1) IN GENERAL.—For the purpose of evaluating the effectiveness of programs of sex education carried out with a grant under this section, evalua-

tions shall be carried out in accordance with paragraphs (2) and (3).

(2) NATIONAL EVALUATION.—

(A) METHOD.—The Secretary shall provide for a national evaluation of a representative sample of programs of sex education carried out with grants under this section to determine—

(i) the effectiveness of such programs in helping to delay the initiation of sexual intercourse and other high-risk behaviors;

(ii) the effectiveness of such programs in preventing adolescent pregnancy;

(iii) the effectiveness of such programs in preventing sexually transmitted disease, including HIV/AIDS;

(iv) the effectiveness of such programs in increasing contraceptive knowledge and contraceptive behaviors when sexual intercourse occurs; and

(v) a list of best practices based upon essential programmatic components of evaluated programs that have led to success described in clauses (i) through (iv).

(B) GRANT CONDITION.—A condition for the receipt of a grant to a State under this section is that the State cooperate with the evaluation under subparagraph (A).

(C) REPORT.—The Secretary shall submit to the Congress—

(i) not later than the end of each fiscal year during the 5-year period beginning with fiscal year 2012, an interim report on the national evaluation under subparagraph (A); and

(ii) not later than March 31, 2017, a final report providing the results of such national evaluation.

(3) INDIVIDUAL STATE EVALUATIONS.—A condition for the receipt of a grant under this section is that the State evaluate of the programs of sex education funded through such grant in accordance with the following requirements:

(A) The evaluation will be conducted by an external, independent entity.

(B) The purposes of the evaluation will be the determination of—

(i) the effectiveness of such programs in helping to delay the initiation of sexual intercourse and other high-risk behaviors;

(ii) the effectiveness of such programs in preventing adolescent pregnancy;

(iii) the effectiveness of such programs in preventing sexually transmitted disease, including HIV/AIDS; and

(iv) the effectiveness of such programs in increasing contraceptive and barrier method knowledge and contraceptive behaviors when sexual intercourse occurs.

(f) LIMITATIONS ON USE OF FUNDS.—

(1) LIMITATIONS ON SECRETARY.—Of the amounts appropriated for a fiscal year for purposes of this section, the Secretary may not use more than—

(A) 7 percent of such amounts for administrative expenses related to carrying out this section for that fiscal year; and

(B) 10 percent of such amounts for the national evaluation under subsection (e)(2).

(2) LIMITATIONS TO STATES.—Of amounts provided to an eligible State under this subsection, the State may not use more than 10 percent of the

grant to conduct any evaluation under subsection (e)(3).

(g) NONDISCRIMINATION REQUIRED.—Programs funded under this section shall not discriminate on the basis of sex, race, ethnicity, national origin, disability, religion, marital status, familial status, sexual orientation, or gender identity. Nothing in this section shall be construed to invalidate or limit rights, remedies, procedures, or legal standards available to victims of discrimination under any other Federal law or any law of a State or a political subdivision of a State, including title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d 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), and the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.).

(h) DEFINITIONS.—For purposes of this section:

(1) The term ''age appropriate'' means, with respect to topics, messages, and teaching methods, those suitable to particular ages or age groups of children, adolescents, and adults, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group.

(2) The term ''eligible State'' means a State that submits to the Secretary an application for a

grant under this section that is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

(3) The term ''HIV/AIDS'' means the human immunodeficiency virus, and includes acquired immune deficiency syndrome.

(4) The term ''medically accurate'', with respect to information, means information that is supported by research, recognized as accurate and objective by leading medical, psychological, psychiatric, and public health organizations and agencies, and, published in journals that are peer reviewed.

(5) The term ''State'' means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the United States Virgin Islands, and any other territory or possession of the United States.

TITLE VI—MENTAL HEALTH

SEC. 601. COMMUNITY MENTAL HEALTH AND ADDICTION SAFETY NET EQUITY ACT.

(a) FEDERALLY QUALIFIED BEHAVIORAL HEALTH CENTERS.—Section 1913 of the Public Health Service Act (42 U.S.C. 300x–3) is amended—

(1) in subsection (a)(2)(A), by striking ''community mental health services'' and inserting ''behavioral health services (of the type offered by federally qualified behavioral health centers consistent with subsection (c)(3))'';

(2) in subsection (b)—

(A) by striking paragraph (1) and inserting the following:

''(1) services under the plan will be provided only through appropriate, qualified community programs (which may include federally qualified behavioral health centers, child mental health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental health primary consumer-directed programs); and''; and

(B) in paragraph (2), by striking ''community mental health centers'' and inserting ''federally qualified behavioral health centers''; and

(3) by striking subsection (c) and inserting the following:

''(c) CRITERIA FOR FEDERALLY QUALIFIED BEHAVIORAL HEALTH CENTERS.—

''(1) IN GENERAL.—The Administrator shall certify, and recertify at least every 5 years, federally

qualified behavioral health centers as meeting the criteria specified in this subsection.

''(2) REGULATIONS.—Not later than 18 months after the date of the enactment of this section, the Administrator shall issue final regulations for certifying nonprofit or local government centers as centers under paragraph (1).

''(3) CRITERIA.—The criteria referred to in subsection (b)(2) are that the center performs each of the following:

''(A) Provide services in locations that ensure services will be promptly available, be physically accessible, provide reasonable policy modifications, and be provided in a manner which preserves human dignity and assures continuity of care.

''(B) Provide services in a mode of service delivery appropriate for the target population.

''(C) Provide individuals with a choice of service options where there is more than one efficacious treatment.

''(D) Employ a core staff of clinical staff that is multidisciplinary and culturally and linguistically competent.

''(E) Provide services, within the limits of the capacities of the center, to any individual residing or employed in the service area of the center, regardless of the ability of the individual to pay.

''(F) Provide, directly or through contract, to the extent covered for adults in the State Medicaid plan under title XIX of the Social Security Act and for children in accordance with section 1905(r) of such Act regarding early and periodic screening, diagnosis, and treatment, each of the following services:

''(i) Screening, assessment, and diagnosis, including risk assessment.

''(ii) Person-centered treatment planning or similar processes, including risk assessment and crisis planning.

''(iii) Outpatient clinic mental health services, including screening, assessment, diagnosis, psychotherapy, substance abuse counseling, medication management, and integrated treatment for mental illness and substance abuse which shall be evidence-based (including cognitive behavioral ther-

apy and other such therapies which are evidence-based).

''(iv) Outpatient clinic primary care services (which includes obstetrical and gynecological care and psychiatric and mental health care), including screening and monitoring of key health indicators and health risk (including screening for diabetes, hypertension, and cardiovascular disease and monitoring of weight, height, body mass index (BMI), blood pressure, blood glucose or HbA1C, and lipid profile).

''(v) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

''(vi) Targeted case management (services to assist individuals gaining access to needed medical, social, educational, and other home- and community-based services and applying for income security and other benefits to which they may be entitled).

''(vii) Psychiatric rehabilitation services including skills training, assertive com-

munity treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutic foster care services, and such other evidence-based practices as the Secretary may require.

''(viii) Peer support and counselor services and family supports.

''(G) Maintain linkages, and where possible enter into formal contracts with the following:

''(i) Inpatient psychiatric facilities and substance abuse detoxification and residential programs.

''(ii) Adult and youth peer support and counselor services.

''(iii) Family support services for families of children with serious mental disorders.

''(iv) Other home- and community-based or regional services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities, housing agencies and programs, employers, and other social services.

"(v) Onsite or offsite access to primary care services (which includes obstetrical and gynecological care and psychiatric and mental health care).

"(vi) Enabling services, including outreach, transportation, and translation.

"(vii) Health and wellness services, including services for tobacco cessation.".

(b) MEDICAID COVERAGE AND PAYMENT FOR FEDERALLY QUALIFIED BEHAVIORAL HEALTH CENTER SERVICES.—

(1) PAYMENT FOR SERVICES PROVIDED BY FEDERALLY QUALIFIED BEHAVIORAL HEALTH CENTERS.—Section 1902(bb) of the Social Security Act (42 U.S.C. 1396a(bb)) is amended—

(A) in the heading, by striking "AND RURAL HEALTH CLINICS" and inserting ", FEDERALLY QUALIFIED BEHAVIORAL HEALTH CENTERS, AND RURAL HEALTH CLINICS";

(B) in paragraph (1), by inserting "(and beginning with fiscal year 2012 with respect to services furnished on or after January 1, 2012, and each succeeding fiscal year, for services described in section 1905(a)(2)(D) furnished by a

federally qualified behavioral health center)'' after ''by a rural health clinic'';

(C) in paragraph (2)—

(i) by striking the heading and inserting ''INITIAL FISCAL YEAR'';

(ii) by inserting ''(or, in the case of services described in section 1905(a)(2)(D) furnished by a federally qualified behavioral health center, for services furnished on and after January 1, 2012, during fiscal year 2012)'' after ''January 1, 2001, during fiscal year 2001'';

(iii) by inserting ''(or, in the case of services described in section 1905(a)(2)(D) furnished by a federally qualified behavioral health center, during fiscal years 2010 and 2011)'' after ''1999 and 2000''; and

(iv) by inserting ''(or, in the case of services described in section 1905(a)(2)(D) furnished by a federally qualified behavioral health center, during fiscal year 2012)'' before the period;

(D) in paragraph (3)—

(i) in the heading, by striking ''FISCAL YEAR 2002 AND SUCCEEDING'' and inserting ''SUCCEEDING''; and

(ii) by inserting ''(or, in the case of services described in section 1905(a)(2)(D) furnished by a federally qualified behavioral health center, for services furnished during fiscal year 2013 or a succeeding fiscal year)'' after ''2002 or a succeeding fiscal year'';

(E) in paragraph (4)—

(i) by inserting ''(or as a federally qualified behavioral health center after fiscal year 2011)'' after ''or rural health clinic after fiscal year 2000'';

(ii) by striking ''furnished by the center or'' and inserting ''furnished by the federally qualified health center, services described in section 1905(a)(2)(D) furnished by the federally qualified behavioral health center, or'';

(iii) in the second sentence, by striking ''or rural health clinic'' and inserting '', federally qualified behavioral health center, or rural health clinic'';

(F) in paragraph (5), in each of subparagraphs (A) and (B), by striking ''or rural health clinic'' and inserting '', federally qualified behavioral health center, or rural health clinic''; and

(G) in paragraph (6), by striking ''or to a rural health clinic'' and inserting '', to a federally qualified behavioral health center for services described in section 1905(a)(2)(D), or to a rural health clinic''.

(2) INCLUSION OF FEDERALLY QUALIFIED BEHAVIORAL HEALTH CENTER SERVICES IN THE TERM MEDICAL ASSISTANCE.—Section 1905(a)(2) of the Social Security Act (42 U.S.C. 1396d(a)(2)) is amended—

(A) by striking ''and'' before ''(C)''; and

(B) by inserting before the semicolon at the end the following: '', and (D) federally qualified behavioral health center services (as defined in subsection (l)(4))''.

(3) DEFINITION OF FEDERALLY QUALIFIED BEHAVIORAL HEALTH CENTER SERVICES.—Section 1905(l) of the Social Security Act (42 U.S.C. 1396d(l)) is amended by adding at the end the following paragraph:

''(4)(A) The term 'federally qualified behavioral health center services' means services furnished to an individual at a federally qualified behavioral health center (as defined by subparagraph (B)).

''(B) The term 'federally qualified behavioral health center' means an entity that is certified under section 1913(c) of the Public Health Service Act as meeting the criteria described in paragraph (3) of such section.''.

(c) MENTAL HEALTH AND ADDICTION SAFETY NET STUDIES.—

(1) PAPERWORK REDUCTION STUDY.—

(A) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act, the Institute of Medicine shall submit to the appropriate committees of Congress a report that evaluates the combined paperwork burden of federally qualified behavioral health centers certified section 1913(c) of the Public Health Service Act, as inserted by subsection (a).

(B) SCOPE.—In preparing the report under subparagraph (A), the Institute of Medicine shall examine licensing, certification, service definitions, claims payment, billing codes,

and financial auditing requirements utilized by the Office of Management and Budget, the Centers for Medicare & Medicaid Services, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Office of the Inspector General, State Medicaid agencies, State departments of health, State departments of education, and State and local juvenile justice and social services agencies to—

(i) establish an estimate of the combined nationwide cost of complying with the requirements described in this subparagraph, in terms of both administrative funding and staff time;

(ii) establish an estimate of the per capita cost to each federally qualified behavioral health center certified under section 1913(c) of the Public Health Service Act to comply with the requirements described in this subparagraph, in terms of both administrative funding and staff time; and

(iii) make administrative and statutory recommendations to Congress, which

may include a uniform methodology, to reduce the paperwork burden experienced by such federally qualified behavioral health centers.

(2) WAGE STUDY.—

(A) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act, the Institute of Medicine shall conduct a nationwide analysis, and submit a report to the appropriate committees of Congress, concerning the compensation structure of professional and paraprofessional personnel employed by federally qualified behavioral health centers certified under section 1913(c) of the Public Health Service Act, as inserted by subsection (a), as compared with the compensation structure of comparable health safety net providers and relevant private sector health care employers.

(B) SCOPE.—In preparing the report under subparagraph (A), the Institute of Medicine shall examine compensation disparities, if such disparities are determined to exist, by type of personnel, type of provider or private sector employer, and by geographic region.

SEC. 602. MINORITY FELLOWSHIP PROGRAM.

Title V of the Public Health Service Act is amended by inserting after section 506B of such Act (42 U.S.C. 290aa–5b) the following:

''SEC. 506C. MINORITY FELLOWSHIP PROGRAM.

''(a) FELLOWSHIPS.—The Administrator shall maintain a program, to be known as the Minority Fellowship Program, under which the Administrator awards grants or contracts to national associations or other appropriate entities for the financial support of graduate students, postdoctoral fellows, and residents in the professions of psychology, psychiatry, social work, psychiatric advance-practice nursing, and marriage and family therapy to students who demonstrate a commitment to clinical or research careers focused on racial and ethnic minority populations.

''(b) TERM OF FINANCIAL SUPPORT.—Financial support provided to an individual pursuant to subsection (a) shall be for a term of not more than 12 months and may be renewed thereafter.''.

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. 544. INTERPROFESSIONAL HEALTH CARE TEAMS FOR PROVISION OF BEHAVIORAL HEALTH CARE IN PRIMARY CARE SETTINGS.

''(a) GRANTS.—The Secretary, acting through the Director of the Office of Minority Health of the Administration, shall award grants to eligible entities for the purpose of providing technical assistance and training regarding the effective development and implementation of integrated 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) serving a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)).''.

SEC. 604. ADDRESSING RACIAL AND ETHNIC MINORITY MENTAL HEALTH DISPARITIES RESEARCH GAPS.

Not later than 6 months after the date of the enactment of this Act, the Director of the National Institute on Minority Health and Health Disparities shall enter into an arrangement with the Institute of Medicine (or, if the Institute declines to enter into such an arrangement, another appropriate entity)—

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

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

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

(B) an identification of gaps in knowledge and research needs; and

(C) recommendations for an interprofessional research agenda at the National Institutes of Health aimed at reducing and ultimately eliminating mental and behavioral health disparities in such racial and ethnic minority groups.

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 2012''.

(b) FINDINGS.—Congress makes the following findings:

(1) Lung cancer is the leading cause of cancer death for both men and women, accounting for 28 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 88 percent, for prostate cancer to 99 percent, and for colon cancer to 64 percent.

(4) However, the 5-year survival rate for lung cancer is still only 15 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 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, notwithstanding their similar smoking rate.

(8) Members of the baby boomer generation are entering their sixties, 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) Additional strategies are necessary to further enhance the existing tests and therapies available to diagnose and treat lung cancer in the future.

(12) 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''.

(13) 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.

(14) 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 2015 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. 417G. LUNG CANCER MORTALITY REDUCTION PROGRAM.

"(a) IN GENERAL.—Not later than 6 months after the date of the enactment of this section, 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 546 of the Lung Cancer Mortality Reduction Act of 2012, 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 2017.

"(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 these 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 529 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, including consideration of how lung cancer screening and treatment affect men and women differently, and the issuance of updated guidelines.

''(5) 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.

''(6) 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:

''DRUGS RELATING TO LUNG CANCER

''SEC. 529. (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; and

''(3) a drug to curtail or prevent nicotine addiction.

''(c) BOARD.—The Board established under the Lung Cancer Mortality Reduction Act of 2012 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 529, 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 shall coordinate with the Secretary of Health and Human Services—

(1) in the development of the Lung Cancer Mortality Reduction Program under section 417H;

(2) 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

(3) 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 composed of—

(A) the Secretary of Health and Human Services;

(B) the Secretary of Defense;

(C) the Secretary of Veterans Affairs; and

(D) two 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.

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 2012'' 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 2010, more than 217,730 new patients were diagnosed with prostate cancer and more than 32,000 men died from this disease.

(3) Roughly 2,000,000 Americans 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, namely 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. For example, it is not fully understood how much of 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 (roughly 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 as one of eight high-volume, high-cost areas in the Resource Utilization Report program authorized by Congress under the Medicare Improvements for Patients and Providers Act of 2008.

(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 those 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, including recommendations to improve the research portfolio of the Department of Veterans Affairs, Department of Defense, National Institutes of Health, and other Federal agencies to ensure that scientifically based strategic planning is imple-

mented 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 subsection (a) shall be composed of representatives from such Federal agencies, as each Secretary determines necessary, to coordinate 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 pro-

gram areas 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 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 determined 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 determines to be appropriate.

(6) SUBMISSION OF RECOMMENDATIONS TO CONGRESS.—The Secretary of Veterans Affairs shall submit to Congress any recommendations submitted to the Secretary under paragraph (2)(E).

(7) FEDERAL ADVISORY COMMITTEE ACT.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the Federal Advisory Committee 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.

(8) SUNSET DATE.—The Prostate Cancer Task Force shall terminate at the end of fiscal year 2016.

(d) PROSTATE CANCER RESEARCH.—

(1) RESEARCH COORDINATION.—The Secretary of Veterans Affairs, in coordination with the Secretaries of Defense and of Health and Human Services, shall establish and carry out a program to coordinate and intensify prostate cancer research as needed. Specifically, 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) better understand 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 socioeconomic groups,

such as the African-American, Latino, 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 section.

(2) PROSTATE CANCER ADVISORY BOARD.—There is established in the Office of the Chief Scientist of the Food and Drug Administration a Prostate Cancer Scientific Advisory Board. Such board shall be responsible for accelerating real-time shar-

ing 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) needed outreach and educational efforts to raise awareness in these communities; and

(iv) appropriate access and utilization of imaging modalities.

(e) TELEHEALTH AND RURAL ACCESS PILOT PROJECT.—

(1) IN GENERAL.—The Secretary of Veterans Affairs, the Secretary of Defense, and the Secretary of Health and Human Services (in this section referred to 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, American Indians, 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 facilities of the Indian Health Service, 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 12 months 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 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.

SEC. 703. 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 2012, 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), and

(3) of this subsection) to such commonwealth or territory for such fiscal year.''.

(2) TECHNICAL AMENDMENT.—Section 1108(g)(4) of such Act is further amended by striking ''(3), and (4)'' and inserting ''and (3)''.

(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 United States Virgin Islands, Guam, the Commonwealth of 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, 2011.

SEC. 704. CANCER PREVENTION AND TREATMENT DEMONSTRATION FOR ETHNIC AND RACIAL MINORITIES.

(a) DEMONSTRATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct demonstration projects (in this section referred to as ''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, and appropriate use of Medicare-covered services and referral patterns among those target individuals with cancer;

(C) eliminate disparities in the rate of preventive cancer screening measures, such as Pap smears, prostate cancer screenings, and CT 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 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 workers, and promotores 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 nine demonstration projects, including the following:

(A) Two projects for each of the four following major racial and ethnic minority groups:

(i) American Indians and Alaska Natives, Eskimos and Aleuts.

(ii) Asian-Americans.

(iii) Blacks/African-Americans.

(iv) Hispanic/Latinos.

(v) Native Hawaiians and other Pacific Islanders.

The two projects must target different ethnic subpopulations.

(B) One project within the Pacific Islands or United States insular areas.

(C) At least one project each in a rural area and inner-city area.

(3) EXPANSION OF PROJECTS; IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—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; or

(B) do not increase expenditures under the Medicare program and reduce racial and ethnic health disparities in the quality of health care services provided to target individuals and increase satisfaction of beneficiaries and health care providers;

the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects.

(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) CONTENTS 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 to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

SEC. 705. REDUCING CANCER TREATMENT DISPARITIES WITHIN MEDICARE.

(a) DEVELOPMENT OF MEASURES OF DISPARITIES IN QUALITY OF CANCER CARE.—

(1) DEVELOPMENT OF MEASURES.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this section 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—

(i) develop a uniform set of measures to evaluate disparities in the quality of cancer care; and

(ii) annually update such set of measures.

(B) 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 decisionmaking, patient experience of care, resource use, and practice capabilities, such as care coordination.

(2) ENDORSEMENT OF MEASURES.—Any measure included in the set of measures developed pursuant to this subsection must have been endorsed by the entity with a contract under section 1890(a) of the Social Security Act (42 U.S.C. 1395aaa(a)).

(b) ESTABLISHMENT OF REPORTING PROCESS.—

(1) IN GENERAL.—The Secretary shall establish a reporting process that 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 developed pursuant to subsection (a).

(3) ASSESSMENT OF CHANGES.—Within this reporting process, the Secretary shall also establish a format that assesses changes in both the absolute and relative disparities 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 developed pursuant to subsection (a).

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 2012''.

(b) FINDINGS.—Congress finds the following:

(1) Approximately 5,300,000 Americans are chronically infected with the hepatitis B virus (referred to in this section as ''HBV''), the hepatitis C virus (referred to in this section as ''HCV''), or both.

(2) In the United States, chronic HBV and HCV are the most common cause of liver cancer, one of the most lethal and fastest growing cancers in this country. It is the most common cause of chronic liver disease, liver cirrhosis, and the most common indication for liver transplantation. It is

also a leading cause of death in Americans living with HIV/AIDS, many of whom are coinfected with chronic HBV, chronic HCV, or both. At least 15,000 deaths per year in the United States can be attributed to chronic HBV and HCV.

(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 easily transmitted and is 100 times more infectious than HIV. According to the CDC, HBV is transmitted through percutaneous (i.e., puncture through the skin) or mucosal contact with infectious blood or body fluids. HCV is transmitted by percutaneous exposures to infectious blood.

(5) The CDC conservatively estimates that in 2008 approximately 18,000 Americans were newly infected with HCV and more than 38,000 Americans were newly infected with HBV.

(6) There were 6 outbreaks reported to CDC for investigation in 2008 related to health care ac-

quired infection of HBV and HCV, potentially exposing more than 52,000 Americans to the viruses, in 2009–2010 there were 15 outbreaks in which more than 30,000 people were potentially exposed.

(7) 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, more than 50 percent of infected individuals will develop cirrhosis, end-stage liver disease, or liver cancer. Since most of those with chronic HBV and HCV 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.

(8) HBV and HCV disproportionately affect certain populations in the United States. Although representing only 5 percent of the population, Asian-Americans and Pacific Islanders account for over half of the 1,400,000 domestic chronic HBV cases. Baby boomers (those born between 1946 and 1964) account for more than half of domestic chronic hepatitis C cases. In addition, African-Americans, Latinos, and American Indian/Alaskan Natives are among the groups which have disproportionately

high rates of HBV and/or HCV infections in the United States.

(9) For both chronic HBV and chronic HCV, behavioral changes 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.

(10) For those chronically infected with HBV or HCV, regular monitoring can lead to the early detection of liver cancer at a stage where cure is still possible. Liver cancer is the third deadliest cancer in the United States however, liver cancer has received little funding for research, prevention, or treatment.

(11) Treatment for chronic HCV can eradicate the disease in approximately 75 percent of those currently treated. The treatment of chronic HBV can effectively suppress viral replication in the overwhelming majority (>80%) of those treated thereby reducing the risk of transmission and progression to liver scarring or liver cancer even though a complete cure is much less common than for HCV.

(12) To combat the HBV and HCV epidemics in the United States, in May 2011, the Department

of Health and Human Services released Combating the Silent Epidemic of Viral Hepatitis: Action Plan for the Prevention, Care & Treatment of Viral Hepatitis (hereafter referred to as the HHS Action Plan). The Institute of Medicine (IOM) of the National Academies 2010 reported on the Federal response to HBV and HCV titled: Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C. These recommendations and guidelines provide a framework for HBV and HCV prevention, education, control, research, and medical management programs.

(13) The annual health care costs attributable to HBV and HCV in the United States are significant. For HBV, it is estimated to be approximately $1,000,000,000 to 2,000,000,000 ($1,000 to $2,000 per infected person). More than $1,000,000,000 is spent each year for HBV-related hospitalizations. The indirect costs of chronic HBV infection are harder to measure, but include reduced physical and emotional quality of life, reduced economic productivity, long-term disability, and premature death. 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.

(14) According to the IOM 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.

(15) Screening and testing for HBV and HCV is aligned with the Healthy People 2020 goal; 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.

(16) 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.

(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.) is amended—

(1) by striking section 317N (42 U.S.C. 247b–15); and

(2) by adding at the end the following:

"PART X—BIENNIAL ASSESSMENT OF HHS HEPATITIS B AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH, AND MEDICAL MANAGEMENT PLAN

"SEC. 399NN. 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. 399NN–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 399NN(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 language 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 knowl-

edge about the value of hepatitis A and hepatitis B immunization, risk factors, the 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 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 (2) 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 dis-

eases, and substance abuse, and programs for individuals in correctional settings).

''(2) 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 program 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 language 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 country 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 19 years of age or younger through the Vaccines for Children Program;

"(ii) ensuring that the recommendations of the Advisory Committee on Immunization Practices 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 susceptible 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 susceptible adults, particularly those in their 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.

''(3) INCREASED SUPPORT FOR ADULT VIRAL HEPATITIS COORDINATORS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall provide increased support to Adult Viral Hepatitis 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 hepa-

titis 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 enactment of this part, the Secretary shall submit the report to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate.

"(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, chron-

ic 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. 399NN–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 relating 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.''.

(d) ENHANCING SAMHSA'S ROLE IN HEPATITIS ACTIVITIES.—Paragraph (6) of section 501(d) of the Public Health Service Act (42 U.S.C. 290aa(d)) is amended by striking ''HIV or tuberculosis'' and inserting ''HIV, tuberculosis, or hepatitis''.

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 2012''.

(b) FINDINGS.—The Congress finds the following:

(1) Between 20,000 and 30,000 Americans 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 Hispanic/Latino 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.—Part B of the Public Health Service Act (42 U.S.C. 311 et seq.) is amended by inserting after section 317W, as added, the following:

"SEC. 317X. 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 Sec-

retary 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—

''(A) shall identify the incidence and prevalence of acquired bone marrow failure diseases in the United States;

''(B) shall 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 acquired 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) shall 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; and

"(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, including 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 (MDS);

''(2) aplastic anemia;

''(3) paroxysmal nocturnal hemoglobinuria (PNH);

''(4) pure red cell aplasia;

''(5) acute myeloid leukemia that has progressed from myelodysplastic syndromes; or

''(6) large granular lymphocytic leukemia.''.

(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 Administrator 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. 274j) 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.

(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:

''MINORITY-FOCUSED PROGRAMS ON ACQUIRED BONE MARROW FAILURE DISEASES

''SEC. 1707B. (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—

''(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,

at the national minority health resource center supported under section 1707(b)(8) (including by means of the center's Web site, 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.

''(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 serv-

ices 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 Secretary 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 317X(d).''.

(f) DIAGNOSIS AND QUALITY OF CARE FOR ACQUIRED BONE MARROW FAILURE DISEASES.—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 practices and quality of care with respect to patients with acquired bone marrow failure diseases.

(g) DEFINITION.—In this section, the term ''acquired bone marrow failure disease'' means—

(1) myelodysplastic syndromes (MDS);

(2) aplastic anemia;

(3) paroxysmal nocturnal hemoglobinuria (PNH);

(4) pure red cell aplasia;

(5) acute myeloid leukemia that progressed from myelodysplastic syndromes; or

(6) large granular lymphocytic leukemia.

Subtitle D—Cardiovascular Disease, Chronic Disease, 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 which 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 determined appropriate by the Secretary.

(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) asthma;

(7) diabetes;

(8) kidney diseases;

(9) eye diseases and disorders, including glaucoma;

(10) HIV/AIDS and sexually transmitted diseases;

(11) uterine fibroids;

(12) autoimmune disease;

(13) mental health conditions;

(14) dental health conditions and oral diseases;

(15) environmental and related health illnesses and conditions;

(16) Sickle cell disease;

(17) violence and injury prevention and control;

(18) genetic and related conditions;

(19) heart disease and stroke;

(20) tuberculosis;

(21) chronic obstructive pulmonary disease; and

(22) other diseases determined appropriate by the Secretary.

(d) DISSEMINATION.—Not later than 24 months after the date of enactment of this title, the Secretary shall publish and disseminate to health care provider organizations the guidelines developed under subsection (a).

SEC. 732. COVERAGE OF THE SHINGLES VACCINE UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(1) in subsection (s)(10)(A), by inserting '', shingles vaccine and its administration,'' before ''and, subject to''; and

(2) in subsection (ww)(2)(A), by inserting ''shingles,'' after ''Pneumococcal,''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to shingles vaccine furnished on or after January 1 of the first calendar year beginning more than 60 days after the date of the enactment of this Act.

SEC. 733. 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 2012, $25,300,000 for fiscal year 2013, $27,800,000 for fiscal year 2014, $30,800,000 for fiscal year 2015, and $34,000,000 for fiscal year 2016.''.

SEC. 734. 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.) is amended by adding at the end the following:

''SEC. 399V–7. REPORT ON CARDIOVASCULAR CARE FOR WOMEN AND MINORITIES.

''Not later than September 30, 2014, and annually thereafter, the Secretary shall prepare and submit to the 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. 735. COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES IN MEDICAID.

(a) REQUIRING 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), 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 by striking ''in the case of pregnant women''.

(c) REMOVAL OF COST SHARING FOR COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE.—

(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)) 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 re-

ferred to in section 1905(bb)(2)(A)'' each place it appears; and

(B) in each of subsections (a)(2)(D) and (b)(2)(D) by inserting ''and 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 non-prescription 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 1905(bb)(2)(A),'' after ''section 1905(a)(4)(C),''.

(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 1905(bb)(2)(A).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 2012.

SEC. 736. 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. 737. 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:

''PARTICIPATION IN AN APPROVED CLINICAL TRIAL

''SEC. 1944. (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 the 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 their 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 estab-

lished under such subparagraph, with such process to include establishment and operation of a 24-hour toll-free telephone number and e-mail 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 section 2709(d) of the Public Health Service Act.".

(b) CONFORMING AMENDMENTS.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (82)(C), by striking "and" at the end;

(2) in paragraph (83), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (83) the following:

''(84) 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, 2012.

(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 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.

Subtitle E—HIV/AIDS

SEC. 741. FINDINGS.

The Congress finds the following:

(1) Over one million people are estimated to be living with HIV in the United States according to the Centers for Disease Control and Prevention.

(2) Annually there are over 17,000 deaths in people with an HIV diagnoses in 40 States and 5 dependent areas of the United States.

(3) The Centers for Disease Control and Prevention estimates that in 2009 there were approximately 48,100 people newly infected with HIV. Though this number seems to be staying relatively stable, the number of new infections is rapidly increasing among certain populations especially among young African-American men who have sex with men

who had an overall 48 percent increase in new infections from 2006 to 2009.

(4) HIV disproportionately affects certain populations in the United States. Though African-Americans represent less than 13 percent of the population, African-Americans account for almost half (46 percent) of all people living with HIV in the United States. Men who have sex with men (MSM) make up approximately 2 percent of the population, but account for over half (53 percent) of individuals living with HIV and are the only risk group in which HIV infections continue to increase.

(5) Disparities exist among Latinos; they make up 15 percent of US population and 17 percent of new infections (2006).

(6) Though American Indians/Alaska Natives represent less than 1 percent of the total number of HIV/AIDS cases, American Indians and Alaska Natives rank third in rates of HIV/AIDS diagnosis, after African-Americans and Latinos.

(7) While Asian-Americans, Native Hawaiians, and Pacific Islanders HIV/AIDS cases account for approximately 1 percent of cases nationally, Asian Americans and Pacific Islanders were the only racial/ethnic groups with a statistically significant in-

crease in new HIV diagnoses between 2001 and 2008.

(8) The limited data available on transgender individuals point to a disproportionate burden of HIV infection.

(9) Stigma and discrimination contribute to these disparities.

(10) For HIV, early detection and treatment can have huge effects. New research suggests that treatment of individuals not only slows disease progression, but can also greatly reduce the risk of transmission to other individuals.

(11) To combat the HIV epidemic in the United States, the National HIV/AIDS Strategy (NHAS) from the White House Office of National AIDS Policy 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, sexual orientation, gender identity, or socioeconomic circumstance, will have unfettered access to high quality, life extending care, free from stigma and discrimination.''.

(12) Although the cost of education, treatment and care, and research are not inconsequential, they are substantially less than the annual health care cost attributable to HIV in the United States. The lifetime cost of HIV care and treatment in 2004 was estimated to be $405,000 to $648,000 dollars annually. Preventing 40,000 new infections in the United States each year would save $12.8 billion annually.

SEC. 742. ADDRESSING HIV/AIDS IN COMMUNITIES OF COLOR.

(a) NATIONAL OBSERVANCE DAYS.—It is the sense of the Congress that national observance days highlighting the impact of HIV/AIDS 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 HIV/AIDS Awareness Day.

(5) Caribbean American HIV/AIDS Awareness Day.

(b) CALL TO ACTION.—It is the sense of the Congress that the President should call on members of communities of color—

(1) to become involved at the local community level in HIV/AIDS testing, policy, and advocacy;

(2) to become aware, engaged, and empowered on the HIV/AIDS 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/AIDS, and seek care when appropriate.

SEC. 743. HIV/AIDS REDUCTION IN RACIAL AND ETHNIC MINORITY COMMUNITIES.

(a) EXPANDED FUNDING.—The Secretary, 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 Administrator of the Substance Abuse and Mental Health Services Administration, 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/AIDS 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) women;

(2) youth;

(3) men who have sex with men;

(4) persons who engage in intravenous drug abuse;

(5) homeless individuals; and

(6) individuals incarcerated or in the penal system.

SEC. 744. REPEALING INEFFECTIVE AND INCOMPLETE ABSTINENCE-ONLY EDUCATION PROGRAM.

(a) IN GENERAL.—Title V of the Social Security Act (42 U.S.C. 701 et seq.) is amended by striking section 510.

(b) RESCISSION.—Amounts appropriated for each of fiscal years 2010 and 2011 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 enactment of this Act) that are unobligated as of the date of enactment of this Act are rescinded.

(c) REPROGRAM OF ELIMINATED ABSTINENCE-ONLY FUNDS FOR THE PERSONAL RESPONSIBILITY EDUCATION PROGRAM (PREP).—Section 513(f) of the Social Security Act (42 U.S.C. 713(f)) is amended by striking ''for each of fiscal years 2010 through 2014'' and inserting ''for fiscal year 2010, $75,000,000 increased by an amount equal to the unobligated portion of funds appropriated for each of fiscal years 2010 and 2011 under section 510(d) that are rescinded under subsection (b), and $125,000,000 for each of fiscal years 2012 through 2014''.

SEC. 745. DENTAL EDUCATION LOAN REPAYMENT PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services 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/AIDS; 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.—The provisions of 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) The term ''dental education loan''—

(A) means a loan that is incurred for the cost of attendance (including tuition, other rea-

sonable 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) The term ''dentist'' means a graduate of a school of dentistry who has completed postgraduate training in general or pediatric dentistry.

(3) The term ''HIV/AIDS'' means human immunodeficiency virus and acquired immune deficiency syndrome.

(4) 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) The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 746. REPORT ON THE IMPLEMENTATION OF THE NATIONAL HIV/AIDS STRATEGY.

(a) REPORT REQUIRED.—Not later than 6 months after the date of the enactment of this Act, the President, in consultation with the heads of all relevant agencies including the Department of Education, the Department of Health and Human Services, the Department of Housing and Urban Development, the Department of Justice, the

Department of Labor, the Department of Veterans Affairs, and the Social Security Administration, shall transmit to the Congress and make publicly available a report on the status of the implementation of the National HIV/AIDS Strategy.

(b) CONTENTS.—The report required by subsection (a) shall include a description, analysis, and evaluation of—

(1) key steps taken by the Federal Government towards the achievement of the goals of the National HIV/AIDS Strategy, including the goals of—

(A) reducing the number of people who become infected with HIV;

(B) increasing access to care and optimizing health outcomes for people living with HIV; and

(C) reducing HIV-related health disparities;

(2) the extent to which the National HIV/AIDS Strategy has improved coordination of efforts to maximize the effective delivery of HIV/AIDS prevention, care, and treatment services at the community level, including coordination—

(A) within and among Federal agencies and departments;

(B) between the Federal Government and State and local governments and health departments;

(C) between the Federal Government and nonprofit foundations and civil society organizations, including community- and faith-based organizations focused on addressing the issue of HIV/AIDS; and

(D) between the Federal Government and private businesses;

(3) efforts by the Federal Government to educate, involve, and establish and strengthen partnerships with civil society organizations, including community- and faith-based organizations, in order to implement the National HIV/AIDS Strategy and achieve its goals;

(4) how Federal resources are being deployed to implement the Strategy, including—

(A) the amount of funding used to date, by each Federal agency and department, to implement the National HIV/AIDS Strategy;

(B) a brief summary for each Federal agency and department of the number and function of all Federal employees assisting in implementing the Strategy; and

(C) an estimate of the amount of funding necessary to implement the National HIV/AIDS Strategy, by each Federal agency and department, for the next fiscal year; and

(5) what additional steps, if any, are necessary to fully implement the National HIV/AIDS Strategy, including—

(A) whether any existing statutory laws, policies, or regulations are impeding the implementation of the National HIV/AIDS Strategy, at the Federal, State, or local level, and whether any changes to such laws, policies, or regulations are necessary or recommended; and

(B) whether any Federal agencies or departments require additional statutory authority to effectively carry out their duties as part of the National HIV/AIDS Strategy.

(c) USE OF PREVIOUSLY APPROPRIATED FUNDS.—Funding for the report required under subsection (a) shall derive from discretionary funds of the departments and agencies specified in such subsection.

SEC. 747. ADDRESSING HIV/AIDS IN THE AFRICAN-AMERICAN COMMUNITY.

(a) SENSE OF CONGRESS ON NATIONAL BLACK CLERGY HIV/AIDS AWARENESS SUNDAY.—It is the sense of Congress that—

(1) there should be established a National Black Clergy HIV/AIDS Awareness Sunday on which the Congress and the President call on members of the Black clergy—

(A) to become involved at the local community level in HIV/AIDS testing, policy, and advocacy;

(B) to discuss the HIV/AIDS epidemic with their congregations and the community at-large; and

(C) to urge members of their congregations to reduce risk factors, practice safe sex and other preventive measures, be tested for HIV/AIDS, and seek care when appropriate; and

(2) an appropriate Sunday should be selected for this occasion.

(b) SENSE OF CONGRESS ON FEDERAL AGENCIES WITH RESPONSIBILITY FOR PREVENTING, TESTING FOR, AND TREATING HIV/AIDS.—It is the sense of Congress that all Federal agencies with a responsibility for preventing, testing for, and treating HIV/AIDS should—

(1) adopt policies for prevention, testing, and treatment that are consistent with the guidelines issued in 2006 by the Centers for Disease Control and Prevention, entitled ''Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings''; and

(2) begin a systemic, aggressive approach to implementing voluntary, routine testing as part of all health exams, including in emergency rooms, clinics, and private physician offices.

(c) SENSE OF CONGRESS ON FEDERAL BUREAU OF PRISONS PROCEDURES FOR INMATES WITH HIV.—It is the sense of Congress that the Federal Bureau of Prisons should implement procedures for—

(1) voluntary HIV testing as a routine component of inmate care; and

(2) referral to care as a routine component of release planning for inmates with HIV/AIDS, including referral to community-based care and faith-based institutions.

SEC. 748. NATIONAL BLACK CLERGY FOR THE ELIMINATION OF HIV/AIDS.

(a) SHORT TITLE.—This section may be cited as the ''National Black Clergy for the Elimination of HIV/AIDS Act of 2012''.

(b) FINDINGS.—Congress finds the following:

(1) It has been estimated that more than 1,200,000 people in the United States are living with HIV/AIDS, and approximately 500,000 of them are Black. Blacks are 8 times more likely to have AIDS than their White counterparts. Within the Black community, the subpopulation most disproportionately impacted by HIV/AIDS is Black men who have sex with men (MSM) with prevalence rates twice those of White MSM. Black women account for the majority of new AIDS cases among women and are 23 times more likely to be living with AIDS than White women and 4 times more likely than Latinas.

(2) On October 7–8, 2007, 186 Black clergy, consisting of Baptist, COGIC, Methodist, Protestant, AME, and Pentecostal, together with, medical, policy, and AIDS leaders, were brought together by the National Black Leadership Commission on AIDS (NBLCA), the oldest and largest Black AIDS organization of its kind in America, hosted by Time Warner, Inc., with other foundation support, to participate in the National Black Clergy Conclave On HIV/AIDS Policy.

(3) The attendees included faith leaders across traditional, mega, and activist churches representing millions of congregants: the National Medical Association (NMA) representing 30,000 African-American physicians; the National Conference of Black Mayors; the National Caucus of Black State Legislators; and the Health Brain Trust of the Congressional Black Caucus and key African-American HIV/AIDS advocates from across the United States. This group developed a plan of action that has become the National Black Clergy for the Elimination of HIV/AIDS Act of 2012 to respond to the ''on the ground'' emergency in prevention, care, and treatment for AIDS in Black America.

(4) In August 2007, the NMA, the oldest and largest organization representing 30,000 African-American physicians, released a consensus report entitled ''Addressing The HIV/AIDS Crisis In The African American Community: Fact, Fiction and Policy''; and specifically called on the next President of the United States to declare HIV/AIDS in African-American communities a public health emergency and worked with NBLCA to organize clergy to advocate for the specific needs of Black physicians, their patients, and those at risk in African-American com-

munities; and have pledged to advocate and work with clergy to develop, execute, and implement these initiatives as a part of their rightful role of leadership in African-American communities and culture.

(5) The National Conference of Black Mayors has pledged to work with clergy, medical, and community leaders to develop and support these initiatives on a local level and to help them to continue to develop a policy agenda leading to the elimination of HIV/AIDS.

(6) The National Caucus of Black State Legislators pledged to take the initiatives herein to their body and develop plans of action for Black State Legislators to work with local clergy, health departments, and CBOs to adopt and implement these initiatives on a national level.

(7) At their April 2008 annual meeting, the National Policy Alliance (NPA), consisting of the Joint Center For Political and Economic Studies (secretariat) and the National Black Caucus of School Board Members, National Black Caucus of Local Elected Officials; the Judicial Council of the National Bar Association; the National Association of Black County Officials; Blacks in Government and the CBC; NCBM; WCM, voted unanimously to

support, endorse, and encourage the passage of the National Black Clergy for the Elimination of HIV/AIDS Act of 2012 and to organize their respective members to endorse and support the passage of this bill.

(8) The World Conference of Black Mayors has ratified its support of these initiatives and legislation, and pledged to assist the clergy to take them internationally.

(9) The National Black Leadership Commission on AIDS, the Balm in Gilead, and the Black AIDS Institute have been recognized by the clergy for their tradition and history of service and will work with clergy to conduct community and policy development, linkages to local departments of health and other services, infrastructure development, education media, and fund development activities.

(10) Bishop T.D. Jakes of the Potters House in Dallas, Texas, and Rev. Calvin O. Butts of the Abyssinian Baptist Church in Harlem, New York, and chairman of the National Black Leadership Commission on AIDS have been recognized as the organizers of this group and will help guide and lead the development efforts of fellow clergy through this process.

(11) The National Conclave on HIV/AIDS for Black Clergy calls upon the President, Congress, and corporate America to declare the HIV/AIDS crisis in the African-American community a ''public health emergency''.

(12) The Black clergy will aggressively seek to have every person under the sphere of their influence tested for HIV in order to know the person's status.

(13) The Black clergy will promote HIV/AIDS awareness to ensure that all Black clergy serving in their denominations and other congregations are equipped to address issues related to this disease in a factual and scientifically sound manner.

(14) The Black clergy will use the ABC/D model as a behavioral guideline for prevention initiatives:

(A) A–Abstain.

(B) B–Be Faithful.

(C) C–Use Condoms.

(D) D–Don't Engage in Risky Behaviors.

(c) DEFINITIONS APPLICABLE THROUGHOUT SECTION.—In this section—

(1) the terms ''HIV'' and ''HIV/AIDS'' have the meanings given to such terms in section 2689 of

the Public Health Service Act (42 U.S.C. 300ff–88); and

(2) the term ''Secretary'' means the Secretary of Health and Human Services.

(d) SERVICES TO REDUCE HIV/AIDS IN THE AFRICAN-AMERICAN COMMUNITY.—For the purpose of reducing HIV/AIDS in the African-American community, the Secretary, 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/AIDS prevention and testing activities;

(2) HIV/AIDS prevention activities; and

(3) HIV/AIDS testing activities.

(e) GRANTS FOR SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES TO PUBLIC HEALTH AGENCIES AND FAITH-BASED ORGANIZATIONS.—The Secretary, acting through the Administrator of the Substance Abuse and Mental Health Services Administration, may make grants to public health agencies and faith-based organizations to—

(1) conduct HIV/AIDS and sexually transmitted disease outreach, prevention, and testing activities that are targeted to the African-American community; and

(2) in connection with such activities, provide substance abuse testing and mental health services to members of such community.

(f) SERVICES FOR HIV/AIDS AFFECTED YOUTH WHO ARE SEPARATED FROM THEIR FAMILIES.—The Secretary, acting through the Administrator of the Substance Abuse and Mental Health Services Administration, may make grants to faith- and community-based organizations to provide family reunification services, mental health counseling, HIV/AIDS and sexually transmitted disease testing, and substance abuse testing and treatment to youth who—

(1)(A) have run away from home;

(B) are homeless; or

(C) reside in a detention center or foster care; and

(2) are HIV positive or at risk for HIV/AIDS, including young men who have sex with men.

(g) PUBLIC HEALTH INTERVENTION AND PREVENTION ACTIVITIES.—

(1) IN GENERAL.—For the purpose of reducing HIV/AIDS, sexually transmitted diseases, tuberculosis, and viral hepatitis in African-American communities, the Secretary, acting through the Director of the Centers for Disease Control and Prevention,

may make grants to faith-based organizations for public health intervention and prevention activities, including the use of rapid testing in traditional and nontraditional settings to increase the number of individuals who know their status at the point of care and are put into treatment.

(2) PARTNERSHIPS.—In carrying out this subsection, the Secretary shall encourage grantees to enter into partnerships with public health agencies.

(h) HIV/AIDS PREVENTION AND EDUCATION.—

(1) PREVENTION ACTIVITIES.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall expand and intensify HIV/AIDS prevention activities in African-American communities. Such activities—

(A) shall be targeted to specific populations;

(B) shall be comprehensive and accurately based on science and research; and

(C) shall include information on abstinence, the proper use of condoms, risks associated with unprotected sex, and the value of sexual delay particularly among young adolescents and teenagers.

(2) EDUCATION.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall expand and intensify HIV/AIDS educational activities targeting Black women, youth, and men who have sex with men.

(3) COORDINATION.—The Secretary shall carry out this subsection in coordination with public schools of all levels, Black organizations, historically Black colleges and universities, and faith-based organizations and institutions.

(i) BUILDING CAPACITY OF COMMUNITIES.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall expand funding to eligible entities to build the capacity of African-American communities to respond to HIV/AIDS.

(2) EMPHASIS.—In carrying out this subsection, the Secretary shall emphasize the provision of funding for policy development, education, technical assistance, and training—

(A) to national and local faith-based organizations; and

(B) to organizations with a significant history of working within the African-American community on HIV/AIDS issues, an inter-

denominational center of seminaries specializing in the training of African-American clergy, and historically Black colleges and universities.

(3) DEFINITION.—In this subsection, the term ''eligible entity'' means a national or community-based organization with a history and tradition of service to African-American communities.

(j) NATIONAL MEDIA OUTREACH CAMPAIGN.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall implement a national media outreach campaign that urges all sexually active individuals to be tested for and know their HIV/AIDS status.

(2) REQUIREMENTS.—The national media outreach campaign under this subsection shall—

(A) be science-driven and targeted to African-American men, women, and youth; and

(B) give special emphasis to Black women and men who have sex with men.

(3) COORDINATION; CONSULTATION.—The Secretary shall carry out this subsection—

(A) in coordination with Black media outlets for print, electronic, and Web-based media and Black media associations, including the Na-

tional Association of Black Owned Broadcasters and the National Newspaper Publishers Association; and

(B) in consultation with an advisory board including representatives of the National Medical Association, faith leaders, elected and appointed officials, social marketing experts, and business and community stakeholders.

(k) RESEARCH TO DEVELOP BEHAVIORAL STRATEGIES TO REDUCE TRANSMISSION OF HIV/AIDS.—

(1) IN GENERAL.—The Secretary, acting through the Director of the National Institutes of Health, may conduct or support culturally competent research to develop evidence-based behavioral strategies to reduce the transmission of HIV/AIDS within the African-American community.

(2) PRIORITY.—In carrying out this subsection, the Secretary shall prioritize research that focuses on populations within the African-American community that are at increased risk for HIV/AIDS, including—

(A) men who have sex with men; and

(B) women.

(l) STUDY OF BIOLOGICAL AND BEHAVIORAL FACTORS.—The Secretary, acting through the Director of the

National Institute on Minority Health and Health Disparities, may make grants for—

(1) the study of biological and behavioral factors that lead to increased HIV/AIDS prevalence in the African-American community, to be conducted by researchers with a history and tradition of service to Black communities; and

(2) behavioral and structural network research and interventions, in collaboration with other institutes and centers of the National Institutes of Health, indigenous faith and national and community-based organizations with a history and tradition of conducting such research for Black communities, with a special emphasis on Black women and Black men who have sex with men.

(m) HEALTH CARE PROFESSIONALS TREATING INDIVIDUALS WITH HIV/AIDS.—Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

"Subpart 4—Health Care Professionals Treating Individuals With HIV/AIDS

"SEC. 781. BETTER CARE FOR INDIVIDUALS WITH HIV/AIDS.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the African-

American church community, may award grants for any of the following:

''(1) Development of curricula for training primary care providers in HIV/AIDS prevention and care.

''(2) Training health care professionals with expertise in HIV/AIDS to provide care to individuals with HIV/AIDS.

''(3) Development by grant recipients under title XXVI and other persons of policies for providing culturally relevant and sensitive treatment to individuals with HIV/AIDS, with particular emphasis on treatment to African-Americans and children with HIV/AIDS.

''(4) Development and implementation of programs to increase the use of telemedicine to respond to HIV/AIDS-specific health care needs in rural and minority communities, with particular emphasis given to medically underserved communities and the southern States.

''(5) Creation of faith- and community-based certification programs for providers in HIV/AIDS care and support services.

''(6) Establishment of comfort care centers that provide mental, emotional, and psychosocial coun-

seling for people with HIV/AIDS and implement additional protocols to be carried out in the centers that address the needs of children and young adults who are infected with the disease and are transitioning from childhood to adulthood.

''(7) Incentive payments to health care providers supported by the Health Resources and Services Administration to implement HIV/AIDS testing consistent with the guidelines issued in 2006 by the Centers for Disease Control and Prevention entitled 'Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings'.

''(b) DEFINITIONS.—In this section—

''(1) the term 'HIV/AIDS' has the meaning given to such term in section 2689; and

''(2) the term 'primary care' includes obstetrical and gynecological care and psychiatric and mental health care.''.

(n) REPORT ON IMPACT OF HIV/AIDS IN THE AFRICAN-AMERICAN COMMUNITY.—

(1) IN GENERAL.—The Secretary shall submit to Congress and the President an annual report on the impact of HIV/AIDS in the African-American community.

(2) CONTENTS.—The report under subsection (a) shall include information on the—

(A) progress that has been made in reducing the impact of HIV/AIDS in such community;

(B) opportunities that exist to make additional progress in reducing the impact of HIV/AIDS in such community;

(C) challenges that may impede such additional progress; and

(D) Federal funding necessary to achieve substantial reductions in HIV/AIDS in the African-American community.

SEC. 749. REDUCING THE SPREAD OF SEXUALLY TRANSMITTED INFECTIONS IN CORRECTIONAL FACILITIES.

(a) SHORT TITLE.—This section may be cited as the ''Justice for the Unprotected Against Sexually Transmitted Infections among the Confined and Exposed Act'' or the ''JUSTICE Act''.

(b) FINDINGS.—The Congress makes the following findings:

(1) According to the Bureau of Justice Statistics (BJS), 2,292,133 persons were incarcerated in the United States as of the end of 2009. Between

1998 and 2008, the number of persons incarcerated in Federal or State correctional facilities increased by an average of 2.4 percent per year. One in every 32 United States residents was on probation, in jail or prison, or on parole at the end of 2009.

(2) As of 2009, 66.8 percent of incarcerated persons were racial or ethnic minorities. Based on current incarceration rates, BJS estimates that African-American males are 6 times more likely to be held in custody than White males, while Hispanic males are a little more than 2 times more likely to be held in custody. Across all age categories, African-American males were incarcerated at higher rates than Hispanic or White males.

(3) There is a disproportionately high rate of HIV/AIDS among incarcerated persons, especially among minorities. Approximately 25 percent of the HIV-positive population of the United States passes through correctional facilities each year. BJS has determined that the rate of confirmed AIDS cases is 2.4 times higher among incarcerated persons than in the general population. Minorities account for the majority of AIDS-related deaths among incarcerated persons, with African-American incarcerated persons 2.8 times more likely than White incarcerated per-

sons and 1.4 times more likely than Hispanic incarcerated persons to die from AIDS-related causes. Nearly two-thirds of AIDS-related deaths are among Black, non-Hispanic males.

(4) Studies suggest that other sexually transmitted infections (STIs), such as gonorrhea, chlamydia, syphilis, genital herpes, viral hepatitis, and human papillomavirus, also exist at a higher rate among incarcerated persons than in the general population. For instance, researchers have estimated that the rate of hepatitis C (HCV) infection among incarcerated persons is somewhere between 8 and 20 times higher than that of the general population.

(5) Correctional facilities lack a uniform system of STI testing and reporting. Establishing a uniform data collection system would assist in developing and targeting counseling and treatment programs for incarcerated persons. Better developed and targeted programs may reduce the spread of STIs.

(6) Although Congress has acted to reduce the spread of sexual violence in correctional facilities by enacting the National Prison Rape Elimination Act (PREA) of 2003, BJS reported that approximately 4.4 percent of incarcerated persons in prisons and 3.1 percent of persons in jail reported experiencing

one or more incidents of sexual victimization by another incarcerated person or correctional facility staff in the previous year.

(7) Approximately 95 percent of all incarcerated persons eventually return to society. According to one study, every year approximately 100,000 persons infected with both HIV and HCV are released from correctional facilities. These individuals comprise approximately 50 percent of all persons with both infections in the United States.

(8) According to the Centers for Disease Control and Prevention (CDC), latex condoms, when used consistently and correctly, are highly effective in preventing the transmission of HIV. Latex condoms also reduce the risk of other STIs. Despite the effectiveness of condoms in reducing the spread of STIs, the Bureau of Prisons does not recommend their use in correctional facilities.

(9) The distribution of condoms in correctional facilities is currently legal in certain parts of the United States and the world. The States of Vermont and Mississippi and the District of Columbia allow condom distribution programs in their correctional facilities. The cities of New York, San Francisco, Los Angeles, Washington DC, and Philadelphia also

allow condom distribution in their correctional facilities. However, these States and cities operate fewer than 1 percent of all correctional facilities.

(10) A 2007 report by the Massachusetts General Hospital Division of Infectious Diseases and the University of California, San Francisco, found that the proportion of European prison systems allowing condoms rose from 53 percent in 1989 to 81 percent in 1997. The same report also found that no prison system allowing the distribution of condoms had reversed their decision, and no prison system reported an increase in sexual activity among incarcerated persons as a result of a decision to allow condom distribution.

(11) In 2000 and 2001, researchers surveyed 300 incarcerated persons and 100 correctional officers at the Central Detention Facility, a correctional facility operated by the District of Columbia at which condoms are available. Researchers found that both incarcerated persons and correctional officers generally supported the condom distribution program and considered it to be important. Furthermore, the researchers determined that the program had not caused any major security infractions. In Canada, the Expert Committee on AIDS and Pris-

ons surveyed more than 400 correctional officers in the Federal prison system of Canada in 1995 and reported that 82 percent of those responding indicated that the availability of condoms had created no problems at their facility.

(12) The American Public Health Association, the United Nations Joint Program on HIV/AIDS, and the World Health Organization have endorsed the effectiveness of condom distribution programs in correctional facilities.

(13) Many correctional facilities in the United States do not provide comprehensive testing and treatment programs to reduce the spread of STIs. According to BJS surveys from 2005, only 996 of the 1,821 Federal and State correctional facilities (i.e. 54.7 percent) provided HIV/AIDS counseling programs.

(14) Individuals who are enrolled in Medicaid prior to incarceration face a suspension of their benefits upon incarceration, and in some States a termination of their Medicaid eligibility. The Federal Government encourages States to automatically re-enroll incarcerated persons on Medicaid upon their release from a correctional facility, unless the State reaches

a determination that the individual is no longer eligible for reasons other than their prior incarceration.

(15) Formerly incarcerated individuals who are newly released from correctional facilities often face delays in the resumption of their Medicaid benefits which may exacerbate any health issues which they face.

(16) Incarcerated individuals living with HIV/AIDS who are eligible for Medicaid would benefit from prompt and automatic enrollment upon their release in order to ensure their continued ability to access health services, including antiretroviral treatment.

(c) 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 Bureau of Prisons to allow community organizations to distribute sexual barrier protection devices and to engage in STI counseling and STI prevention education in Federal correctional facilities. These activities shall be subject to all relevant Federal laws and

regulations which govern visitation in correctional facilities.

(2) INFORMATION REQUIREMENT.—Any community organization permitted to distribute sexual barrier protection devices under paragraph (1) must 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) must offer comprehensive sexuality education.

(3) POSSESSION OF DEVICE PROTECTED.—No Federal correctional facility may, 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.

(d) SENSE OF CONGRESS REGARDING DISTRIBUTION OF SEXUAL BARRIER PROTECTION DEVICES IN STATE PRISON SYSTEMS.—It is the sense of 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.

(e) AUTOMATIC REINSTATEMENT OF MEDICAID BENEFITS.—

(1) 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:

''(15) 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 if—

''(I) 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) 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 medical assistance that is provided after the date that the eligible indi-

vidual 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 the subparagraph (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 subclause (I), on the date that such individual is released from a public institution the suspension of continuous eligibility under such subclause 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 subclause.

''(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) is diagnosed with human immunodeficiency virus.''.

(2) SUPPLEMENTAL FUNDING FOR STATE IMPLEMENTATION OF AUTOMATIC REINSTATEMENT OF MEDICAID BENEFITS.—

(A) IN GENERAL.—Subject to paragraph (6), for each State for which the Secretary of Health and Human Services has approved an

application under paragraph (3), 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) shall be increased by 5.0 percentage points for payments to the State for the activities permitted under paragraph (2) for a period of one year.

(B) USE OF FUNDS.—A State may only use increased matching payments authorized under paragraph (1)—

(i) to strengthen 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 section 1902(e)(15)(E) of the Social Security Act); and

(ii) for medical assistance (as such term is defined in section 1905(a) of the Social Security Act) provided to such eligible individuals.

(C) APPLICATION AND AGREEMENT.—The Secretary may only make payments to a State in the increased amount if—

(i) the State has amended the State plan under section 1902 of the Social Security Act to incorporate the requirements of subsection (e)(15) of such section;

(ii) the State has submitted an application to the Secretary that includes a plan for implementing the requirements of section 1902(e)(15) of the Social Security Act under the State's amended State plan before the end of the 90-day period beginning on the date that the State receives increased matching payments under paragraph (1);

(iii) the State's application meets the satisfaction of the Secretary; and

(iv) the State enters an agreement with the Secretary that states that—

(I) the State will only use the increased matching funds for the uses permitted under paragraph (2); and

(II) at the end of the period under paragraph (1), the State will submit to the Secretary, and make publicly available, a report that con-

tains the information required under paragraph (4).

(D) REQUIRED REPORT INFORMATION.—The information that is required in the report under paragraph (3)(D)(ii) includes—

(i) the results of an evaluation of the impact of the implementation of the requirements of section 1902(e)(15) of the Social Security Act on improving the State's processes for enrolling of individuals who are released for public institutions into the Medicaid program;

(ii) the number of individuals who were automatically enrolled (or whose enrollment is reinstated) under such section 1902(e)(15) during the period under paragraph (1); and

(iii) any other information that is required by the Secretary.

(E) INCREASE IN CAP ON MEDICAID PAYMENTS TO TERRITORIES.—Subject to paragraph (6), the amounts otherwise determined for Puerto Rico, the United States Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa

under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) shall each be increased by the necessary amount to allow for the increase in the Federal matching payments under paragraph (1), but only for the period under such paragraph for such State. In the case of such an increase for a territory, subsection (a)(1) of such section 1108 shall be applied without regard to any increase in payment made to the territory under part E of title IV of such Act that is attributable to the increase in Federal medical assistance percentage effected under paragraph (1) for the territory.

(F) LIMITATIONS.—

(i) TIMING.—With respect to a State, at the end of the period under paragraph (1), no increased matching payments may be made to such State under this subsection.

(ii) 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), or an increase in a cap amount under para-

graph (5), if eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) 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 restricted eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) 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.

(iii) NO WAIVER AUTHORITY.—The Secretary may not waive the application of this subsection under section 1115 of the Social Security Act or otherwise.

(iv) LIMITATION OF MATCHING PAYMENTS TO 100 PERCENT.—In no case shall an increase in Federal matching payments under this subsection result in Federal matching payments that exceed 100 percent.

(3) EFFECTIVE DATE.—

(A) 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 and shall apply to services furnished on or after such date.

(B) 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 requirement imposed by the amendments made by this subsection, 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.

(f) SURVEY OF AND REPORT ON CORRECTIONAL FACILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF STIS.—

(1) SURVEY.—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, no later than 180 days after the date of enactment of this Act and annually thereafter for 5 years, to determine the following:

(A) 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.

(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; and

(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) COUNSELING, TREATMENT, AND SUPPORTIVE SERVICES.—Whether the correctional facility requires incarcerated persons to participate in counseling, treatment, and supportive services related to STIs, or whether it offers such programs to incarcerated persons.

(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/or ethnicity of individuals tested;

(iii) the age of individuals tested; and

(iv) the gender of individuals tested.

(G) PRE-RELEASE 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) PRE-RELEASE 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 paragraph (8) to entities

that accept the State Medicaid program, including if applicable—

(i) the number of such individuals, including those diagnosed with the human immunodeficiency virus, 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, 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.—The Attorney General shall transmit to Congress and make publicly available

the results of the survey required under paragraph (1), both for the Nation as a whole and disaggregated as to each State and each correctional facility. To the maximum extent possible, the Attorney General shall issue the first report no later than 1 year after the date of enactment of this Act and shall issue reports annually thereafter for 5 years.

(g) 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 (h)(3).

(2) CONTENTS OF STRATEGY.—The strategy 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 infor-

mation 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 violence 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 pre-test 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 incarcerated persons who were—

(i) enrolled in their State Medicaid program prior to incarceration in a correctional facility are automatically re-enrolled in such program upon their release; and

(ii) not enrolled in their State Medicaid program prior to incarceration, but who are diagnosed with the human immunodeficiency virus 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 (I).

(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.—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 subsection (a). The progress report shall include an evaluation of the implementation of the strategy using the monitoring system and performance indi-

cators provided for in subparagraphs (I) and (J) of paragraph (2).

(h) 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 that includes information about abstinence and about the proper use and disposal of sexual barrier protection devices and which is—

(A) evidence-based;

(B) medically accurate;

(C) age and developmentally appropriate;

(D) gender and identity sensitive;

(E) culturally and linguistically appropriate; and

(F) 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/AIDS, 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.

SEC. 750. STOP AIDS IN PRISON.

(a) SHORT TITLE.—This section may be cited as the ''Stop AIDS in Prison Act of 2012''.

(b) COMPREHENSIVE HIV/AIDS POLICY.—

(1) IN GENERAL.—The Bureau of Prisons (hereinafter in this section referred to as the ''Bureau'') shall develop a comprehensive policy to provide HIV testing, treatment, and prevention for inmates within the correctional setting and upon reentry.

(2) PURPOSE.—The purposes of such policy are the following:

(A) To stop the spread of HIV/AIDS among inmates.

(B) To protect prison guards and other personnel from HIV/AIDS infection.

(C) To provide comprehensive medical treatment to inmates who are living with HIV/AIDS.

(D) To promote HIV/AIDS awareness and prevention among inmates.

(E) To encourage inmates to take personal responsibility for their health.

(F) To reduce the risk that inmates will transmit HIV/AIDS to other persons in the community following their release from prison.

(3) CONSULTATION.—The Bureau 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 regarding the development of such policy.

(4) TIME LIMIT.—The Bureau shall draft appropriate regulations to implement such policy not later than 1 year after the date of the enactment of this Act.

(c) REQUIREMENTS FOR POLICY.—The policy created under subsection (b) shall provide for the following:

(1) TESTING AND COUNSELING UPON INTAKE.—

(A)(i) Subject to clause (ii), health care personnel shall provide routine HIV testing to all inmates as a part of a comprehensive medical examination immediately following admission to a facility.

(ii) Health care personnel shall not be required to 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 paragraph (9).

(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/AIDS PREVENTION EDUCATION.—

(A) Health care personnel shall improve HIV/AIDS awareness through frequent educational programs for all inmates. HIV/AIDS educational programs may be provided by community based organizations, local health departments, and inmate peer educators. Such HIV/AIDS educational programs shall include information on modes of transmission, including transmission through tattooing, sexual contact,

and intravenous drug use; prevention methods; treatment; and disease progression. HIV/AIDS educational programs shall be culturally sensitive, conducted in a variety of languages, and present scientifically accurate information in a clear and understandable manner.

(B) HIV/AIDS 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 audio-visual materials shall be made available to all inmates. These materials shall be culturally sensitive, written for low literacy levels, and available in a variety of languages.

(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/AIDS.

(C) An inmate's request for an HIV test shall not be considered an indication that the inmate has put himself or herself at risk of infection 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 paragraph (9).

(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) Medical 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/AIDS, 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 request and obtain these services as routine medical services.

(8) TESTING, COUNSELING, AND REFERRAL PRIOR TO REENTRY.—

(A)(i) Subject to clauses (ii) and (iii), health care personnel shall provide routine HIV testing to all inmates no more than 3 months prior to their release and reentry into the community.

(ii) Inmates who are already known to be infected shall not be required to be tested again.

(iii) The requirement under clause (i) 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 paragraph (9).

(C) To all inmates who test positive for HIV and all inmates who already are known to have HIV/AIDS, 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 condition 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/AIDS; 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.

(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 paragraph (9). 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.

(d) 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 individual 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 AIDS in Prison Act of 2012'' 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 fol-

lowing: ''Such rules shall also provide that the initial test under this section be performed as part of the routine health screening conducted at intake.''.

(e) REPORTING REQUIREMENTS.—

(1) REPORT ON HEPATITIS AND OTHER DISEASES.—Not later than 1 year after the date of the enactment of this Act, the Bureau shall provide a report to the Congress on Bureau policies and procedures to provide testing, treatment, and prevention education programs for hepatitis and other diseases transmitted through sexual activity and intravenous drug use. The Bureau 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 the enactment of this Act, and then annually thereafter, the Bureau 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.—Reports under subparagraph (A) shall discuss—

(i) the incidence among inmates of HIV/AIDS, hepatitis, and other diseases transmitted through sexual activity and intravenous drug use; and

(ii) updates on Bureau testing, treatment, and prevention education programs for these diseases.

(C) MATTERS PERTAINING TO HIV/AIDS ONLY.—Reports under subparagraph (A) 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/AIDS.

(D) CONSULTATION.—The Bureau 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 reports under subparagraph (A).

SEC. 751. SERVICES TO REDUCE HIV/AIDS IN RACIAL AND ETHNIC MINORITY COMMUNITIES.

For the purpose of reducing HIV/AIDS in racial and ethnic minority communities, the Secretary, 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/AIDS prevention and testing activities;

(2) HIV/AIDS prevention activities; and

(3) HIV/AIDS testing activities.

SEC. 752. HEALTH CARE PROFESSIONALS TREATING INDIVIDUALS WITH HIV/AIDS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

"Subpart 5—Health Care Professionals Treating Individuals With HIV/AIDS

"SEC. 785. HEALTH CARE PROFESSIONALS TREATING INDIVIDUALS WITH HIV/AIDS.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with racial and ethnic minority community organizations, may award grants for any of the following:

''(1) Development of curricula for training primary care providers in HIV/AIDS prevention and care.

''(2) Training health care professionals with expertise in HIV/AIDS to provide care to individuals with HIV/AIDS.

''(3) Development by grant recipients under title XXVI and other persons of policies for providing culturally relevant and sensitive treatment to individuals with HIV/AIDS, with particular emphasis on treatment to racial and ethnic minorities, men who have sex with men, and women and children with HIV/AIDS.

''(4) Development and implementation of programs to increase the use of telemedicine to respond to HIV/AIDS-specific health care needs in rural and minority communities, with particular emphasis

given to medically underserved communities and insular areas.

''(5) Creation of faith- and community-based certification programs for providers in HIV/AIDS care and support services.

''(6) Establishment of comfort care centers that provide mental, emotional, and psychosocial counseling for people with HIV/AIDS and implement additional protocols to be carried out in the centers that address the needs of children and young adults who are infected with the disease and are transitioning from childhood to adulthood.

''(7) Incentive payments to health care providers supported by the Health Resources and Services Administration to implement HIV/AIDS testing consistent with the guidelines issued in 2006 by the Centers for Disease Control and Prevention entitled 'Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings'.

''(b) DEFINITIONS.—In this section—

''(1) the term 'HIV/AIDS' has the meaning given to such term in section 2689; and

''(2) the term 'primary care' includes obstetrical and gynecological care and psychiatric and mental health care.''.

SEC. 753. REPORT ON IMPACT OF HIV/AIDS IN RACIAL AND ETHNIC MINORITY COMMUNITIES.

(a) IN GENERAL.—The Secretary shall submit to the Congress and the President an annual report on the impact of HIV/AIDS in racial and ethnic minority communities.

(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/AIDS in racial and ethnic minority communities.

SEC. 754. STUDY ON STATUS OF HIV/AIDS EPIDEMIC AMONG AFRICAN-AMERICANS.

The Secretary shall—

(1) seek to enter into an agreement with the Institute of Medicine to document, in collaboration with an academic organization which specializes in the identification and reduction of health disparities within the African-American community, all aspects of the HIV/AIDS epidemic among African-Americans, including the role that historical racial or ethnic barriers play in sustaining the epidemic among African-Americans;

(2) submit a report to the President, the Director of the Office of National AIDS Policy Coordination, the Director of the White House Domestic Policy Council, the Director of White House Office of Faith-Based and Neighborhood Partnerships, key Federal agencies, and the relevant committees of the Congress on the status of the HIV/AIDS epidemic among African-Americans in the United States; and

(3) include in such report—

(A) specific recommendations on the implementation of Federal policies to reduce the burden of HIV/AIDS in the African-American community; and

(B) a special focus on the Black clergy and the church as a unique resource in the African-American community.

Subtitle F—Diabetes

SEC. 755. TREATMENT OF DIABETES IN MINORITY COMMUNITIES.

(a) SHORT TITLE.—This subtitle may be cited as the ''Minority Diabetes Initiative Act''.

(b) GRANTS REGARDING TREATMENT OF DIABETES IN MINORITY COMMUNITIES.—Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by inserting after section 330L the following:

''SEC. 330M. GRANTS REGARDING TREATMENT OF DIABETES IN MINORITY COMMUNITIES.

''(a) IN GENERAL.—The Secretary may make grants to public and nonprofit private health care providers for the purpose of providing treatment for diabetes in minority communities.

''(b) RECIPIENTS OF GRANTS.—The public and nonprofit private health care providers to whom grants may be made under subsection (a) include physicians, podiatrists, community-based organizations, health care organizations, community health centers, and State, local, and tribal health departments.

''(c) SCOPE OF TREATMENT ACTIVITIES.—The Secretary shall ensure that grants under subsection (a) cover a variety of diabetes-related health care services, including routine care for diabetic patients, public education on dia-

betes prevention and control, eye care, foot care, and treatment for kidney disease and other complications of diabetes.

''(d) APPROPRIATE CULTURAL CONTEXT.—A condition for the receipt of a grant under subsection (a) is that the applicant involved agrees that, in the program carried out with the grant, services will be provided in the languages most appropriate for, and with consideration for the cultural backgrounds of, the individuals for whom the services are provided.

''(e) OUTREACH SERVICES.—A condition for the receipt of a grant under subsection (a) is that the applicant involved agrees to provide outreach activities to inform the public of the services of the program, and to provide offsite information on diabetes.

''(f) REPORTING OF DATA.—A condition for the receipt of a grant under subsection (a) is that the applicant involved agrees—

''(1) to collect and report data, on a time basis determined appropriate by the Secretary, on race, ethnicity, sex, gender, primary language, disability status, and socioeconomic status; and

''(2) to develop research methodologies that ensure reporting of data stratified as described in paragraph (1).

''(g) APPLICATION FOR GRANT.—A grant may be made under subsection (a) only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.''.

SEC. 756. ELIMINATING DISPARITIES IN DIABETES PREVENTION ACCESS AND CARE.

(a) RESEARCH, TREATMENT, AND EDUCATION.—

(1) IN GENERAL.—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 the National Institutes of Health shall expand, intensify, and support ongoing research and other activities with respect to pre-diabetes and diabetes, particularly type 2, in minority populations, including research to identify clinical, socioeconomic, geographical, cultural, and organizational factors that contribute to type 2 diabetes in such populations.

''(b) CERTAIN ACTIVITIES.—Activities under subsection (a) regarding type 2 diabetes in minority populations shall include the following:

''(1) Continuing research on behavior and obesity, including through the obesity research center that is sponsored by the National Institutes of Health.

''(2) Research on environmental factors that may contribute to the increase in type 2 diabetes.

''(3) Support for new methods to identify environmental triggers and genetic interactions that lead to the development of type 2 diabetes in minority newborns. Such research should follow the newborns through puberty, an increasingly high-risk period for developing type 2 diabetes.

''(4) Research to identify genes that predispose individuals to the onset of developing type 1 and type 2 diabetes and to the development of complications.

''(5) Research to prevent complications in individuals who have already developed diabetes, such as research that attempts to identify the genes that predispose individuals with diabetes to the development of complications.

''(6) Research methods and alternative therapies to control blood glucose.

''(7) Support of ongoing research efforts examining the level of glycemia at which adverse out-

comes develop during pregnancy and to address the many clinical issues associated with minority mothers and fetuses during diabetic and gestational diabetic pregnancies.

''(c) EDUCATION.—The Director of the National Institutes of Health 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 485F (relating to centers of excellence) 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 (MARC) program internships and mentoring opportunities for recruitment.

''(d) COLLECTION AND REPORTING OF DATA.—

''(1) IN GENERAL.—The Secretary shall ensure that research and other activities undertaken pursuant to this section include the collection and reporting, on a time basis determined appropriate by the Secretary, data on race, ethnicity, sex, gender, primary language, disability status and socioeconomic status.

''(2) GRANTS.—To qualify for a grant under this section, grantees shall develop research methodologies that ensure annual reporting of data stratified as described in paragraph (1).

''(e) DEFINITION.—For purposes of this section, the term 'minority population' means a racial and ethnic minority group, as defined in section 1707(g).''.

(2) DIABETES MELLITUS INTERAGENCY COORDINATING COMMITTEE.—Section 429 of the Public Health Service Act (42 U.S.C. 285c–3) is amended by adding at the end the following new subsection:

''(c)(1) The Diabetes Mellitus Interagency Coordinating Committee shall submit to the Secretary a biennial report that shall include an assessment of the Federal activities and programs related to diabetes in minority populations. Such assessment shall—

''(A) compile the current activities of all current Federal health programs to allow for the assessment of their adequacy as a systemic method of addressing the impact of diabetes mellitus on minority populations;

''(B) develop strategic planning activities to develop an effective and comprehensive Federal plan to address diabetes mellitus within minority populations which will involve all appropriate Federal health programs and shall—

''(i) include steps to address issues including type 1 and type 2 diabetes in children and the disproportionate impact of diabetes mellitus on minority populations; and

''(ii) remain consistent with the programs and activities identified in section 399O, as well as remaining consistent with the intent of the Eliminating Disparities in Diabetes Prevention Access and Care Act of 2010; and

''(C) assess the implementation of such a plan throughout Federal health programs.

''(2) For the purposes of this subsection, the term 'minority population' means a racial and ethnic minority group, as defined in section 1707(g).''.

(b) RESEARCH, EDUCATION, AND OTHER ACTIVITIES.—Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 317T the following section:

"SEC. 317U. 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 other 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) Expanding the National Diabetes Laboratory capacity for translational research and the identification of genetic and immunological risk factors associated with diabetes.

"(B) Improving the understanding of diabetes prevalence among Asian-American, Native Hawaiian and other Pacific Islanders by enhancing data in the National Health and Nutrition Examination Survey by oversampling these populations in appropriate geographic areas, or

by another method determined appropriate to collect this data.

''(C) Within the Division of Diabetes Translation, providing for prevention research to better understand how to influence health care systems changes to improve quality of care being delivered to such populations, and within the Division of Diabetes Translation, carrying out model demonstration projects to design, implement, and evaluate effective diabetes prevention and control intervention for such populations.

''(D) Through the Division of Diabetes Translation, carrying out culturally appropriate community-based interventions designed to address issues and problems experienced by such populations.

''(E) Conducting applied research within the Division of Diabetes Translation to reduce health disparities within such populations with diabetes.

''(F) Conducting applied research on primary prevention within the Division of Diabetes Translation to specifically focus on such populations with pre-diabetes.

''(b) EDUCATION.—

''(1) IN GENERAL.—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 programs to educate the public on the causes and effects of diabetes in minority populations.

''(2) CERTAIN ACTIVITIES.—Programs under paragraph (1) regarding education on diabetes in minority populations shall include carrying out public awareness campaigns directed toward such populations to aggressively emphasize the importance and impact of physical activity and diet in regard to diabetes and diabetes-related complications through the National Diabetes Education Program.

''(c) DIABETES; HEALTH PROMOTION, PREVENTION ACTIVITIES, AND ACCESS.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall carry out culturally appropriate diabetes health promotion and prevention programs for minority populations.

''(2) CERTAIN ACTIVITIES.—Activities regarding culturally appropriate diabetes health promotion

and prevention programs for minority populations shall include the following:

"(A) Expanding the Diabetes Prevention and Control Program (currently existing in all the States and territories) and providing funds for education and community outreach on diabetes.

"(B) Providing funds for an expansion of the Diabetes Prevention Program Initiative that focuses on physical inactivity and diet and its relation to type 2 diabetes within such populations.

"(C) Providing funds to strengthen existing surveillance systems to improve the quality, accuracy, and timeliness of morbidity and mortality diabetes data for such populations.

"(d) COLLECTION AND REPORTING OF DATA.—The Secretary shall ensure that research and other activities undertaken pursuant to this section include the collection and reporting, on a time basis determined appropriate by the Secretary, data on race, ethnicity, sex, gender, primary language, disability status and socioeconomic status.

"(e) DEFINITION.—For purposes of this section, the term 'minority population' means a racial and ethnic minority group, as defined in section 1707(g).".

(c) RESEARCH, EDUCATION, AND OTHER ACTIVITIES.—Part P of title III of the Public Health Service Act is amended—

(1) by redesignating the section 399R inserted by section 2 of Public Law 110–373 as section 399S;

(2) by redesignating the section 399R inserted by section 3 of Public Law 110–374 as section 399T; and

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

"SEC. 399V–8. 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) Making grants for diabetes-focused education classes or training programs on cultural sen-

sitivity and patient care within such populations for health care providers.

''(2) Providing funds to community health centers for programs that provide diabetes services and screenings.

''(3) Providing additional funds for the Health Careers Opportunity Program, 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 within minority populations focused on diabetes treatment and care.

''(4) Developing a diabetes focus within, and providing additional funds for, the National Health Service Corps Scholarship program to place individuals in areas that are disproportionately affected by diabetes and to provide health care services to such areas.

''(5) Establishing a diabetes ambassador program for recruitment efforts to increase the number of underrepresented minorities currently serving in student, faculty, or administrative positions in institutions of higher learning, hospitals, and community health centers.

''(6) Establishing a loan repayment program that focuses on diabetes care and prevention in minority populations.

''(c) COLLECTION AND REPORTING OF DATA.—

''(1) IN GENERAL.—The Secretary shall ensure that research and other activities undertaken pursuant to this section include the collection and reporting, on a time basis determined appropriate by the Secretary, data on race, ethnicity, sex, gender, primary language, disability status and socioeconomic status.

''(2) GRANTS.—To qualify for a grant under this section, grantees shall develop research methodologies that ensure annual reporting of data stratified as described in paragraph (1).''.

(d) 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 subsection (c), is further amended by adding at the end the following section:

''SEC. 399V–9. RESEARCH, EDUCATION, AND OTHER ACTIVITIES REGARDING DIABETES IN MINORITY POPULATIONS.

''(a) RESEARCH AND OTHER ACTIVITIES.—

''(1) IN GENERAL.—In addition to activities under sections 317U and 434B, the Secretary shall conduct and support research and other activities with respect to diabetes within minority populations.

''(2) CERTAIN ACTIVITIES.—Activities under paragraph (1) regarding diabetes in minority populations shall include the following:

''(A) Through the National Center on Minority Health and Health Disparities, the Office of Minority Health under section 1707, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and the Indian Health Service, establishing partnerships within minority populations to conduct studies on cultural, familial, and social factors that may influence health promotion, diabetes management, and prevention.

''(B) Through the Indian Health Service, in collaboration with other appropriate Federal agencies, coordinating the collection of data on ethnic and culturally appropriate diabetes treatment, care, prevention, and services by health care professionals to the American Indian population.

''(3) PROGRAMS RELATING TO CLINICAL RESEARCH.—

''(A) EDUCATION REGARDING CLINICAL TRIALS.—The Secretary shall carry out education and awareness programs designed to increase participation of minority populations in clinical trials.

''(B) MINORITY RESEARCHERS.—The Secretary shall carry out mentorship programs for minority researchers who are conducting or intend to conduct research on diabetes in minority populations.

''(C) SUPPLEMENTING CLINICAL RESEARCH REGARDING CHILDREN.—The Secretary shall make grants to supplement clinical research programs to assist such programs in obtaining the services of health professionals and other resources to provide specialized care for children with type 1 and type 2 diabetes.

''(4) ADDITIONAL PROGRAMS.—Activities under paragraph (1) regarding education on diabetes shall include providing funds for new and existing diabetes-focused education grants and programs for present and future students and clinicians in the

medical field from minority populations, including for the following:

"(A) For Federal and State loan repayment programs for health profession students within communities of color.

"(B) For the Office of Minority Health under section 1707 for training health profession students to focus on diabetes within such populations.

"(b) COLLECTION AND REPORTING OF DATA.—

"(1) IN GENERAL.—The Secretary shall ensure that research and other activities undertaken pursuant to this section include the collection and reporting, on a time basis determined appropriate by the Secretary, data on race, ethnicity, sex, gender, primary language, disability status and socioeconomic status.

"(2) GRANTS.—To qualify for a grant under this section, grantees shall develop research methodologies that ensure annual reporting of data stratified as described in paragraph (1).

"(c) DEFINITION.—For purposes of this section, the term 'minority population' means a racial and ethnic minority group as defined in section 1707(g).".

(e) SENSE OF THE CONGRESS.—It is the sense of the Congress that States and localities are encourage to recognize established times of diabetes awareness, such as American Diabetes Month (November), American Diabetes Alert Day (annually on the 4th Tuesday of March), and World Diabetes Day (November 14th).

Subtitle G—Lung Disease

SEC. 761. EXPANSION OF THE NATIONAL ASTHMA EDUCATION AND PREVENTION PROGRAM.

(a) 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 the Healthy People 2020 initiative; 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) description of how the Federal Government may better coordinate and improve its response to asthma including identifying any barriers that may exist;

(B) 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.

(b) REPORT TO CONGRESS.—At the end of the 5-year period following the submission of the report under subsection (a), 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. 762. 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.''.

SEC. 763. 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.

SEC. 764. CHRONIC OBSTRUCTIVE PULMONARY 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 chronic obstructive pulmonary 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 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 Institute of Medicine in the report entitled ''A Nationwide Framework for Surveillance of Cardiovascular and Chronic Lung Diseases'' (July 22, 2011).

(c) 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.

(d) 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.

(e) 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 (b).

TITLE VIII—HEALTH INFORMATION TECHNOLOGY

Subtitle A—Reducing Health Disparities Through Health IT

SEC. 801. HRSA ASSISTANCE TO HEALTH CENTERS FOR PROMOTION OF HEALTH IT.

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 (as defined in section 3000(1) of such Act (42 U.S.C. 300jj(1)) for the management of chronic diseases and health conditions.

SEC. 802. ASSESSMENT OF USE OF HEALTH IT IN RACIAL AND ETHNIC MINORITY COMMUNITIES.

(a) NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY.—

(1) IN GENERAL.—The National Coordinator for Health Information Technology shall conduct an evaluation of the level of use and accessibility of

electronic health records in racial and ethnic minority communities.

(2) CONTENT.—In conducting the evaluation under paragraph (1), the National Coordinator shall publish the results of a study regarding the 100,000 providers recruited by the Regional Extension Center established under section 3012 of the Public Health Service Act (42 U.S.C. 300jj–32), including the race and ethnicity of such providers and the populations served by such providers.

(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 the Data Brief 79 published by such Center in November 2011 (entitled ''Electronic Health Record Systems and Intent to Apply for Meaningful Use Incentives Among Office-Based Physician Practices'').

(c) INSTITUTE OF MEDICINE.—The Secretary of Health and Human Services may enter into an agreement with the Institute of Medicine of the National Academies that provides such Institute will evaluate the impact of health information technology in racial and ethnic minority communities and publish a report regarding such evaluation.

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), by adding at the end the following new paragraph:

''(8) Activities described in the previous paragraphs of this subsection with respect to communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)).''; and

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

''(e) ANNUAL REPORT ON EXPENDITURES.—The National Coordinator shall report annually to the Congress on activities and expenditures under this section.''.

SEC. 812. PRIORITIZING REGIONAL EXTENSION CENTER ASSISTANCE TO RACIAL AND ETHNIC MINORITY GROUPS.

(a) IN GENERAL.—Section 3012(c)(4)(C) of the Public Health Service Act (42 U.S.C. 300jj–32(c)(4)(C)) is

amended by inserting ''or individuals from racial and ethnic minority groups (as defined in section 1707(g))'' after ''medically underserved individuals''.

(b) BIENNIAL EVALUATION.—Section 3012(c)(8) of such Act (42 U.S.C. 300jj–32(c)(8)) is amended—

(1) by inserting: ''Each evaluation panel shall include at least one consumer advocate from a racial and ethnic minority community served by the center involved and at least one representative of a minority-serving institution.'' after '' 'and of Federal officials.''; and

(2) by inserting ''and shall determine the degree to which such center provides outreach and assistance to providers predominantly serving racial and ethnic minority groups (as defined in section 1707(g))'' after ''specified in paragraph (3)''.

SEC. 813. EXTENDING COMPETITIVE GRANTS FOR THE DEVELOPMENT OF LOAN PROGRAMS TO FACILITATE ADOPTION OF CERTIFIED EHR TECHNOLOGY BY PROVIDERS SERVING RACIAL AND ETHNIC MINORITY GROUPS.

Section 3014(e) of the Public Health Service Act (42 U.S.C. 300jj–34(e)) is amended—

(1) in paragraph (3), by striking at the end ''or'';

(2) in paragraph (4), by striking the period at the end and inserting ''; or''; and

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

''(5) carry out any of the activities described in a previous paragraph of this subsection with respect to communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)).''.

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, an Hispanic-serving institution, a tribal college or university, or an Asian-American-, Native American-, and Pacific Islander-serving institution with an accredited public health, health policy, or health services research program.''.

SEC. 822. IOM STUDY AND REPORT ON PRIVACY CONCERNS OF CERTAIN MINORITY POPULATIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall seek to enter into an agreement with the Institute of Medicine of the National Academies to—

(1) complete a study—

(A) on the privacy concerns, relating to the exchange of health information, of individuals described in subsection (b);

(B) on how such concerns may create barriers for such individuals to access health care

or participate in the exchange of health information; and

(C) including recommendations for overcoming such barriers for such individuals; and

(2) not later than 24 months after the date of the enactment of this Act, submit to Congress a report on the results of such study.

If such Institute declines to conduct the study and submit the report, the Secretary shall enter into an agreement with another appropriate public or nonprofit private entity to conduct the study and submit the report.

(b) INDIVIDUALS DESCRIBED.—For purposes of subsection (a), the individuals described in this subsection are individuals from racial and ethnic minority groups (as defined in section 1707(g)), including such individuals who—

(1) are immigrants, as well as citizens living within immigrant households (''mixed-status'' households) in the United States;

(2) are lesbian, gay, bisexual, or transgender; or

(3) have a mental health disability or a record of a mental health disability or treatment for a mental health disability.

SEC. 823. STUDY OF HEALTH INFORMATION TECHNOLOGY IN MEDICALLY UNDERSERVED AREAS.

(a) IN GENERAL.—Not later than 24 months after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) enter into an agreement with the Institute of Medicine of the National Academies (or, if the Institute of Medicine declines, another appropriate public or nonprofit private entity) 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) 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;

(3) examine the impact of health information technology on improving health care-related decisions by both patients and providers in such areas;

(4) 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;

(5) assess the feasibility and costs associated with the use of health information technology in such areas;

(6) evaluate whether the adoption and use of qualified electronic health records (as described in section 3000(13) of the Public Health Service Act (42 U.S.C. 300jj(13)) is effective in reducing health disparities, including analysis of clinical quality measures reported by Medicare and Medicaid providers pursuant to programs to encourage the adoption and use of certified EHR technology;

(7) 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

(8) 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(6) of the Public Health Service Act (42 U.S.C. 295p(6)); or

(4) an area or population that—

(A) is not described in paragraphs (1) through (3) of this subsection;

(B) experiences significant barriers to accessing quality health services; and

(C) has a high prevalence of diseases or conditions described in title VII of this Act, with such diseases or conditions having a dis-

proportionate 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.

Subtitle D—Closing Gaps in Funding To Adopt Certified EHRs

SEC. 831. APPLICATION OF MEDICARE HITECH PAYMENTS TO HOSPITALS IN PUERTO RICO.

(a) IN GENERAL.—Subsection (n)(6)(B) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by striking ''subsection (d) hospital'' and inserting ''hospital that is a subsection (d) hospital or a subsection (d) Puerto Rico hospital''.

(b) OFFSETTING REDUCTION.—Subsection (n)(2) of such section is amended by adding at the end the following new subparagraph:

''(H) BUDGET NEUTRALITY ADJUSTMENT.—The Secretary shall reduce the applicable amounts that would otherwise be determined under this subsection with respect to—

''(i) the first fiscal year to which this subparagraph applies by an amount that the Secretary estimates would ensure that estimated aggregate payments under this

subsection for such fiscal year are not increased as a result of the amendments made by subsection (a) of section 831 of the Health Equity and Accountability Act of 2012; or

''(ii) a succeeding fiscal year by an amount that the Secretary estimates would ensure that estimated aggregate payments under this subsection for such fiscal year are not increased as a result of the amendments made by subsections (a) and (c) of such section.''.

(c) CONFORMING AMENDMENTS.—(1) Subsection (b)(3)(B)(ix) of such section is amended—

(A) in subclause (I), by striking ''(n)(6)(A)'' and inserting ''(n)(6)(B)''; and

(B) in subclause (II), by striking ''subsection (d) hospital'' and inserting ''an eligible hospital''.

(2) Paragraphs (2) and (4)(A) of section 1853(m) of the Social Security Act (42 U.S.C. 1395w–23(m)) are each amended by striking ''1886(n)(6)(A)'' and inserting ''1886(n)(6)(B)''.

(d) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by sub-

sections (a), (b) and (c) by program instruction or otherwise.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to payments for payment years for fiscal years beginning 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 by striking ''insofar as the assistant is practicing'' and all that follows through ''so led''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to amounts expended under 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, RACE, COLOR, NATIONAL ORIGIN, SEXUAL ORIENTATION, GENDER IDENTITY, OR DISABILITY STATUS.

No person in the United States shall, on the basis of sex, race, color, national origin, 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 care service or research program or activity receiving Federal financial assistance.

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 B the following:

"Subtitle C—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 which receive Federal financial assistance are in compliance with title VI of the Civil Rights Act, which prohibits discrimination on the basis of race, color, or national origin. The activities of the Office shall include the following:

"(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 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', and 'In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce', and 'The National Partnership for Action to End Health Disparities', and other related reports by the Institute of Medicine. 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, 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.

''(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 compliance with the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race, Ethnicity and the available language standards.

''(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; and

''(F) civil rights.

''(d) REPORT.—Not later than December 31, 2012, 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.

''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 their 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 an agency within the Department of Health and Human Services 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, and compliance with the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity and the available language standards.

''(5) The conduct of publicly available studies regarding discrimination within Federal health programs administered by the agency as well as dis-

parity 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 Committee 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 in 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.

''(2) DEPARTMENT OF JUSTICE.—The Office for Civil Rights in the Department of Justice shall continue to maintain the power to institute formal proceedings when an agency Office for Civil Rights determines that a recipient of Federal financial assistance is not in compliance with the disparity reduction standards of the 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.''.

SEC. 904. UNITED STATES COMMISSION ON CIVIL RIGHTS.

Section 3 of the Civil Rights Commission Act of 1983 (42 U.S.C. 1975a) 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 racial or ethnic minority groups, coordinate such activities of—

''(A) the Office for Civil Rights within 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).''.

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 American populace 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 have the poorest health status and face substantial cultural, social, and economic barriers to obtaining quality health care.

(3) Efforts to improve minority health have been limited by inadequate resources (funding, staffing, and stewardship) and accountability.

(b) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) funding should be doubled by fiscal year 2013 for the National Institute for Minority 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;

(2) adequate funding by fiscal year 2013, and subsequent funding increases, should be provided for health professions training programs, the Racial and Ethnic Approaches to Community Health (REACH) at the Centers for Disease Control and Prevention, the Minority HIV/AIDS Initiative, and the Excellence Centers to Eliminate Ethnic/Racial Disparities (EXCEED) Program at the Agency for Healthcare Research and Quality;

(3) funding should be restored to the Racial and Ethnic Approaches to Community Health (REACH) program at the Centers for Disease Control and Prevention, which has been a successful program at the community health level;

(4) 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 2013; and

(5) 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 National Institutes of Health during the period beginning January 1, 1990, and ending December 31, 2011.

(B) All recipients of such grants, contracts, and cooperative agreements.

(C) All members of the peer review panels of such applicants and recipients, respectively.

(2) REPORT.—Not later than six months after the date of the enactment of this Act, the Comptroller General shall complete the study under para-

graph (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 six 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)), as added by section 10334(c) of the Patient Protection and Affordable Care Act, 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 2020, the Comptroller General of the United States shall submit to Congress a report that identifies, with respect to minority community-based organizations that applied during the applicable report period for Federal funding provided pursuant to the provisions of (and amendments made by) the Patient Protection and Affordable Care Act for purposes of achieving health equity and eliminating health disparities, the percentage of such organizations that were awarded such funding.

(d) ANNUAL REPORT ON ACTIVITIES OF NATIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH DISPARITIES.—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 the 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

SEC. 1001. CODIFICATION OF EXECUTIVE ORDER 12898.

(a) IN GENERAL.—The President of the United States is authorized and directed to execute, administer, and enforce as a matter of Federal law the provisions of Executive Order 12898, dated February 11, 1994 (''Federal Actions To Address Environmental Justice In Minority Populations and Low-Income Populations''), with such modifications as are provided in this section.

(b) DEFINITION OF ENVIRONMENTAL JUSTICE.—For purposes of carrying out the provisions of Executive Order 12898, the following definitions shall apply:

(1) The term ''environmental justice'' means the fair treatment and meaningful involvement of all people regardless of race, color, national origin, educational level, or income with respect to the development, implementation, and enforcement of environmental laws and regulations in order to ensure that—

(A) minority and low-income communities have access to public information relating to human health and environmental planning, regulations, and enforcement; and

(B) no minority or low-income population is forced to shoulder a disproportionate burden of the negative human health and environmental impacts of pollution or other environmental hazard.

(2) The term ''fair treatment'' means policies and practices that ensure that no group of people, including racial, ethnic, or socioeconomic groups bear disproportionately high and adverse human health or environmental effects resulting from Federal agency programs, policies, and activities.

(c) JUDICIAL REVIEW AND RIGHTS OF ACTION.—The provisions of section 6–609 of Executive Order 12898 shall not apply for purposes of this Act.

SEC. 1002. IMPLEMENTATION OF RECOMMENDATIONS BY ENVIRONMENTAL PROTECTION AGENCY.

(a) INSPECTOR GENERAL RECOMMENDATIONS.—The Administrator of the Environmental Protection Agency shall, as promptly as practicable, carry out each of the following recommendations of the Inspector General of the agency as set forth in Report No. 2006–P–00034 entitled ''EPA needs to conduct environmental justice reviews of its programs, policies and activities'':

(1) The recommendation that the Agency's program and regional offices identify which programs, policies, and activities need environmental justice reviews and require these offices to establish a plan to complete the necessary reviews.

(2) The recommendation that the Administrator of the Agency ensure that these reviews 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 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 developing rules under laws administered by the Environmental Protection Agency, the Administrator of the Agency shall, as promptly as practicable, carry out each of the following recommendations of the Comptroller General of the United States as set forth in GAO Report numbered GAO–05–289 entitled ''EPA Should Devote More Attention to Environmental Justice when Developing Clean Air Rules'':

(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 such workgroups to identify potential environmental justice issues through such steps as providing workgroup members with guidance and training to helping them identify potential environmental justice problems and involving envi-

ronmental justice coordinators in the workgroups when 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 such impacts.

(4) The recommendation that the Administrator direct appropriate Agency officers and employees to respond fully when feasible to public comments on environmental justice, including improving the Agency's explanation of the basis for its conclusions, together with supporting data.

(c) 2004 INSPECTOR GENERAL REPORT.—The Administrator of the Environmental Protection Agency shall, as promptly as practicable, carry out each of the following recommendations of the Inspector General of the Agency as set forth in the report entitled ''EPA Needs to Consistently Implement the Intent of the Executive Order on Environmental Justice'' (Report No. 2004–P–00007):

(1) The recommendation that the Agency clearly define the mission of the Office of Environmental Justice (OEJ) and provide Agency staff with an understanding of the roles and responsibilities of the Office.

(2) The recommendation that the Agency establish (through issuing guidance or a policy statement from the Administrator) specific time frames for the development of definitions, goals, and measurements regarding environmental justice and provide the regions and program offices a standard and consistent definition for a minority and low-income community, with instructions on how the Agency will implement and operationalize environmental justice into the Agency's daily activities.

(3) The recommendation that the Agency ensure the comprehensive training program currently under development 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.

The Administrator shall submit an initial report to Congress within 6 months after the enactment of this Act regarding the Administrator's strategy for implementing the recommendations referred to in paragraphs (1), (2), and (3). Thereafter, the Administrator shall provide semiannual reports to Congress regarding the Administrator's progress in implementing such recommendations and modifying the Administrator's emergency management

procedures to incorporate environmental justice in the Agency's Incident Command Structure (in accordance with the December 18, 2006, letter from the Deputy Administrator to the Acting Inspector General of the Agency).

(d) FEDERAL ACTION PLAN FOR SAVING LIVES, PROTECTING PEOPLE AND THEIR FAMILIES FROM RADON.—

(1) IN GENERAL.—Because radon is a naturally occurring radioactive gas that is recognized as the leading cause of lung cancer among nonsmokers and is a particular environmental threat for low-income and minority individuals because of the lack of information about radon levels in their own homes, the Administrator of the Environmental Protection Agency shall within 6 months after the date of the enactment of this Act, implement the action plan entitled ''Protecting People and Families from Radon: A Federal Action Plan for Saving Lives'' (June 20, 2011), working with the Secretary of Health and Human Services acting through the Director of the Centers for Disease Control and Prevention, and with the other Federal agencies mentioned in and as set forth in the action plan.

(2) SPECIFIC STEPS.—In carrying out paragraph (1), the Administrator shall take steps to achieve each of the following:

(A) The recommendation that the workgroup comprised of the Federal agencies participating in the development of the action plan referred to in paragraph (1) implement specific steps within the current authority and activities of each Federal agency to reduce exposure to radon.

(B) The recommendation that such workgroup meet on the 1-year anniversary of the plan to assess and recognize achievements of the plan.

(3) REPORT.—The Administrator shall report to the Congress on the 1-year assessment of the plan's implementation, including the challenges remaining and the progress in reducing radon exposure particularly to low-income and minority families.

SEC. 1003. GRANT PROGRAM.

(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 Adminis-

trator 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) has established a coalition—

(i) with not less than 1 community-based organization; and

(ii) with not less than 1—

(I) public health entity;

(II) health care provider organization; or

(III) academic institution, including any minority-serving institution (including an Hispanic-serving institution, a historically Black college or university, and a tribal college or university);

(C) ensures planned activities and funding streams are coordinated to improve community health; and

(D) 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.

(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) COOPERATIVE AGREEMENTS.—An eligible entity may use a grant under this section—

(1) to promote environmental health; and

(2) to address environmental health disparities.

(e) AMOUNT OF COOPERATIVE AGREEMENT.—

(1) IN GENERAL.—The Director shall award grants to eligible entities at the 2 different funding levels described in this subsection.

(2) 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.

(3) 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 (2)).

(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 (2)(C)(ii), including—

(I) air quality;

(II) water quality;

(III) solid waste;

(IV) land use;

(V) housing;

(VI) food safety;

(VII) crime;

(VIII) injuries; and

(IX) health care services;

(ii) building partnerships between planning, public health, and other sectors, 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, asthma, 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 those conditions influence the concerns and needs of people who have impaired mobility and use assistance devices, including wheelchairs and lower limb prostheses; and

(iv) convening intervention programs that examine the role of the social environment in connection with the physical and chemical environment in—

(I) determining access to nutritional food; and

(II) improving physical activity to reduce morbidity and increase quality of life.

SEC. 1004. 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) consumption of nutritional foods;

(C) rates of crime;

(D) air, water, and soil quality;

(E) risk of injury;

(F) accessibility to health care services; and

(G) 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 (such as 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; and

(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 and low-income urban and rural communities.

(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, urban planning, and transpor-

tation research communities in the United States and abroad.

SEC. 1005. ENVIRONMENT AND PUBLIC HEALTH RESTORATION.

(a) FINDINGS.—

(1) GENERAL FINDINGS.—The Congress finds as follows:

(A) As human beings, we share our environment with a wide variety of habitats and ecosystems that nurture and sustain a diversity of species.

(B) The abundance of natural resources in our environment forms the basis for our 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 our natural environment and its resources, the health and diversity of plant and animal wildlife, the availability of critical habitats, the quality of our air and our water, and our global climate.

(D) The intervention of the Federal Government is necessary to minimize and mitigate human impact on the environment for the ben-

efit of public health, to maintain air quality and water quality, to sustain the diversity of plants and animals, to combat global climate change, and to protect the environment.

(E) Laws and regulations in the United States have been created 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.

(F) Such laws include the Antiquities Act of 1906 (16 U.S.C. 431 et seq.) initiated by President Theodore Roosevelt to create the national park system, the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.), the Clean Air Act (42 U.S.C. 7401 et seq.), the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (Public Law 96–510), the Endangered Species Act of 1973 (Public Law 93–205), and the National Forest Management Act of 1976 (Public Law 94–588).

(G) Attempts to repeal or weaken key environmental safeguards pose dangers to the pub-

lic health, air quality, water quality, wildlife, and the environment.

(2) FINDINGS ON CHANGES AND PROPOSED CHANGES IN LAW.—The 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) On May 9, 2002, the Environmental Protection Agency (EPA) and the Army Corps of Engineers put forth a final rule that reconciled regulations implementing section 404 of the Federal Water Pollution Control Act by redefining the term ''fill material'' and amending the definition of the term ''discharge of fill material'', reversing a 25-year-old regulation. The new rule fails to restrict the dumping of hardrock mining waste, construction debris, and other industrial wastes into rivers, streams, lakes, and wetlands. The rule further 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) On February 12, 2003, the Environmental Protection Agency published the rule ''National Pollutant Discharge Elimination System Permit Regulation and Effluent Limitation Guidelines and Standards for Concentrated Animal Feeding Operations'', new livestock waste regulations that aimed to control factory farm pollution but which would severely undermine existing protections under the Federal Water Pollution Control Act. This regulation allows large-scale animal factories to foul the Nation's waters 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. 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 EPA. On November 20, 2008, the Environmental Protection Agency published a revised final rule which undermines environmental protection provisions by removing mandatory permitting requirements and allowing large animal farms to self-certify the absence of pollutant discharge activity.

(iii) On March 19, 2003, the Environmental Protection Agency published a new rule regarding the Total Maximum Daily Load program of the Federal Water Pollution Control Act that regulates the maximum amount of a particular pollutant that can be present in a body of water and still meet water quality standards. The new rule withdrew the existing regulation put forth on July 13, 2000, and halted momentum in cleaning up polluted waterways throughout the Nation. By abandoning the existing rule, the Environmental Protection

Agency is undermining the effectiveness of clean-up plans and is allowing States to avoid cleaning polluted waters entirely by dropping them from their clean-up lists. 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. The result of dropping the July 2000 rule 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) On December 2, 2008, the Environmental Protection Agency and the Army Corps of Engineers jointly issued a guidance document in the form of a legal memorandum, titled ''Clean Water Act Jurisdiction Following the U.S. Supreme Court's Decision in Rapanos v. United States & Carabell v. United States''. This new guidance dictates enforcement actions under the Federal Water Pollution Control Act and calls for a complicated ''case-by-case'' analysis to determine jurisdiction for waterways that do not flow all year. Such

actions 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. Further, the definition provided therein for ''waters of the United States'' is applicable to the Federal Water Pollution Control Act 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 the Federal Water Pollution Control Act.

(B) FORESTS AND LAND MANAGEMENT.—

(i) On December 3, 2003, the President signed into law the Healthy Forests Restoration Act of 2003 (Public Law 108–148; 16 U.S.C. 6501 et seq.). Although the law attempts to reduce the risk of catastrophic forest fires, it provides a boon to timber companies by accelerating the aggressive thinning of backcountry forests that are far from at-risk communities. The

law allows for increased logging of large, fire-resistant trees that are not in close proximity of homes and communities; it 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; and it limits public participation by reducing the number of environmental project reviews.

(ii) On April 21, 2008, the Department of Agriculture issued a Final Planning Rule and Record of Decision for National Forest System Land Management Planning. Similar to rules enacted by the Administration on January 5, 2005, later remanded back to the agency in Federal district court for violating the National Environmental Policy Act of 1969, the Endangered Species Act of 1973, and the Administrative Procedure Act (''Citizens for Better Forestry v. United States Department of Agriculture'', 481 F. Supp. 2d 1059 (N.D. Cal. 2007)), this revised rule

eliminates strict forest planning standards established in 1982, and opens millions of acres of public lands to damaging and invasive logging, mining, and drilling operations. These regulations would reverse more than 20 years of protection for wildlife and national forests by removing the overall goal of ensuring ecological sustainability in managing the national forest system, weakening the National Forest Management Act of 1976, and effectively ending the review of forest management plans under the National Environmental Policy Act of 1969.

(iii) On September 20, 2006, the District Court for the Northern District of California vacated the Protection of Inventoried Roadless Areas rule, enacted on May 13, 2005, which gave State Governors 18 months to petition the Federal Government to either restore the previous rule for their States, or submit a new management and development plan for national forest areas inventoried under the rule. Despite the enjoinment of the Administration's 2005

rule, and the subsequent restoration of the original Roadless Area Conservation Rule, the U.S. Forest Service has continued to allow States to petition for a special rule under the authority of the Administrative Procedure Act, publishing a final special rule for Idaho on October 16, 2008. As a result, 58.5 million acres of wild national forests are still vulnerable to logging, road building, and other developments that may fragment natural habitats and negatively impact fish and wildlife.

(iv) On November 17, 2008, the Department of the Interior's Bureau of Land Management (BLM) signed the Record of Decision (ROD) amending 12 resource management plans in Colorado, Utah, and Wyoming, opening 2,000,000 acres of public lands to commercial tar sands and oil shale exploration and development. On November 18, 2008, the BLM published a final rule for Oil Shale Management setting the policies and procedures for a commercial leasing program for the management of federally owned oil shale in those

three States. 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 lands poses a serious threat to land conservation, endangered and threatened species, and critical habitat. Domestic shale oil production allowed by these regulations is highly water and energy intensive, the impacts of which will intensify existing water scarcity in the arid Western Region and potentially degrade air and water quality for surrounding populations.

(C) SCIENTIFIC REVIEW.—On December 16, 2008, the United States Fish and Wildlife Service of the Department of the Interior and the National Oceanic and Atmospheric Administration of the Department of Commerce jointly issued a new rule amending regulations governing interagency cooperation under section 7 of the Endangered Species Act of 1973 (ESA). This rule undermines the intention of the ESA to protect species and the ecosystems upon which they 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. Under this new rule, Federal agencies can unilaterally circumvent the formal review process, eliminating longstanding and scientifically grounded safeguards that serve to protect the biodiversity of our Nation's ecosystems and avert harm to thousands of endangered and threatened species.

(b) STATEMENT OF POLICY.—It is the policy of the United States Government to work in conjunction with States, territories, tribal governments, international organizations, and foreign governments in order to act 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 to enjoy.

(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 will 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) Final revisions to the Federal Water Pollution Control Act regulatory definitions of ''fill material'' and ''discharge of fill material'', finalized and published in the Federal Register on May 9, 2002 (67 FR 31129), amending part 232 of title 40, Code of Federal Regulations.

(ii) Revised National Pollutant Discharge Elimination System Permit Regulation and Effluent Limitation Guidelines and Standards for Concentrated Animal Feeding Operations in response to the ''Waterkeeper Alliance, et al. v. Environmental Protection Agency'' decision, finalized and published in the Federal Register on November 20, 2008 (73 FR 225), amending parts 9, 122, and 412 of title 40, Code of Federal Regulations.

(iii) A March 19, 2003, rule published in the Federal Register (68 FR 13608)

withdrawing a July 13, 2000, rule revising the Total Maximum Daily Load program of the Federal Water Pollution Control Act (65 FR 43586), amending parts 9, 122, 123, 124, and 130 of title 40, Code of Federal Regulations.

(iv) Official Guidance Document, ''Clean Water Act Jurisdiction Following the United States Supreme Court's Decision in Rapanos v. United States & Carabell v. United States'', issued on December 2, 2008, relating to jurisdiction under section 404 of the Federal Water Pollution Control Act.

(B) FORESTS AND LAND MANAGEMENT.—

(i) Healthy Forests Restoration Act of 2003, signed into law on December 3, 2003 (Public Law 108–148; 16 U.S.C. 6501 et seq.).

(ii) National Forest System Land Management Planning Rule, finalized and published in the Federal Register on April 21, 2008 (73 FR 21468), replacing the 2005 final rule (70 FR 1022, Jan. 5, 2005), as amended March 3, 2006 (71 FR

10837) and the 2000 final rule adopted on November 9, 2000 (65 FR 67514) as amended on September 29, 2004 (69 FR 58055), amending title 36, Code of Federal Regulations, part 219.

(iii) The application of the Administrative Procedure Act (5 U.S.C. 551 to 559, 701 to 706, et seq.), such that States may petition for a special rule for the roadless areas in all or part of said State.

(iv) Record of Decision, ''Oil Shale and Tar Sands Resources Resource Management Plan Amendments'', issued on November 17, 2008, along with the Final Rule, Oil Shale Management-General, published in the Federal Register on November 18, 2008 (73 FR 223), amending title 43, Code of Federal Regulations, parts 3900, 3910, 3920, and 3930.

(C) SCIENTIFIC REVIEW.—Final Rule, Interagency Cooperation Under the Endangered Species Act, published in the Federal Register on December 16, 2008, amending title 50, Code of Federal Regulations, part 402.

(2) METHOD.—In conducting the study under paragraph (1), the National Academy of Sciences may utilize and compare existing scientific studies regarding the regulations, laws, and proposed laws listed in paragraph (1).

(3) REPORT.—Under the arrangement entered into under paragraph (1), not later than 270 days after the date on which such arrangement is entered into, 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 listed in paragraph (1), a report containing—

(A) a description of the impact of all such regulations, laws, and proposed laws on public health, air quality, water quality, wildlife, and the environment, compared to the impact of preexisting regulations, or laws in effect, 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 listed 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 and agency that has issued or implemented a regulation or law listed in subsection (c)(1) shall submit to the Congress a plan describing the steps such department or such 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 such regulation or law.

SEC. 1006. HEALTHY FOOD FINANCING INITIATIVE.

(a) IN GENERAL.—Subtitle D of the Department of Agriculture Reorganization Act of 1994 (7 U.S.C. 6951) is amended by adding at the end the following:

"SEC. 242. HEALTHY FOOD FINANCING INITIATIVE.

''(a) PURPOSE.—The purpose of this section is to establish a program to improve access to healthy foods in underserved areas, to create and preserve quality jobs, and to revitalize low-income communities by providing loans and grants to eligible fresh, healthy food retailers to overcome the higher costs and initial barriers to entry in underserved, urban, suburban, and rural areas.

''(b) DEFINITIONS.—In this section:

''(1) COMMUNITY DEVELOPMENT FINANCIAL INSTITUTION.—The term 'community development financial institution' has the meaning given the term in section 103 of the Community Development Banking and Financial Institutions Act of 1994 (12 U.S.C. 4702).

''(2) FOOD ACCESS ORGANIZATION.—The term 'food access organization' means a nonprofit organization with expertise in improving access to healthy food in underserved communities.

''(3) INITIATIVE.—The term 'Initiative' means the Healthy Food Financing Initiative established in the Department by subsection (c)(1).

''(4) LOCAL FUNDS.—The term 'local funds' means the allocation of national funds and any other forms of financial assistance (including grants, loans, and equity investments) that are raised by partnerships to carry out the purposes of this section.

''(5) NATIONAL FUNDS.—The term 'national funds' means any Federal appropriation made to carry out this section and any other forms of financial assistance (including grants, loans, and equity investments) that are raised by the national fund manager to carry out the purposes of this section.

''(6) NATIONAL FUND MANAGER.—The term 'national fund manager' means a community development financial institution in existence as of the date of enactment of this section and certified by the Community Development Financial Institutions Fund of the Department of the Treasury that is designated by the Secretary to manage the Initiative for purposes of—

''(A) raising private capital;

''(B) providing financial and technical assistance to partnerships; and

''(C) funding eligible projects directly at the request of partnerships to attract fresh, healthy food retailers to underserved urban, suburban, and rural areas, in accordance with this section.

''(7) PARTNERSHIP.—

''(A) IN GENERAL.—The term 'partnership' means a regional, State, or local public and private partnership that is organized to improve access to fresh, healthy foods by providing financial and technical assistance to eligible projects.

''(B) INCLUSIONS.—The term 'partnership' includes—

''(i) an unit of State, local, or tribal government or a quasi-public State or local government agency;

''(ii) a food access or community health organization committed to improving access to healthy foods;

''(iii) a community development financial institution or other organization that is capable of administering a loan and

grant program in accordance with this section; and

''(iv) other organizations interested in improving access to healthy foods in underserved areas.

''(c) ESTABLISHMENT.—

''(1) IN GENERAL.—There is established in the Department a Healthy Food Financing Initiative.

''(2) MANAGEMENT.—Not later than 1 year after the date of enactment of this section, the Secretary shall select and enter into a grant agreement with a national fund manager who shall be responsible for the management of the Initiative nationally.

''(3) ELIGIBLE PROJECTS.—

''(A) IN GENERAL.—Subject to the requirements of this paragraph, the national fund manager shall establish the eligibility criteria for projects to be assisted by the Initiative.

''(B) REQUIREMENTS.—To be eligible to receive assistance through the Initiative, a project shall—

''(i) include a supermarket, grocery store, farmers market, or other fresh, healthy food retailer;

''(ii) consist of a for-profit business enterprise, a member- or worker-owned cooperative, or a nonprofit organization;

''(iii) meet the eligibility criteria established under this section;

''(iv) continue to be a viable business enterprise with a financial viability plan;

''(v) require an investment of public funding to move forward and be competitive;

''(vi) operate on a self-service basis;

''(vii) in accordance with subparagraph (C), expand or preserve the availability of healthy, fresh, high quality unprepared and unprocessed foods, particularly fresh fruits and vegetables, in underserved areas; and

''(viii) agree to accept benefits under the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

''(C) REQUIREMENTS.—

''(i) DEFINITIONS.—In this subparagraph:

"(I) PERISHABLE FOOD.—

"(aa) IN GENERAL.—The term 'perishable food' means food that is fresh, refrigerated, or frozen.

"(bb) EXCLUSION.—The term 'perishable food' does not include packaged or canned goods.

"(II) STAPLE FOOD.—

"(aa) IN GENERAL.—The term 'staple food' means food that is a basic dietary item, including bread, flour, fruits, vegetables, and meat.

"(bb) EXCLUSIONS.—The term 'staple food' does not include snack or accessory food (such as chips, soda, coffee, condiments, and spices) or ready-to-eat, prepared food.

"(III) VARIETY.—The term 'variety' means an assortment of different types of food items.

''(ii) IN GENERAL.—For purposes of subparagraph (B)(vii), to expand or preserve the availability of fresh fruits and vegetables in underserved areas shall mean, with respect to a project, that the project maintains a store that—

''(I) carries a full line of fresh produce, as defined by the national fund manager to reflect differences in project size and overall store size;

''(II) sells food for home preparation and consumption; and

''(III) at a minimum—

''(aa) offers for sale at least 3 different varieties of food in each of the 4 staple food groups (bread and grains, dairy, fruits and vegetables, and meat, poultry, and fish), with perishable food in at least 2 categories, on a daily basis; or

''(bb) has a store at which at least 50 percent of the total sales of the store (including food and nonfood items or services)

are from the sale of eligible staple food.

''(D) INCOME CRITERIA.—Each eligible project shall be located in—

''(i) a low- or moderate-income census tract, as determined by the Bureau of the Census of the Department of Commerce;

''(ii) a population census tract that is treated as a low-income community under section 45D(e) of the Internal Revenue Code of 1986; or

''(iii) an area that significantly serves an adjacent area that meets the criteria described in clause (i) or (ii), as approved by the national fund manager.

''(E) UNDERSERVED CRITERIA.—

''(i) IN GENERAL.—Each eligible project shall be located in an underserved area, as determined by the partnerships according to criteria established by the national fund manager.

''(ii) FACTORS.—In determining whether an area is an underserved area, the following factors shall be taken into consideration:

''(I) Population density.

''(II) Below average supermarket density or sales.

''(III) Car ownership.

''(IV) Geographical or physical barriers, such as highways, mountains, major parks, or bodies of water.

''(iii) LOCATIONS.—On an annual basis, the national fund manager shall collect data and publish maps that show the location of underserved areas.

''(4) PRIORITY PROJECTS.—

''(A) IN GENERAL.—Priority shall be given to projects that—

''(i) are located in severely distressed low-income communities, as defined by the Community Development Financial Institutions Fund of the Department of the Treasury; and

''(ii) include 1 or more of the following characteristics:

''(I) The project will create or retain quality jobs in the community, as determined in accordance with subparagraph (B).

''(II) The project has community support in terms of store quality, affordability, site location, and coordination with local community plans or other programs promoting community and economic development.

''(III) The project supports regional food systems and locally grown foods, to the extent available.

''(IV) In major metropolitan areas, the project is associated with a transit-oriented development project.

''(V) In areas with public transit, the project is accessible by public transit.

''(VI) The project involves the reuse of a building that is listed in or eligible for the National Register of Historic Places.

''(VII) The project involves a brownfield or grayfield (as those terms are used in the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9601 et seq.)).

''(VIII) The estimated energy consumption of the project, calculated using building energy software approved by the Department of Energy, will qualify the project for designation under the Energy Star program established by section 324A of the Energy Policy and Conservation Act (42 U.S.C. 6294a).

''(IX) The project involves women- and minority-owned businesses.

''(B) QUALITY JOBS.—For purposes of subparagraph (A)(ii)(I), a quality job is a job that—

''(i) provides wages that are comparable to or better than similar positions in existing businesses of similar size in similar local economies;

''(ii) offers benefits that are comparable to or better than what is offered for similar positions in existing local businesses of similar size in similar local economies; and

''(iii) is targeted for residents of neighborhoods with a high proportion of persons of low income (as that term is defined in section 102(a) of the Housing and Community Development Act of 1974 (42 U.S.C. 5302(a))) through local targeted hiring programs.

''(d) DUTIES OF THE SECRETARY.—

''(1) IN GENERAL.—The Secretary shall—

''(A) designate a national fund manager to manage national funds;

''(B) oversee the Initiative nationally;

''(C) work closely with the designated national fund manager—

''(i) to ensure that funds are used appropriately and in the most effective manner practicable; and

''(ii) to develop the program strategy into a detailed work plan, program, and operating budget;

''(D) review and approve the operating budget for the national fund manager to ensure that the administrative costs are—

''(i) reasonable (not more than 5 percent of the total budget);

''(ii) connected to the costs of operations; and

''(iii) reflect efficient operations by the national fund manager; and

''(E) make available to the public an annual report, using data obtained from the Department of Agriculture, the Department of Health and Human Services, and the Community Development Financial Institutions, that describes the impacts of the Initiative, including tracking health and economic development indicators at the local, State, and national levels to determine the impacts of individual projects and the collective impact in local areas and statewide of funded projects and the Initiative overall.

''(2) NATIONAL FUND MANAGER.—The Secretary shall—

''(A) select the national fund manager through a competitive process from among community development financial institutions that have a proven and recent track record of success and effectiveness in—

''(i) attracting private capital;

''(ii) developing and managing programs that provide grants and loans to support supermarkets and other fresh, healthy food retail business enterprises in low- and moderate-income communities, including the development of grocery stores, farmers markets, and other fresh, healthy food retail models;

''(iii) making and servicing loans that are similar to loans proposed in the Initiative or having a record of otherwise successfully investing in fresh, healthy food retail development projects;

''(iv) effectively managing multiple contracts and subcontractors;

''(v) effectively managing large capital pools, of at least $100,000,000; and

''(vi) providing or contracting for the provision of technical assistance; and

''(B) administer the Initiative by approving the disbursement of funds to the national fund manager in a manner that facilitates the implementation of the overall Initiative.

''(3) COORDINATION.—

''(A) IN GENERAL.—Not later than 45 days after the date of receipt of an award, the national fund manager shall develop, with guidance from and in consultation with the Secretary, and submit to the Secretary, a detailed work plan.

''(B) APPROVAL REQUIRED.—The Secretary shall review and approve the work plan, program budget, and administrative costs under subsection (e)(4)(C) prior to entering into an agreement with the national fund manager to administer the Initiative.

''(4) PERFORMANCE TARGETS.—

''(A) IN GENERAL.—The Secretary shall conduct financial audits of, and establish performance targets for, the national fund manager, which shall include, at a minimum, the requirements described in this paragraph.

''(B) GEOGRAPHIC SPREAD.—Partnerships funded by the Initiative shall be geographically diverse and representative of the underserved areas across the United States.

''(C) FOCUS ON LOW-INCOME COMMUNITIES.—A substantial portion of the projects funded by partnerships shall serve very low-

and low-income communities, as defined by the Bureau of the Census of the Department of Commerce.

''(D) FINANCIAL EFFECTIVENESS OF THE NATIONAL FUND MANAGER.—The national fund manager and any local financial institution involved in a partnership shall demonstrate ongoing capacity and timeliness in raising private capital and disbursing funds as required under the Initiative.

''(E) TECHNICAL ASSISTANCE EFFECTIVENESS OF THE NATIONAL FUND MANAGER.—The provision of technical assistance by the national fund manager shall be evaluated based on—

''(i) the responsiveness of the national fund manager to requests for assistance; and

''(ii) the ability of the national fund manager to craft programs that develop needed new capacities in partnerships.

''(F) IMPACT.—Performance targets shall address the allocation of funds by the national fund manager to partnerships and the tracking and reporting of the impacts of the funds in im-

proving access to fresh, healthy foods and in achieving other related impacts.

''(e) DUTIES OF THE NATIONAL FUND MANAGER.—

''(1) ALLOCATION OF FUNDS.—

''(A) IN GENERAL.—The national fund manager shall—

''(i) allocate at least 70 percent of any Federal appropriation made to carry out this section to partnerships that are selected based on the criteria described in paragraph (3); and

''(ii) retain not more than 30 percent of any Federal appropriation made to carry out this section to undertake financing activities described in subparagraph (C), including a reasonable amount for administrative costs (not to exceed 5 percent) approved by the Secretary in accordance with paragraph (4)(C).

''(B) USE OF THE NATIONAL FUNDS BY PARTNERSHIP PROGRAMS.—

''(i) IN GENERAL.—As a condition on the receipt of funds, each partnership shall use—

''(I) the national funds received from the national fund manager under subparagraph (A)(i) to create 1 or more revolving loan programs or other revolving pools of capital or other products to facilitate financing of local projects as determined by the agreement between the partnership and the national fund manager; and

''(II) any remaining funds for grants, or, as approved, for innovative financing mechanisms.

''(ii) LIMITATIONS.—

''(I) IN GENERAL.—Use of funds for administrative costs and other purposes shall be—

''(aa) limited in accordance with the terms of the agreement negotiated between the national fund manager and partnerships;

''(bb) based on whether administrative costs are reasonable, connected to the costs of operation, and reflect efficient operations by the partnership; and

''(cc) determined using criteria including geographic coverage, program duration, and total funding amount.

''(II) GOAL.—The goal of this clause to limit administrative costs to the maximum extent practicable, but in no case may the amount used for administrative costs exceed 10 percent of the Federal funds allocated.

''(C) USE OF THE NATIONAL FUNDS BY THE NATIONAL FUND MANAGER.—The national fund manager shall use national funds described in subparagraph (A)(ii) to undertake financing and other activities to enhance and maximize the effectiveness of the Initiative, as determined by the agreement with the Secretary, including—

''(i) attracting other forms of financial assistance to match or leverage the national funds;

''(ii) awarding national funds to partnerships in accordance with paragraph (3);

''(iii) creating and managing pools of grant or loan capital that blend or leverage

national funds with other forms of financial assistance, including capital in the form of tax credits under section 45D of the Internal Revenue Code of 1986, for the benefit of partnerships;

''(iv) creating and managing pools of grant or loan capital that blend or leverage the national funds with other forms of financial assistance, including capital in the form of tax credits under section 45D of the Internal Revenue Code of 1986, to finance eligible local projects identified by partnerships or the national fund manager that have special or unique characteristics;

''(v) providing loans or grants directly to eligible local projects as matching funds if requested by a partnership;

''(vi) providing credit enhancement or other financial products and instruments for the benefit of partnerships or eligible local projects;

''(vii) providing technical assistance; and

"(viii) funding reasonable administrative costs approved by the Secretary in accordance with paragraph (4)(C).

"(2) RESPONSIBILITIES OF THE NATIONAL FUND MANAGER.—The designated national fund manager shall—

"(A) raise other forms of financial assistance to match or leverage the national funds;

"(B) use administrative funds to develop appropriate training programs and offer technical assistance services to—

"(i) partnerships;

"(ii) State, local, and tribal governments;

"(iii) the food retail industry; and

"(iv) food access and health advocacy organizations to augment local capacities;

"(C) develop financial products such as loans, grants, and credit enhancement tools that can be used by partnerships to incentivize and support the development and retention of supermarkets and other fresh, healthy food retail in underserved areas;

"(D) award Initiative funds to eligible partnerships through an annual competitive process in accordance with paragraph (3);

"(E) contract with a national food access organization to assist in the review of applications from partnerships and to provide technical assistance to local food access organizations in the proposed partnerships;

"(F) award and disburse funds to partnerships or eligible local projects in a timely manner;

"(G) create and meet performance benchmarks and reporting guidelines, as approved by the Secretary, including for—

"(i) the amount of capital raised and leveraged from financial institutions, partnerships, and other resources;

"(ii) the geographic diversity of partnerships; and

"(iii) the proportion of projects funded by the partnership that are in severely distressed low-income communities;

"(H) develop program guidelines and operating procedures for the Initiative, including—

"(i) maximum grant and loan amounts for projects;

"(ii) eligible uses of funds;

"(iii) prudent underwriting criteria;

"(iv) performance targets;

"(v) reporting guidelines;

"(vi) limits on administrative costs; and

"(vii) implementation milestones;

"(I) monitor the performance of partnerships; and

"(J) collect data, compile information, and conduct such research studies as the national fund manager determines to be relevant to the successful implementation of the Initiative, including—

"(i) to assess national and local market conditions;

"(ii) to determine barriers to market entry; and

"(iii) to identify opportunities for the development or retention of supermarkets and other fresh, healthy food retail enterprises in underserved communities.

''(3) CRITERIA FOR AWARDING NATIONAL FUNDS TO PARTNERSHIPS.—

''(A) IN GENERAL.—The national fund manager shall award national funds to partnerships through a competitive process on an annual basis.

''(B) FIRST ROUND PRIORITY.—In the first round of funding, the national fund manager shall give priority to existing partnerships that have demonstrable capacity to implement fresh food financing programs in underserved areas quickly.

''(C) ADDITIONAL ROUNDS.—Additional rounds shall be designed to promote geographic diversity.

''(D) CRITERIA.—In awarding national funds to partnerships, the national fund manager shall consider—

''(i) the amount of funds and other resources pledged by a partnership to match or leverage national funds;

''(ii) the degree of State, local, or tribal government support of the partnership as evidenced by matching grant and loan funds or other types of support, such as al-

location of tax-exempt bonds, loan guarantees, and coordination of resources from other State or local economic development programs;

''(iii) the capacity of the partnership to successfully develop and manage loan and grant programs;

''(iv) the lack of supermarkets and other fresh, healthy food retail enterprises in low- and moderate-income areas that would be served by the partnership;

''(v) the experience of the food access or community health organization of the partnership in outreach about access to healthy foods and local healthy food access issues;

''(vi) the degree of community engagement and support in the development and retention of supermarkets and other fresh, healthy food retail enterprises; and

''(vii) the contribution of the program of the partnership to the overall geographic diversity of the Initiative.

''(4) ADMINISTRATIVE COSTS.—

''(A) IN GENERAL.—Not later than 45 days after the date of receipt of an award, the national fund manager shall submit to the Secretary for approval a 3-year program and operating budget and detailed work plan that shall include—

''(i) costs for research and evaluation, technical assistance, and training; and

''(ii) program and operating costs.

''(B) EARNED REVENUES.—Earned revenues from loan fees and interest may be expended on program and operating costs in accordance with the budget approved by the Secretary.

''(C) BASIS OF REVIEW.—The Secretary shall base the review under subparagraph (A) on—

''(i) the likelihood of the plan and expenditures to further the purposes of this section; and

''(ii) whether the administrative costs are reasonable, connected to the costs of operation, and reflect efficient operations by the national fund manager.

''(f) PARTNERSHIPS.—

''(1) IN GENERAL.—Each partnership that receives assistance through the Initiative shall provide financial and technical assistance to eligible fresh, healthy food retail projects in underserved areas within the defined communities of the partnership.

''(2) ADMINISTRATION.—Each partnership shall designate a community development financial institution or other organization that is capable of administering a loan and grant program—

''(A) to execute grant agreements with the national fund manager; and

''(B) to serve as the manager of local funds.

''(3) RESPONSIBILITIES OF PARTNERSHIPS.—A partnership shall—

''(A) raise other forms of financial assistance to match the national funds received by the partnership;

''(B) provide marketing and outreach to communities, the supermarket industry, other fresh, healthy food retailers, State and local government officials, and civic and public interest organizations—

''(i) to solicit applications from underserved areas from across the State or locality to be served by the partnership; and

''(ii) to inform the communities and other persons about the availability of grants, loans, training, and technical assistance;

''(C) review and underwrite projects to determine whether—

''(i) a proposed project meets the criteria for eligible projects under subsection (c)(3); and

''(ii) a proposed project meets the criteria for priority projects under subsection (c)(4);

''(D) provide technical assistance services to eligible fresh, healthy food retail operators and developers;

''(E) track and report outcomes, including—

''(i) the number of jobs created or retained;

''(ii) the quantity of fresh, healthy food retail space created or retained; and

''(iii) such other health and economic indicators as are required by the national fund manager;

''(F) monitor and audit funded projects to ensure compliance with the Initiative, the national fund manager, and partnership program requirements for a period of at least 3 years;

''(G) submit an annual report to the national fund manager that describes—

''(i) the activities of the partnership;

''(ii) the expenditure of local funds; and

''(iii) success in meeting performance targets and satisfying such other terms and conditions as are specified in the agreement between the partnership and the national fund manager; and

''(H) coordinate with the national fund manager for the smooth operation of the Initiative.

''(4) ADMINISTRATIVE COSTS.—

''(A) IN GENERAL.—As a condition on the receipt of assistance under this section, each partnership shall submit to the national fund manager for approval a 3-year budget and plan

for all program and operating costs, including—

''(i) costs for research and evaluation, technical assistance, and training; and

''(ii) administrative and operating costs.

''(B) EARNED REVENUES.—Earned revenues from loan fees and interest may be expended on program and operating costs in accordance with the budget approved by the national fund manager.

''(C) BASIS OF REVIEW.—The national fund manager shall base the review under subparagraph (A) on the likelihood of the budget and plan to further the purposes of this section.

''(g) EVALUATION AND MONITORING.—

''(1) IN GENERAL.—Program evaluation and financial audits shall occur at all levels of the Initiative to ensure that—

''(A) national and local funds are used properly; and

''(B) the objectives of the Initiative are met.

''(2) PROGRAM EVALUATION AND FINANCIAL AUDITS.—

''(A) IN GENERAL.—The Secretary shall—

''(i) conduct periodic program evaluations and financial audits of the national fund manager, partnerships, and projects funded by the Initiative; and

''(ii) share with the national fund manager the results of the evaluations and audits.

''(B) FUNDED PROJECTS.—The Secretary or the national fund manager shall evaluate partnerships to assess the health and economic impacts of projects funded by the Initiative.

''(C) OTHER IMPACTS.—

''(i) SECRETARY OF HEALTH AND HUMAN SERVICES.—The Secretary of Health and Human Services shall conduct research studies and evaluate the health impacts of the Initiative.

''(ii) COMMUNITY DEVELOPMENT FINANCIAL INSTITUTIONS.—Representatives of the Community Development Financial Institutions shall conduct research studies and evaluate the economic impacts of the Initiative.

''(D) PARTNERSHIPS.—

''(i) IN GENERAL.—Each partnership shall—

''(I) conduct periodic administrative and financial audits of projects funded by the Initiative; and

''(II) share with the national fund manager the results of the audits.

''(ii) FAILURE OF PARTNERSHIP.—In a case in which a partnership fails, the national fund manager shall take over the portfolio of the failed partnership.

''(h) ADMINISTRATIVE PROVISIONS.—Not later than 180 days after the date of enactment of this section, the Secretary shall promulgate such regulations as may be necessary to carry out this section, including regulations—

''(1) for the conduct of a performance evaluation at the end of the initial 5-year period;

''(2) to terminate the contract for cause; and

''(3) to extend the contract for an additional 5-year period.''.

(b) CONFORMING AMENDMENT.—Section 296(b) of the Department of Agriculture Reorganization Act of 1994 (7 U.S.C. 7014(b)) is amended—

(1) in paragraph (6)(C), by striking ''or'' at the end;

(2) in paragraph (7), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following:

''(8) the authority of the Secretary to establish in the Department the Healthy Food Financing Initiative in accordance with section 242.''.

SEC. 1007. 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 (whether residents, clean-up workers, or volunteers) affected by the explosion of the mobile offshore drilling unit Deepwater Horizon that occurred on April 20, 2010.

(b) SPECIFIC COMPONENTS; REPORTING.—In carrying out subsection (a), the Comptroller General shall—

(1) assess the type, size, and scope of programs administered by the Department of Health and Human Services that focus on provision of health care to communities in the Gulf Coast;

(2) identify the merits and disadvantages associated with each the programs;

(3) perform an analysis of the costs and benefits of the programs;

(4) determine whether there is any duplication of programs; and

(5) not later than 180 days after the date of the enactment of this Act, report findings and recommendations for improving access to health care for racial and ethnic minorities to the Congress.

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