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112TH CONGRESS
1ST SESSION

H. R. 2954

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

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 15, 2011

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

A BILL

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

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the ''Health Equity and
5 Accountability Act of 2011''.

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

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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, dis-

ability 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 reimbursement, 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: Standardization 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 otherwise) that all data collected pursuant to subsection (a) are protected—

"(1) under the same privacy protections as the Secretary applies to other health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (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 "(1) implement subsection (a) while minimizing
2 the cost and administrative burdens of data collec-
3 tion and reporting;
4 "(2) expand awareness among Federal agencies,
5 States, territories, Indian tribes, health providers,
6 health plans, health insurance issuers, and the gen-
7 eral public that data collection, analysis, and report-
8 ing by race, ethnicity, primary language, sexual ori-
9 entation, disability status, gender identity, and socio-
10 economic status is legal and necessary to assure eq-
11 uity and nondiscrimination in the quality of health
12 care services;
13 "(3) ensure that future patient record systems
14 have data code sets for racial, ethnic, primary lan-
15 guage, sexual orientation, disability status, gender
16 identity, and socioeconomic status identifiers and
17 that such identifiers can be retrieved from clinical
18 records, including records transmitted electronically;
19 "(4) improve health and health care data collec-
20 tion and analysis for more population groups if such
21 groups can be aggregated into the minimum race
22 and ethnicity categories, including exploring the fea-
23 sibility of enhancing collection efforts in States for
24 racial and ethnic groups that comprise a significant
25 proportion of the population of the State;

"(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

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

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

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

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

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

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

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

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

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

or health services research and or is designed to improve the public's health.

"(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2012 through 2017.

"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 2011 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, 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, 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 Language 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 provide race, ethnicity, primary language, 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.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section,

such sums as may be necessary for each of fiscal years 2012 through 2017.''.

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).

"(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2012 through 2017.".

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 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.

(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 on immigrants, as well as citizens living within immigrant households (mixed-status households), in order to measure disparities in health coverage, health care access and quality, and health status among these populations, and

1 "(ii) include ensuing recommendations
2 and results in a report to the Secretary
3 that includes best practices to protect the
4 privacy of respondents to the full extent of
5 applicable law;
6 "(B) promulgate standards based on the
7 recommendations and results of subparagraph
8 (A) for the optional collection of data in major
9 health surveys and research; and
10 "(C) provide clear guidance that immi-
11 grant and mixed-status households are optional
12 uniform categories and data concerning such
13 households shall—
14 "(i) not be required to be collected by
15 the standards under subparagraph (B);
16 "(ii) be collected only in accordance
17 with—
18 "(I) the 'Tri-Agency Guidance'
19 issued by the Food and Nutrition
20 Service of the Department of Agri-
21 culture, the Centers for Medicare &
22 Medicaid Services, the Administration
23 for Children and Families, and Office
24 for Civil Rights; and
25 "(II) other applicable law; and

"(iii) not be collected for program application and enrollment processes beyond statutory requirements.".

SEC. 112. STANDARDS FOR MEASURING SOCIOECONOMIC STATUS IN COLLECTION OF HEALTH DATA.

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

(1) in paragraph (1)(A), by inserting "socioeconomic status," before "and disability status";

(2) in paragraph (1)(C), by inserting "socioeconomic status," before "and disability status"; and

(3) in paragraph (2)(B), by inserting "socioeconomic status," before "and disability status".

SEC. 113. SAFETY AND EFFECTIVENESS OF DRUGS WITH RESPECT TO RACIAL AND ETHNIC BACKGROUND.

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

"SEC. 505E. SAFETY AND EFFECTIVENESS OF DRUGS WITH RESPECT TO RACIAL AND ETHNIC BACKGROUND.

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

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

"(1)(A) the investigations required under section 505(b)(1)(A) shall include adequate and well-controlled investigations of the disparity; or

"(B) the evidence required under section 351(a) of the Public Health Service Act for approval of a biologics license application for the drug shall include adequate and well-controlled investigations of the disparity; and

"(2) if the investigations confirm that there is a disparity, the labeling of the drug shall include appropriate information about the disparity.

"(b) POSTMARKET STUDIES.—

"(1) IN GENERAL.—If there is evidence that there may be a disparity on the basis of racial or ethnic background as to the safety or effectiveness of a drug for which there is an approved application under section 505 or a license under section 351 of the Public Health Service Act, the Secretary may by order require the holder of the approved application or license to conduct, by a date specified by the Secretary, postmarketing studies to investigate the disparity.

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

"(3) STUDY DESIGN.—The Secretary may specify all aspects of study design, including the number of studies and study participants, and the other demographic characteristics of study participants included, in the order requiring postmarket studies of the drug.

"(4) MODIFICATIONS OF STUDY DESIGN.—The Secretary may by order modify any aspect of the study design as necessary after issuing an order under paragraph (1).

"(5) STUDY RESULTS.—The results from studies required under paragraph (1) shall be submitted to the Secretary as supplements to the drug application or biological license application.

"(c) DISPARITY.—The term 'evidence that there may be a disparity on the basis of racial or ethnic background for adult and pediatric populations as to the safety or effectiveness of a drug' includes—

"(1) evidence that there is a disparity on the basis of racial or ethnic background as to safety or

effectiveness of a drug in the same chemical class as the drug;

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

"(3) other evidence as the Secretary may determine.

"(d) APPLICATIONS UNDER SECTIONS 505(b)(2) AND 505(j).—

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

"(2) LABELING.—Notwithstanding clauses (iii) and (iv) of section 505(j)(5)(B), the Secretary may require that the labeling of a drug approved under section 505(j) that omits information relating to a

disparity on the basis of racial or ethnic background as to the safety or effectiveness of the drug include a statement of any appropriate contraindications, warnings, or precautions related to the disparity that the Secretary considers necessary.''.

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

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

(c) DRUG FEES.—Section 736(a)(1)(A)(ii) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379h) is amended by adding after ''are required'' the following: '', including supplements required under section 505E''.

SEC. 114. GAO STUDY ON COMPLIANCE WITH EXISTING FDA REQUIREMENTS TO PRESENT DRUG AND DEVICE SAFETY AND EFFECTIVENESS DATA BY SEX, AGE, AND RACIAL AND ETHNIC SUBGROUPS.

(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 requirements 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 Rep-

resentatives and the Committee on Health, Education, Labor, and Pensions of the Senate a response to that report, 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. 115. 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) DEFINITIONS.—In this section:

''(1) COMMUNITY GROUP.—The term 'community group' means a group of NHOPI who are organized at the community level, and may include a

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

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

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

"(4) GOVERNMENT REPRESENTATIVES.—The term 'government representatives' means representatives from Hawaii, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, the Republic of Palau, and the Republic of the Marshall Islands.

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

1 Islands, the Republic of Palau, or any other Pacific
2 island.
3 "(6) INSULAR AREA.—The term 'insular area'
4 means Guam, the Commonwealth of Northern Mar-
5 iana Islands, American Samoa, the United States
6 Virgin Islands, the Federated States of Micronesia,
7 the Republic of Palau, or the Republic of the Mar-
8 shall Islands.
9 "(b) NATIONAL STRATEGY.—
10 "(1) IN GENERAL.—The Secretary, acting
11 through the Director of the National Center for
12 Health Statistics (referred to in this section as
13 'NCHS') of the Centers for Disease Control and
14 Prevention, and other agencies within the Depart-
15 ment of Health and Human Services as the Sec-
16 retary determines appropriate, shall develop and im-
17 plement an ongoing and sustainable national strat-
18 egy for identifying and evaluating the health status
19 and health care needs of NHOPI populations living
20 in the continental United States, Hawaii, American
21 Samoa, the Commonwealth of the Northern Mariana
22 Islands, the Federated States of Micronesia, Guam,
23 the Republic of Palau, and the Republic of the Mar-
24 shall Islands.

1 "(2) CONSULTATION.—In developing and imple-
2 menting a national strategy, as described in para-
3 graph (1), not later than 180 days after the date of
4 enactment of the Health Equity and Accountability
5 Act of 2011, the Secretary—
6 "(A) shall consult with representatives of
7 community groups, designated organizations,
8 and nonprofit, nongovernmental organizations
9 and with government representatives of NHOPI
10 populations; and
11 "(B) may solicit the participation of rep-
12 resentatives from other Federal departments.
13 "(c) PRELIMINARY HEALTH SURVEY.—
14 "(1) IN GENERAL.—The Secretary, acting
15 through the Director of NCHS, shall conduct a pre-
16 liminary health survey in order to identify the major
17 areas and regions in the continental United States,
18 Hawaii, American Samoa, the Commonwealth of the
19 Northern Mariana Islands, the Federated States of
20 Micronesia, Guam, the Republic of Palau, and the
21 Republic of the Marshall Islands in which NHOPI
22 people reside.
23 "(2) CONTENTS.—The health survey described
24 in paragraph (1) shall include health data and any
25 other data the Secretary determines to be—

1 "(A) useful in determining health status
2 and health care needs; or
3 "(B) required for developing or imple-
4 menting a national strategy.
5 "(3) METHODOLOGY.—Methodology for the
6 health survey described in paragraph (1), including
7 plans for designing questions, implementation, sam-
8 pling, and analysis, shall be developed in consulta-
9 tion with community groups, designated organiza-
10 tions, nonprofit, nongovernmental organizations, and
11 government representatives of NHOPI populations,
12 as determined by the Secretary.
13 "(4) TIMEFRAME.—The survey required under
14 this subsection shall be completed not later than 18
15 months after the date of enactment of the Health
16 Equity and Accountability Act of 2011.
17 "(d) PROGRESS REPORT.—Not later than 2 years
18 after the date of enactment of the Health Equity and Ac-
19 countability Act of 2011, the Secretary shall submit to
20 Congress a progress report, which shall include the na-
21 tional strategy described in subsection (b)(1).
22 "(e) STUDY AND REPORT BY THE IOM.—
23 "(1) IN GENERAL.—The Secretary shall enter
24 into an agreement with the Institute of Medicine to

conduct a study, with input from stakeholders in insular areas, on the following:

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

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

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

"(D) The progress toward implementation of recommendations of the Committee on Health Care Services in the United States—Associated Pacific Basin of the Institute of Medicine that are set forth in the 1998 report, 'Pacific Partnerships for Health: Charting a New Course for the 21st Century'.

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

2011, a report containing a description of the results of the study conducted under paragraph (1), including the conclusions and recommendations of the Institute of Medicine for each of the items described in subparagraphs (A) through (D) of such paragraph.

"(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2012 through 2017.".

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 eliminating 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' includes a community health advocate, a lay health educator, a community health representative, a peer health promoter, a community health outreach worker, and in Spanish, promotores de salud.

''(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.

1 "(8) HEALTH CARE GROUP.—The term 'health
2 care group' means a group of physicians organized,
3 at least in part, for the purposes of providing physi-
4 cians' services under the Medicaid, SCHIP, or Medi-
5 care programs and may include a hospital and any
6 other individual or entity furnishing services covered
7 under the Medicaid, SCHIP, or Medicare programs
8 that is affiliated with the health care group.
9 "(9) HEALTH-CARE SERVICES.—The term
10 'health care services' means services that address
11 physical as well as mental health conditions in all
12 care settings.
13 "(10) HEALTH CARE-RELATED SERVICES.—The
14 term 'health-care-related services' means human or
15 social services programs or activities that provide ac-
16 cess, referrals or links to health care.
17 "(11) INDIAN TRIBE.—The term 'Indian tribe'
18 means any Indian tribe, band, nation, or other orga-
19 nized group or community, including any Alaska Na-
20 tive village or group or regional or village corpora-
21 tion as defined in or established pursuant to the
22 Alaska Native Claims Settlement Act (85 Stat. 688)
23 (43 U.S.C. 1601 et seq.), which is recognized as eli-
24 gible for the special programs and services provided

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

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

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

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

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

20 "(19) MINORITY.—

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

"(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

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

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

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

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

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

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

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

"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

1 and activities by limited-English-proficient individ-
2 uals; and
3 "(5) to ensure compliance with title VI of the
4 Civil Rights Act of 1964 and that health care pro-
5 viders and organizations do not discriminate in the
6 provision of services.
7 "(b) FEDERALLY CONDUCTED PROGRAMS AND AC-
8 TIVITIES.—
9 "(1) IN GENERAL.—Not later than 120 days
10 after the date of enactment of this title, each Fed-
11 eral agency that carries out health-care-related ac-
12 tivities shall prepare a plan to improve access cul-
13 tural competence to the federally conducted, health-
14 are-related programs and activities of the agency by
15 limited-English-proficient individuals. Each Federal
16 agency must ensure that such plan is fully imple-
17 mented not later than one year after the date of en-
18 actment of this Act.
19 "(2) PLAN REQUIREMENT.—Each plan under
20 paragraph (1) shall include—
21 "(A) the steps the agency will take to en-
22 sure that limited-English-proficient individuals
23 have access to the agency's federally conducted
24 health care and health-care-related programs
25 and activities;

"(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.

1 "(2) REQUIREMENTS.—The agency-specific
2 guidance developed under paragraph (1) shall take
3 into account the types of health care services pro-
4 vided by the recipients, the individuals served by the
5 recipients, and other factors set out in such stand-
6 ards.

7 "(3) EXISTING GUIDANCES.—A Federal agency
8 that has developed a guidance for purposes of title
9 VI of the Civil Rights Act of 1964 shall examine
10 such existing guidance, as well as the programs and
11 activities to which such guidance applies, to deter-
12 mine if modification of such guidance is necessary to
13 comply with this subsection.

14 "(4) CONSULTATION.—Each Federal agency
15 shall consult with the Department of Justice in es-
16 tablishing the guidances under this subsection.

17 "(d) CONSULTATIONS.—

18 "(1) IN GENERAL.—In carrying out this sec-
19 tion, each Federal agency that carriers out health
20 care and health-care-related activities shall ensure
21 that stakeholders, such as limited-English-proficient
22 individuals and their representative organizations,
23 recipients of Federal assistance, and other appro-
24 priate individuals or entities, have an adequate op-

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 ''(1) implement strategies to recruit, retain, and
2 promote individuals at all levels of the organization
3 to maintain a diverse staff and leadership that can
4 provide culturally and linguistically appropriate
5 health care to patient populations of the service area
6 of the organization;
7 ''(2) ensure that staff at all levels and across all
8 disciplines of the organization receive ongoing edu-
9 cation and training in culturally and linguistically
10 appropriate service delivery;
11 ''(3) offer and provide language assistance serv-
12 ices, including trained bilingual staff and interpreter
13 services, at no cost to each patient with limited-
14 English proficiency at all points of contact, in a
15 timely manner during all hours of operation;
16 ''(4) notify patients, in a culturally appropriate
17 manner, of their right to receive language assistance
18 services in their primary language;
19 ''(5) ensure the competence of language assist-
20 ance provided to limited-English-proficient patients
21 by interpreters and bilingual staff, and ensure that
22 family, particularly minor children, and friends are
23 not used to provide interpretation services—
24 ''(A) except in case of emergency; or

1 "(B) except on request of the patient, who
2 has been informed in his or her preferred lan-
3 guage of the availability of free interpretation
4 services;
5 "(6) make available easily understood patient-
6 related materials, if such materials exist for non-lim-
7 ited-English-proficient patients, including informa-
8 tion or notices about termination of benefits and
9 post signage in the languages of the commonly en-
10 countered groups or groups represented in the serv-
11 ice area of the organization;
12 "(7) develop and implement clear goals, poli-
13 cies, operational plans, and management account-
14 ability and oversight mechanisms to provide cul-
15 turally and linguistically appropriate services;
16 "(8) conduct initial and ongoing organizational
17 assessments of culturally and linguistically appro-
18 priate services-related activities and integrate valid
19 linguistic, competence-related measures into the in-
20 ternal audits, performance improvement programs,
21 patient satisfaction assessments, and outcomes-based
22 evaluations of the organization;
23 "(9) ensure that, consistent with the privacy
24 protections provided for under the regulations pro-
25 mulgated under section 264(c) of the Health Insur-

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-

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

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

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

15 **''SEC. 3403. ROBERT T. MATSUI CENTER FOR CULTURAL**
16 **AND LINGUISTIC COMPETENCE IN HEALTH**
17 **CARE.**

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

1 "(1) INTERPRETATION SERVICES.—The Center
2 shall provide resources via the Internet to identify
3 and link health care providers to competent inter-
4 preter and translation services.
5 "(2) TRANSLATION OF WRITTEN MATERIAL.—
6 "(A) The Center shall provide, directly or
7 through contract, vital documents from com-
8 petent translation services for providers of
9 health care and health-care-related services at
10 no cost to such providers. Materials may be
11 submitted for translation into non-English lan-
12 guages. Translation services shall be provided
13 in a timely and reasonable manner and in ac-
14 cordance with the guidelines and standards set
15 forth in subsection (c) when such standards be-
16 come available. The quality of such translation
17 services shall be monitored and reported pub-
18 licly.
19 "(B) For each form developed or revised
20 by the Secretary that will be used by LEP indi-
21 viduals in health care or health-care-related set-
22 tings, the Center shall translate the form, at a
23 minimum, into the top 15 non-English lan-
24 guages in the United States according to the
25 most recent data from the American Commu-

1 nity Survey or its replacement. The translation
2 must be completed within 45 days of the Sec-
3 retary receiving final approval of the form from
4 the Office of Management and Budget.
5 "(3) TOLL-FREE CUSTOMER SERVICE TELE-
6 PHONE NUMBER.—The Center shall provide,
7 through a toll-free number, a customer service line
8 for LEP individuals—
9 "(A) to obtain information about federally
10 conducted or funded health programs, including
11 Medicare, Medicaid, and SCHIP;
12 "(B) to obtain assistance with applying for
13 or accessing these programs and understanding
14 Federal notices written in English; and
15 "(C) to learn how to access language serv-
16 ices.
17 "(4) HEALTH INFORMATION CLEARING-
18 HOUSE.—
19 "(A) IN GENERAL.—The Center shall de-
20 velop and maintain an information clearing-
21 house to facilitate the provision of language
22 services by providers of health care and health-
23 care-related services to reduce medical errors,
24 improve medical outcomes, to improve cultural
25 competence, reduce health care costs caused by

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

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

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

18 "(I) intake forms;

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

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

1 "(IV) documents concerning in-
2 formed consent, advanced directives,
3 and waivers of rights.
4 "(ii) Clinical information, such as how
5 to take medications, how to prevent trans-
6 mission of a contagious disease, and other
7 prevention and treatment instructions.
8 "(iii) Public health, patient education,
9 and outreach materials, such as immuniza-
10 tion notices, health warnings, or screening
11 notices.
12 "(iv) Additional health or health-care-
13 related materials as determined appro-
14 priate by the Director of the Center.
15 "(C) STRUCTURE OF FORMS.—The oper-
16 ating the clearinghouse, the Center shall—
17 "(i) ensure that the documents posted
18 in English and non-English languages are
19 culturally appropriate;
20 "(ii) allow public review of the docu-
21 ments before dissemination in order to en-
22 sure that the documents are understand-
23 able and culturally appropriate for the tar-
24 get populations;

1 "(iii) allow health care providers to
2 customize the documents for their use;
3 "(iv) facilitate access to these docu-
4 ments;
5 "(v) provide technical assistance with
6 respect to the access and use of such infor-
7 mation; and
8 "(vi) carry out any other activities the
9 Secretary determines to be useful to fulfill
10 the purposes of the clearinghouse.
11 "(D) LANGUAGE ASSISTANCE PRO-
12 GRAMS.—The Center shall provide for the col-
13 lection and dissemination of information on cur-
14 rent examples of language assistance programs
15 and strategies to improve language services for
16 LEP individuals, including case studies using
17 de-identified patient information, program sum-
18 maries, and program evaluations.
19 "(E) CULTURAL AND LINGUISTIC COM-
20 PETENCE MATERIALS.—The Center shall pro-
21 vide information relating to culturally and lin-
22 guistically competent health care for minority
23 populations residing in the United States to all
24 health care providers and health-care-related

1 services at no cost. Such information shall in-
2 clude—
3 "(i) tenets of culturally and linguis-
4 tically competent care;
5 "(ii) cultural and linguistic com-
6 petence self-assessment tools;
7 "(iii) cultural and linguistic com-
8 petence training tools;
9 "(iv) strategic plans to increase cul-
10 tural and linguistic competence in different
11 types of providers of health care and
12 health-care-related services, including re-
13 gional collaborations among health care or-
14 ganizations; and
15 "(v) cultural and linguistic com-
16 petence information for educators, practi-
17 tioners, and researchers.
18 "(F) INFORMATION ABOUT PROGRESS.—
19 The Center shall regularly collect and make
20 publicly available information about the
21 progress of entities receiving grants under sec-
22 tion 3404 regarding successful innovations in
23 implementing the obligations under this sub-
24 section and provide public notice in the entities'

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

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

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

22 "(d) MEMBERSHIP.—

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

1 "(A) Four members from organizations
2 that advocate on behalf of LEP individuals.
3 "(B) One member who represents a profes-
4 sional interpreter association (that is not the
5 National Council on Interpreting in Health
6 Care) or translator association.
7 "(C) One member from a nonprofit com-
8 munity-based organization that provides lan-
9 guage services.
10 "(D) Three members recommended by the
11 National Council on Interpreting in Health
12 Care, including one who individual who is a
13 professional interpreter.
14 "(E) Four members who are health care or
15 mental health providers or represent health care
16 provider associations, including one individual
17 who represents a health care practice of fewer
18 than 5 clinicians.
19 "(F) One member who works in or has ex-
20 tensive knowledge of issues related to health
21 care risk management.
22 "(2) GEOGRAPHIC REPRESENTATION.—The
23 membership of the Working Group shall reflect a
24 broad geographic representation including both

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-

1 sachusetts, and Oregon who have experience in
2 the development or implementation of their or-
3 ganizations' interpreter and translator certifi-
4 cation programs;
5 "(B) Federal agencies including the Office
6 for Civil Rights, the Office of Minority Health,
7 the Centers for Medicare & Medicaid Services,
8 and the National Institute on Minority Health
9 and Health Disparities; and
10 "(C) other individuals or entities deter-
11 mined appropriate by the Secretary who have
12 specific expertise that will be useful to the
13 Working Group.
14 "(7) PUBLICATION.—
15 "(A) DRAFT STANDARDS.—Not later than
16 18 months after the date of enactment of this
17 title, the Working Group shall—
18 "(i) prepare and make available to the
19 public through the Internet, the Federal
20 Register, and other appropriate public
21 channels, a proposed set of interpretation
22 and translation guidelines and standards
23 for training, assessment, and certification;
24 and

"(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.

"(F) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for the activities of the Working Group and Advisory Panel for each of fiscal years 2012 through 2016, and for the funding of the pilot project.

"(9) DEEMED STATUS.—

"(A) CERTIFICATION BY PRIVATE ORGANIZATION.—If a private accreditation organization

1 establishes training, assessment, or certification
2 standards for interpreters or translators in
3 health care which the Secretary determines are
4 at least equivalent to the training, assessment,
5 or certification standards promulgated by the
6 Secretary as described in subsection (c), the
7 Secretary shall find that all organizations or in-
8 dividuals accredited by such organization com-
9 ply also with the standard described in sub-
10 section (c) if—
11 ''(i) such organization or individual
12 authorizes the organization to release to
13 the Secretary upon the Secretary's request
14 (or such State agency as the Secretary
15 may designate) a copy of the most current
16 accreditation survey of such organization
17 or individual made by the organization, to-
18 gether with any other information directly
19 related to the survey as the Secretary may
20 require (including corrective action plans);
21 and
22 ''(ii) such organization releases such a
23 copy and any such information to the Sec-
24 retary.

"(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.

"(g) AUTHORIZATION OF APPROPRIATIONS.—In addition to the amounts authorized under subsection (e)(8)(F), there are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2012 through 2016.

"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

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

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

10 "(1) be—

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

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

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

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

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

21 "(F) a public hospital;

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

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

1 "(2) prepare and submit to the Secretary an
2 application, at such time, in such manner, and ac-
3 companied by such additional information as the
4 Secretary may require.
5 "(c) USE OF FUNDS.—An entity shall use funds re-
6 ceived under a grant under this section to—
7 "(1) develop, implement, and evaluate models of
8 providing competent interpretation services through
9 on-site interpretation, telephonic interpretation, or
10 video interpretation;
11 "(2) implement strategies to recruit, retain, and
12 promote individuals at all levels of the organization
13 to maintain a diverse staff and leadership that can
14 promote and provide language services to patient
15 populations of the service area of the organization;
16 "(3) develop and maintain a needs assessment
17 that identifies the current demographic, cultural,
18 and epidemiological profile of the community to ac-
19 curately plan for and implement language services
20 needed in service area of the organization;
21 "(4) develop a strategic plan to implement lan-
22 guage services;
23 "(5) develop participatory, collaborative part-
24 nerships with communities encompassing the LEP

1 patient populations being served to gain input in de-
2 signing and implementing language services;
3 ''(6) develop and implement grievance resolu-
4 tion processes that are culturally and linguistically
5 sensitive and capable of identifying, preventing, and
6 resolving complaints by LEP individuals; or
7 ''(7) develop short-term medical mental health
8 interpretation training courses and incentives for bi-
9 lingual health care staff who are asked to interpret
10 in the workplace;
11 ''(8) develop formal training programs, includ-
12 ing continued professional development and edu-
13 cation programs as well as supervision, for individ-
14 uals interested in becoming dedicated health care in-
15 terpreters and culturally competent providers;
16 ''(9) provide staff language training instruction,
17 which shall include information on the practical limi-
18 tations of such instruction for non-native speakers;
19 ''(10) develop policies that address compensa-
20 tion in salary for staff who receive training to be-
21 come either a staff interpreter or bi-lingual provider;
22 ''(11) develop other language assistance services
23 as determined appropriate by the Secretary;
24 ''(12) develop, implement, and evaluate models
25 of improving cultural competence; and

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

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

17 "(e) EVALUATION.—

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

uation 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.

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

"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.

1 "(c) USE OF FUNDS.—Research under this section
2 shall be designed to do one or more of the following:
3 "(1) To identify the barriers to mental and be-
4 havioral services that are faced by LEP individuals.
5 "(2) To identify health care providers' and
6 health administrators' attitudes, knowledge, and
7 awareness of the barriers to quality health care serv-
8 ices that are faced by LEP individuals.
9 "(3) To identify optimal approaches for deliv-
10 ering language access.
11 "(4) To identify best practices for data collec-
12 tion, including—
13 "(A) the collection by providers of health
14 care and health-care-related services of data on
15 the race, ethnicity, and primary language of re-
16 cipients of such services, taking into account ex-
17 isting research conducted by the Government or
18 private sector;
19 "(B) the development and implementation
20 of data collection and reporting systems; and
21 "(C) effective privacy safeguards for col-
22 lected data.
23 "(5) To develop a minimum data collection set
24 for primary language.

"(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.

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

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 (1) ESTABLISHMENT.—

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

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

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

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

1 under this subsection shall be for a 3-year pe-
2 riod.
3 (2) ELIGIBILITY REQUIREMENTS.—To be eligi-
4 ble for a grant under this subsection, an entity must
5 meet the following requirements:
6 (A) MEDICARE PROVIDER.—The entity
7 must be—
8 (i) a provider of services under part A
9 of title XVIII of the Social Security Act;
10 (ii) a provider of services under part
11 B of such title;
12 (iii) a Medicare Advantage organiza-
13 tion offering a Medicare Advantage plan
14 under part C of such title; or
15 (iv) a PDP sponsor offering a pre-
16 scription drug plan under part D of such
17 title.
18 (B) UNDERSERVED COMMUNITIES.—The
19 entity must serve a community that with re-
20 spect to necessary langauge services for improv-
21 ing access and utilization of health care amoung
22 limited-English proficienct individuals, is
23 disproportinaly underserved.
24 (C) APPLICATION.—The entity must pre-
25 pare and submit to the Secretary an applica-

tion, 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.—

1 (A) VARIATION IN GRANTEES.—In award-
2 ing grants under this subsection, the Secretary
3 shall select grantees to ensure the following:
4 (i) The grantees provide many dif-
5 ferent types of language services.
6 (ii) The grantees serve Medicare bene-
7 ficiaries who speak different languages,
8 and who, as a population, have differing
9 needs for language services.
10 (iii) The grantees serve Medicare
11 beneficiaries in both urban and rural set-
12 tings.
13 (iv) The grantees serve Medicare
14 beneficiaries in at least two geographic re-
15 gions, as defined by the Secretary.
16 (v) The grantees serve Medicare bene-
17 ficiaries in at least two large metropolitan
18 statistical areas with racial, ethnic, and
19 economicly diverse populations.
20 (B) PRIORITY FOR PARTNERSHIPS WITH
21 COMMUNITY ORGANIZATIONS AND AGENCIES.—
22 In awarding grants under this subsection, the
23 Secretary shall give priority to eligible entities
24 that have a partnership with—
25 (i) a community organization; or

(ii) a consortia of community organizations, state agecenices, 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 competent interpreter and translation services without undue delay.

(D) MA ORGANIZATIONS AND PDP SPONSORS.—If a grantee is a MA 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 subparagraph (A) with respect to the service area of a grantee for the year.

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

(7) ASSURANCES.—Grantees under this subsection shall—

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

1 training in linguistically appropriate service de-
2 livery;
3 (B) ensure the linguistic competence of bi-
4 lingual providers;
5 (C) offer and provide appropriate language
6 services at no additional charge to each patient
7 with limited-English proficiency for all points of
8 contact between the patient and the grantee, in
9 a timely manner during all hours of operation;
10 (D) notify Medicare beneficiaries of their
11 right to receive language services in their pri-
12 mary language;
13 (E) post signage in the primary languages
14 commonly used by the patient population in the
15 service area of the organization; and
16 (F) ensure that—
17 (i) primary language data is collected
18 for recipients of language services and
19 such data is consistent with standards de-
20 veloped under title XXXIV of the Public
21 Health Service Act, as added by section
22 202 of this Act, to the extent such stand-
23 ards are available upon the initiation of the
24 demonstration program; and

(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-pro-

1 ficient Medicare beneficiaries not participating,
2 based on the data provided under paragraph (9)
3 and any other information available to the Sec-
4 retary.
5 (B) The effect of delivering langauge serv-
6 ices on—
7 (i) Medicare beneficiary access to care
8 and utilization of services;
9 (ii) the efficiency and cost effective-
10 ness of health care delivery;
11 (iii) patient satisfaction;
12 (iv) health outcomes; and
13 (v) the provision of culturally appro-
14 priate services provided to such
15 benificiaries.
16 (C) The extent to which bilingual staff, in-
17 terpreters, and translators providing services
18 under such demonstration were trained or ac-
19 credited and the nature of accreditation or
20 training needed by type of provider, service, or
21 other category as determined by the Secretary
22 to ensure the provision of high-quality interpre-
23 tation, translation, or other language services to
24 Medicare beneficiaries if such services are ex-

panded 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.

(11) APPROPRIATIONS.—There is appropriated to carry out this subsection, in equal parts from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, $16,000,000 for each fiscal year of the demonstration program.

(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 subparagrpah (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 edesignating 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 of subparagraph (J) the following:

''(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 langauge access services' in section 3400 of the Public Health Service Act.

"(2) INTERPRETER SERVICES DEFINED.—For the 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

1 language into a written message in another language that
2 retains the intended meaning of the original message.
3 "(5) LIMITED-ENGLISH-PROFICIENT AND LEP DE-
4 FINED.—The terms 'Limited-English-proficient' and
5 'LEP' have the meaning given the term 'limited english
6 proficient' under section 9101(25) of the Elementary and
7 Secondary Education Act of 1965, except that subpara-
8 graphs (A), (B), and (D) of such section not apply.".
9 (5) WAIVER OF BUDGET NEUTRALITY.—For
10 the 3-year period beginning on the date of enact-
11 ment of this section, the budget neutrality provision
12 of section 1848(c)(2)(B)(ii) of the Social Security
13 Act (42 U.S.C. 1395w–4(c)(2)(B)(ii)) shall not
14 apply to language services (as such term is defined
15 in section 1861(iii) of such Act).
16 (c) MEDICARE PART C AND PART D.—
17 (1) IN GENERAL.—Medicare Advantage plans
18 under part C of the Social Security Act and Pre-
19 scription Drug Plans under part D of such Act shall
20 provide effective language services to enrollees of
21 such plans.
22 (2) REPORTING REQUIREMENTS.—Medicare
23 Advantage and Prescription Drug plans shall annu-
24 ally submit to the Secretary of Health and Human
25 Services a report that contains information on the

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

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

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

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

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

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

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

(1) 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 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) 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

1 Secretary may require to ascertain the entity's
2 eligibility for funding under this subsection.
3 (3) ELIGIBLE COSTS DEFINED.—
4 (A) IN GENERAL.—In this subsection, the
5 term ''eligible costs'' means, with respect to an
6 eligible entity that provides language services to
7 LEP individuals, the product of—
8 (i) the average per person cost of lan-
9 guage services, determined according to
10 the methodology devised under subpara-
11 graph (B); and
12 (ii) the number of limited-English-pro-
13 ficient individuals who are provided lan-
14 guage services by the entity and for whom
15 no reimbursement is available for such
16 services under the amendments made by
17 subsections (a), (b), (c), or (d) or by pri-
18 vate health insurance.
19 (B) METHODOLOGY.—
20 (i) IN GENERAL.—The Secretary shall
21 establish a methodology to determine the
22 average per person cost of language serv-
23 ices.
24 (ii) DIFFERENT ENTITIES.—In estab-
25 lishing such methodology, the Secretary

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.—The amendments made by this section shall take effect on October 1, 2011.

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 Qual-

1 ity and the Administrator of the Health Resources and
2 Services Administration, in consultation with the Director
3 of the National Institute on Minority Health and Health
4 Disparities and the Office of Minority Health, shall award
5 grants to eligible entities to improve health care for pa-
6 tient populations that have low functional health literacy.
7 (b) ELIGIBILITY.—To be eligible to receive a grant
8 under subsection (a), an entity shall—
9 (1) be a hospital, health center or clinic, health
10 plan, or other health entity (including a nonprofit
11 minority health organization or association); and
12 (2) prepare and submit to the Secretary an ap-
13 plication at such time, in such manner, and con-
14 taining such information as the Secretary may re-
15 quire.
16 (c) USE OF FUNDS.—
17 (1) AGENCY FOR HEALTHCARE RESEARCH AND
18 QUALITY.—Grants awarded under subsection (a)
19 through the Agency for Healthcare Research and
20 Quality shall be used—
21 (A) to define and increase the under-
22 standing of health literacy;
23 (B) to investigate the correlation between
24 low health literacy and health and health care;

(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.

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

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.

(a) REPORT.—Not later than 1 year after the date of enactment of this Act and annually thereafter, the Secretary of Health and Human Services shall enter into a contract with the 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.

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

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.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Education for each of fiscal years 2012 through 2015 $250,000,000 to carry out this section.

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 language 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.".

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;

1 "(C) the populations served through the
2 grants;
3 "(D) the organizations and institutions re-
4 ceiving the grants; and
5 "(E) the tracking efforts that were used to
6 follow the progress of participants.
7 "(2) A description of the entity's plan to
8 achieve workforce diversity goals that includes, to
9 the extent relevant to such entity—
10 "(A) the number of underrepresented mi-
11 nority health professionals that will be needed
12 in various disciplines over the next 10 years to
13 achieve population parity;
14 "(B) the level of funding needed to fully
15 expand and adequately support health profes-
16 sions pipeline programs;
17 "(C) the impact such programs have had
18 on the admissions practices and policies of
19 health professions schools;
20 "(D) the management strategy necessary
21 to effectively administer and institutionalize
22 health profession pipeline programs; and
23 "(E) the impact that the Government Per-
24 formance and Results Act (GPRA) has had on
25 evaluating the performance of grantees and

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.

1 "(D) The Bureau of Labor Statistics of
2 the Department of Labor.
3 "(E) The Public Health Practice Program
4 Office—Office of Workforce Policy and Plan-
5 ning.
6 "(F) The National Institute on Minority
7 Health and Health Disparities.
8 "(G) The Agency for Healthcare Research
9 and Quality.
10 "(H) The Institute of Medicine Study
11 Committee for the 2004 workforce diversity re-
12 port.
13 "(I) The Indian Health Service.
14 "(J) Minority-serving academic institu-
15 tions.
16 "(K) Consumer organizations.
17 "(L) Health professional associations, in-
18 cluding those that represent underrepresented
19 minority populations.
20 "(M) Researchers in the area of health
21 workforce.
22 "(N) Health workforce accreditation enti-
23 ties.
24 "(O) Private foundations that have spon-
25 sored workforce diversity initiatives.

1 "(2) The grantee shall ensure that, in addition
2 to the representatives under paragraph (1), the
3 group has not less than 5 health professions stu-
4 dents representing various health profession fields
5 and levels of training.
6 "(c) ACTIVITIES.—The working group established
7 under subsection (a) shall convene at least twice each year
8 to complete the following activities:
9 "(1) Review current public and private health
10 workforce diversity initiatives.
11 "(2) Identify successful health workforce diver-
12 sity programs and practices.
13 "(3) Examine challenges relating to the devel-
14 opment and implementation of health workforce di-
15 versity initiatives.
16 "(4) Draft a national strategic work plan for
17 health workforce diversity, including recommenda-
18 tions for public and private sector initiatives.
19 "(5) Develop a framework and methods for the
20 evaluation of current and future health workforce di-
21 versity initiatives.
22 "(6) Develop recommended standards for work-
23 force diversity that could be applicable to all health
24 professions programs and programs funded under
25 this Act.

1 "(7) Develop curriculum guidelines for diversity
2 training.
3 "(8) Develop a strategy for the inclusion of
4 community members on admissions committees for
5 health profession schools.
6 "(9) Other activities determined appropriate by
7 the Secretary.
8 "(d) ANNUAL REPORT.—Not later than 1 year after
9 the establishment of the working group under subsection
10 (a), and annually thereafter, the working group shall pre-
11 pare and make available to the general public for com-
12 ment, an annual report on the activities of the working
13 group. Such report shall include the recommendations of
14 the working group for improving health workforce diver-
15 sity.
16 "(e) AUTHORIZATION OF APPROPRIATIONS.—There
17 is authorized to be appropriated to carry out this section
18 such sums as may be necessary for each of fiscal years
19 2012 through 2017.

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

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

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

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

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

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

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

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

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

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

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

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

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

"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;

1 "(E) Asian-American, Native American,
2 and Pacific Islander-serving institutions;
3 "(F) institutions that have programs to re-
4 cruit and retain underrepresented minority
5 health professionals, in which a significant
6 number of the enrolled participants are under-
7 represented minorities;
8 "(G) health professional associations,
9 which may include underrepresented minority
10 health professional associations; and
11 "(H) institutions—
12 "(i) located in communities with pre-
13 dominantly underrepresented minority pop-
14 ulations;
15 "(ii) with whom partnerships have
16 been formed for the purpose of increasing
17 workforce diversity; and
18 "(iii) in which at least 20 percent of
19 the enrolled participants are underrep-
20 resented minorities; and
21 "(2) submit to the Secretary an application at
22 such time, in such manner, and containing such in-
23 formation as the Secretary may require.
24 "(c) USE OF FUNDS.—Amounts received under a
25 grant under subsection (a) shall be used to expand existing

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

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

10 ''(2) scholarship, fellowship, grant, loan repay-
11 ment, and loan cancellation programs;

12 ''(3) postbaccalaureate programs;

13 ''(4) academic enrichment programs, particu-
14 larly targeting those who would not be competitive
15 for health professions schools;

16 ''(5) kindergarten through 12th grade and
17 other health pipeline programs;

18 ''(6) mentoring programs;

19 ''(7) internship or rotation programs involving
20 hospitals, health systems, health plans and other
21 health entities;

22 ''(8) community partnership development for
23 purposes relating to workforce diversity; or

24 ''(9) leadership training.

1 "(d) REPORTS.—Not later than 1 year after receiving
2 a grant under this section, and annually for the term of
3 the grant, a grantee shall submit to the Secretary a report
4 that summarizes and evaluates all activities conducted
5 under the grant.

6 "(e) DEFINITION.—In this section, the term 'Asian-
7 American, Native American, and Pacific Islander-serving
8 institutions' has the same meaning as the term 'Asian
9 American and Native American Pacific Islander-serving
10 institution' as defined in section 371(c) of the Higher
11 Education Act of 1965 (20 U.S.C. 1067q(c)).

12 "(f) AUTHORIZATION OF APPROPRIATIONS.—There
13 is authorized to be appropriated to carry out this section,
14 such sums as may be necessary for each of fiscal years
15 2012 through 2017.

16 **"SEC. 3415. CAREER DEVELOPMENT FOR SCIENTISTS AND**
17 **RESEARCHERS.**

18 "(a) IN GENERAL.—The Secretary, acting through
19 the Director of the National Institutes of Health, the Di-
20 rector of the Centers for Disease Control and Prevention,
21 the Commissioner of Food and Drugs, and the Director
22 of the Agency for Healthcare Research and Quality, shall
23 award grants that expand existing opportunities for sci-
24 entists and researchers and promote the inclusion of
25 underrepresented minorities in the health professions.

1 "(b) RESEARCH FUNDING.—The head of each entity
2 within the Department of Health and Human Services
3 shall establish or expand existing programs to provide re-
4 search funding to scientists and researchers in training.
5 Under such programs, the head of each such entity shall
6 give priority in allocating research funding to support
7 health research in traditionally underserved communities,
8 including underrepresented minority communities, and re-
9 search classified as community or participatory.

10 "(c) DATA COLLECTION.—The head of each entity
11 within the Department of Health and Human Services
12 shall collect data on the number (expressed as an absolute
13 number and a percentage) of underrepresented minority
14 and nonminority applicants who receive and are denied
15 agency funding at every stage of review. Such data shall
16 be reported annually to the Secretary and the appropriate
17 committees of Congress.

18 "(d) STUDENT LOAN REIMBURSEMENT.—The Sec-
19 retary shall establish a student loan reimbursement pro-
20 gram to provide student loan reimbursement assistance to
21 researchers who focus on racial and ethnic disparities in
22 health. The Secretary shall promulgate regulations to de-
23 fine the scope and procedures for the program under this
24 subsection.

1 "(e) STUDENT LOAN CANCELLATION.—The Sec-
2 retary shall establish a student loan cancellation program
3 to provide student loan cancellation assistance to research-
4 ers who focus on racial and ethnic disparities in health.
5 Students participating in the program shall make a min-
6 imum 5-year commitment to work at an accredited health
7 profession school. The Secretary shall promulgate addi-
8 tional regulations to define the scope and procedures for
9 the program under this subsection.

10 "(f) AUTHORIZATION OF APPROPRIATIONS.—There
11 is authorized to be appropriated to carry out this section,
12 such sums as may be necessary for each of fiscal years
13 2012 through 2017.

14 **"SEC. 3416. CAREER SUPPORT FOR NON-RESEARCH**
15 **HEALTH PROFESSIONALS.**

16 "(a) IN GENERAL.—The Secretary, acting through
17 the Director of the Centers for Disease Control and Pre-
18 vention, the Administrator of the Substance Abuse and
19 Mental Health Services Administration, the Administrator
20 of the Health Resources and Services Administration, and
21 the Administrator of the Centers for Medicare and Med-
22 icaid Services shall establish a program to award grants
23 to eligible individuals for career support in non-research-
24 related health care.

1 "(b) ELIGIBILITY.—To be eligible to receive a grant
2 under subsection (a) an individual shall—
3 "(1) be a student in a health professions school,
4 a graduate of such a school who is working in a
5 health profession, or a faculty member of such a
6 school; and
7 "(2) submit to the Secretary an application at
8 such time, in such manner, and containing such in-
9 formation as the Secretary may require.
10 "(c) USE OF FUNDS.—An individual shall use
11 amounts received under a grant under this section to—
12 "(1) support the individual's health activities or
13 projects that involve underserved communities, in-
14 cluding racial and ethnic minority communities;
15 "(2) support health-related career advancement
16 activities;
17 "(3) to pay, or as reimbursement for payments
18 of, student loans for individuals who are health pro-
19 fessionals and are focused on health issues affecting
20 underserved communities, including racial and eth-
21 nic minority communities; and
22 "(4) to establish and promote leadership train-
23 ing programs to decrease health disparities and to
24 increase cultural competence with the goal of in-
25 creasing diversity in leadership positions.

1 "(d) DEFINITION.—In this section, the term 'career
2 in non-research-related health care' means employment or
3 intended employment in the field of public health, health
4 policy, health management, health administration, medi-
5 cine, nursing, pharmacy, psychology, social work, psychi-
6 atry, other mental and behavioral health, allied health,
7 community health, social work, or other fields determined
8 appropriate by the Secretary, other than in a position that
9 involves research.

10 "(e) AUTHORIZATION OF APPROPRIATIONS.—There
11 is authorized to be appropriated to carry out this section,
12 such sums as may be necessary for each of fiscal years
13 2012 through 2017.

14 **"SEC. 3417. RESEARCH ON THE EFFECT OF WORKFORCE DI-**
15 **VERSITY ON QUALITY.**

16 "(a) IN GENERAL.—The Director of the Agency for
17 Healthcare Research and Quality, in collaboration with
18 the Deputy Assistant Secretary for Minority Health and
19 the Director of the National Institute on Minority Health
20 and Health Disparities, shall award grants to eligible enti-
21 ties to expand research on the link between health work-
22 force diversity and quality health care.

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

1 "(1) be a clinical, public health, or health serv-
2 ices research entity or other entity determined ap-
3 propriate by the Director; and
4 "(2) submit to the Secretary an application at
5 such time, in such manner, and containing such in-
6 formation as the Secretary may require.
7 "(c) USE OF FUNDS.—Amounts received under a
8 grant awarded under subsection (a) shall be used to sup-
9 port research that investigates the effect of health work-
10 force diversity on—
11 "(1) language access;
12 "(2) cultural competence;
13 "(3) patient satisfaction;
14 "(4) timeliness of care;
15 "(5) safety of care;
16 "(6) effectiveness of care;
17 "(7) efficiency of care;
18 "(8) patient outcomes;
19 "(9) community engagement;
20 "(10) resource allocation;
21 "(11) organizational structure;
22 "(12) compliance of care; or
23 "(13) other topics determined appropriate by
24 the Director.

1 "(d) PRIORITY.—In awarding grants under sub-
2 section (a), the Director shall give individualized consider-
3 ation to all relevant aspects of the applicant's background.
4 Consideration of prior research experience involving the
5 health of underserved communities shall be such a factor.
6 "(e) AUTHORIZATION OF APPROPRIATIONS.—There
7 is authorized to be appropriated to carry out this section,
8 such sums as may be necessary for each of fiscal years
9 2012 through 2017.

10 **"SEC. 3418. HEALTH DISPARITIES EDUCATION PROGRAM.**

11 "(a) ESTABLISHMENT.—The Secretary, acting
12 through the National Institute on Minority Health and
13 Health Disparities and in collaboration with the Office of
14 Minority Health, the Office for Civil Rights, the Centers
15 for Disease Control and Prevention, the Centers for Medi-
16 care & Medicaid Services, the Health Resources and Serv-
17 ices Administration, and other appropriate public and pri-
18 vate entities, shall establish and coordinate a health and
19 health care disparities education program to support, de-
20 velop, and implement educational initiatives and outreach
21 strategies that inform health care professionals and the
22 public about the existence of and methods to reduce racial
23 and ethnic disparities in health and health care.
24 "(b) ACTIVITIES.—The Secretary, through the edu-
25 cation program established under subsection (a) shall,

through the use of public awareness and outreach campaigns targeting the general public and the medical community at large—

"(1) disseminate scientific evidence for the existence and extent of racial and ethnic disparities in health care, including disparities that are not otherwise attributable to known factors such as access to care, patient preferences, or appropriateness of intervention, as described in the 2002 Institute of Medicine Report entitled 'Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care', as well as the impact of disparities related to age, disability status, socioeconomic status, sex, gender identity, and sexual orientation on racial and ethnic minorities;

"(2) disseminate new research findings to health care providers and patients to assist them in understanding, reducing, and eliminating health and health care disparities;

"(3) disseminate information about the impact of linguistic and cultural barriers on health care quality and the obligation of health providers who receive Federal financial assistance to ensure that 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.

"(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2012 through 2017.".

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

1 Administration, shall award grants to Hispanic-serving
2 health professions schools for the purpose of carrying out
3 programs to recruit Hispanic individuals to enroll in and
4 graduate from such schools, which may include providing
5 scholarships and other financial assistance as appropriate.
6 "(b) ELIGIBILITY.—In subsection (a), the term 'His-
7 panic-serving health professions school' means an entity
8 that—
9 "(1) is a school or program under section
10 799B;
11 "(2) has an enrollment of full-time equivalent
12 students that is made up of at least 9 percent His-
13 panic students;
14 "(3) has been effective in carrying out pro-
15 grams to recruit Hispanic individuals to enroll in
16 and graduate from the school;
17 "(4) has been effective in recruiting and retain-
18 ing Hispanic faculty members;
19 "(5) has a significant number of graduates who
20 are providing health services to medically under-
21 served populations or to individuals in health profes-
22 sional shortage areas; and
23 "(6) Regional Hispanic Centers of Excellence.".

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.

1 "(b) PRIORITY.—In awarding cooperative agreements
2 under this section, the Secretary shall give priority to any
3 school of public health or school of allied health that has
4 an established track record of serving medically under-
5 served communities.

6 "(c) REQUIREMENTS.—Awardees must design and
7 implement an online degree program, that meet the fol-
8 lowing restrictions:

9 "(1) Enrollment of individuals who have ob-
10 tained a secondary school diploma or its recognized
11 equivalent.

12 "(2) Maintaining a significant enrollment of
13 underrepresented minority or disadvantaged stu-
14 dents.

15 "(d) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated to carry out this section,
17 such sums as may be necessary for each of fiscal years
18 2012 through 2017.".

19 **SEC. 305. NATIONAL REPORT ON THE PREPAREDNESS OF**
20 **HEALTH PROFESSIONALS TO CARE FOR DI-**
21 **VERSE POPULATIONS.**

22 The Secretary of Health and Human Services, in col-
23 laboration with the Bureau of Health Professions, the Of-
24 fice of Minority Health and the National Institute on Mi-
25 nority Health and Health Disparities, shall prepare and

disseminate a report that details and assesses the preparedness of health professionals to care for racially and ethnically diverse populations. Such information, which shall be collected by the Bureau of Health Professions, shall include—

(1) with respect to health professions education, the number and percentage of hours of classroom discussion relating to minority health issues, including cultural competence;

(2) a description of the coursework involved in such education;

(3) a description of the results of an evaluation of the preparedness of students in such education;

(4) a description of the types of exposure that students have during their education to minority patient populations; and

(5) a description of model programs and practices.

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;

1 "(2) have experience in health disparity elimi-
2 nation programs;
3 "(3) facilitate the entry of disadvantaged indi-
4 viduals into institutions of higher education; and
5 "(4) provide counseling or other services de-
6 signed to assist disadvantaged individuals in success-
7 fully completing their education at the postsecondary
8 level.
9 "(e) STIPENDS.—The Secretary may approve sti-
10 pends under this section for individuals for any period of
11 education in student-enhancement programs (other than
12 regular courses) at health professions schools, programs,
13 or entities, except that such a stipend may not be provided
14 to an individual for more than 6 months, and such a sti-
15 pend may not exceed $20 per day (notwithstanding any
16 other provision of law regarding the amount of stipends).
17 "(f) AUTHORIZATION OF APPROPRIATIONS.—There
18 is authorized to be appropriated to carry out this section,
19 such sums as may be necessary for each of fiscal years
20 2012 through 2017.
21 **"SEC. 3420. LOUIS STOKES PUBLIC HEALTH SCHOLARS**
22 **PROGRAM.**
23 "(a) IN GENERAL.—The Director of the Centers for
24 Disease Control and Prevention, in collaboration with the
25 Deputy Assistant Secretary for Minority Health, shall

1 award scholarships to postsecondary students who seek a
2 career in public health.

3 "(b) ELIGIBILITY.—To be eligible to receive a schol-
4 arship under subsection (a) an individual shall—

5 "(1) have experience in public health research
6 or public health practice, or other health professions
7 as determined appropriate by the Director of the
8 Centers for Disease Control and Prevention;

9 "(2) reside in a health professional shortage
10 area as determined by the Secretary;

11 "(3) have expressed an interest in public health;

12 "(4) demonstrate promise for becoming a leader
13 in public health;

14 "(5) secure admission to a 4-year institution of
15 higher education;

16 "(6) comply with subsection (f); and

17 "(7) submit to the Secretary an application at
18 such time, in such manner, and containing such in-
19 formation as the Secretary may require.

20 "(c) USE OF FUNDS.—Amounts received under an
21 award under subsection (a) shall be used to support oppor-
22 tunities for students to become public health professionals.

23 "(d) PRIORITY.—In awarding grants under sub-
24 section (a), the Director shall give priority to those stu-
25 dents that—

1 "(1) are from disadvantaged backgrounds;
2 "(2) have secured admissions to a minority-
3 serving institution; and
4 "(3) have identified a health professional as a
5 mentor at their school or institution and an aca-
6 demic advisor to assist in the completion of their
7 baccalaureate degree.
8 "(e) SCHOLARSHIPS.—The Secretary may approve
9 payment of scholarships under this section for such indi-
10 viduals for any period of education in student under-
11 graduate tenure, except that such a scholarship may not
12 be provided to an individual for more than 4 years, and
13 such scholarships may not exceed $10,000 per academic
14 year (notwithstanding any other provision of law regard-
15 ing the amount of scholarship).
16 "(f) AUTHORIZATION OF APPROPRIATIONS.—There
17 is authorized to be appropriated to carry out this section,
18 such sums as may be necessary for each of fiscal years
19 2012 through 2017.

20 **"SEC. 3420A. PATSY MINK HEALTH AND GENDER RESEARCH**
21 **FELLOWSHIP PROGRAM.**

22 "(a) IN GENERAL.—The Director of the Centers for
23 Disease Control and Prevention, in collaboration with the
24 Deputy Assistant Secretary for Minority Health, the Ad-
25 ministrator of the Substance Abuse and Mental Health

1 Services Administration, and the Director of the Indian
2 Health Services, shall award research fellowships to post-
3 baccalaureate students to conduct research that will exam-
4 ine gender and health disparities and to pursue a career
5 in the health professions.

6 ''(b) ELIGIBILITY.—To be eligible to receive a fellow-
7 ship under subsection (a) an individual shall—

8 ''(1) have experience in health research or pub-
9 lic health practice;

10 ''(2) reside in a health professional shortage
11 area as determined by the Secretary;

12 ''(3) have expressed an interest in the health
13 professions;

14 ''(4) demonstrate promise for becoming a leader
15 in the field of women's health;

16 ''(5) secure admission to a health professions
17 school or graduate program with an emphasis in
18 gender studies;

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

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

23 ''(c) USE OF FUNDS.—Amounts received under an
24 award under subsection (a) shall be used to support oppor-
25 tunities for students to become researchers and advance

1 the research base on the intersection between gender and
2 health.

3 "(d) PRIORITY.—In awarding grants under sub-
4 section (a), the Director of the Centers for Disease Con-
5 trol and Prevention shall give priority to those applicants
6 that—

7 "(1) are from disadvantaged backgrounds; and
8 "(2) have identified a mentor and academic ad-
9 visor who will assist in the completion of their grad-
10 uate or professional degree and have secured a re-
11 search assistant position with a researcher working
12 in the area of gender and health.

13 "(e) FELLOWSHIPS.—The Director of the Centers for
14 Disease Control and Prevention may approve fellowships
15 for individuals under this section for any period of edu-
16 cation in the student's graduate or health profession ten-
17 ure, except that such a fellowship may not be provided
18 to an individual for more than 3 years, and such a fellow-
19 ship may not exceed $18,000 per academic year (notwith-
20 standing any other provision of law regarding the amount
21 of fellowship).

22 "(f) AUTHORIZATION OF APPROPRIATIONS.—There
23 is authorized to be appropriated to carry out this section,
24 such sums as may be necessary for each of fiscal years
25 2012 through 2017.

"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

1 to advance their knowledge about international issues re-
2 lating to health care access and quality.

3 "(d) PRIORITY.—In awarding grants under sub-
4 section (a), the Director shall give priority to those appli-
5 cants that—

6 "(1) are from a disadvantaged background; and

7 "(2) have identified a mentor at a health pro-
8 fessions school or institution, an academic advisor to
9 assist in the completion of their graduate or profes-
10 sional degree, and an advisor from an international
11 health non-governmental organization, private volun-
12 teer organization, or other international institution
13 or program that focuses on increasing health care
14 access and quality for residents in developing coun-
15 tries.

16 "(e) FELLOWSHIPS.—The Secretary shall approve
17 fellowships for college seniors or recent graduates, except
18 that such a fellowship may not be provided to an indi-
19 vidual for more than 6 months, may not be awarded to
20 a graduate that has not been enrolled in school for more
21 than 1 year, and may not exceed $4,000 per academic year
22 (notwithstanding any other provision of law regarding the
23 amount of fellowship).

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

1 such sums as may be necessary for each of fiscal years
2 2012 through 2017.

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

5 "(a) IN GENERAL.—The Director of the Agency for
6 Healthcare Research and Quality, the Director of the Cen-
7 ters for Medicaid & Medicare, and the Administrator for
8 Health Resources and Services Administration, in collabo-
9 ration with the Deputy Assistant Secretary for Minority
10 Health, shall award grants to eligible entities to expose
11 entering graduate students to the health professions.

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

14 "(1) be a clinical, public health or health serv-
15 ices organization, community-based or nonprofit en-
16 tity, or other entity determined appropriate by the
17 Director of the Agency for Healthcare Research and
18 Quality;

19 "(2) serve in a health professional shortage
20 area as determined by the Secretary;

21 "(3) work with students obtaining a degree in
22 the health professions; and

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

1 "(c) USE OF FUNDS.—Amounts received under a
2 grant awarded under subsection (a) shall be used to sup-
3 port opportunities that expose students to non-research-
4 based health professions, including—
5 "(1) public health policy;
6 "(2) health care and pharmaceutical policy;
7 "(3) health care administration and manage-
8 ment;
9 "(4) health economics; and
10 "(5) other professions determined appropriate
11 by the Director of the Agency for Healthcare Re-
12 search and Quality.
13 "(d) PRIORITY.—In awarding grants under sub-
14 section (a), the Director of the Agency for Healthcare Re-
15 search and Quality shall give priority to those entities
16 that—
17 "(1) have experience with health disparity elimi-
18 nation programs;
19 "(2) facilitate training in the fields described in
20 subsection (c); and
21 "(3) provide counseling or other services de-
22 signed to assist such individuals in successfully com-
23 pleting their education at the postsecondary level.
24 "(e) STIPENDS.—The Secretary may approve the
25 payment of stipends for individuals under this section for

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).

"(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2012 through 2017.".

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 Services to ensure that there is collaboration between the goals of the program under this section and programs of the Health Resources and Services Administration that promote health workforce diversity. The Secretary of Education shall take such measures as may be necessary to encourage participants in programs under this section to consider health profession careers.

"(h) FUNDING.—From amounts appropriated pursuant to the authority of section 402A(g), the Secretary shall, to the extent practicable, allocate funds for projects authorized by this section in an amount which is not less than $31,000,000 for each of the fiscal years 2012 through 2018.".

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 in-

1 serting "Subject to subparagraphs (J), (K), and (L),
2 such rules";
3 (2) in subparagraph (J), by striking "Such
4 rules" and inserting "Subject to subparagraph (L),
5 such rules";
6 (3) in subparagraph (K), by striking "In deter-
7 mining" and inserting "Subject to subparagraph
8 (L), in determining"; and
9 (4) by adding at the end the following new sub-
10 paragraph:
11 "(L) For purposes of cost-reporting peri-
12 ods beginning on or after October 1, 2011, in
13 determining the hospital's number of full-time
14 equivalent residents for purposes of this sub-
15 paragraph, all the time spent by an intern or
16 resident in an approved medical residency train-
17 ing program shall be counted toward the deter-
18 mination of full-time equivalency if the hos-
19 pital—
20 "(i) is recognized as a subsection (d)
21 hospital;
22 "(ii) is recognized as a subsection (d)
23 Puerto Rico hospital;

"(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) in clause (x)(II), by striking "In determining" and inserting "Subject to subclause (x)(IV), in determining";

(2) in clause (x)(III), by striking "In determining" and inserting "Subject to subclause (x)(IV), in determining"; and

(3) 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 institutions 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 eligi-

ble 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 2011".

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

1 cancer, diabetes, and hypertension—and suffer
2 worse health outcomes, worse health status, and
3 higher mortality rates than their White counter-
4 parts.

5 (3) Several recent studies also show that health
6 disparities are a function of not only access to health
7 care, but also the social determinants of health—in-
8 cluding the environment, the physical structure of
9 communities, nutrition and food options, educational
10 attainment, employment, race, ethnicity, geography,
11 and language preference—that directly and indi-
12 rectly affect the health, health care, and wellness of
13 individuals and communities.

14 (4) Integrally involving and fully supporting the
15 communities most affected by health inequities in
16 the assessment, planning, launch, and evaluation of
17 health disparity elimination efforts is among the
18 leading recommendations made to adequately ad-
19 dress and ultimately reduce health disparities.

20 (5) Recommendations also include supporting
21 the efforts of community stakeholders from a broad
22 crosssection—including, but not limited to local
23 businesses, local departments of commerce, edu-
24 cation, labor, urban planning, and transportation,
25 and community-based and other nonprofit organiza-

tions—to find areas of common ground around health disparity elimination and collaborate to improve the overall health and wellness of a community and its residents.

SEC. 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.

1 (L) Educational and community-based
2 health programs.
3 (M) Environmental health.
4 (N) Family planning.
5 (O) Food safety.
6 (P) Health communication.
7 (Q) Health disease and stroke.
8 (R) HIV/AIDS.
9 (S) Immunization and infectious diseases.
10 (T) Occupational safety and health.
11 (U) Oral health.
12 (V) Physical activity and fitness.
13 (W) Public health infrastructure.
14 (X) Respiratory diseases.
15 (Y) Sexually transmitted diseases.
16 (Z) Substance abuse.
17 (AA) Tobacco use.
18 (BB) Vision and hearing.
19 (CC) The degree to which those who have
20 disabilities have access to health services, in-
21 cluding physical activity and fitness, including
22 the ability to physically access the locations
23 where such services are provided.
24 (c) PROCEDURE.—

1 (1) REQUEST.—A request under subsection (a)
2 shall—
3 (A) describe the bounds of the area to be
4 designated as a health empowerment zone and
5 the process used to select those bounds;
6 (B) demonstrate that the partnership sub-
7 mitting the request is an eligible community
8 partnership described in subsection (b)(1);
9 (C) demonstrate that the area is an eligible
10 area described in subsection (b)(2);
11 (D) include a comprehensive assessment of
12 disparities in health status and health care ex-
13 perience by one or more communities in the
14 area;
15 (E) set forth—
16 (i) a vision and a set of values for the
17 area; and
18 (ii) a comprehensive and holistic set of
19 goals to be achieved in the area through
20 designation as a health empowerment zone;
21 and
22 (F) include a strategic plan for achieving
23 the goals described in subparagraph (E)(ii).
24 (2) APPROVAL.—Not later than 60 days after
25 the receipt of a request for designation of an area

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.

SEC. 407. AUTHORIZATION OF APPROPRIATIONS.

To carry out this subtitle, there is authorized to be appropriated $100,000,000 for fiscal year 2012.

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 "(1) be a health center, hospital, health plan,
2 health system, community clinic. or other health en-
3 tity determined appropriate by the Secretary—
4 "(A) that, by legal mandate or explicitly
5 adopted mission, provides patients with access
6 to services regardless of their ability to pay;
7 "(B) that provides care or treatment for a
8 substantial number of patients who are unin-
9 sured, are receiving assistance under a State
10 program under title XIX of the Social Security
11 Act, or are members of vulnerable populations,
12 as determined by the Secretary; and
13 "(C)(i) with respect to which, not less than
14 50 percent of the entity's patient population is
15 made up of racial and ethnic minorities; or
16 "(ii) that—
17 "(I) serves a disproportionate percent-
18 age of local, minority racial and ethnic pa-
19 tients, or that has a patient population, at
20 least 50 percent of which is limited-English
21 proficient; and
22 "(II) provides an assurance that
23 amounts received under the grant will be
24 used only to support quality improvement

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;

1 "(E) physician or patient reminder sys-
2 tems;
3 "(F) educational interventions; or
4 "(G) other activities determined appro-
5 priate by the Secretary.
6 "(d) USE OF FUNDS.—An entity shall use amounts
7 received under a grant under subsection (a) to support
8 the implementation and evaluation of health care quality
9 improvement activities or minority health and health care
10 disparity reduction activities that include—
11 "(1) with respect to health care systems, activi-
12 ties relating to improving—
13 "(A) patient safety;
14 "(B) timeliness of care;
15 "(C) effectiveness of care;
16 "(D) efficiency of care;
17 "(E) patient centeredness; and
18 "(F) health information technology; and
19 "(2) with respect to patients, activities relating
20 to—
21 "(A) staying healthy;
22 "(B) getting well;
23 "(C) living with illness or disability; and
24 "(D) coping with end-of-life issues.

1 "(e) COMMON DATA SYSTEMS.—The Secretary shall
2 provide financial and other technical assistance to grant-
3 ees under this section for the development of common data
4 systems.

5 "(f) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated to carry out this section,
7 such sums as may be necessary for each of fiscal years
8 2010 through 2015.

9 **"SEC. 3452. CENTERS OF EXCELLENCE.**

10 "(a) IN GENERAL.—The Secretary, acting through
11 the Administrator of the Health Resources and Services
12 Administration, shall designate centers of excellence at
13 public hospitals, and other health systems serving large
14 numbers of minority patients, that—

15 "(1) meet the requirements of section
16 3451(b)(1);

17 "(2) demonstrate excellence in providing care to
18 minority populations; and

19 "(3) demonstrate excellence in reducing dispari-
20 ties in health and health care.

21 "(b) REQUIREMENTS.—A hospital or health system
22 that serves as a Center of Excellence under subsection (a)
23 shall—

24 "(1) design, implement, and evaluate programs
25 and policies relating to the delivery of care in ra-

1 cially, ethnically, and linguistically diverse popu-
2 lations;
3 ''(2) provide training and technical assistance
4 to other hospitals and health systems relating to the
5 provision of quality health care to minority popu-
6 lations; and
7 ''(3) develop activities for graduate or con-
8 tinuing medical education that institutionalize a
9 focus on cultural competence training for health care
10 providers.
11 ''(c) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated to carry out this section,
13 such sums as may be necessary for each of fiscal years
14 2010 through 2015.

15 **"SEC. 3453. RECONSTRUCTION AND IMPROVEMENT GRANTS**
16 **FOR PUBLIC HEALTH CARE FACILITIES SERV-**
17 **ING PACIFIC ISLANDERS AND THE INSULAR**
18 **AREAS.**

19 ''(a) IN GENERAL.—The Secretary shall provide di-
20 rect financial assistance to designated health care pro-
21 viders and community health centers in American Samoa,
22 Guam, the Commonwealth of the Northern Mariana Is-
23 lands, the United States Virgin Islands, Puerto Rico, and
24 Hawaii for the purposes of reconstructing and improving
25 health care facilities and services.

1 "(b) ELIGIBILITY.—To be eligible to receive direct fi-
2 nancial assistance under subsection (a), an entity shall be
3 a public health facility or community health center located
4 in American Samoa, Guam, the Commonwealth of the
5 Northern Mariana Islands, the United States Virgin Is-
6 lands, Puerto Rico, or Hawaii that—
7 "(1) is owned or operated by—
8 "(A) the Government of American Samoa,
9 Guam, the Commonwealth of the Northern
10 Mariana Islands, the United States Virgin Is-
11 lands, Puerto Rico, or Hawaii or a unit of local
12 government; or
13 "(B) a nonprofit organization; and
14 "(2)(A) provides care or treatment for a sub-
15 stantial number of patients who are uninsured, re-
16 ceiving assistance under a State program under a
17 title XVIII of the Social Security Act, or a State
18 program under title XIX of such Act, or who are
19 members of a vulnerable population, as determined
20 by the Secretary; or
21 "(B) serves a disproportionate percentage of
22 local, minority racial and ethnic patients.
23 "(c) REPORT.—Not later than 180 days after the
24 date of enactment of this title and annually thereafter, the
25 Secretary shall submit to the Congress and the President

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.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as necessary to carry out this section.".

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 Secretary shall submit to the Congress the results of the study under subsection (a)(1) and the prediction made under subsection (a)(2).

(2) REPORTING OF DEMOGRAPHIC CHARACTERISTICS.—The Secretary shall 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)'' 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.—Section 1905(b)(2) of such Act (42 U.S.C. 1396d(b)(2)) is amended by inserting after "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

1 percentage determined by the Secretary in consulta-
2 tion (for the United States Virgin Islands, Guam,
3 the Commonwealth of the Northern Mariana Is-
4 lands, and American Samoa) with the Secretary of
5 the Interior)''.

6 (2) 2-FISCAL-YEAR TRANSITION.—Notwith-
7 standing any other provision of law, during fiscal
8 years 2012 and 2013, the Federal medical assist-
9 ance percentage established under section 1905(b) of
10 the Social Security Act (42 U.S.C. 1396d(b)) for
11 Puerto Rico, the United States Virgin Islands,
12 Guam, the Commonwealth of the Northern Mariana
13 Islands, and American Samoa shall be the highest
14 such Federal medical assistance percentage applica-
15 ble to any of the 50 States or the District of Colum-
16 bia for the fiscal year involved, taking into account
17 the application of subsections (a) and (b)(1) of 5001
18 of division B of the American Recovery and Rein-
19 vestment Act of 2009 (Public Law 111–5) to such
20 States and District of Columbia for calendar quar-
21 ters during such fiscal years for which such sub-
22 sections apply respectively.

23 (3) PER CAPITA INCOME DATA.—

24 (A) REPORT TO CONGRESS.—Not later
25 than October 1, 2012, the Secretary of Health

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. CLARIFICATION OF MEDICAID COVERAGE FOR CITIZENS OF FREELY ASSOCIATED STATES.

(a) IN GENERAL.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at the end the following:

''(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 the Medicaid program), 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 the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.''.

(b) CONFORMING DEFINITION OF QUALIFIED ALIEN.—Section 431(b) of such Act (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), but only with respect to the program

1 defined in section 402(b)(3)(C) (relating to the Med-
2 icaid program).''.

3 (c) SETTING FMAP AT 100 PERCENT.—The third
4 sentence of section 1905(b) of the Social Security Act (42
5 U.S.C. 1396d(b)) is amended by inserting before the pe-
6 riod at the end the following: ''; with respect to medical
7 assistance for individuals described in section
8 402(b)(2)(G) of the Personal Responsibility and Work Op-
9 portunity Reconciliation Act of 1996''.

10 (d) EFFECTIVE DATE.—The amendments made by
11 this Act take effect on October 1, 2011, and apply to bene-
12 fits and assistance provided on or after that date.

13 **SEC. 416. EXTENSION OF MEDICARE SECONDARY PAYER.**

14 (a) IN GENERAL.—Section 1862(b)(1)(C) of the So-
15 cial Security Act (42 U.S.C. 1395y(b)(1)(C)) is amend-
16 ed—

17 (1) in the last sentence, by inserting '', and be-
18 fore January 1, 2012'' after ''prior to such date)'';
19 and

20 (2) by adding at the end the following new sen-
21 tence: ''Effective for items and services furnished on
22 or after January 1, 2012 (with respect to periods
23 beginning on or after the date that is 42 months
24 prior to such date), clauses (i) and (ii) shall be ap-

plied 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.—From funds appropriated under subsection (f), the Secretary of Health and Human Services (in this section referred to as the ''Secretary''), acting through the United States members of the United States-Mexico Border Health Commission, shall award

1 grants to eligible entities to address priorities and rec-
2 ommendations to improve the health of border area resi-
3 dents that are established by—
4 (1) the United States members of the United
5 States-Mexico Border Health Commission;
6 (2) the State border health offices; and
7 (3) the Secretary.
8 (c) APPLICATION.—An eligible entity that desires a
9 grant under subsection (b) shall submit an application to
10 the Secretary at such time, in such manner, and con-
11 taining such information as the Secretary may require.
12 (d) USE OF FUNDS.—An eligible entity that receives
13 a grant under subsection (b) shall use the grant funds
14 for—
15 (1) programs relating to—
16 (A) maternal and child health;
17 (B) primary care and preventative health;
18 (C) public health and public health infra-
19 structure;
20 (D) health education and promotion;
21 (E) oral health;
22 (F) mental and behavioral health;
23 (G) substance abuse;
24 (H) health conditions that have a high
25 prevalence in the border area;

(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) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $200,000,000 for fiscal year 2012, and such sums as may be necessary for each succeeding fiscal year.

SEC. 418. REMOVING MEDICARE BARRIER TO HEALTH CARE.

Section 1818(a)(3) of the Social Security Act (42 U.S.C. 1395i–2(a)(3)) is amended by amending subparagraph (B) to read as follows: ''(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 415(c), is amended by inserting ''or are received through a program operated by an urban Indian organization through a grant or contract under title V of such Act''.

(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 Na-

1 tive Hawaiian (as defined in section 12(2) of the Native
2 Hawaiian Health Care Improvement Act) through a feder-
3 ally qualified health center or a Native Hawaiian health
4 care system (as defined in section 12(6) of such Act),
5 whether directly, by referral, or under contract or other
6 arrangement between such federally qualified health cen-
7 ter or Native Hawaiian health care system and another
8 health care provider'' before the period.

9 (b) EFFECTIVE DATE.—The amendment made by
10 this section shall apply to medical assistance provided on
11 or after the date of enactment of this Act.

12 CHAPTER 2—EXPANSION OF ACCESS

13 SEC. 421. GRANTS FOR RACIAL AND ETHNIC APPROACHES 14 TO COMMUNITY HEALTH.

15 (a) PURPOSE.—It is the purpose of this section to
16 provide for the awarding of grants to assist communities
17 in mobilizing and organizing resources in support of effec-
18 tive and sustainable programs that will reduce or eliminate
19 disparities in health and health care experienced by racial
20 and ethnic minority individuals.

21 (b) AUTHORITY TO AWARD GRANTS.—The Sec-
22 retary, acting through the Centers for Disease Control and
23 Prevention, shall award grants to eligible entities to assist
24 in designing, implementing, and evaluating culturally and
25 linguistically appropriate, science-based, and community-

1 driven sustainable strategies to eliminate racial and ethnic
2 health and health care disparities.
3 (c) ELIGIBLE ENTITIES.—To be eligible to receive a
4 grant under this section, an entity shall—
5 (1) represent a coalition—
6 (A) whose principal purpose is to develop
7 and implement interventions to reduce or elimi-
8 nate a health or health care disparity in a tar-
9 geted racial or ethnic minority group in the
10 community served by the coalition; and
11 (B) that includes—
12 (i) members selected from among—
13 (I) public health departments;
14 (II) community-based organiza-
15 tions;
16 (III) university and research or-
17 ganizations;
18 (IV) American Indian tribal or-
19 ganizations, national American Indian
20 organizations, Indian Health Service,
21 or organizations serving Alaska Na-
22 tives; and
23 (V) interested public or private
24 health care providers or organizations

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

1 section, including the outreach efforts of the Office of Mi-
2 nority Health and Health Disparity Elimination and the
3 Centers for Disease Control and Prevention.

4 (h) ADMINISTRATIVE BURDENS.—The Secretary
5 shall make every effort to minimize duplicative or unneces-
6 sary administrative burdens on grantees.

7 (i) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated such sums as may be
9 necessary to carry out this section.

10 **SEC. 422. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.**

11 (a) ELIMINATION OF ISOLATION TEST FOR COST-
12 BASED AMBULANCE REIMBURSEMENT.—

13 (1) IN GENERAL.—Section 1834(l)(8) of the
14 Social Security Act (42 U.S.C. 1395m(l)(8)) is
15 amended—

16 (A) in subparagraph (B)—

17 (i) by striking ''owned and''; and

18 (ii) by inserting ''(including when
19 such services are provided by the entity
20 under an arrangement with the hospital)''
21 after ''hospital''; and

22 (B) by striking the comma at the end of
23 subparagraph (B) and all that follows and in-
24 serting a period.

1 (2) EFFECTIVE DATE.—The amendments made
2 by this subsection shall apply to services furnished
3 on or after January 1, 2012.
4 (b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE
5 TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT
6 REQUIREMENT.—
7 (1) IN GENERAL.—Section 1820(c)(2) of the
8 Social Security Act (42 U.S.C. 1395i–4(c)(2)) is
9 amended—
10 (A) in subparagraph (B)(iii), by striking
11 ''provides not more than'' and inserting ''sub-
12 ject to subparagraph (F), provides not more
13 than''; and
14 (B) by adding at the end the following new
15 subparagraph:
16 ''(F) ALTERNATIVE TO 25 INPATIENT BED
17 LIMIT REQUIREMENT.—
18 ''(i) IN GENERAL.—A State may elect
19 to treat a facility, with respect to the des-
20 ignation of the facility for a cost reporting
21 period, as satisfying the requirement of
22 subparagraph (B)(iii) relating to a max-
23 imum number of acute care inpatient beds
24 if the facility elects, in accordance with a
25 method specified by the Secretary and be-

fore 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 peri-

ods 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.

1 "(2) For purposes of paragraph (1)(B), beds in a
2 psychiatric or rehabilitation unit of the hospital which is
3 a distinct part of the hospital shall not be counted.
4 "(3) Paragraph (1)(D) shall not be construed to pro-
5 hibit any of the following from qualifying as a rural com-
6 munity hospital:
7 "(A) A replacement facility (as defined by the
8 Secretary in regulations in effect on January 1,
9 2012) with the same service area (as defined by the
10 Secretary in regulations in effect on such date).
11 "(B) A facility obtaining a new provider num-
12 ber pursuant to a change of ownership.
13 "(C) A facility which has a binding written
14 agreement with an outside, unrelated party for the
15 construction, reconstruction, lease, rental, or financ-
16 ing of a building as of January 1, 2012.
17 "(4) Nothing in this subsection shall be construed as
18 prohibiting a critical access hospital from qualifying as a
19 rural community hospital if the critical access hospital
20 meets the conditions otherwise applicable to hospitals
21 under subsection (e) and section 1866.
22 "(5) Nothing in this subsection shall be construed as
23 prohibiting a rural community hospital participating in
24 the demonstration program under section 410A of the
25 Medicare Prescription Drug, Improvement, and Mod-

1 ernization Act of 2003 (Public Law 108–173; 117 Stat.
2 2313) from qualifying as a rural community hospital if
3 the rural community hospital meets the conditions other-
4 wise applicable to hospitals under subsection (e) and sec-
5 tion 1866.''.

6 (b) PAYMENT.—

7 (1) INPATIENT HOSPITAL SERVICES.—Section
8 1814 of the Social Security Act (42 U.S.C. 1395f)
9 is amended by adding at the end the following new
10 subsection:

11 ''Payment for Inpatient Services Furnished in Rural
12 Community Hospitals

13 ''(m) The amount of payment under this part for in-
14 patient hospital services furnished in a rural community
15 hospital, other than such services furnished in a psy-
16 chiatric or rehabilitation unit of the hospital which is a
17 distinct part, is, at the election of the hospital in the appli-
18 cation referred to in section 1861(jjj)(1)(E)—

19 ''(1) 101 percent of the reasonable costs of pro-
20 viding such services, without regard to the amount
21 of the customary or other charge, or

22 ''(2) the amount of payment provided for under
23 the prospective payment system for inpatient hos-
24 pital services under section 1886(d).''.

(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 30-PERCENT REDUCTION IN REIMBURSEMENT FOR BAD DEBT.—Section 1861(v)(1)(T) of such Act (42 U.S.C. 1395x(v)(1)(T)) is amended by inserting "(other than for a rural community hospital)" after "In determining such reasonable costs for hospitals".

(c) BENEFICIARY COST-SHARING FOR OUTPATIENT SERVICES.—Section 1834(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 costsharing 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 costsharing 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 costsharing shall apply.

"(C) For all other items and services, the amount of costsharing 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

1 community hospital,'' after ''critical access hospital
2 services,''.
3 (2) PART B PAYMENT.—Section 1833(a) of
4 such Act (42 U.S.C. 1395l(a)), as amended by sec-
5 tion 203(b)(2), is amended—
6 (A) in paragraph (2), in the matter before
7 subparagraph (A), by striking ''and (I)'' and in-
8 serting ''(I), and (K)'';
9 (B) by striking ''and'' at the end of para-
10 graph (9);
11 (C) by striking the period at the end of
12 paragraph (10) and inserting ''; and''; and
13 (D) by adding at the end the following:
14 ''(11) in the case of outpatient services fur-
15 nished by a rural community hospital, the amounts
16 described in section 1834(p).''.
17 (3) TECHNICAL AMENDMENTS.—
18 (A) CONSULTATION WITH STATE AGEN-
19 CIES.—Section 1863 of such Act (42 U.S.C.
20 1395z) is amended by striking ''and (dd)(2)''
21 and inserting ''(dd)(2), (mm)(1), and (jjj)(1)''.
22 (B) PROVIDER AGREEMENTS.—Section
23 1866(a)(2)(A) of such Act (42 U.S.C.
24 1395cc(a)(2)(A)) is amended by inserting ''sec-
25 tion 1834(p)(2),'' after ''section 1833(b),''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2011.

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 participating in a pilot project under this section a performance target using one of the following methodologies, as determined appropriate by the Secretary:

(A) ADJUSTED HISTORICAL PERFORMANCE TARGET.—The Secretary shall establish for the agency—

(i) a base expenditure amount equal to the average total payments made to the agency under parts A and B of title XVIII of the Social Security Act 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).

1 (3) LIMITATION ON EXPENDITURES.—The Sec-
2 retary shall limit incentive payments under this sec-
3 tion in order to ensure that the aggregate expendi-
4 tures under title XVIII of the Social Security Act
5 (including incentive payments under this subsection)
6 do not exceed the amount that the Secretary esti-
7 mates would have been expended if the pilot projects
8 under this section had not been implemented.
9 (d) WAIVER AUTHORITY.—The Secretary may waive
10 such provisions of titles XI and XVIII of the Social Secu-
11 rity Act as the Secretary determines to be appropriate for
12 the conduct of the pilot projects under this section.
13 (e) REPORT TO CONGRESS.—Not later than 5 years
14 after the date that the first pilot project under this section
15 is implemented, the Secretary shall submit to Congress a
16 report on the pilot projects. Such report shall contain a
17 detailed description of issues related to the expansion of
18 the projects under subsection (f) and recommendations for
19 such legislation and administrative actions as the Sec-
20 retary considers appropriate.
21 (f) EXPANSION.—If the Secretary determines that
22 any of the pilot projects under this section enhance health
23 outcomes for Medicare beneficiaries and reduce expendi-
24 tures under title XVIII of the Social Security Act, the Sec-

retary 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 imple-

1 mentation of a national plan for rural health
2 quality improvement. The national plan shall—
3 (i) identify objectives for rural health
4 quality improvement;
5 (ii) identify strategies to eliminate
6 known gaps in rural health system capacity
7 and improve rural health quality; and
8 (iii) provide for Federal programs to
9 identify opportunities for strengthening
10 and aligning policies and programs to im-
11 prove rural health quality.
12 (B) DEMONSTRATION PROJECTS.—The
13 Commission shall design demonstration projects
14 to test alternative models for rural health qual-
15 ity improvement, including with respect to both
16 personal and population health.
17 (C) MONITORING.—The Commission shall
18 monitor progress toward the objectives identi-
19 fied pursuant to paragraph (1)(A).
20 (3) MEMBERSHIP.—
21 (A) NUMBER.—The Commission shall be
22 composed of 11 members appointed by the Sec-
23 retary.
24 (B) SELECTION.—The Secretary shall se-
25 lect the members of the Commission from

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 & Medicaid Services to the Commission to assist in carrying out this subsection.

(6) REPORTS TO CONGRESS.—Not later than 1 year after the establishment of the Commission, and annually thereafter, the Commission shall submit a report to the Congress on rural health quality. Each such report shall include the following:

(A) An inventory of relevant programs and recommendations for improved coordination and integration of policy and programs.

(B) An assessment of achievement of the objectives identified in the national plan developed under paragraph (2) and recommendations for realizing such objectives.

(C) Recommendations on Federal legislation, regulations, or administrative policies to enhance rural health quality and outcomes.

(b) RURAL HEALTH QUALITY DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Not later than 270 days after the date of the enactment of this section, the Secretary, in consultation with the Rural Health Quality Advisory Commission, the Office of Rural Health Policy of the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services, shall make grants to eligible entities for 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 reporting, clinical care protocols, and information technology applications).

(2) ELIGIBLE ENTITIES.—In this subsection, the term ''eligible entity'' means a consortium that—

(A) shall include—

(i) at least one health care provider or health care delivery system located in a rural area; and

(ii) at least one organization representing multiple community stakeholders; and

(B) may include other partners such as rural research centers.

(3) CONSULTATION.—In developing the program for awarding grants under this subsection, the Secretary shall consult with the Administrator of the Agency for Healthcare Research and Quality, rural health care providers, rural health care researchers, and private and nonprofit groups (including national associations) which are undertaking similar efforts.

(4) EXPEDITED WAIVERS.—The Secretary shall expedite the processing of any waiver that—

(A) is authorized under title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq.); 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.

(c) APPROPRIATION.—

(1) IN GENERAL.—Out of funds in the Treasury not otherwise appropriated, there are appro-

priated to the Secretary to carry out this section $30,000,000 for the period of fiscal years 2012 through 2016.

(2) AVAILABILITY.—

(A) IN GENERAL.—Funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year 2016.

(B) REPORT.—For purposes of carrying out subsection (b)(8), funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year 2017.

(3) RESERVATION.—Of the amount appropriated under paragraph (1), the Secretary shall reserve—

(A) $5,000,000 to carry out subsection (a); and

(B) $25,000,000 to carry out subsection (b), of which—

(i) 2 percent shall be for the provision of technical assistance to grant recipients; and

(ii) 5 percent shall be for independent evaluation under subsection (b)(7).

SEC. 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 disparities and to promote and enhance health system development; and

"(4) under subsection (e), to provide for the planning and implementation of small rural health care provider quality improvement activities.

"(b) RURAL HEALTH CARE SERVICES OUTREACH GRANTS.—

1 "(1) GRANTS.—The Director of the Office of
2 Rural Health Policy of the Health Resources and
3 Services Administration may award grants to eligible
4 entities to promote rural health care services out-
5 reach by expanding the delivery of health care serv-
6 ices to include new and enhanced services in rural
7 areas. The Director may award the grants for peri-
8 ods of not more than 3 years.

9 "(2) ELIGIBILITY.—To be eligible to receive a
10 grant under this subsection for a project, an enti-
11 ty—

12 "(A) shall be a rural public or rural non-
13 profit private entity, a facility that qualifies as
14 a rural health clinic under title XVIII of the
15 Social Security Act, a public or nonprofit entity
16 existing exclusively to provide services to mi-
17 grant and seasonal farm workers in rural areas,
18 or a tribal government whose grant-funded ac-
19 tivities will be conducted within federally recog-
20 nized tribal areas;

21 "(B) shall represent a consortium com-
22 posed of members—

23 "(i) that include 3 or more independ-
24 ently owned health care entities; and

1 "(ii) that may be nonprofit or for-
2 profit entities; and
3 "(C) shall not previously have received a
4 grant under this subsection for the same or a
5 similar project, unless the entity is proposing to
6 expand the scope of the project or the area that
7 will be served through the project.
8 "(3) APPLICATIONS.—To be eligible to receive a
9 grant under this subsection, an eligible entity shall
10 prepare and submit to the Director an application at
11 such time, in such manner, and containing such in-
12 formation as the Director may require, including—
13 "(A) a description of the project that the
14 eligible entity will carry out using the funds
15 provided under the grant;
16 "(B) a description of the manner in which
17 the project funded under the grant will meet
18 the health care needs of rural populations in
19 the local community or region to be served;
20 "(C) a plan for quantifying how health
21 care needs will be met through identification of
22 the target population and benchmarks of service
23 delivery or health status, such as—

"(i) quantifiable measurements of health status improvement for projects focusing on health promotion; or

"(ii) benchmarks of increased access to primary care, including tracking factors such as the number and type of primary care visits, identification of a medical home, or other general measures of such access;

"(D) a description of how the local community or region to be served will be involved in the development and ongoing operations of the project;

"(E) a plan for sustaining the project after Federal support for the project has ended;

"(F) a description of how the project will be evaluated;

"(G) the administrative capacity to submit annual performance data electronically as specified by the Director; and

"(H) other such information as the Director determines to be appropriate.

"(c) RURAL HEALTH NETWORK DEVELOPMENT GRANTS.—

"(1) GRANTS.—

1 "(A) IN GENERAL.—The Director may
2 award rural health network development grants
3 to eligible entities to promote, through planning
4 and implementation, the development of inte-
5 grated health care networks that have combined
6 the functions of the entities participating in the
7 networks in order to—
8 "(i) achieve efficiencies and economies
9 of scale;
10 "(ii) expand access to, coordinate, and
11 improve the quality of the health care de-
12 livery system through development of orga-
13 nizational efficiencies;
14 "(iii) implement health information
15 technology to achieve efficiencies, reduce
16 medical errors, and improve quality;
17 "(iv) coordinate care and manage
18 chronic illness; and
19 "(v) strengthen the rural health care
20 system as a whole in such a manner as to
21 show a quantifiable return on investment
22 to the participants in the network.
23 "(B) GRANT PERIODS.—The Director may
24 award such a rural health network development
25 grant—

1 "(i) for a period of 3 years for imple-
2 mentation activities; or
3 "(ii) for a period of 1 year for plan-
4 ning activities to assist in the initial devel-
5 opment of an integrated health care net-
6 work, if the proposed participants in the
7 network do not have a history of collabo-
8 rative efforts and a 3-year grant would be
9 inappropriate.
10 "(2) ELIGIBILITY.—To be eligible to receive a
11 grant under this subsection, an entity—
12 "(A) shall be a rural public or rural non-
13 profit private entity, a facility that qualifies as
14 a rural health clinic under title XVIII of the
15 Social Security Act, a public or nonprofit entity
16 existing exclusively to provide services to mi-
17 grant and seasonal farm workers in rural areas,
18 or a tribal government whose grant-funded ac-
19 tivities will be conducted within federally recog-
20 nized tribal areas;
21 "(B) shall represent a network composed
22 of participants—
23 "(i) that include 3 or more independ-
24 ently owned health care entities; and

1 "(ii) that may be nonprofit or for-
2 profit entities; and
3 "(C) shall not previously have received a
4 grant under this subsection (other than a 1-
5 year grant for planning activities) for the same
6 or a similar project.
7 "(3) APPLICATIONS.—To be eligible to receive a
8 grant under this subsection, an eligible entity, in
9 consultation with the appropriate State office of
10 rural health or another appropriate State entity,
11 shall prepare and submit to the Director an applica-
12 tion at such time, in such manner, and containing
13 such information as the Director may require, in-
14 cluding—
15 "(A) a description of the project that the
16 eligible entity will carry out using the funds
17 provided under the grant;
18 "(B) an explanation of the reasons why
19 Federal assistance is required to carry out the
20 project;
21 "(C) a description of—
22 "(i) the history of collaborative activi-
23 ties carried out by the participants in the
24 network;

1 "(ii) the degree to which the partici-
2 pants are ready to integrate their func-
3 tions; and
4 "(iii) how the local community or re-
5 gion to be served will benefit from and be
6 involved in the activities carried out by the
7 network;
8 "(D) a description of how the local com-
9 munity or region to be served will experience in-
10 creased access to quality health care services
11 across the continuum of care as a result of the
12 integration activities carried out by the net-
13 work, including a description of—
14 "(i) return on investment for the com-
15 munity and the network members; and
16 "(ii) other quantifiable performance
17 measures that show the benefit of the net-
18 work activities;
19 "(E) a plan for sustaining the project after
20 Federal support for the project has ended;
21 "(F) a description of how the project will
22 be evaluated;
23 "(G) the administrative capacity to submit
24 annual performance data electronically as speci-
25 fied by the Director; and

1 "(H) other such information as the Direc-
2 tor determines to be appropriate.
3 "(d) DELTA RURAL DISPARITIES AND HEALTH SYS-
4 TEMS DEVELOPMENT GRANTS.—
5 "(1) GRANTS.—The Director may award grants
6 to eligible entities to support reduction of health dis-
7 parities, improve access to health care, and enhance
8 rural health system development in the Delta Re-
9 gion.
10 "(2) ELIGIBILITY.—To be eligible to receive a
11 grant under this subsection, an entity shall be a
12 rural public or rural nonprofit private entity, a facil-
13 ity that qualifies as a rural health clinic under title
14 XVIII of the Social Security Act, a public or non-
15 profit entity existing exclusively to provide services
16 to migrant and seasonal farm workers in rural
17 areas, or a tribal government whose grant-funded
18 activities will be conducted within federally recog-
19 nized tribal areas.
20 "(3) APPLICATIONS.—To be eligible to receive a
21 grant under this subsection, an eligible entity shall
22 prepare and submit to the Director an application at
23 such time, in such manner, and containing such in-
24 formation as the Director may require, including—

1 "(A) a description of the project that the
2 eligible entity will carry out using the funds
3 provided under the grant;
4 "(B) an explanation of the reasons why
5 Federal assistance is required to carry out the
6 project;
7 "(C) a description of the manner in which
8 the project funded under the grant will meet
9 the health care needs of the Delta Region;
10 "(D) a description of how the local com-
11 munity or region to be served will experience in-
12 creased access to quality health care services as
13 a result of the activities carried out by the enti-
14 ty;
15 "(E) a description of how health dispari-
16 ties will be reduced or the health system will be
17 improved;
18 "(F) a plan for sustaining the project after
19 Federal support for the project has ended;
20 "(G) a description of how the project will
21 be evaluated including process and outcome
22 measures related to the quality of care provided
23 or how the health care system improves its per-
24 formance;

1 "(H) a description of how the grantee will
2 develop an advisory group made up of rep-
3 resentatives of the communities to be served to
4 provide guidance to the grantee to best meet
5 community need; and
6 "(I) other such information as the Director
7 determines to be appropriate.
8 "(e) SMALL RURAL HEALTH CARE PROVIDER QUAL-
9 ITY IMPROVEMENT GRANTS.—
10 "(1) GRANTS.—The Director may award grants
11 to provide for the planning and implementation of
12 small rural health care provider quality improvement
13 activities. The Director may award the grants for
14 periods of 1 to 3 years.
15 "(2) ELIGIBILITY.—To be eligible for a grant
16 under this subsection, an entity—
17 "(A) shall be—
18 "(i) a rural public or rural nonprofit
19 private health care provider or provider of
20 health care services, such as a rural health
21 clinic; or
22 "(ii) another rural provider or net-
23 work of small rural providers identified by
24 the Director as a key source of local care;
25 and

1 "(B) shall not previously have received a
2 grant under this subsection for the same or a
3 similar project.
4 "(3) PREFERENCE.—In awarding grants under
5 this subsection, the Director shall give preference to
6 facilities that qualify as rural health clinics under
7 title XVIII of the Social Security Act.
8 "(4) APPLICATIONS.—To be eligible to receive a
9 grant under this subsection, an eligible entity shall
10 prepare and submit to the Director an application at
11 such time, in such manner, and containing such in-
12 formation as the Director may require, including—
13 "(A) a description of the project that the
14 eligible entity will carry out using the funds
15 provided under the grant;
16 "(B) an explanation of the reasons why
17 Federal assistance is required to carry out the
18 project;
19 "(C) a description of the manner in which
20 the project funded under the grant will assure
21 continuous quality improvement in the provision
22 of services by the entity;
23 "(D) a description of how the local com-
24 munity or region to be served will experience in-
25 creased access to quality health care services as

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

1 committees of Congress a report on the progress and ac-
2 complishments of the grant programs described in sub-
3 sections (b), (c), (d), and (e).

4 "(h) DEFINITIONS.—In this section:

5 "(1) The term 'Delta Region' has the meaning
6 given to the term 'region' in section 382A of the
7 Consolidated Farm and Rural Development Act (7
8 U.S.C. 2009aa).

9 "(2) The term 'Director' means the Director of
10 the Office of Rural Health Policy of the Health Re-
11 sources and Services Administration.

12 "(i) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this section
14 $40,000,000 for fiscal year 2012, and such sums as may
15 be necessary for each of fiscal years 2013 through 2016.".

16 **SEC. 427. COMMUNITY HEALTH CENTER COLLABORATIVE**
17 **ACCESS EXPANSION.**

18 Section 330 of the Public Health Service Act (42
19 U.S.C. 254b) is amended by adding at the end the fol-
20 lowing:

21 "(t) MISCELLANEOUS PROVISIONS.—

22 "(1) RULE OF CONSTRUCTION WITH RESPECT
23 TO RURAL HEALTH CLINICS.—

24 "(A) IN GENERAL.—Nothing in this sec-
25 tion shall be construed to prevent a community

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 Sec-

1 retary of Health and Human Services shall, in consulta-
2 tion with representatives of States, physicians, health care
3 practitioners, and patient advocates, encourage and facili-
4 tate the adoption of provisions allowing for multistate
5 practitioner practice across State lines.

6 (b) DEFINITIONS.—In subsection (a):

7 (1) TELEHEALTH SERVICE.—The term ''tele-
8 health service'' has the meaning given that term in
9 subparagraph (F) of section 1834(m)(4) of the So-
10 cial Security Act (42 U.S.C. 1395m(m)(4)).

11 (2) PHYSICIAN, PRACTITIONER.—The terms
12 ''physician'' and ''practitioner'' have the meaning
13 given those terms in subparagraphs (D) and (E), re-
14 spectively, of such section.

15 (3) MEDICARE PROGRAM.—The term ''Medicare
16 program'' means the program of health insurance
17 administered by the Secretary of Health and Human
18 Services under title XVIII of the Social Security Act
19 (42 U.S.C. 1395 et seq.).

20 **SEC. 429. SCORING OF PREVENTIVE HEALTH SAVINGS.**

21 Section 202 of the Congressional Budget and Im-
22 poundment Control Act of 1974 (2 U.S.C. 602) is amend-
23 ed by adding at the end the following new subsection:

24 ''(h) SCORING OF PREVENTIVE HEALTH SAVINGS.—

"(1) 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 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(A) in subsection (i)—

(i) in paragraph (20), by adding ''or'' after the semicolon at the end; and

(ii) in paragraph (21), by striking ''; or'' and inserting a period;

(B) by redesignating subsection (y), as added by section 6043(b) of the Deficit Reduction Act of 2005, as subsection (x); and

(C) by redesignating subsection (z), as added by section 6081(a) of the Deficit Reduction Act of 2005, as subsection (y).

(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.

1 "(2) To support research, demonstrations, and
2 evaluations to test new and innovative models for
3 the discharge of activities described in paragraph
4 (1).
5 "(3) To increase knowledge and understanding
6 of health risk factors for veterans who are members
7 of a racial or ethnic minority group.
8 "(4) To develop mechanisms that support bet-
9 ter health care information dissemination, education,
10 prevention, and services delivery to veterans from
11 disadvantaged backgrounds, including veterans who
12 are members of a racial or ethnic minority group.
13 "(5) To enter into contracts or agreements with
14 appropriate public and nonprofit private entities to
15 develop and carry out programs to provide bilingual
16 or interpretive services to assist veterans who are
17 members of a racial or ethnic minority group and
18 who lack proficiency in speaking the English lan-
19 guage in accessing and receiving health care services
20 through the Veterans Health Administration.
21 "(6) To carry out programs to improve access
22 to health care services through the Veterans Health
23 Administration for veterans with limited proficiency
24 in speaking the English language, including the de-

1 velopment and evaluation of demonstration and pilot
2 projects for that purpose.
3 "(7) To advise the Under Secretary of Health
4 on matters relating to the development, implementa-
5 tion, and evaluation of health professions education
6 in decreasing disparities in health care outcomes be-
7 tween veterans who are members of a racial or eth-
8 nic minority group and other veterans, including
9 cutural competency as a method of eliminating such
10 health disparities.
11 "(8) To perform such other functions and du-
12 ties as the Secretary or the Under Secretary for
13 Health considers appropriate.
14 "(d) DEFINITIONS.—In this section:
15 "(1) The term 'racial or ethnic minority group'
16 means the following:
17 "(A) American Indians (including Alaska
18 Natives, Eskimos, and Aleuts).
19 "(B) Asian Americans.
20 "(C) Native Hawaiians and other Pacific
21 Islanders.
22 "(D) Blacks.
23 "(E) Hispanics.
24 "(2) The term 'Hispanic' means individuals
25 whose origin is Mexican, Puerto Rican, Cuban, Cen-

tral 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 section 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)''.

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

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

Part Q of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

"SEC. 399Z–2. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS IN WOMEN AND CHILDREN.

"(a) GRANTS AUTHORIZED.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention 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.

"(b) USE OF FUNDS.—Grants awarded pursuant to subsection (a) may be used to support community health workers—

"(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

1 XVIII of such Act, and Medicaid under title XIX of
2 such Act;
3 ''(2) to educate, guide, and provide outreach in
4 a community setting regarding health problems prev-
5 alent among women and children and especially
6 among racial and ethnic minority women and chil-
7 dren;
8 ''(3) to educate, guide, and provide experiential
9 learning opportunities that target behavioral risk
10 factors including—
11 ''(A) poor nutrition;
12 ''(B) physical inactivity;
13 ''(C) being overweight or obese;
14 ''(D) tobacco use;
15 ''(E) alcohol and substance use;
16 ''(F) injury and violence;
17 ''(G) risky sexual behavior;
18 ''(H) mental health problems;
19 ''(I) musculoskeletal health;
20 ''(J) dental and oral health problems; and
21 ''(K) understanding informed consent;
22 ''(4) to educate and guide regarding effective
23 strategies to promote positive health behaviors with-
24 in the family;

1 "(5) to promote community wellness and awareness; and

3 "(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.

8 "(c) APPLICATION.—

9 "(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.

14 "(2) CONTENTS.—Each application submitted pursuant to paragraph (1) shall—

16 "(A) describe the activities for which assistance under this section is sought;

18 "(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;

24 "(C) contain an assurance that the applicant will evaluate the effectiveness of commu-

nity 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.

1 "(d) PRIORITY.—In awarding grants under sub-
2 section (a), the Secretary shall give priority to those appli-
3 cants—
4 "(1) who propose to target geographic areas—
5 "(A) with a high percentage of residents
6 who are eligible for health insurance but are
7 uninsured or underinsured; and
8 "(B) with a high percentage of families for
9 whom English is not their primary language;
10 "(2) with experience in providing health or
11 health-related social services to individuals who are
12 underserved with respect to such services; and
13 "(3) with documented community activity and
14 experience with community health workers.
15 "(e) COLLABORATION WITH ACADEMIC INSTITU-
16 TIONS.—The Secretary shall encourage community health
17 worker programs receiving funds under this section to col-
18 laborate with academic institutions, including minority-
19 serving institutions. Nothing in this section shall be con-
20 strued to require such collaboration.
21 "(f) QUALITY ASSURANCE AND
22 COSTEFFECTIVENESS.—The Secretary shall establish
23 guidelines for assuring the quality of the training and su-
24 pervision of community health workers under the pro-

1 grams funded under this section and for assuring the
2 costeffectiveness of such programs.

3 "(g) MONITORING.—The Secretary shall monitor
4 community health worker programs identified in approved
5 applications and shall determine whether such programs
6 are in compliance with the guidelines established under
7 subsection (f).

8 "(h) TECHNICAL ASSISTANCE.—The Secretary may
9 provide technical assistance to community health worker
10 programs identified in approved applications with respect
11 to planning, developing, and operating programs under the
12 grant.

13 "(i) REPORT TO CONGRESS.—

14 "(1) IN GENERAL.—Not later than 4 years
15 after the date on which the Secretary first awards
16 grants under subsection (a), the Secretary shall sub-
17 mit to Congress a report regarding the grant
18 project.

19 "(2) CONTENTS.—The report required under
20 paragraph (1) shall include the following:

21 "(A) A description of the programs for
22 which grant funds were used.

23 "(B) The number of individuals served.

24 "(C) An evaluation of—

1 "(i) the effectiveness of these pro-
2 grams;
3 "(ii) the cost of these programs; and
4 "(iii) the impact of the project on the
5 health outcomes of the community resi-
6 dents.
7 "(D) Recommendations for sustaining the
8 community health worker programs developed
9 or assisted under this section.
10 "(E) Recommendations regarding training
11 to enhance career opportunities for community
12 health workers.
13 "(j) DEFINITIONS.—In this section:
14 "(1) COMMUNITY HEALTH WORKER.—The term
15 'community health worker' means an individual who
16 promotes health or nutrition within the community
17 in which the individual resides—
18 "(A) by serving as a liaison between com-
19 munities and health care agencies;
20 "(B) by providing guidance and social as-
21 sistance to community residents;
22 "(C) by enhancing community residents'
23 ability to effectively communicate with health
24 care providers;

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

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

"(F) by providing referral and followup services.

"(2) COMMUNITY SETTING.—The term 'community setting' means a home or a community organization located in the neighborhood in which a participant resides.

"(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 un-

1 derserved population, as defined by section
2 330(b)(3); and
3 ''(B) a significant portion of which is a
4 health professional shortage area as designated
5 under section 332.
6 ''(5) SUPPORT.—The term 'support' means the
7 provision of training, supervision, and materials
8 needed to effectively deliver the services described in
9 subsection (b), reimbursement for services, and
10 other benefits.
11 ''(6) TARGET POPULATION.—The term 'target
12 population' means women of reproductive age, re-
13 gardless of their current childbearing status and
14 children under 21 years of age.
15 ''(k) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated to carry out this section
17 $15,000,000 for each of fiscal years 2012 through 2016.''.
18 **SEC. 502. REMOVING BARRIERS TO HEALTH CARE AND NU-**
19 **TRITION ASSISTANCE FOR CHILDREN, PREG-**
20 **NANT WOMEN, AND LAWFULLY PRESENT IN-**
21 **DIVIDUALS.**
22 (a) MEDICAID.—Section 1903(v) of the Social Secu-
23 rity Act (42 U.S.C. 1396b(v)) is amended by striking
24 paragraph (4) and inserting the following new paragraph:

"(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 regarding maternal exposures during breastfeeding that may be associated with health risks to a breast-fed infant, such as exposures to medications, chemicals, infections, foodborne pathogens, illnesses, nutrition, 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.

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $5,000,000 for fiscal year 2012, $6,000,000 for fiscal year 2013, $7,000,000 for fiscal year 2014, $8,000,000 for fiscal year 2015, and $9,000,000 for fiscal year 2016.

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,

1 such State shall not be eligible for such a grant for
2 any subsequent fiscal year.
3 "(3) AUTHORIZATION OF APPROPRIATIONS.—
4 For purposes of carrying out the grant program
5 under this section, including for administrative pur-
6 poses, there is authorized to be appropriated
7 $10,000,000 for each of fiscal years 2012 through
8 2018.
9 "(b) PREGNANCY-RELATED DEATH REVIEW.—
10 "(1) REVIEW OF PREGNANCY-RELATED DEATH
11 AND PREGNANCY-ASSOCIATED DEATH CASES.—For
12 purposes of subsection (a), with respect to a State
13 that receives a grant under subsection (a), the fol-
14 lowing shall apply:
15 "(A) MANDATORY REPORTING OF PREG-
16 NANCY-RELATED DEATHS.—
17 "(i) IN GENERAL.—The State shall,
18 through the State maternal mortality re-
19 view committee, develop a process, sepa-
20 rate from any reporting process established
21 by the State department of health prior to
22 the date of the enactment of this section,
23 that provides for mandatory and confiden-
24 tial case reporting by individuals and enti-
25 ties described in clause (ii) of pregnancy-

1 related deaths to the State department of
2 health.
3 "(ii) INDIVIDUALS AND ENTITIES DE-
4 SCRIBED.—Individuals and entities de-
5 scribed in this clause include each of the
6 following:
7 "(I) Health care providers.
8 "(II) Medical examiners.
9 "(III) Medical coroners.
10 "(IV) Hospitals.
11 "(V) Free-standing birth centers.
12 "(VI) Other health care facilities.
13 "(VII) Any other individuals re-
14 sponsible for completing death certifi-
15 cates.
16 "(VIII) Any other appropriate in-
17 dividuals or entities specified by the
18 Secretary.
19 "(B) VOLUNTARY REPORTING OF PREG-
20 NANCY-RELATED AND PREGNANCY-ASSOCIATED
21 DEATHS.—
22 "(i) The State shall, through the
23 State maternal mortality review committee,
24 develop a process for and encourage, sepa-
25 rate from any reporting process established

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 ad-

1 dress made available under subclause
2 (I).
3 "(C) DEVELOPMENT OF CASE-FINDING.—
4 The State, through the vital statistics unit of
5 the State, shall annually identify pregnancy-re-
6 lated and pregnancy-associated deaths occur-
7 ring in such State during the year involved
8 by—
9 "(i) matching all death records, with
10 respect to such year, for women of child-
11 bearing age to live birth certificates and in-
12 fant death certificates to identify deaths of
13 women that occurred during pregnancy
14 and within one year after the end of a
15 pregnancy;
16 "(ii) identifying deaths reported dur-
17 ing such year as having an underlying or
18 contributing cause of death related to
19 pregnancy, regardless of the time that has
20 passed between the end of the pregnancy
21 and the death;
22 "(iii) collecting data from medical ex-
23 aminer and coroner reports; and
24 "(iv) any other methods the States
25 may devise to identify maternal deaths,

1 such as through review of a random sam-
2 ple of reported deaths of women of child-
3 bearing age to ascertain cases of preg-
4 nancy-related and pregnancy-associated
5 deaths that are not discernable from a re-
6 view of death certificates alone.
7 When feasible and for purposes of effectively
8 collecting and obtaining data on pregnancy-re-
9 lated and pregnancy-associated deaths, the
10 State shall adopt the most recent standardized
11 birth and death certificates, as issued by the
12 National Center for Vital Health Statistics, in-
13 cluding the recommended checkbox section for
14 pregnancy on the death certificates.
15 ''(D) CASE INVESTIGATION AND DEVELOP-
16 MENT OF CASE SUMMARIES.—Following receipt
17 of reports by the State department of health
18 pursuant to subparagraph (A) or (B) and col-
19 lection by the vital statistics unit of the State
20 of possible cases of pregnancy-related and preg-
21 nancy-associated deaths pursuant to subpara-
22 graph (C), the State, through the State mater-
23 nal mortality review committee established
24 under subsection (a), shall investigate each
25 case, utilizing the case abstraction form de-

1 scribed in subsection (c), and prepare de-identi-
2 fied case summaries, which shall be reviewed by
3 the committee and included in applicable re-
4 ports. For purposes of subsection (a), under the
5 processes established under subparagraphs (A),
6 (B), and (C), a State department of health or
7 vital statistics unit of a State shall provide to
8 the State maternal mortality review committee
9 access to information collected pursuant to such
10 subparagraphs as necessary to carry out this
11 subparagraph. Data and information collected
12 for the case summary and review are for pur-
13 poses of public health activities, in accordance
14 with HIPAA privacy and security law (as de-
15 fined in section 3009(a)(2) of the Public Health
16 Service Act). Such case investigations shall in-
17 clude data and information obtained through—
18 "(i) medical examiner and autopsy re-
19 ports of the woman involved;
20 "(ii) medical records of the woman,
21 including such records related to health
22 care prior to pregnancy, prenatal and post-
23 natal care, labor and delivery care, emer-
24 gency room care, hospital discharge
25 records, and any care delivered up until

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

1 pregnancy-associated deaths and dis-
2 parities.
3 ''(III) Develop recommendations,
4 based on the review of the case sum-
5 maries under paragraph (1)(D) and
6 aggregate statistical reports under
7 subclause (II), to improve maternal
8 care, social and health services, and
9 public health policy and institutions,
10 including with respect to improving
11 access to maternal care, improving the
12 availability of social services, and
13 eliminating disparities in maternal
14 care and outcomes.
15 ''(ii) OPTIONAL COMMITTEE ACTIVI-
16 TIES.—For purposes of subsection (a), a
17 maternal mortality review committee estab-
18 lished by a State under such subsection
19 may present findings and recommendations
20 regarding a specific case or set of cir-
21 cumstances directly to a health care facil-
22 ity or its local or State professional organi-
23 zation for the purpose of instituting policy
24 changes, educational activities, or other-

1 wise improving the quality of care provided
2 by the facilities.
3 "(B) COMPOSITION OF MATERNAL MOR-
4 TALITY REVIEW COMMITTEES.—
5 "(i) IN GENERAL.—Each State mater-
6 nal mortality review committee established
7 pursuant to a grant under subsection (a)
8 shall be multi-disciplinary, consisting of
9 health care and social service providers,
10 public health officials, other persons with
11 professional expertise on maternal health
12 and mortality, and patient and community
13 advocates who represent those communities
14 within such State that are the most af-
15 fected by maternal mortality. Membership
16 on such a committee of a State shall be re-
17 viewed annually by the State department
18 of health to ensure that membership rep-
19 resentation requirements are being fulfilled
20 in accordance with this paragraph.
21 "(ii) REQUIRED MEMBERSHIP.—Each
22 such review committee shall include—
23 "(I) representatives from medical
24 specialities providing care to pregnant
25 and postpartum patients, including

1 obstetricians (including generalists
2 and maternal fetal medicine special-
3 ists), and family practice physicians;
4 ''(II) certified nurse midwives,
5 certified midwives, and advanced prac-
6 tice nurses;
7 ''(III) hospital-based nurses;
8 ''(IV) representatives of the State
9 department of health maternal and
10 child health department;
11 ''(V) social service providers or
12 social workers;
13 ''(VI) the chief medical exam-
14 iners or designees;
15 ''(VII) facility representatives,
16 such as from hospitals or free-stand-
17 ing birth centers; and
18 ''(VIII) community or patient ad-
19 vocates who represent those commu-
20 nities within the State that are the
21 most affected by maternal mortality.
22 ''(iii) ADDITIONAL MEMBERS.—Each
23 such review committee may also include
24 representatives from other relevant aca-
25 demic, health, social service, or policy pro-

1 fessions, or community organizations, on
2 an ongoing basis, or as needed, as deter-
3 mined beneficial by the review committee,
4 including—
5 ''(I) anesthesiologists;
6 ''(II) emergency physicians;
7 ''(III) pathologists;
8 ''(IV) epidemiologists or biostat-
9 isticians;
10 ''(V) intensivists;
11 ''(VI) vital statistics officers;
12 ''(VII) nutritionists;
13 ''(VIII) mental health profes-
14 sionals;
15 ''(IX) substance abuse treatment
16 specialists;
17 ''(X) representatives of relevant
18 advocacy groups;
19 ''(XI) academics;
20 ''(XII) representatives of bene-
21 ficiaries of the State plan under the
22 Medicaid program under title XIX;
23 ''(XIII) paramedics;
24 ''(XIV) lawyers;

1 "(XV) risk management special-
2 ists;
3 "(XVI) representatives of the de-
4 partments of health or public health
5 of major cities in the State involved;
6 and
7 "(XVII) policy makers.
8 "(iv) DIVERSE COMMUNITY MEMBER-
9 SHIP.—The composition of such a com-
10 mittee, with respect to a State, shall in-
11 clude—
12 "(I) representatives from diverse
13 communities, particularly those com-
14 munities within such State most se-
15 verely affected by pregnancy-related
16 deaths or pregnancy-associated deaths
17 and by a lack of access to relevant
18 maternal care services, from commu-
19 nity maternal child health organiza-
20 tions, and from minority advocacy
21 groups;
22 "(II) members, including health
23 care providers, from different geo-
24 graphic regions in the State, including

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 reporting 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 de-

1 velop a uniform, comprehensive case abstraction
2 form and make such form available to States for
3 State maternal mortality review committees for use
4 by such committees in order to—
5 "(A) ensure that the cases and information
6 collected and reviewed by such committees can
7 be pooled for review by the Department of
8 Health and Human Services and its agencies;
9 and
10 "(B) preserve the uniformity of the infor-
11 mation and its use for Federal public health
12 purposes.
13 "(2) PERMISSIBLE STATE MODIFICATION.—
14 Each State may modify the form developed under
15 paragraph (1) for implementation and use by such
16 State or by the State maternal mortality review com-
17 mittee of such State by including on such form addi-
18 tional information to be collected, but may not alter
19 the standard questions on such form, in order to en-
20 sure that the information can be collected and re-
21 viewed centrally at the Federal level.
22 "(d) TREATMENT AS PUBLIC HEALTH AUTHORITY
23 FOR PURPOSES OF HIPAA.—For purposes of applying
24 HIPAA privacy and security law (as defined in section
25 3009(a)(2) of the Public Health Service Act), a State ma-

1 ternal mortality review committee of a State established
2 pursuant to this section to carry out activities described
3 in subsection (b)(2)(A) shall be deemed to be a public
4 health authority described in section 164.501 (and ref-
5 erenced in section 164.512(b)(1)(i)) of title 45, Code of
6 Federal Regulations (or any successor regulation), car-
7 rying out public health activities and purposes described
8 in such section 164.512(b)(1)(i) (or any such successor
9 regulation).

10 "(e) PUBLIC DISCLOSURE OF INFORMATION.—

11 "(1) IN GENERAL.—For fiscal year 2012 or a
12 subsequent fiscal year, each State receiving a grant
13 under this section for such year shall, subject to
14 paragraph (3), provide for the public disclosure, and
15 submission to the information clearinghouse estab-
16 lished under paragraph (2), of the information in-
17 cluded in the report of the State under section
18 506(a)(2)(F) for such year (relating to the findings
19 for such year of the State maternal mortality review
20 committee established by the State under this sec-
21 tion).

22 "(2) INFORMATION CLEARINGHOUSE.—The
23 Secretary of Health and Human Services shall es-
24 tablish an information clearinghouse, that shall be
25 administered by the Director of the Centers for Dis-

ease 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 sub-

1 ject to discovery, subpoena, or introduction into evi-
2 dence in any civil, criminal, legislative, or other pro-
3 ceeding. Such records shall not be open to public in-
4 spection.

5 "(2) TESTIMONY OF MEMBERS OF COM-
6 MITTEE.—

7 "(A) IN GENERAL.—Members of a State
8 maternal mortality review committee under this
9 section may not be questioned in any civil,
10 criminal, legislative, or other proceeding regard-
11 ing information presented in, or opinions
12 formed as a result of, a meeting or communica-
13 tion of the committee.

14 "(B) CLARIFICATION.—Nothing in this
15 subsection shall be construed to prevent a mem-
16 ber of such a committee from testifying regard-
17 ing information that was obtained independent
18 of such member's participation on the com-
19 mittee, or that is public information.

20 "(3) AVAILABILITY OF INFORMATION FOR RE-
21 SEARCH PURPOSES.—Nothing in this subsection
22 shall prohibit the publishing by such a committee or
23 the Department of Health and Human Services of
24 statistical compilations and research reports that—

"(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,

1 and reducing exposure to smoking during pregnancy and
2 after birth.

3 (b) TARGETED POPULATIONS.—The campaign under
4 subsection (a) shall be designed to reduce health dispari-
5 ties through the targeting of populations with high rates
6 of sudden unexpected infant death and sudden unex-
7 plained death in childhood.

8 (c) CONSULTATION.—In establishing and imple-
9 menting the campaign under subsection (a), the Secretary
10 shall consult with national organizations representing
11 health care providers, including nurses and physicians,
12 parents, child care providers, children's advocacy and safe-
13 ty organizations, maternal and child health programs and
14 women's, infants, and children nutrition professionals, and
15 other individuals and groups determined necessary by the
16 Secretary for such establishment and implementation.

17 (d) GRANTS.—

18 (1) IN GENERAL.—In carrying out the cam-
19 paign under subsection (a), the Secretary shall
20 award grants to national organizations, State and
21 local health departments, and community-based or-
22 ganizations for the conduct of education and out-
23 reach programs for nurses, parents, child care pro-
24 viders, public health agencies, and community orga-
25 nizations.

(2) APPLICATION.—To be eligible to receive a grant under paragraph (1), an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

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

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

1 "(2) in collaboration with systems that serve
2 large numbers of at-risk youth such as juvenile jus-
3 tice or foster care systems.
4 "(d) PROJECT REQUIREMENTS.—As a condition of
5 receipt of a grant under this section, an entity shall agree
6 that, with respect to information and skills provided
7 through the grant—
8 "(1) such information and skills will be—
9 "(A) age-appropriate;
10 "(B) evidence-based or evidence-informed;
11 "(C) provided in accordance with section
12 399OO–5(b); and
13 "(D) culturally sensitive and relevant to
14 the target populations; and
15 "(2) any information provided about contracep-
16 tives shall include the health benefits and side ef-
17 fects of all contraceptives and barrier methods.
18 "(e) EVALUATION.—Of the total amount made avail-
19 able to carry out this section for a fiscal year, the Sec-
20 retary, acting through the Director of the Centers for Dis-
21 ease Control and Prevention and other agencies as appro-
22 priate, shall allot up to 10 percent of such amount to carry
23 out a rigorous, independent evaluation to determine the
24 extent and the effectiveness of activities funded through
25 this section during such fiscal year in changing attitudes

1 and behavior of teenagers with respect to healthy relation-
2 ships and childbearing.

3 "(f) GRANTS FOR INDIAN TRIBES OR TRIBAL ORGA-
4 NIZATIONS.—Of the total amount made available to carry
5 out this section for a fiscal year, the Secretary shall re-
6 serve 5 percent of such amount to award grants under
7 this section to Indian tribes and tribal organizations in
8 such manner, and subject to such requirements, as the
9 Secretary, in consultation with Indian tribes and tribal or-
10 ganizations, determines appropriate.

11 "(g) ELIGIBLE ENTITY DEFINED.—

12 "(1) IN GENERAL.—In this section, the term
13 'eligible entity' means a State, local, or tribal agen-
14 cy; a school or postsecondary institution; an after-
15 school program; a nonprofit organization; or a com-
16 munity or faith-based organization.

17 "(2) PREVENTING EXCLUSION OF SMALLER
18 COMMUNITY-BASED ORGANIZATIONS.—In carrying
19 out this section, the Secretary shall ensure that the
20 amounts and requirements of grants provided under
21 this section do not preclude receipt of such grants
22 by community-based organizations with a dem-
23 onstrated history of effectively working with adoles-
24 cents in racial or ethnic minority or immigrant com-

munities 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, sexual or reproductive 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

1 "(F) the effectiveness of media campaigns
2 in addressing healthy relationship development,
3 dating violence prevention, and teenage preg-
4 nancy; and
5 "(3) tests research-based strategies for address-
6 ing high rates of unintended teenage pregnancy
7 through programs that emphasize healthy relation-
8 ships and violence prevention.
9 "(b) PRIORITY.—In carrying out this section, the
10 Secretary shall give priority to research that incor-
11 porates—
12 "(1) interdisciplinary approaches;
13 "(2) a strong emphasis on community-based
14 participatory research; or
15 "(3) translational research.
16 **"SEC. 399OO–4. HHS ADOLESCENT HEALTH WORK GROUP.**
17 "(a) PURPOSE.—Not later than 30 days after the
18 date of the enactment of this part, the Secretary shall di-
19 rect the interagency adolescent health workgroup within
20 the Office of Adolescent Health of the Department of
21 Health and Human Services to—
22 "(1) include in the work of the group strategies
23 for teenage dating violence prevention and healthy
24 teenage relationships with a particular focus among

1 racial or ethnic minority or immigrant communities;
2 and
3 ''(2) with respect to including such strategies,
4 consult, to the greatest extent possible, with the
5 Federal Interagency Workgroup on Teen Dating Vi-
6 olence formed under the leadership of the National
7 Institute of Justice of the Department of Justice.
8 ''(b) REPORT REQUIREMENT.—The Secretary,
9 through the Office of Adolescent Health, shall periodically
10 submit to Congress a report that—
11 ''(1) includes a review of the evidence-based
12 programs on preventing teenage pregnancy, which
13 are carried out and identified by the Office; and
14 ''(2) identifies the programs of the Department
15 of Health and Human Services that include teenage
16 dating violence prevention and the promotion of
17 healthy teenage relationships as part of a strategy to
18 prevent teenage pregnancy.
19 **''SEC. 399OO–5. GENERAL GRANT PROVISIONS.**
20 ''(a) APPLICATIONS.—To seek a grant under this
21 part, an entity shall submit an application to the Secretary
22 in such form, in such manner, and containing such agree-
23 ments, assurances, and information as the Secretary may
24 require.

1 "(b) ADDITIONAL REQUIREMENTS.—A grant may be
2 made under this part only if the applicant involved agrees
3 that information, activities, and services provided under
4 the grant—
5 "(1) will be evidence-based or evidence in-
6 formed;
7 "(2) will be factually and medically accurate
8 and complete; and
9 "(3) if directed to a particular population
10 group, will be provided in an appropriate language
11 and cultural context.
12 "(c) TRAINING AND TECHNICAL ASSISTANCE.—
13 "(1) IN GENERAL.—Of the total amount made
14 available to carry out this part for a fiscal year, the
15 Secretary shall use 10 percent to provide, directly or
16 through a competitive grant process, training and
17 technical assistance to the grant recipients under
18 this part, including by disseminating research and
19 information regarding effective and promising prac-
20 tices, providing consultation and resources on a
21 broad array of teenage and unintended pregnancy
22 and violence prevention strategies, and developing
23 resources and materials.
24 "(2) COLLABORATION.—In carrying out this
25 subsection, the Secretary shall collaborate with enti-

ties 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 COERCION.—The term 'reproductive coercion' means, with respect to a person, coercive behavior that interferes with the ability of such person to control the reproductive decision-making 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.

"(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 Congress a report on the impact that the programs under this part had on reducing teenage pregnancies.

"SEC. 399OO–8. AUTHORIZATION OF APPROPRIATIONS.

"(a) IN GENERAL.—There are authorized to be appropriated to carry out this part such sums as may be necessary for each of the fiscal years 2012 through 2016.

"(b) AVAILABILITY.—Amounts appropriated pursuant to subsection (a)—

"(1) are authorized to remain available until expended; and

"(2) are in addition to amounts otherwise made available for such purposes.".

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

1 enhance surveillance data and public health research
2 on gestational diabetes.
3 "(2) AREAS TO BE ADDRESSED.—The research
4 project developed under paragraph (1) shall ad-
5 dress—
6 "(A) procedures to establish accurate and
7 efficient systems for the collection of gestational
8 diabetes data within each State and common-
9 wealth, territory, or possession of the United
10 States;
11 "(B) the progress of collaborative activities
12 with the National Vital Statistics System, the
13 National Center for Health Statistics, and
14 State health departments with respect to the
15 standard birth certificate, in order to improve
16 surveillance of gestational diabetes;
17 "(C) postpartum methods of tracking
18 women with gestational diabetes after delivery
19 as well as targeted interventions proven to
20 lower the incidence of type 2 diabetes in that
21 population;
22 "(D) variations in the distribution of diag-
23 nosed and undiagnosed gestational diabetes,
24 and of impaired fasting glucose tolerance and

1 impaired fasting glucose, within and among
2 groups of women; and
3 "(E) factors and culturally sensitive inter-
4 ventions that influence risks and reduce the in-
5 cidence of gestational diabetes and related com-
6 plications during childbirth, including cultural,
7 behavioral, racial, ethnic, geographic, demo-
8 graphic, socioeconomic, and genetic factors.
9 "(3) REPORT.—Not later than 2 years after the
10 date of the enactment of this section, and annually
11 thereafter, the Secretary shall generate a report on
12 the findings and recommendations of the research
13 project including prevalence of gestational diabetes
14 in the multisite area and disseminate the report to
15 the appropriate Federal and non-Federal agencies.
16 "(b) EXPANSION OF GESTATIONAL DIABETES RE-
17 SEARCH.—
18 "(1) IN GENERAL.—The Secretary shall expand
19 and intensify public health research regarding gesta-
20 tional diabetes. Such research may include—
21 "(A) developing and testing novel ap-
22 proaches for improving postpartum diabetes
23 testing or screening and for preventing type 2
24 diabetes in women with a history of gestational
25 diabetes; and

"(B) conducting public health research to further understanding of the epidemiologic, socioenvironmental, behavioral, translation, and biomedical factors and health systems that influence the risk of gestational diabetes and the development of type 2 diabetes in women with a history of gestational diabetes.

"(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $5,000,000 for each of fiscal years 2012 through 2016.

"(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.

1 "(2) PRIORITY.—In making grants under this
2 subsection, the Secretary shall give priority to
3 projects focusing on—
4 "(A) helping women who have 1 or more
5 risk factors for developing gestational diabetes;
6 "(B) working with women with a history of
7 gestational diabetes during a previous preg-
8 nancy;
9 "(C) providing postpartum care for women
10 with gestational diabetes;
11 "(D) tracking cases where women with a
12 history of gestational diabetes developed type 2
13 diabetes;
14 "(E) educating mothers with a history of
15 gestational diabetes about the increased risk of
16 their child developing diabetes;
17 "(F) working to prevent gestational diabe-
18 tes and prevent or delay the development of
19 type 2 diabetes in women with a history of ges-
20 tational diabetes; and
21 "(G) achieving outcomes designed to assess
22 the efficacy and cost-effectiveness of interven-
23 tions that can inform decisions on long-term
24 sustainability, including third-party reimburse-
25 ment.

"(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 gestational 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.

"(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $5,000,000 for each of fiscal years 2012 through 2016.

"(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 Federal 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.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of the fiscal years 2012 through 2016.

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

1 pregnancy and sexually transmitted diseases, including
2 HIV/AIDS.

3 (b) REQUIREMENTS FOR SEX EDUCATION PRO-
4 GRAMS.—A program of sex education described in this
5 subsection is a program that—

6 (1) is age appropriate and medically accurate;

7 (2) stresses the value of abstinence while not ig-
8 noring those young people who have been or are sex-
9 ually active;

10 (3) provides information about the health bene-
11 fits and side effects of contraceptive and barrier
12 methods used—

13 (A) as a means to prevent pregnancy; and

14 (B) to reduce the risk of contracting sexu-
15 ally transmitted disease, including HIV/AIDS;

16 (4) encourages family communication between
17 parent and child about sexuality;

18 (5) cultivates a respectful dialogue about sexu-
19 ality, including sexual orientation and gender iden-
20 tity, and embraces the principles of nondiscrimina-
21 tion based on sexual orientation and gender identity;

22 (6) counters the perpetuation of narrow gender
23 roles, including the sexualization of female children,
24 adolescents, and adults;

(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-

1 tions shall be carried out in accordance with para-
2 graphs (2) and (3).
3 (2) NATIONAL EVALUATION.—
4 (A) METHOD.—The Secretary shall pro-
5 vide for a national evaluation of a representa-
6 tive sample of programs of sex education car-
7 ried out with grants under this section to deter-
8 mine—
9 (i) the effectiveness of such programs
10 in helping to delay the initiation of sexual
11 intercourse and other high-risk behaviors;
12 (ii) the effectiveness of such programs
13 in preventing adolescent pregnancy;
14 (iii) the effectiveness of such pro-
15 grams in preventing sexually transmitted
16 disease, including HIV/AIDS;
17 (iv) the effectiveness of such programs
18 in increasing contraceptive knowledge and
19 contraceptive behaviors when sexual inter-
20 course occurs; and
21 (v) a list of best practices based upon
22 essential programmatic components of
23 evaluated programs that have led to suc-
24 cess described in clauses (i) through (iv).

(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.

(i) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $50,000,000 for each of the fiscal years 2012 through 2016.

TITLE VI—MENTAL HEALTH

SEC. 601. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES UNDER PART B OF THE MEDICARE PROGRAM.

(a) COVERAGE OF SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

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

(B) in subparagraph (FF), by inserting ''and'' at the end; and

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

''(GG) marriage and family therapist services (as defined in subsection (kkk)(1)) and mental health counselor services (as defined in subsection (kkk)(3));''.

(2) DEFINITIONS.—Section 1861 of such Act (42 U.S.C. 1395x), as amended by sections 202(b)(1)(A) and 423(a), is amended by adding at the end the following new subsection:

1 "Marriage and Family Therapist Services; Marriage and
2 Family Therapist; Mental Health Counselor Serv-
3 ices; Mental Health Counselor
4 "(kkk)(1) The term 'marriage and family therapist
5 services' means services performed by a marriage and
6 family therapist (as defined in paragraph (2)) for the diag-
7 nosis and treatment of mental illnesses, which the mar-
8 riage and family therapist is legally authorized to perform
9 under State law (or the State regulatory mechanism pro-
10 vided by State law) of the State in which such services
11 are performed, as would otherwise be covered if furnished
12 by a physician or as an incident to a physician's profes-
13 sional service, but only if no facility or other provider
14 charges or is paid any amounts with respect to the fur-
15 nishing of such services.
16 "(2) The term 'marriage and family therapist' means
17 an individual who—
18 "(A) possesses a master's or doctoral degree
19 which qualifies for licensure or certification as a
20 marriage and family therapist pursuant to State
21 law;
22 "(B) after obtaining such degree has performed
23 at least 2 years of clinical supervised experience in
24 marriage and family therapy; and

"(C) in the case of an individual performing services in a State that provides for licensure or certification of marriage and family therapists, is licensed or certified as a marriage and family therapist in such State.

"(3) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (4)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

"(4) The term 'mental health counselor' means an individual who—

"(A) possesses a master's or doctor's degree in mental health counseling or a related field;

"(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

"(C) in the case of an individual performing services in a State that provides for licensure or cer-

tification of mental health counselors or professional counselors, is licensed or certified as a mental health counselor or professional counselor in such State.''.

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of such Act (42 U.S.C. 1395k(a)(2)(B)) is amended by adding at the end the following new clause:

''(v) marriage and family therapist services and mental health counselor services;''.

(4) AMOUNT OF PAYMENT.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking ''and (Z)'' and inserting ''(Z)''; and

(B) by inserting before the semicolon at the end the following: '', and (AA) with respect to marriage and family therapist services and mental health counselor services under section 1861(s)(2)(GG), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under subparagraph (L)''.

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUN-

1 SELOR SERVICES FROM SKILLED NURSING FACILITY
2 PROSPECTIVE PAYMENT SYSTEM.—Section
3 1888(e)(2)(A)(ii) of such Act (42 U.S.C.
4 1395yy(e)(2)(A)(ii)) is amended by inserting ''mar-
5 riage and family therapist services (as defined in
6 section 1861(kkk)(1)), mental health counselor serv-
7 ices (as defined in section 1861(kkk)(3)),'' after
8 ''qualified psychologist services,''.
9 (6) INCLUSION OF MARRIAGE AND FAMILY
10 THERAPISTS AND MENTAL HEALTH COUNSELORS AS
11 PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Sec-
12 tion 1842(b)(18)(C) of such Act (42 U.S.C.
13 1395u(b)(18)(C)) is amended by adding at the end
14 the following new clauses:
15 ''(vii) A marriage and family therapist (as de-
16 fined in section 1861(kkk)(2)).
17 ''(viii) A mental health counselor (as defined in
18 section 1861(kkk)(4)).''.
19 (b) COVERAGE OF CERTAIN MENTAL HEALTH SERV-
20 ICES PROVIDED IN CERTAIN SETTINGS.—
21 (1) RURAL HEALTH CLINICS AND FEDERALLY
22 QUALIFIED HEALTH CENTERS.—Section
23 1861(aa)(1)(B) of the Social Security Act (42
24 U.S.C. 1395x(aa)(1)(B)) is amended by striking ''or
25 by a clinical social worker (as defined in subsection

(hh)(1)),'' and inserting '', by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection (kkk)(2)), or by a mental health counselor (as defined in subsection (kkk)(4)),''.

(2) HOSPICE PROGRAMS.—Section 1861(dd)(2)(B)(i)(III) of such Act (42 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by inserting ''or one marriage and family therapist (as defined in subsection (kkk)(2))'' after ''social worker''.

(c) AUTHORIZATION OF MARRIAGE AND FAMILY THERAPISTS TO DEVELOP DISCHARGE PLANS FOR POST-HOSPITAL SERVICES.—Section 1861(ee)(2)(G) of the Social Security Act (42 U.S.C. 1395x(ee)(2)(G)) is amended by inserting ''marriage and family therapist (as defined in subsection (kkk)(2)),'' after ''social worker,''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished on or after January 1, 2012.

SEC. 602. 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

1 qualified behavioral health centers as meeting the
2 criteria specified in this subsection.

3 "(2) REGULATIONS.—Not later than 18 months
4 after the date of the enactment of this section, the
5 Administrator shall issue final regulations for certi-
6 fying nonprofit or local government centers as cen-
7 ters under paragraph (1).

8 "(3) CRITERIA.—The criteria referred to in
9 subsection (b)(2) are that the center performs each
10 of the following:

11 "(A) Provide services in locations that en-
12 sure services will be promptly available, be
13 physically accessible, provide reasonable policy
14 modifications, and be provided in a manner
15 which preserves human dignity and assures con-
16 tinuity of care.

17 "(B) Provide services in a mode of service
18 delivery appropriate for the target population.

19 "(C) Provide individuals with a choice of
20 service options where there is more than one ef-
21 ficacious treatment.

22 "(D) Employ a core staff of clinical staff
23 that is multidisciplinary and culturally and lin-
24 guistically competent.

1 "(E) Provide services, within the limits of
2 the capacities of the center, to any individual
3 residing or employed in the service area of the
4 center, regardless of the ability of the individual
5 to pay.
6 "(F) Provide, directly or through contract,
7 to the extent covered for adults in the State
8 Medicaid plan under title XIX of the Social Se-
9 curity Act and for children in accordance with
10 section 1905(r) of such Act regarding early and
11 periodic screening, diagnosis, and treatment,
12 each of the following services:
13 "(i) Screening, assessment, and diag-
14 nosis, including risk assessment.
15 "(ii) Person-centered treatment plan-
16 ning or similar processes, including risk as-
17 sessment and crisis planning.
18 "(iii) Outpatient clinic mental health
19 services, including screening, assessment,
20 diagnosis, psychotherapy, substance abuse
21 counseling, medication management, and
22 integrated treatment for mental illness and
23 substance abuse which shall be evidence-
24 based (including cognitive behavioral ther-

1 apy and other such therapies which are
2 evidence-based).
3 "(iv) Outpatient clinic primary care
4 services, including screening and moni-
5 toring of key health indicators and health
6 risk (including screening for diabetes, hy-
7 pertension, and cardiovascular disease and
8 monitoring of weight, height, body mass
9 index (BMI), blood pressure, blood glucose
10 or HbA1C, and lipid profile).
11 "(v) Crisis mental health services, in-
12 cluding 24-hour mobile crisis teams, emer-
13 gency crisis intervention services, and cri-
14 sis stabilization.
15 "(vi) Targeted case management
16 (services to assist individuals gaining ac-
17 cess to needed medical, social, educational,
18 and other home- and community-based
19 services and applying for income security
20 and other benefits to which they may be
21 entitled).
22 "(vii) Psychiatric rehabilitation serv-
23 ices including skills training, assertive com-
24 munity treatment, family psychoeducation,
25 disability self-management, supported em-

1 ployment, supported housing services,
2 therapeutic foster care services, and such
3 other evidence-based practices as the Sec-
4 retary may require.
5 ''(viii) Peer support and counselor
6 services and family supports.
7 ''(G) Maintain linkages, and where possible
8 enter into formal contracts with the following:
9 ''(i) Inpatient psychiatric facilities and
10 substance abuse detoxification and residen-
11 tial programs.
12 ''(ii) Adult and youth peer support
13 and counselor services.
14 ''(iii) Family support services for fam-
15 ilies of children with serious mental dis-
16 orders.
17 ''(iv) Other home- and community-
18 based or regional services, supports, and
19 providers, including schools, child welfare
20 agencies, juvenile and criminal justice
21 agencies and facilities, housing agencies
22 and programs, employers, and other social
23 services.
24 ''(v) Onsite or offsite access to pri-
25 mary care services.

"(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 behav-

ioral 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.

(C) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection $550,000 for each of the fiscal years 2012 and 2013.

(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.

(C) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this paragraph, $550,000 for each of the fiscal years 2012 and 2013.

SEC. 603. 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.

"(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $10,000,000 for each of fiscal years 2012 through 2016".

SEC. 604. 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)).

"(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $20,000,000 for each of fiscal years 2012 through 2014.".

SEC. 605. 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 2011''.

(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 pros-

tate 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 great-

er 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. 417H. 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 2011, 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.

1 "(4) With respect to the Agency for Healthcare
2 Research and Quality, the conduct of a biannual re-
3 view of lung cancer screening, diagnostic, and treat-
4 ment protocols, and the issuance of updated guide-
5 lines.

6 "(5) The cooperation and coordination of all
7 minority and health disparity programs within the
8 Department of Health and Human Services to en-
9 sure that all aspects of the Lung Cancer Mortality
10 Reduction Program under this section adequately
11 address the burden of lung cancer on minority and
12 rural populations.

13 "(6) The cooperation and coordination of all to-
14 bacco control and cessation programs within agen-
15 cies of the Department of Health and Human Serv-
16 ices to achieve the goals of the Lung Cancer Mor-
17 tality Reduction Program under this section with
18 particular emphasis on the coordination of drug and
19 other cessation treatments with early detection pro-
20 tocols.".

21 (2) FEDERAL FOOD, DRUG, AND COSMETIC
22 ACT.—Subchapter B of chapter V of the Federal
23 Food, Drug, and Cosmetic Act (21 U.S.C. 360aaa et
24 seq.) is amended by adding at the end the following:

"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 2011 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 ap-

pointed by the Secretary of Health and Human Services.

(g) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—To carry out this section (and the amendments made by this section), there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2012 through 2016.

(2) LUNG CANCER MORTALITY REDUCTION PROGRAM.—Of the amounts authorized to be appropriated by subsection (a), there are authorized to be appropriated—

(A) $25,000,000 for fiscal year 2012, and such sums as may be necessary for each of fiscal years 2013 through 2016, for the activities described in section 417H(b)(1)(B) of the Public Health Service Act, as added by subsection (d)(1);

(B) $25,000,000 for fiscal year 2012, and such sums as may be necessary for each of fiscal years 2013 through 2016, for the activities described in section 417H(b)(1)(C) of such Act;

(C) $10,000,000 for fiscal year 2012, and such sums as may be necessary for each of fiscal years 2013 through 2016, for the activities

described in section 417H(b)(1)(D) of such Act; and

(D) $15,000,000 for fiscal year 2012, and such sums as may be necessary for each of fiscal years 2013 through 2016, for the activities described in section 417H(b)(3) of such Act.

SEC. 702. EXPANDING PROSTATE CANCER RESEARCH, OUTREACH, SCREENING, TESTING, ACCESS, AND TREATMENT EFFECTIVENESS.

(a) SHORT TITLE.—This section may be cited as the ''Prostate Research, Outreach, Screening, Testing, Access, and Treatment Effectiveness Act of 2011'' 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 dis-

ease, 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 eti-

ology, 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 encour-

1 age the translation of research into practice, to iden-
2 tify and implement best practices, in order to foster
3 an integrated and consistent focus on effective pre-
4 vention, diagnosis, and treatment of this disease.
5 (c) PROSTATE CANCER COORDINATION AND EDU-
6 CATION.—
7 (1) INTERAGENCY PROSTATE CANCER COORDI-
8 NATION AND EDUCATION TASK FORCE.—Not later
9 than 180 days after the date of the enactment of
10 this section, the Secretary of Veterans Affairs, in co-
11 operation with the Secretary of Defense and the Sec-
12 retary of Health and Human Services, shall estab-
13 lish an Interagency Prostate Cancer Coordination
14 and Education Task Force (in this section referred
15 to as the ''Prostate Cancer Task Force'').
16 (2) DUTIES.—The Prostate Cancer Task Force
17 shall—
18 (A) develop a summary of advances in
19 prostate cancer research supported or con-
20 ducted by Federal agencies relevant to the diag-
21 nosis, prevention, and treatment of prostate
22 cancer, including psychosocial impairments re-
23 lated to prostate cancer treatment, and compile
24 a list of best practices that warrant broader
25 adoption in health care programs;

(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 implemented in support of research and health care program priorities;

(ii) designed to ensure that the research and health care programs and activities of the Department of Veterans Affairs, the Department of Defense, the Department of Health and Human Services, and other Federal agencies are free of unnecessary duplication;

(iii) regarding public participation in decisions relating to prostate cancer research and health care programs to increase the involvement of patient advocates, community organizations, and med-

ical 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 program 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

1 screening blood test, including improvements or
2 alternatives to the prostate specific antigen test
3 and additional tests to distinguish indolent from
4 aggressive disease;
5 (B) better understand the etiology of the
6 disease (including an analysis of lifestyle factors
7 proven to be involved in higher rates of prostate
8 cancer, such as obesity and diet, and in dif-
9 ferent ethnic, racial, and socioeconomic groups,
10 such as the African-American, Latin-American,
11 and American Indian populations and men with
12 a family history of prostate cancer) to improve
13 prevention efforts;
14 (C) expand basic research into prostate
15 cancer, including studies of fundamental molec-
16 ular and cellular mechanisms;
17 (D) identify and provide clinical testing of
18 novel agents for the prevention and treatment
19 of prostate cancer;
20 (E) establish clinical registries for prostate
21 cancer;
22 (F) use the National Institute of Bio-
23 medical Imaging and Bioengineering and the
24 National Cancer Institute for assessment of ap-
25 propriate imaging modalities; and

(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 sharing of the latest research data and accelerating movement of new medicines to patients.

(3) UNDERSERVED MINORITY GRANT PROGRAM.—In carrying out such program, the Secretary shall—

(A) award grants to eligible entities to carry out components of the research outlined in paragraph (1);

(B) integrate and build upon existing knowledge gained from comparative effectiveness research; and

(C) recognize and address—

(i) the racial and ethnic disparities in the incidence and mortality rates of prostate cancer and men with a family history of prostate cancer;

(ii) any barriers in access to care and participation in clinical trials that are specific to racial, ethnic, and other underserved minorities and men with a family history of prostate cancer;

(iii) 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, Latin-Americans, 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, Latin-Americans, 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 nonspecial-

1 ized medical providers to provide health services
2 for prostate cancer in medically underserved
3 and tribal areas, including the exploration of in-
4 novative medical home models with collabora-
5 tion between urologists, other relevant medical
6 specialists, including oncologists, radiologists,
7 and primary care teams and coordination of
8 care through the efficient use of primary care
9 teams and physician extenders; and
10 (C) the effectiveness of using telehealth
11 services to provide prostate cancer treatment in
12 medically underserved areas, including the use
13 of tumor boards to facilitate better patient
14 counseling.
15 (4) REPORT.—Not later than 12 months after
16 the completion of the pilot projects under this sub-
17 section, the Secretaries shall submit to Congress a
18 report describing the outcomes of such pilot projects,
19 including any cost savings and efficiencies realized,
20 and providing recommendations, if any, for expand-
21 ing the use of telehealth services.
22 (f) EDUCATION AND AWARENESS.—
23 (1) IN GENERAL.—The Secretary of Veterans
24 Affairs shall develop a national education campaign
25 for prostate cancer. Such campaign shall involve the

use of written educational materials and public service announcements consistent with the findings of the Prostate Cancer Task Force under subsection (c), that are intended to encourage men to seek prostate cancer screening when appropriate.

(2) RACIAL DISPARITIES AND THE POPULATION OF MEN WITH A FAMILY HISTORY OF PROSTATE CANCER.—In developing the national campaign under paragraph (1), the Secretary shall ensure that such educational materials and public service announcements are more readily available in communities experiencing racial disparities in the incidence and mortality rates of prostate cancer and by men of any race classification with a family history of prostate cancer.

(3) GRANTS.—In carrying out the national campaign under this section, the Secretary shall award grants to nonprofit private entities to enable such entities to test alternative outreach and education strategies.

(g) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There is authorized to be appropriated to carry out this section for the period of fiscal years 2012 through 2016 an amount equal to the savings described in paragraph (2).

(2) CORRESPONDING REDUCTION.—The amount authorized to be appropriated by provisions of law other than this section for the period of fiscal years 2012 through 2016 for Federal research and health care program activities related to prostate cancer is reduced by the amount of Federal savings projected to be achieved over such period by implementation of subsection (c)(2)(C) of this section.

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.—Such section 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 (1) IN GENERAL.—The Secretary of Health and
2 Human Services (in this section referred to as the
3 ''Secretary'') shall conduct demonstration projects
4 (in this section referred to as ''demonstration
5 projects'') for the purpose of developing models and
6 evaluating methods that—
7 (A) improve the quality of items and serv-
8 ices provided to target individuals in order to
9 facilitate reduced disparities in early detection
10 and treatment of cancer;
11 (B) improve clinical outcomes, satisfaction,
12 quality of life, and appropriate use of Medicare-
13 covered services and referral patterns among
14 those target individuals with cancer;
15 (C) eliminate disparities in the rate of pre-
16 ventive cancer screening measures, such as Pap
17 smears, prostate cancer screenings, and CT
18 scans for lung cancer among target individuals;
19 (D) promote collaboration with community-
20 based organizations to ensure cultural com-
21 petency of health care professionals and lin-
22 guistic access for persons with limited-English
23 proficiency; and
24 (E) encourage the incorporation of commu-
25 nity health workers to increase the efficiency

and appropriateness of cervical cancer 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 promotor, 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 preven-

tion 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/Latin-Americans.

(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 DISPARITIES WITHIN MEDICARE.

(a) DEVELOPMENT OF MEASURES OF DISPARITIES IN QUALITY OF CANCER CARE.—

(1) DEVELOPMENT OF MEASURES.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall enter into an agreement with the National Quality Forum under which the National Quality Forum shall develop a uniform set of measures to evaluate disparities in the quality of cancer care, endorse such set

1 of measures through its multistakeholder consensus
2 development process, and annually update such set
3 of measures.

4 (2) MEASURES TO BE INCLUDED.—Such set of
5 measures shall include, with respect to the treatment
6 of cancer, measures of patient outcomes, the process
7 for delivering medical care related to such treat-
8 ment, patient counseling and engagement in deci-
9 sionmaking, patient experience of care, resource use,
10 and practice capabilities, such as care coordination.

11 (b) ESTABLISHMENT OF REPORTING PROCESS.—

12 (1) IN GENERAL.—The Secretary shall establish
13 a reporting process that provides for a method for
14 health care providers specified under paragraph (2)
15 to submit to the Secretary and make public data on
16 the performance of such providers during each re-
17 porting period through use of the measures devel-
18 oped pursuant to subsection (a). Such data shall be
19 submitted in a form and manner and at a time spec-
20 ified by the Secretary.

21 (2) SPECIFICATION OF PROVIDERS TO REPORT
22 ON MEASURES.—The Secretary shall specify the
23 classes of Medicare providers of services and sup-
24 pliers, including hospitals, cancer centers, physi-
25 cians, primary care providers, and specialty pro-

viders, that will be required under such process to publicly report on the measures specified under 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 established under 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 2011".

(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 acquired 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

1 their infection and can unknowingly exacerbate their
2 own disease progression.
3 (8) HBV and HCV disproportionately affect
4 certain populations in the United States. Although
5 representing only 5 percent of the population, Asian-
6 Americans and Pacific Islanders account for over
7 half of the 1,400,000 domestic chronic HBV cases.
8 Baby boomers (those born between 1946 and 1964)
9 account for more than half of domestic chronic hepa-
10 titis C cases. In addition, African-Americans, Latin-
11 Americans, and American Indian/Alaskan Natives
12 are among the groups which have disproportionately
13 high rates of HBV and/or HCV infections in the
14 United States.
15 (9) For both chronic HBV and chronic HCV,
16 behavioral changes can slow disease progression if
17 diagnosis is made early. Early diagnosis, which is
18 determined through simple blood tests, can reduce
19 the risk of transmission and disease progression
20 through education and vaccination of household
21 members and other susceptible persons at risk.
22 (10) For those chronically infected with HBV
23 or HCV, regular monitoring can lead to the early de-
24 tection of liver cancer at a stage where cure is still
25 possible. Liver cancer is the third deadliest cancer in

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

1 care providers or the public on viral hepatitis in
2 order to be consistent with the plan.

3 "(b) PUBLICATION OF NOTICE OF ASSESSMENTS.—
4 Not later than October 1 of the first even-numbered year
5 beginning after the date of the enactment of this part,
6 and October 1 of each even-numbered year thereafter, the
7 Secretary shall publish in the Federal Register a notice
8 of the results of the assessments conducted under para-
9 graph (1). Such notice shall include—

10 "(1) a description of any revisions to the plan
11 referred to in subsection (a) as a result of the as-
12 sessment;

13 "(2) an explanation of the basis for any such
14 revisions, including the ways in which such revisions
15 can reasonably be expected to further promote the
16 original goals and objectives of the plan; and

17 "(3) in the case of a determination by the Sec-
18 retary that the plan does not need revision, an expla-
19 nation of the basis for such determination.

20 **"SEC. 399NN–1. ELEMENTS OF PROGRAM.**

21 "(a) EDUCATION AND AWARENESS PROGRAMS.—The
22 Secretary, acting through the Director of the Centers for
23 Disease Control and Prevention, the Administrator of the
24 Health Resources and Services Administration, and the
25 Administrator of the Substance Abuse and Mental Health

1 Services Administration, and in accordance with the plan
2 referred to in section 399NN(a), shall implement pro-
3 grams to increase awareness and enhance knowledge and
4 understanding of hepatitis B and hepatitis C. Such pro-
5 grams shall include—

6 "(1) the conduct of culturally and language ap-
7 propriate health education in primary and secondary
8 schools, college campuses, public awareness cam-
9 paigns, and community outreach activities (especially
10 to the ethnic communities with high rates of chronic
11 hepatitis B and chronic hepatitis C and other high-
12 risk groups) to promote public awareness and knowl-
13 edge about the value of hepatitis A and hepatitis B
14 immunization, risk factors, the transmission and
15 prevention of hepatitis B and hepatitis C, the value
16 of screening for the early detection of hepatitis B
17 and hepatitis C, and options available for the treat-
18 ment of chronic hepatitis B and chronic hepatitis C;

19 "(2) the promotion of immunization programs
20 that increase awareness and access to hepatitis A
21 and hepatitis B vaccines for susceptible adults and
22 children;

23 "(3) the training of health care professionals
24 regarding the importance of vaccinating individuals
25 infected with hepatitis C and individuals who are at

1 risk for hepatitis C infection against hepatitis A and
2 hepatitis B;
3 ''(4) the training of health care professionals
4 regarding the importance of vaccinating individuals
5 chronically infected with hepatitis B and individuals
6 who are at risk for chronic hepatitis B infection
7 against the hepatitis A virus;
8 ''(5) the training of health care professionals
9 and health educators to make them aware of the
10 high rates of chronic hepatitis B and chronic hepa-
11 titis C in certain adult ethnic populations, and the
12 importance of prevention, detection, and medical
13 management of hepatitis B and hepatitis C and of
14 liver cancer screening;
15 ''(6) the development and distribution of health
16 education curricula (including information relating
17 to the special needs of individuals infected with hep-
18 atitis B and hepatitis C, such as the importance of
19 prevention and early intervention, regular moni-
20 toring, the recognition of psychosocial needs, appro-
21 priate treatment, and liver cancer screening) for in-
22 dividuals providing hepatitis B and hepatitis C coun-
23 seling; and

1 "(7) support for the implementation curricula
2 described in paragraph (6) by State and local public
3 health agencies.
4 "(b) IMMUNIZATION, PREVENTION, AND CONTROL
5 PROGRAMS.—
6 "(1) IN GENERAL.—The Secretary, acting
7 through the Director of the Centers for Disease
8 Control and Prevention, shall support the integra-
9 tion of activities described in paragraph (2) into ex-
10 isting clinical and public health programs at State,
11 local, territorial, and tribal levels (including commu-
12 nity health clinics, programs for the prevention and
13 treatment of HIV/AIDS, sexually transmitted dis-
14 eases, and substance abuse, and programs for indi-
15 viduals in correctional settings).
16 "(2) ACTIVITIES.—
17 "(A) VOLUNTARY TESTING PROGRAMS.—
18 "(i) IN GENERAL.—The Secretary
19 shall establish a mechanism by which to
20 support and promote the development of
21 State, local, territorial, and tribal vol-
22 untary hepatitis B and hepatitis C testing
23 programs to screen the high-prevalence
24 populations to aid in the early identifica-
25 tion of chronically infected individuals.

1 "(ii) CONFIDENTIALITY OF THE TEST
2 RESULTS.—The Secretary shall prohibit
3 the use of the results of a hepatitis B or
4 hepatitis C test conducted by a testing pro-
5 gram developed or supported under this
6 subparagraph for any of the following:
7 "(I) Issues relating to health in-
8 surance.
9 "(II) To screen or determine
10 suitability for employment.
11 "(III) To discharge a person
12 from employment.
13 "(B) COUNSELING REGARDING VIRAL HEP-
14 ATITIS.—The Secretary shall support State,
15 local, territorial, and tribal programs in a wide
16 variety of settings, including those providing
17 primary and specialty health care services in
18 nonprofit private and public sectors, to—
19 "(i) provide individuals with ongoing
20 risk factors for hepatitis B and hepatitis C
21 infection with client-centered education
22 and counseling which concentrates on—
23 "(I) promoting testing of individ-
24 uals that have been exposed to their

1 blood, family members, and their sex-
2 ual partners; and
3 "(II) changing behaviors that
4 place individuals at risk for infection;
5 "(ii) provide individuals chronically in-
6 fected with hepatitis B or hepatitis C with
7 education, health information, and coun-
8 seling to reduce their risk of—
9 "(I) dying from end-stage liver
10 disease and liver cancer; and
11 "(II) transmitting viral hepatitis
12 to others; and
13 "(iii) provide women chronically in-
14 fected with hepatitis B or hepatitis C who
15 are pregnant or of childbearing age with
16 culturally and language appropriate health
17 information, such as how to prevent hepa-
18 titis B perinatal infection, and to alleviate
19 fears associated with pregnancy or raising
20 a family.
21 "(C) IMMUNIZATION.—The Secretary shall
22 support State, local, territorial, and tribal ef-
23 forts to expand the current vaccination pro-
24 grams to protect every child in the country and
25 all susceptible adults, particularly those infected

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;

1 "(v) expanding the availability of hep-
2 atitis B vaccination for all susceptible
3 adults, particularly those in their reproduc-
4 tive age (women and men less than 45
5 years of age), to protect them from the
6 risk of hepatitis B infection;
7 "(vi) ensuring the vaccination of indi-
8 viduals infected, or at risk for infection,
9 with hepatitis C against hepatitis A, hepa-
10 titis B, and other infectious diseases, as
11 appropriate, for which such individuals
12 may be at increased risk; and
13 "(vii) ensuring the vaccination of indi-
14 viduals infected, or at risk for infection,
15 with hepatitis B against hepatitis A virus
16 and other infectious diseases, as appro-
17 priate, for which such individuals may be
18 at increased risk.
19 "(D) MEDICAL REFERRAL.—The Secretary
20 shall support State, local, territorial, and tribal
21 programs that support—
22 "(i) referral of persons chronically in-
23 fected with hepatitis B or hepatitis C—
24 "(I) for medical evaluation to de-
25 termine the appropriateness for

1 antiviral treatment to reduce the risk
2 of progression to cirrhosis and liver
3 cancer; and
4 ''(II) for ongoing medical man-
5 agement including regular monitoring
6 of liver function and screening for
7 liver cancer; and
8 ''(ii) referral of persons infected with
9 acute or chronic hepatitis B infection or
10 acute or chronic hepatitis C infection for
11 drug and alcohol abuse treatment where
12 appropriate.
13 ''(3) INCREASED SUPPORT FOR ADULT VIRAL
14 HEPATITIS COORDINATORS.—The Secretary, acting
15 through the Director of the Centers for Disease
16 Control and Prevention, shall provide increased sup-
17 port to Adult Viral Hepatitis Coordinators in State,
18 local, territorial, and tribal health departments in
19 order to enhance the additional management, net-
20 working, and technical expertise needed to ensure
21 successful integration of hepatitis B and hepatitis C
22 prevention and control activities into existing public
23 health programs.
24 ''(c) EPIDEMIOLOGICAL SURVEILLANCE.—

1 "(1) IN GENERAL.—The Secretary, acting
2 through the Director of the Centers for Disease
3 Control and Prevention, shall support the establish-
4 ment and maintenance of a national chronic and
5 acute hepatitis B and hepatitis C surveillance pro-
6 gram, in order to identify—
7 "(A) trends in the incidence of acute and
8 chronic hepatitis B and acute and chronic hepa-
9 titis C;
10 "(B) trends in the prevalence of acute and
11 chronic hepatitis B and acute and chronic hepa-
12 titis C infection among groups that may be dis-
13 proportionately affected; and
14 "(C) trends in liver cancer and end-stage
15 liver disease incidence and deaths, caused by
16 chronic hepatitis B and chronic hepatitis C in
17 the high-risk ethnic populations.
18 "(2) SEROPREVALENCE AND LIVER CANCER
19 STUDIES.—The Secretary, acting through the Direc-
20 tor of the Centers for Disease Control and Preven-
21 tion, shall prepare a report outlining the population-
22 based seroprevalence studies currently underway, fu-
23 ture planned studies, the criteria involved in deter-
24 mining which seroprevalence studies to conduct,
25 defer, or suspend, and the scope of those studies, the

1 economic and clinical impact of hepatitis B and hep-
2 atitis C, and the impact of chronic hepatitis B and
3 chronic hepatitis C infections on the quality of life.
4 Not later than one year after the date of the enact-
5 ment of this part, the Secretary shall submit the re-
6 port to the Committee on Energy and Commerce of
7 the House of Representatives and the Committee on
8 Health, Education, Labor, and Pensions of the Sen-
9 ate.

10 ''(3) CONFIDENTIALITY.—The Secretary shall
11 not disclose any individually identifiable information
12 identified under paragraph (1) or derived through
13 studies under paragraph (2).

14 ''(d) RESEARCH.—The Secretary, acting through the
15 Director of the Centers for Disease Control and Preven-
16 tion, the Director of the National Cancer Institute, and
17 the Director of the National Institutes of Health, shall—

18 ''(1) conduct epidemiologic and community-
19 based research to develop, implement, and evaluate
20 best practices for hepatitis B and hepatitis C pre-
21 vention especially in the ethnic populations with high
22 rates of chronic hepatitis B and chronic hepatitis C
23 and other high-risk groups;

24 ''(2) conduct research on hepatitis B and hepa-
25 titis C natural history, pathophysiology, improved

1 treatments and prevention (such as the hepatitis C
2 vaccine), and noninvasive tests that help to predict
3 the risk of progression to liver cirrhosis and liver
4 cancer;

5 "(3) conduct research that will lead to better
6 noninvasive or blood tests to screen for liver cancer,
7 and more effective treatments of liver cancer caused
8 by chronic hepatitis B and chronic hepatitis C; and

9 "(4) conduct research comparing the effective-
10 ness of screening, diagnostic, management, and
11 treatment approaches for chronic hepatitis B, chron-
12 ic hepatitis C, and liver cancer in the affected com-
13 munities.

14 "(e) UNDERSERVED AND DISPROPORTIONATELY AF-
15 FECTED POPULATIONS.—In carrying out this section, the
16 Secretary shall provide expanded support for individuals
17 with limited access to health education, testing, and health
18 care services and groups that may be disproportionately
19 affected by hepatitis B and hepatitis C.

20 "(f) EVALUATION OF PROGRAM.—The Secretary
21 shall develop benchmarks for evaluating the effectiveness
22 of the programs and activities conducted under this sec-
23 tion and make determinations as to whether such bench-
24 marks have been achieved.

"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.

"SEC. 399NN–3. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated to carry out this part $90,000,000 for fiscal year 2012, $90,000,000 for fiscal year 2013, $110,000,000 for fiscal year 2014, $130,000,000 for fiscal year 2015, and $150,000,000 for fiscal year 2016.''.

(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 2011".

(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/Latin-American 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 Secretary shall take into consideration the recommendations of the Advisory Committee on Acquired Bone Marrow Failure Diseases established under subsection (b).

1 "(3) PURPOSES OF REGISTRY.—The National
2 Acquired Bone Marrow Failure Disease Registry—
3 "(A) shall identify the incidence and preva-
4 lence of acquired bone marrow failure diseases
5 in the United States;
6 "(B) shall be used to collect and store data
7 on acquired bone marrow failure diseases, in-
8 cluding data concerning—
9 "(i) the age, race or ethnicity, general
10 geographic location, sex, and family history
11 of individuals who are diagnosed with ac-
12 quired bone marrow failure diseases, and
13 any other characteristics of such individ-
14 uals determined appropriate by the Sec-
15 retary;
16 "(ii) the genetic and environmental
17 factors that may be associated with devel-
18 oping acquired bone marrow failure dis-
19 eases;
20 "(iii) treatment approaches for deal-
21 ing with acquired bone marrow failure dis-
22 eases;
23 "(iv) outcomes for individuals treated
24 for acquired bone marrow failure diseases,
25 including outcomes for recipients of stem

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 "(1) myelodysplastic syndromes (MDS);
2 "(2) aplastic anemia;
3 "(3) paroxysmal nocturnal hemoglobinuria
4 (PNH);
5 "(4) pure red cell aplasia;
6 "(5) acute myeloid leukemia that has pro-
7 gressed from myelodysplastic syndromes; or
8 "(6) large granular lymphocytic leukemia.
9 "(e) AUTHORIZATION OF APPROPRIATIONS.—There
10 is authorized to be appropriated to carry out this section
11 $3,000,000 for each of fiscal years 2012 through 2016.".
12 (d) PILOT STUDIES THROUGH THE AGENCY FOR
13 TOXIC SUBSTANCES AND DISEASE REGISTRY.—
14 (1) PILOT STUDIES.—The Secretary of Health
15 and Human Services, acting through the Adminis-
16 trator of the Agency for Toxic Substances and Dis-
17 ease Registry, shall conduct pilot studies to deter-
18 mine which environmental factors, including expo-
19 sure to toxins, may cause acquired bone marrow fail-
20 ure diseases.
21 (2) COLLABORATION WITH THE RADIATION IN-
22 JURY TREATMENT NETWORK.—In carrying out the
23 directives of this section, the Secretary may collabo-
24 rate with the Radiation Injury Treatment Network
25 of the C.W. Bill Young Cell Transplantation Pro-

gram 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.

(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,000,000 for each of fiscal years 2012 through 2016.

(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 tar-

1 geted to minority populations affected by acquired
2 bone marrow failure diseases.
3 "(2) PROGRAM REQUIREMENTS.—Minority-fo-
4 cused outreach and informational programs author-
5 ized by this section—
6 "(A) shall make information about treat-
7 ment options and clinical trials for acquired
8 bone marrow failure diseases publicly available,
9 and
10 "(B) shall provide referral services for
11 treatment options and clinical trials,
12 at the national minority health resource center sup-
13 ported under section 1707(b)(8) (including by means
14 of the center's Web site, through appropriate loca-
15 tions such as the center's knowledge center, and
16 through appropriate programs such as the center's
17 resource persons network) and through minority
18 health consultants located at each Department of
19 Health and Human Services regional office.
20 "(b) HISPANIC AND ASIAN-AMERICAN AND PACIFIC
21 ISLANDER OUTREACH.—
22 "(1) IN GENERAL.—The Secretary, acting
23 through the Deputy Assistant Secretary for Minority
24 Health, shall undertake a coordinated outreach ef-
25 fort to connect Hispanic, Asian-American, and Pa-

1 cific Islander communities with comprehensive serv-
2 ices focused on treatment of, and information about,
3 acquired bone marrow failure diseases.

4 ''(2) COLLABORATION.—In carrying out this
5 subsection, the Secretary may collaborate with public
6 health agencies, nonprofit organizations, community
7 groups, and online entities to disseminate informa-
8 tion about treatment options and clinical trials for
9 acquired bone marrow failure diseases.

10 ''(c) GRANTS AND COOPERATIVE AGREEMENTS.—

11 ''(1) IN GENERAL.—Not later than 6 months
12 after the date of the enactment of this section, the
13 Secretary, acting through the Deputy Assistant Sec-
14 retary for Minority Health, shall award grants to, or
15 enter into cooperative agreements with, entities to
16 perform research on acquired bone marrow failure
17 diseases.

18 ''(2) REQUIREMENT.—Grants and cooperative
19 agreements authorized by this subsection shall be
20 awarded or entered into on a competitive, peer-re-
21 viewed basis.

22 ''(3) SCOPE OF RESEARCH.—Research funded
23 under this section shall examine factors affecting the
24 incidence of acquired bone marrow failure diseases
25 in minority populations.

1 "(d) DEFINITION.—In this section, the term 'ac-
2 quired bone marrow failure disease' has the meaning given
3 to such term in section 317X(d).

4 "(e) AUTHORIZATION OF APPROPRIATIONS.—There
5 is authorized to be appropriated to carry out this section
6 $2,000,000 for each of fiscal years 2012 through 2016.".

7 (f) DIAGNOSIS AND QUALITY OF CARE FOR AC-
8 QUIRED BONE MARROW FAILURE DISEASES.—

9 (1) GRANTS.—The Secretary of Health and
10 Human Services, acting through the Director of the
11 Agency for Healthcare Research and Quality, shall
12 award grants to entities to improve diagnostic prac-
13 tices and quality of care with respect to patients
14 with acquired bone marrow failure diseases.

15 (2) AUTHORIZATION OF APPROPRIATIONS.—
16 There is authorized to be appropriated to carry out
17 this section $2,000,000 for each of fiscal years 2012
18 through 2016.

19 (g) DEFINITION.—In this section, the term "acquired
20 bone marrow failure disease" means—

21 (1) myelodysplastic syndromes (MDS);

22 (2) aplastic anemia;

23 (3) paroxysmal nocturnal hemoglobinuria
24 (PNH);

25 (4) pure red cell aplasia;

(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

1 (5) other experts determined appropriate by the
2 Secretary.
3 (c) DISEASES.—Screening guidelines for minority
4 populations shall be developed as appropriate under sub-
5 section (a) for—
6 (1) hypertension;
7 (2) hypercholesterolemia;
8 (3) diabetes;
9 (4) cardiovascular disease;
10 (5) cancers, including breast, prostate, colon,
11 cervical, and lung cancer;
12 (6) asthma;
13 (7) diabetes;
14 (8) kidney diseases;
15 (9) eye diseases and disorders, including glau-
16 coma;
17 (10) HIV/AIDS and sexually transmitted dis-
18 eases;
19 (11) uterine fibroids;
20 (12) autoimmune disease;
21 (13) mental health conditions;
22 (14) dental health conditions and oral diseases;
23 (15) environmental and related health illnesses
24 and conditions;
25 (16) Sickle cell disease;

(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).

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

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–5. 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)(D) is amended 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 referred 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 COSTSHARING.—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 to-

bacco 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.

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 Latin-Americans; 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 Latin-Americans.

(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 ra-

cial/ethnic groups with a statistically significant increase 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.

(d) AUTHORIZATION OF APPROPRIATIONS.—For carrying out this section, there are authorized to be appropriated $610,000,0000 for fiscal year 2012 and such sums

as may be necessary for each of fiscal years 2013 through 2016.

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 reasonable educational expenses, and reasonable living costs) at a school of dentistry; and

(B) includes only the portion of the loan that is outstanding on the date the dentist involved begins the service specified in the agreement under subsection (a).

(2) 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.

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2012 through 2016.

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 2011''.

(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 2011 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 communities; 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 2011 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.—

(1) IN GENERAL.—For the purpose of reducing HIV/AIDS in the African-American community, the Secretary, acting through the Deputy Assistant Sec-

1 retary for Minority Health, may make grants to
2 public health agencies and faith-based organizations
3 to conduct—
4 (A) outreach activities related to HIV/
5 AIDS prevention and testing activities;
6 (B) HIV/AIDS prevention activities; and
7 (C) HIV/AIDS testing activities.
8 (2) AUTHORIZATION OF APPROPRIATIONS.—To
9 carry out this section, there are authorized to be ap-
10 propriated $50,000,000 for fiscal year 2012, and
11 such sums as may be necessary for fiscal years 2013
12 through 2016.
13 (e) GRANTS FOR SUBSTANCE ABUSE AND MENTAL
14 HEALTH SERVICES TO PUBLIC HEALTH AGENCIES AND
15 FAITH-BASED ORGANIZATIONS.—
16 (1) IN GENERAL.—The Secretary, acting
17 through the Administrator of the Substance Abuse
18 and Mental Health Services Administration, may
19 make grants to public health agencies and faith-
20 based organizations to—
21 (A) conduct HIV/AIDS and sexually trans-
22 mitted disease outreach, prevention, and testing
23 activities that are targeted to the African-Amer-
24 ican community; and

(B) in connection with such activities, provide substance abuse testing and mental health services to members of such community.

(2) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $90,000,000 for fiscal year 2012 and such sums as may be necessary for fiscal years 2013 through 2016.

(f) SERVICES FOR HIV/AIDS AFFECTED YOUTH WHO ARE SEPARATED FROM THEIR FAMILIES.—

(1) IN GENERAL.—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—

(A)(i) have run away from home;

(ii) are homeless; or

(iii) reside in a detention center or foster care; and

(B) are HIV positive or at risk for HIV/AIDS, including young men who have sex with men.

1 (2) AUTHORIZATION OF APPROPRIATIONS.—To
2 carry out this section, there are authorized to be ap-
3 propriated $5,000,000 for fiscal year 2012, and such
4 sums as may be necessary for fiscal years 2013
5 through 2016.
6 (g) PUBLIC HEALTH INTERVENTION AND PREVEN-
7 TION ACTIVITIES.—
8 (1) IN GENERAL.—For the purpose of reducing
9 HIV/AIDS, sexually transmitted diseases, tuber-
10 culosis, and viral hepatitis in African-American com-
11 munities, the Secretary, acting through the Director
12 of the Centers for Disease Control and Prevention,
13 may make grants to faith-based organizations for
14 public health intervention and prevention activities,
15 including the use of rapid testing in traditional and
16 nontraditional settings to increase the number of in-
17 dividuals who know their status at the point of care
18 and are put into treatment.
19 (2) PARTNERSHIPS.—In carrying out this sec-
20 tion, the Secretary shall encourage grantees to enter
21 into partnerships with public health agencies.
22 (3) AUTHORIZATION OF APPROPRIATIONS.—To
23 carry out this section, there are authorized to be ap-
24 propriated $100,000,000 for fiscal year 2012, and

1 such sums as may be necessary for fiscal years 2013
2 through 2016.
3 (h) HIV/AIDS PREVENTION AND EDUCATION.—
4 (1) PREVENTION ACTIVITIES.—The Secretary,
5 acting through the Director of the Centers for Dis-
6 ease Control and Prevention, shall expand and inten-
7 sify HIV/AIDS prevention activities in African-
8 American communities. Such activities—
9 (A) shall be targeted to specific popu-
10 lations;
11 (B) shall be comprehensive and accurately
12 based on science and research; and
13 (C) shall include information on absti-
14 nence, the proper use of condoms, risks associ-
15 ated with unprotected sex, and the value of sex-
16 ual delay particularly among young adolescents
17 and teenagers.
18 (2) EDUCATION.—The Secretary, acting
19 through the Director of the Centers for Disease
20 Control and Prevention, shall expand and intensify
21 HIV/AIDS educational activities targeting Black
22 women, youth, and men who have sex with men.
23 (3) COORDINATION.—The Secretary shall carry
24 out this section in coordination with public schools
25 of all levels, Black organizations, historically Black

colleges and universities, and faith-based organizations and institutions.

(4) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $90,000,000 for fiscal year 2012, and such sums as may be necessary for fiscal years 2013 through 2016.

(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 section, 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 interdenominational center of seminaries specializing in the training of African-American clergy, and historically Black colleges and universities.

(3) DEFINITION.—In this section, the term ''eligible entity'' means a national or community-based organization with a history and tradition of service to African-American communities.

(4) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $25,000,000 for fiscal year 2012, and such sums as may be necessary for fiscal years 2013 through 2016.

(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 National 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.

(4) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there are authorized to be appropriated $10,000,000 for fiscal year 2012, and such sums as may be necessary for fiscal years 2013 through 2016.

(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 section, 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.

(3) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $10,000,000 for fiscal year 2012, and such sums as may be necessary for fiscal years 2013 through 2016.

(l) STUDY OF BIOLOGICAL AND BEHAVIORAL FACTORS.—

(1) IN GENERAL.—The Secretary, acting through the Director of the National Institute on Minority Health and Health Disparities, may make grants for—

(A) 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

(B) 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.

(2) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there are authorized to be appropriated $100,000,000 for fiscal year 2012, and such sums as may be necessary for fiscal years 2013 through 2016.

(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 "(1) Development of curricula for training pri-
2 mary care providers in HIV/AIDS prevention and
3 care.
4 "(2) Training health care professionals with ex-
5 pertise in HIV/AIDS to provide care to individuals
6 with HIV/AIDS.
7 "(3) Development by grant recipients under
8 title XXVI and other persons of policies for pro-
9 viding culturally relevant and sensitive treatment to
10 individuals with HIV/AIDS, with particular empha-
11 sis on treatment to African-Americans and children
12 with HIV/AIDS.
13 "(4) Development and implementation of pro-
14 grams to increase the use of telemedicine to respond
15 to HIV/AIDS-specific health care needs in rural and
16 minority communities, with particular emphasis
17 given to medically underserved communities and the
18 southern States.
19 "(5) Creation of faith- and community-based
20 certification programs for providers in HIV/AIDS
21 care and support services.
22 "(6) Establishment of comfort care centers that
23 provide mental, emotional, and psychosocial coun-
24 seling for people with HIV/AIDS and implement ad-
25 ditional protocols to be carried out in the centers

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) DEFINITION.—In this section, the term 'HIV/AIDS' has the meaning given to such term in section 2689.

"(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $100,000,000 for fiscal year 2012, and such sums as may be necessary for fiscal years 2013 through 2016.".

(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

1 regulations which govern visitation in correctional
2 facilities.

3 (2) INFORMATION REQUIREMENT.—Any com-
4 munity organization permitted to distribute sexual
5 barrier protection devices under paragraph (1) must
6 ensure that the persons to whom the devices are dis-
7 tributed are informed about the proper use and dis-
8 posal of sexual barrier protection devices in accord-
9 ance with established public health practices. Any
10 community organization conducting STI counseling
11 or STI prevention education under paragraph (1)
12 must offer comprehensive sexuality education.

13 (3) POSSESSION OF DEVICE PROTECTED.—No
14 Federal correctional facility may, because of the pos-
15 session or use of a sexual barrier protection device—

16 (A) take adverse action against an incar-
17 cerated person; or

18 (B) consider possession or use as evidence
19 of prohibited activity for the purpose of any
20 Federal correctional facility administrative pro-
21 ceeding.

22 (4) IMPLEMENTATION.—The Attorney General
23 and Bureau of Prisons shall implement this section
24 according to established public health practices in a
25 manner that protects the health, safety, and privacy

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

1 "(II) such individual is to be re-
2 leased from a public institution on pa-
3 role or on probation, as soon as pos-
4 sible after the date on which the de-
5 termination to release such individual
6 was made, and before the date such
7 individual is released.
8 "(ii) EXCEPTION.—If a State makes a
9 determination that an individual is not eli-
10 gible to be enrolled under the State plan—
11 "(I) on or before the date by
12 which the individual would be enrolled
13 under clause (i), such clause shall not
14 apply to such individual; or
15 "(II) after such date, the State
16 may terminate the enrollment of such
17 individual.
18 "(B) RELATIONSHIP OF ENROLLMENT TO
19 PAYMENT FOR SERVICES.—
20 "(i) IN GENERAL.—Subject to sub-
21 paragraph (A)(ii), an eligible individual
22 who is enrolled, or whose enrollment is re-
23 instated under subparagraph (A), shall be
24 eligible for medical assistance that is pro-
25 vided after the date that the eligible indi-

1 vidual is released from the public institu-
2 tion
3 "(ii) RELATIONSHIP TO PAYMENT
4 PROHIBITION FOR INMATES.—No provision
5 of this paragraph may be construed to per-
6 mit payment for care or services for which
7 payment is excluded under the subpara-
8 graph (A), following paragraph (29), of
9 section 1905(a).
10 "(C) TREATMENT OF CONTINUOUS ELIGI-
11 BILITY.—
12 "(i) SUSPENSION FOR INMATES.—Any
13 period of continuous eligibility under this
14 title shall be suspended on the date an in-
15 dividual enrolled under this title becomes
16 an inmate of a public institution (except as
17 a patient of a medical institution).
18 "(ii) DETERMINATION OF REMAINING
19 PERIOD.—Notwithstanding any changes to
20 State law related to continuous eligibility
21 during the time that an individual is an in-
22 mate of a public institution (except as a
23 patient of a medical institution), subject to
24 clause (iii), with respect to an eligible indi-
25 vidual who was subject to a suspension

1 under subclause (I), on the date that such
2 individual is released from a public institu-
3 tion the suspension of continuous eligibility
4 under such subclause shall be lifted for a
5 period that is equal to the time remaining
6 in the period of continuous eligibility for
7 such individual on the date that such pe-
8 riod was suspended under such subclause.
9 ''(iii) EXCEPTION.—If a State makes
10 a determination that an individual is not
11 eligible to be enrolled under the State
12 plan—
13 ''(I) on or before the date that
14 the suspension of continuous eligibility
15 is lifted under clause (ii), such clause
16 shall not apply to such individual; or
17 ''(II) after such date, the State
18 may terminate the enrollment of such
19 individual.
20 ''(D) AUTOMATIC ENROLLMENT OR REIN-
21 STATEMENT OF ENROLLMENT DEFINED.—For
22 purposes of this paragraph, the term 'automatic
23 enrollment or reinstatement of enrollment'
24 means that the State determines eligibility for
25 medical assistance under the State plan without

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

1 facilities, no later than 180 days after the date of
2 enactment of this Act and annually thereafter for 5
3 years, to determine the following:
4 (A) PREVENTION EDUCATION OFFERED.—
5 The type of prevention education, information,
6 or training offered to incarcerated persons and
7 correctional facility staff regarding sexual vio-
8 lence and the spread of STIs, including whether
9 such education, information, or training—
10 (i) constitutes comprehensive sexuality
11 education;
12 (ii) is compulsory for new incarcerated
13 persons and for new staff; and
14 (iii) is offered on an ongoing basis.
15 (B) ACCESS TO SEXUAL BARRIER PROTEC-
16 TION DEVICES.—Whether incarcerated persons
17 can—
18 (i) possess sexual barrier protection
19 devices;
20 (ii) purchase sexual barrier protection
21 devices;
22 (iii) purchase sexual barrier protection
23 devices at a reduced cost; and
24 (iv) obtain sexual barrier protection
25 devices without cost.

(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-

1 mation and training on sexual violence and the
2 spread of STIs, and comprehensive sexuality
3 education.

4 (B) SEXUAL BARRIER PROTECTION DEVICE
5 ACCESS.—A plan for expanding access to sexual
6 barrier protection devices in correctional facili-
7 ties.

8 (C) SEXUAL VIOLENCE REDUCTION.—A
9 plan for reducing the incidence of sexual vio-
10 lence among incarcerated persons and correc-
11 tional facility staff, developed in consultation
12 with the National Prison Rape Elimination
13 Commission.

14 (D) COUNSELING AND SUPPORTIVE SERV-
15 ICES.—A plan for expanding access to coun-
16 seling and supportive services related to STIs in
17 correctional facilities.

18 (E) TESTING.—A plan for testing incarcer-
19 ated persons for STIs during intake, during
20 regular health exams, and prior to release, and
21 that—

22 (i) is conducted in accordance with
23 guidelines established by the Centers for
24 Disease Control and Prevention;

25 (ii) includes pre-test counseling;

(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

1 strengthening linkages to local communities and
2 health facilities that—
3 (i) provide counseling, testing, care,
4 and treatment services;
5 (ii) may receive persons recently re-
6 leased from incarceration who are living
7 with STIs; and
8 (iii) accept payment through the State
9 Medicaid program.
10 (I) ENROLLMENT IN STATE MEDICAID
11 PROGRAMS.—Plans to ensure that incarcerated
12 persons who were—
13 (i) enrolled in their State Medicaid
14 program prior to incarceration in a correc-
15 tional facility are automatically re-enrolled
16 in such program upon their release; and
17 (ii) not enrolled in their State Med-
18 icaid program prior to incarceration, but
19 who are diagnosed with the human im-
20 munodeficiency virus while incarcerated in
21 a correctional facility, are automatically
22 enrolled in such program upon their re-
23 lease.
24 (J) OTHER PLANS.—Any other plans de-
25 veloped by the Attorney General for reducing

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-

1 cators provided for in subparagraphs (I) and (J) of
2 paragraph (2).
3 (h) APPROPRIATIONS.—
4 (1) IN GENERAL.—There are authorized to be
5 appropriated such sums as may be necessary to
6 carry out this section for each of the fiscal years
7 2012 through 2018.
8 (2) AVAILABILITY OF FUNDS.—Amounts made
9 available under subsection (a) are authorized to re-
10 main available until expended.
11 (i) DEFINITIONS.—For the purposes of this section:
12 (1) COMMUNITY ORGANIZATION.—The term
13 ''community organization'' means a public health
14 care facility or a nonprofit organization which pro-
15 vides health- or STI-related services according to es-
16 tablished public health standards.
17 (2) COMPREHENSIVE SEXUALITY EDUCATION.—
18 The term ''comprehensive sexuality education''
19 means sexuality education that includes information
20 about abstinence and about the proper use and dis-
21 posal of sexual barrier protection devices and which
22 is—
23 (A) evidence-based;
24 (B) medically accurate;
25 (C) age and developmentally appropriate;

(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 2011''.

(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.

1 (C) To provide comprehensive medical
2 treatment to inmates who are living with HIV/
3 AIDS.
4 (D) To promote HIV/AIDS awareness and
5 prevention among inmates.
6 (E) To encourage inmates to take personal
7 responsibility for their health.
8 (F) To reduce the risk that inmates will
9 transmit HIV/AIDS to other persons in the
10 community following their release from prison.
11 (3) CONSULTATION.—The Bureau shall consult
12 with appropriate officials of the Department of
13 Health and Human Services, the Office of National
14 Drug Control Policy, the Office of National AIDS
15 Policy, and the Centers for Disease Control regard-
16 ing the development of such policy.
17 (4) TIME LIMIT.—The Bureau shall draft ap-
18 propriate regulations to implement such policy not
19 later than 1 year after the date of the enactment of
20 this Act.
21 (c) REQUIREMENTS FOR POLICY.—The policy cre-
22 ated under subsection (b) shall provide for the following:
23 (1) TESTING AND COUNSELING UPON IN-
24 TAKE.—

1 (A)(i) Subject to clause (ii), health care
2 personnel shall provide routine HIV testing to
3 all inmates as a part of a comprehensive med-
4 ical examination immediately following admis-
5 sion to a facility.
6 (ii) Health care personnel shall not be re-
7 quired to provide routine HIV testing to an in-
8 mate who is transferred to a facility from an-
9 other facility if the inmate's medical records are
10 transferred with the inmate and indicate that
11 the inmate has been tested previously.
12 (B) To all inmates admitted to a facility
13 prior to the effective date of this policy, health
14 care personnel shall provide routine HIV testing
15 within no more than 6 months. HIV testing for
16 these inmates may be performed in conjunction
17 with other health services provided to these in-
18 mates by health care personnel.
19 (C) All HIV tests under this paragraph
20 shall comply with paragraph (9).
21 (2) PRE-TEST AND POST-TEST COUNSELING.—
22 Health care personnel shall provide confidential pre-
23 test and post-test counseling to all inmates who are
24 tested for HIV. Counseling may be included with

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

1 comprehensive treatment for inmates living with
2 HIV/AIDS, and that the facility maintains ade-
3 quate supplies of such medications to meet in-
4 mates' medical needs. Health care personnel
5 and pharmacy personnel shall also develop and
6 implement automatic renewal systems for these
7 medications to prevent interruptions in care.
8 (D) Correctional staff, health care per-
9 sonnel, and pharmacy personnel shall develop
10 and implement distribution procedures to en-
11 sure timely and confidential access to medica-
12 tions.
13 (7) PROTECTION OF CONFIDENTIALITY.—
14 (A) Health care personnel shall develop
15 and implement procedures to ensure the con-
16 fidentiality of inmate tests, diagnoses, and
17 treatment. Health care personnel and correc-
18 tional staff shall receive regular training on the
19 implementation of these procedures. Penalties
20 for violations of inmate confidentiality by health
21 care personnel or correctional staff shall be
22 specified and strictly enforced.
23 (B) HIV testing, counseling, and treat-
24 ment shall be provided in a confidential setting
25 where other routine health services are provided

1 and in a manner that allows the inmate to re-
2 quest and obtain these services as routine med-
3 ical services.
4 (8) TESTING, COUNSELING, AND REFERRAL
5 PRIOR TO REENTRY.—
6 (A)(i) Subject to clauses (ii) and (iii),
7 health care personnel shall provide routine HIV
8 testing to all inmates no more than 3 months
9 prior to their release and reentry into the com-
10 munity.
11 (ii) Inmates who are already known to be
12 infected shall not be required to be tested
13 again.
14 (iii) The requirement under clause (i) may
15 be waived if an inmate's release occurs without
16 sufficient notice to the Bureau to allow health
17 care personnel to perform a routine HIV test
18 and notify the inmate of the results.
19 (B) All HIV tests under this paragraph
20 shall comply with paragraph (9).
21 (C) To all inmates who test positive for
22 HIV and all inmates who already are known to
23 have HIV/AIDS, health care personnel shall
24 provide—

(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 2011'' after ''under this section''.

(3) SCREENING AS PART OF ROUTINE SCREENING.—Section 4014(e) of title 18, United States Code, is amended by adding at the end the following: ''Such rules shall also provide that the initial test under this section be performed as part of the routine health screening conducted at intake.''.

(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

1 officials of the Department of Health and Human
2 Services, the Office of National Drug Control Policy,
3 the Office of National AIDS Policy, and the Centers
4 for Disease Control and Prevention regarding the
5 development of this report.

6 (2) ANNUAL REPORTS.—

7 (A) GENERALLY.—Not later than 2 years
8 after the date of the enactment of this Act, and
9 then annually thereafter, the Bureau shall re-
10 port to Congress on the incidence among in-
11 mates of diseases transmitted through sexual
12 activity and intravenous drug use.

13 (B) MATTERS PERTAINING TO VARIOUS
14 DISEASES.—Reports under subparagraph (A)
15 shall discuss—

16 (i) the incidence among inmates of
17 HIV/AIDS, hepatitis, and other diseases
18 transmitted through sexual activity and in-
19 travenous drug use; and

20 (ii) updates on Bureau testing, treat-
21 ment, and prevention education programs
22 for these diseases.

23 (C) MATTERS PERTAINING TO HIV/AIDS
24 ONLY.—Reports under subparagraph (A) shall
25 also include—

(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.

(a) IN GENERAL.—For the purpose of reducing HIV/AIDS in racial and ethnic minority communities, the Sec-

retary, 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.

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $50,000,000 for fiscal year 2012, and such sums as may be necessary for fiscal years 2013 through 2016.

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 "(1) Development of curricula for training pri-
2 mary care providers in HIV/AIDS prevention and
3 care.
4 "(2) Training health care professionals with ex-
5 pertise in HIV/AIDS to provide care to individuals
6 with HIV/AIDS.
7 "(3) Development by grant recipients under
8 title XXVI and other persons of policies for pro-
9 viding culturally relevant and sensitive treatment to
10 individuals with HIV/AIDS, with particular empha-
11 sis on treatment to racial and ethnic minorities, men
12 who have sex with men, and women and children
13 with HIV/AIDS.
14 "(4) Development and implementation of pro-
15 grams to increase the use of telemedicine to respond
16 to HIV/AIDS-specific health care needs in rural and
17 minority communities, with particular emphasis
18 given to medically underserved communities and in-
19 sular areas.
20 "(5) Creation of faith- and community-based
21 certification programs for providers in HIV/AIDS
22 care and support services.
23 "(6) Establishment of comfort care centers that
24 provide mental, emotional, and psychosocial coun-
25 seling for people with HIV/AIDS and implement ad-

ditional 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) DEFINITION.—In this section, the term 'HIV/AIDS' has the meaning given to such term in section 2689.

"(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $100,000,000 for fiscal year 2012, and such sums as may be necessary for fiscal years 2013 through 2016.".

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.

(a) IN GENERAL.—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.

(b) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—To carry out this section, there is authorized to be appropriated $2,000,000 for each of fiscal years 2012 and 2013.

(2) SPECIAL RULE.—Of the amount of funds appropriated to carry out this section for a fiscal year—

(A) 45 percent shall be allocated to the Institutes of Medicine pursuant to the agreement entered into under subsection (a)(1);

(B) 45 percent shall be allocated to an academic organization which specializes in the identification and reduction of health disparities within the African-American community pursuant to such agreement; and

(C) 10 percent shall be allocated for administrative costs and other activities under this subsection.

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

1 the purpose of providing treatment for diabetes in minor-
2 ity communities.

3 "(b) RECIPIENTS OF GRANTS.—The public and non-
4 profit private health care providers to whom grants may
5 be made under subsection (a) include physicians, podia-
6 trists, community-based organizations, health care organi-
7 zations, community health centers, and State, local, and
8 tribal health departments.

9 "(c) SCOPE OF TREATMENT ACTIVITIES.—The Sec-
10 retary shall ensure that grants under subsection (a) cover
11 a variety of diabetes-related health care services, including
12 routine care for diabetic patients, public education on dia-
13 betes prevention and control, eye care, foot care, and
14 treatment for kidney disease and other complications of
15 diabetes.

16 "(d) APPROPRIATE CULTURAL CONTEXT.—A condi-
17 tion for the receipt of a grant under subsection (a) is that
18 the applicant involved agrees that, in the program carried
19 out with the grant, services will be provided in the lan-
20 guages most appropriate for, and with consideration for
21 the cultural backgrounds of, the individuals for whom the
22 services are provided.

23 "(e) OUTREACH SERVICES.—A condition for the re-
24 ceipt of a grant under subsection (a) is that the applicant
25 involved agrees to provide outreach activities to inform the

public of the services of the program, and to provide offsite information on diabetes.

''(f) 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.

''(g) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2012 through 2017.''.

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, socio-

1 economic, geographical, cultural, and organizational fac-
2 tors that contribute to type 2 diabetes in such populations.
3 "(b) CERTAIN ACTIVITIES.—Activities under sub-
4 section (a) regarding type 2 diabetes in minority popu-
5 lations shall include the following:
6 "(1) Continuing research on behavior and obe-
7 sity, including through the obesity research center
8 that is sponsored by the National Institutes of
9 Health.
10 "(2) Research on environmental factors that
11 may contribute to the increase in type 2 diabetes.
12 "(3) Support for new methods to identify envi-
13 ronmental triggers and genetic interactions that lead
14 to the development of type 2 diabetes in minority
15 newborns. Such research should follow the newborns
16 through puberty, an increasingly high-risk period for
17 developing type 2 diabetes.
18 "(4) Research to identify genes that predispose
19 individuals to the onset of developing type 1 and
20 type 2 diabetes and to the development of complica-
21 tions.
22 "(5) Research to prevent complications in indi-
23 viduals who have already developed diabetes, such as
24 research that attempts to identify the genes that

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 outcomes 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) DEFINITION.—For purposes of this section, the term 'minority population' means a racial and ethnic minority group, as defined in section 1707(g).

"(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as are necessary for fiscal year 2012 and each subsequent fiscal year.".

(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).

"(3) For the purpose of carrying out this subsection, there are authorized to be appropriated such sums as are

1 necessary for fiscal year 2012 and each subsequent fiscal
2 year.''.

3 (b) RESEARCH, EDUCATION, AND OTHER ACTIVI-
4 TIES.—Part B of title III of the Public Health Service
5 Act (42 U.S.C. 243 et seq.) is amended by inserting after
6 section 317T the following section:

7 **''SEC. 317U. DIABETES IN MINORITY POPULATIONS.**

8 ''(a) RESEARCH AND OTHER ACTIVITIES.—

9 ''(1) IN GENERAL.—The Secretary, acting
10 through the Director of the Centers for Disease
11 Control and Prevention, shall conduct and support
12 research and other activities with respect to diabetes
13 in minority populations.

14 ''(2) CERTAIN ACTIVITIES.—Activities under
15 paragraph (1) regarding diabetes in minority popu-
16 lations shall include the following:

17 ''(A) Expanding the National Diabetes
18 Laboratory capacity for translational research
19 and the identification of genetic and
20 immunological risk factors associated with dia-
21 betes.

22 ''(B) Improving the understanding of dia-
23 betes prevalence among Asian-American, Native
24 Hawaiian and other Pacific Islanders by en-
25 hancing data in the National Health and Nutri-

tion 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

1 Translation to specifically focus on such popu-
2 lations with pre-diabetes.
3 "(b) EDUCATION.—
4 "(1) IN GENERAL.—The Secretary, acting
5 through the Director of the Centers for Disease
6 Control and Prevention, shall direct the Division of
7 Diabetes Translation to conduct and support pro-
8 grams to educate the public on the causes and ef-
9 fects of diabetes in minority populations.
10 "(2) CERTAIN ACTIVITIES.—Programs under
11 paragraph (1) regarding education on diabetes in
12 minority populations shall include carrying out pub-
13 lic awareness campaigns directed toward such popu-
14 lations to aggressively emphasize the importance and
15 impact of physical activity and diet in regard to dia-
16 betes and diabetes-related complications through the
17 National Diabetes Education Program.
18 "(c) DIABETES; HEALTH PROMOTION, PREVENTION
19 ACTIVITIES, AND ACCESS.—
20 "(1) IN GENERAL.—The Secretary, acting
21 through the Director of the Centers for Disease
22 Control and Prevention, shall carry out culturally
23 appropriate diabetes health promotion and preven-
24 tion programs for minority populations.

1 "(2) CERTAIN ACTIVITIES.—Activities regard-
2 ing culturally appropriate diabetes health promotion
3 and prevention programs for minority populations
4 shall include the following:
5 "(A) Expanding the Diabetes Prevention
6 and Control Program (currently existing in all
7 the States and territories) and providing funds
8 for education and community outreach on dia-
9 betes.
10 "(B) Providing funds for an expansion of
11 the Diabetes Prevention Program Initiative that
12 focuses on physical inactivity and diet and its
13 relation to type 2 diabetes within such popu-
14 lations.
15 "(C) Providing funds to strengthen exist-
16 ing surveillance systems to improve the quality,
17 accuracy, and timeliness of morbidity and mor-
18 tality diabetes data for such populations.
19 "(d) DEFINITION.—For purposes of this section, the
20 term 'minority population' means a racial and ethnic mi-
21 nority group, as defined in section 1707(g).
22 "(e) AUTHORIZATION OF APPROPRIATIONS.—For the
23 purpose of carrying out this section, there are authorized
24 to be appropriated such sums as are necessary for fiscal
25 year 2012 and each subsequent fiscal year.".

(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–6. 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-

1 sitivity and patient care within such populations for
2 health care providers.
3 ''(2) Providing funds to community health cen-
4 ters for programs that provide diabetes services and
5 screenings.
6 ''(3) Providing additional funds for the Health
7 Careers Opportunity Program, Centers for Excel-
8 lence, and the Minority Faculty Fellowship Program
9 to partner with the Office of Minority Health under
10 section 1707 and the National Institutes of Health
11 to strengthen programs for career opportunities
12 within minority populations focused on diabetes
13 treatment and care.
14 ''(4) Developing a diabetes focus within, and
15 providing additional funds for, the National Health
16 Service Corps Scholarship program to place individ-
17 uals in areas that are disproportionately affected by
18 diabetes and to provide health care services to such
19 areas.
20 ''(5) Establishing a diabetes ambassador pro-
21 gram for recruitment efforts to increase the number
22 of underrepresented minorities currently serving in
23 student, faculty, or administrative positions in insti-
24 tutions of higher learning, hospitals, and community
25 health centers.

"(6) Establishing a loan repayment program that focuses on diabetes care and prevention in minority populations.".

(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–7. 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

1 partnerships within minority populations to
2 conduct studies on cultural, familial, and social
3 factors that may influence health promotion, di-
4 abetes management, and prevention.

5 "(B) Through the Indian Health Service,
6 in collaboration with other appropriate Federal
7 agencies, coordinating the collection of data on
8 ethnic and culturally appropriate diabetes treat-
9 ment, care, prevention, and services by health
10 care professionals to the American Indian popu-
11 lation.

12 "(3) PROGRAMS RELATING TO CLINICAL RE-
13 SEARCH.—

14 "(A) EDUCATION REGARDING CLINICAL
15 TRIALS.—The Secretary shall carry out edu-
16 cation and awareness programs designed to in-
17 crease participation of minority populations in
18 clinical trials.

19 "(B) MINORITY RESEARCHERS.—The Sec-
20 retary shall carry out mentorship programs for
21 minority researchers who are conducting or in-
22 tend to conduct research on diabetes in minor-
23 ity populations.

24 "(C) SUPPLEMENTING CLINICAL RE-
25 SEARCH REGARDING CHILDREN.—The Sec-

retary 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) DEFINITION.—For purposes of this section, the term 'minority population' means a racial and ethnic minority group as defined in section 1707(g).

"(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized

to be appropriated such sums as are necessary for fiscal year 2012 and each subsequent fiscal year.''.

(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

1 Federal Government and States, with respect to
2 achieving the goals of the Healthy People 2020
3 initiative; and
4 (B) the activities of other entities that par-
5 ticipate in the program, including nonprofit or-
6 ganizations, patient advocacy groups, and med-
7 ical societies; and
8 (2) makes recommendations for the future di-
9 rection of asthma activities, in consultation with re-
10 searchers from the National Institutes of Health and
11 other member bodies of the National Asthma Edu-
12 cation and Prevention Program who are qualified to
13 review and analyze data and evaluate interventions,
14 including—
15 (A) description of how the Federal Govern-
16 ment may better coordinate and improve its re-
17 sponse to asthma including identifying any bar-
18 riers that may exist;
19 (B) description of how the Federal Govern-
20 ment may continue, expand, and improve its
21 private-public partnerships with respect to asth-
22 ma including identifying any barriers that may
23 exist;
24 (C) identification of steps that may be
25 taken to reduce the—

(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.

"(f) ADDITIONAL FUNDING.—In addition to any other authorization of appropriations that is available to the Centers for Disease Control and Prevention for the purpose of carrying out this section, there are authorized

to be appropriated to such Centers such sums as may be necessary for each of fiscal years 2012 through 2016 for the purpose of carrying out this section.''.

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.

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

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).

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

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 assist-

ance 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 IMPACT OF HEALTH IT ON RACIAL AND ETHNIC MINORITY COMMUNITIES; OUTREACH AND ADOPTION OF HEALTH IT IN SUCH COMMUNITIES.

Section 3001(c)(6)(C) of the Public Health Service Act (42 U.S.C. 300jj–11(c)(6)(C)) is amended—

(1) in the heading by inserting ", RACIAL AND ETHNIC MINORITY COMMUNITIES," after "HEALTH DISPARITIES";

(2) by inserting ", in communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g))," after "communities with health disparities"; and

(3) by adding at the end the following new sentence: "In any publication under the previous sentence, the National Coordinator shall include best practices for encouraging partnerships between the Federal Government and private entities to expand outreach for and the adoption of such technology in

communities with a high proportion of individuals from racial and ethnic minority groups (as so defined), while also maintaining the accessibility requirements of section 508 of the Rehabilitation Act to encourage patient involvement in their own health care. The National Coordinator shall—

"(i) not later than 6 months after the submission to the Congress of the reports required by sections 832 and 833 of the Health Equity and Accountability Act of 2011, establish criteria for evaluating the impact of health information technology on communities with a high proportion of individuals from racial and ethnic minority groups (as so defined) taking into account the findings in such reports; and

"(ii) not later than 12 months after the submission to the Congress of such reports, conduct and publish the results of an evaluation of such impact.".

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. 831. 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. 832. 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

1 or participate in the exchange of health infor-
2 mation; and
3 (C) including recommendations for over-
4 coming such barriers for such individuals; and
5 (2) not later than 24 months after the date of
6 the enactment of this Act, submit to Congress a re-
7 port on the results of such study.
8 If such Institute declines to conduct the study and submit
9 the report, the Secretary shall enter into an agreement
10 with another appropriate public or nonprofit private entity
11 to conduct the study and submit the report.
12 (b) INDIVIDUALS DESCRIBED.—For purposes of sub-
13 section (a), the individuals described in this subsection are
14 individuals from racial and ethnic minority groups (as de-
15 fined in section 1707(g)), including such individuals
16 who—
17 (1) are immigrants, as well as citizens living
18 within immigrant households (''mixed-status'' house-
19 holds) in the United States;
20 (2) are lesbian, gay, bisexual, or transgender; or
21 (3) have a mental health disability or a record
22 of a mental health disability or treatment for a men-
23 tal health disability.

SEC. 833. STUDY OF HEALTH INFORMATION TECHNOLOGY IN MEDICALLY UNDERSERVED COMMUNITIES.

(a) STUDY.—The Secretary of Health and Human Services shall seek to enter into an agreement with the Institute of Medicine of the National Academies to conduct a study on the development and implementation of health information technology in communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)) and submit the report under subsection (b). The study shall—

(1) identify barriers to successful implementation of health information technology in these communities;

(2) examine the impact of health information technology on providing quality care and reducing the cost of care to these communities;

(3) examine urban and rural community health systems and determine the impact that health information technology may have on the capacity of primary health providers;

(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 these communities; and

(5) assess the feasibility and the costs of associated with the use of health information technology in these communities.

If such Institute declines to conduct the study, the Secretary shall enter into an agreement with another appropriate public or nonprofit private entity to conduct the study.

(b) REPORT.—The Secretary shall ensure that, not later than 24 months after the date of the enactment of this Act, the study required under subsection (a) is completed and a report on the study is submitted to Congress, including any recommendations for legislation or administrative action.

Subtitle D—Closing Gaps in Funding To Adopt Certified EHRs

SEC. 841. 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 841 of the Health Equity and Accountability Act of 2011; 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 subsections (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. 842. EXTENDING MEDICAID EHR INCENTIVE PAYMENTS TO LONG-TERM CARE FACILITIES AND HOME HEALTH AGENCIES.

Section 1903(t)(2)(B) of the Social Security Act (42 U.S.C. 1396b(t)(2)(B)) is amended—

(1) in clause (i), by striking '', or'' and inserting a semicolon;

(2) in clause (ii), by striking the period at the end and inserting a semicolon; and

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

"(iii) a long-term care facility; or

"(iv) a home health agency (as defined in section 1861(o)).".

SEC. 843. 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

1 Disparity, Confronting Discrimination, and Ensur-
2 ing Equity' (September 1999) in conjunction with
3 the reports by the Institute of Medicine entitled 'Un-
4 equal Treatment: Confronting Racial and Ethnic
5 Disparities in Health Care', 'Crossing the Quality
6 Chasm: A New Health System for the 21st Cen-
7 tury', and 'In the Nation's Compelling Interest: En-
8 suring Diversity in the Health Care Workforce', and
9 'The National Partnership for Action to End Health
10 Disparities', and other related reports by the Insti-
11 tute of Medicine. This plan shall be publicly dis-
12 closed for review and comment and the final plan
13 shall address any comments or concerns that are re-
14 ceived by the Office.

15 ''(2) Investigative and enforcement actions
16 against intentional discrimination and policies and
17 practices that have a disparate impact on minorities.

18 ''(3) The review of racial, ethnic, and primary
19 language health data collected by Federal health
20 agencies to assess health care disparities related to
21 intentional discrimination and policies and practices
22 that have a disparate impact on minorities.

23 ''(4) Outreach and education activities relating
24 to compliance with title VI of the Civil Rights Act.

1 "(5) The provision of technical assistance for
2 health entities to facilitate compliance with title VI
3 of the Civil Rights Act.
4 "(6) Coordination and oversight of activities of
5 the civil rights compliance offices established under
6 section 3442.
7 "(7) Ensuring compliance with the 1997 Office
8 of Management and Budget Standards for Maintain-
9 ing, Collecting, and Presenting Federal Data on
10 Race, Ethnicity and the available language stand-
11 ards.
12 "(c) FUNDING AND STAFF.—The Secretary shall en-
13 sure the effectiveness of the Office of Health Disparities
14 by ensuring that the Office is provided with—
15 "(1) adequate funding to enable the Office to
16 carry out its duties under this section; and
17 "(2) staff with expertise in—
18 "(A) epidemiology;
19 "(B) statistics;
20 "(C) health quality assurance;
21 "(D) minority health and health dispari-
22 ties;
23 "(E) cultural and linguistic competency;
24 and
25 "(F) civil rights.

1 "(d) REPORT.—Not later than December 31, 2012,
2 and annually thereafter, the Secretary, in collaboration
3 with the Director of the Office for Civil Rights and the
4 Deputy Assistant Secretary for Minority Health, shall
5 submit a report to the Committee on Health, Education,
6 Labor, and Pensions of the Senate and the Committee on
7 Energy and Commerce of the House of Representatives
8 that includes—

9 "(1) the number of cases filed, broken down by
10 category;

11 "(2) the number of cases investigated and
12 closed by the office;

13 "(3) the outcomes of cases investigated;

14 "(4) the staffing levels of the office including
15 staff credentials;

16 "(5) the number of other lingering and emerg-
17 ing cases in which civil rights inequities can be dem-
18 onstrated; and

19 "(6) the number of cases remaining open and
20 an explanation for their open status.

21 "(e) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this section,
23 such sums as may be necessary for each of fiscal years
24 2012 through 2017.

"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 admin-

1 istered by an agency within the Department of
2 Health and Human Services including the establish-
3 ment of disparity reduction standards to encompass
4 disparities in health and health care related to race,
5 national origin, language, ethnicity, sex, age, dis-
6 ability, sexual orientation, and gender identity.

7 ''(2) The development and implementation of
8 program-specific guidelines that interpret and apply
9 Department of Health and Human Services guid-
10 ance under title VI of the Civil Rights Act of 1964
11 and section 1557 of the Patient Protection and Af-
12 fordable Care Act to each Federal health program
13 administered by the agency.

14 ''(3) The development of a disparity-reduction
15 impact analysis methodology that shall be applied to
16 every rule issued by the agency and published as
17 part of the formal rulemaking process under sections
18 555, 556, and 557 of title 5, United States Code.

19 ''(4) Oversight of data collection, analysis, and
20 publication requirements for all recipients of Federal
21 financial assistance under each Federal health pro-
22 gram administered by the agency, and compliance
23 with the 1997 Office of Management and Budget
24 Standards for Maintaining, Collecting, and Pre-

1 senting Federal Data on Race and Ethnicity and the
2 available language standards.
3 "(5) The conduct of publicly available studies
4 regarding discrimination within Federal health pro-
5 grams administered by the agency as well as dis-
6 parity reduction initiatives by recipients of Federal
7 financial assistance under Federal health programs.
8 "(6) Annual reports to the Committee on
9 Health, Education, Labor, and Pensions and the
10 Committee on Finance of the Senate and the Com-
11 mittee on Energy and Commerce and the Committee
12 on Ways and Means of the House of Representatives
13 on the progress in reducing disparities in health and
14 health care through the Federal programs adminis-
15 tered by the agency.
16 "(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS
17 IN THE DEPARTMENT OF JUSTICE.—
18 "(1) DEPARTMENT OF HEALTH AND HUMAN
19 SERVICES.—The Office for Civil Rights in the De-
20 partment of Health and Human Services shall pro-
21 vide standard-setting and compliance review inves-
22 tigation support services to the Civil Rights Compli-
23 ance Office for each agency.
24 "(2) DEPARTMENT OF JUSTICE.—The Office
25 for Civil Rights in the Department of Justice shall

1 continue to maintain the power to institute formal
2 proceedings when an agency Office for Civil Rights
3 determines that a recipient of Federal financial as-
4 sistance is not in compliance with the disparity re-
5 duction standards of the agency.

6 ''(e) DEFINITION.—In this section, the term 'Federal
7 health programs' mean programs—

8 ''(1) under the Social Security Act (42 U.S.C.
9 301 et seq.) that pay for health care and services;
10 and

11 ''(2) under this Act that provide Federal finan-
12 cial assistance for health care, biomedical research,
13 health services research, and programs designed to
14 improve the public's health.''.

15 **SEC. 904. UNITED STATES COMMISSION ON CIVIL RIGHTS.**

16 (a) COORDINATION WITHIN DEPARTMENT OF JUS-
17 TICE OF ACTIVITIES REGARDING HEALTH DISPARI-
18 TIES.—Section 3 of the Civil Rights Commission Act of
19 1983 (42 U.S.C. 1975a) is amended—

20 (1) in paragraph (1), by striking ''and'' at the
21 end;

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

24 (3) by adding at the end the following:

"(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).".

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 5 of the Civil Rights Commission Act of 1983 (42 U.S.C. 1975c) is amended by striking the first sentence and inserting the following: "For the purpose of carrying out this Act, there are authorized to be appropriated $30,000,000 for fiscal year 2012, and such sums as may be necessary for each of the fiscal years 2013 through 2017.".

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 (1) IN GENERAL.—The Comptroller General of
2 the United States shall conduct a study on the racial
3 and ethnic diversity among the following groups:
4 (A) All applicants for grants, contracts,
5 and cooperative agreements awarded by the Na-
6 tional Institutes of Health during the period be-
7 ginning January 1, 1990, and ending December
8 31, 2011.
9 (B) All recipients of such grants, con-
10 tracts, and cooperative agreements.
11 (C) All members of the peer review panels
12 of such applicants and recipients, respectively.
13 (2) REPORT.—Not later than six months after
14 the date of the enactment of this Act, the Comp-
15 troller General shall complete the study under para-
16 graph (1) and submit to Congress a report con-
17 taining the results of such study.
18 (b) NIH REPORT ON CERTAIN AUTHORITY OF NA-
19 TIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH
20 DISPARITIES.—Not later than six months after the date
21 of the enactment of this Act, and biennially thereafter, the
22 Director of the National Institutes of Health, in collabora-
23 tion with the Director of the National Institute on Minor-
24 ity Health and Health Disparities, shall submit to Con-
25 gress a report that details and evaluates—

(1) 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 environmental 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

1 definitions of the key environmental justice concepts
2 (such as ''low-income'', ''minority'', and ''disproportionately impacted'') and instructions for implementation of those concepts.
5 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).
18 (d) FEDERAL ACTION PLAN FOR SAVING LIVES, PROTECTING PEOPLE AND THEIR FAMILIES FROM RADON.—
21 (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 infor-

mation 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 Administrator of the Environmental Protection Agency and the Director of the National Institute of Environmental Health Sciences.

(2) ELIGIBLE ENTITY.—The term ''eligible entity'' means a State or local community that—

(A) bears a disproportionate burden of exposure to environmental health hazards;

(B) 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

1 various organizations within public health,
2 planning, development, and environmental
3 services and shall include stakeholders
4 from vulnerable groups such as children,
5 the elderly, disabled, and minority ethnic
6 groups that are often not actively involved
7 in democratic or decisionmaking processes.
8 (iii) DUTIES.—A PPC shall—
9 (I) identify key stakeholders and
10 engage and coordinate potential part-
11 ners in the planning process;
12 (II) establish a formal advisory
13 group to plan for the establishment of
14 services;
15 (III) conduct an in-depth review
16 of the nature and extent of the need
17 for an environmental health assess-
18 ment, including a local epidemiological
19 profile, an evaluation of the service
20 provider capacity of the community,
21 and a profile of any target popu-
22 lations; and
23 (IV) define the components of
24 care and form essential programmatic

1 linkages with related providers in the
2 community.
3 (C) ENVIRONMENTAL HEALTH ASSESS-
4 MENT.—
5 (i) IN GENERAL.—A PPC shall carry
6 out an environmental health assessment to
7 identify environmental health concerns.
8 (ii) ASSESSMENT PROCESS.—The
9 PPC shall—
10 (I) define the goals of the assess-
11 ment;
12 (II) generate the environmental
13 health issue list;
14 (III) analyze issues with a sys-
15 tems framework;
16 (IV) develop appropriate commu-
17 nity environmental health indicators;
18 (V) rank the environmental
19 health issues;
20 (VI) set priorities for action;
21 (VII) develop an action plan;
22 (VIII) implement the plan; and
23 (IX) evaluate progress and plan-
24 ning for the future.

(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.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) $25,000,000 for fiscal year 2012; and

(2) such sums as may be necessary for fiscal years 2013 through 2016.

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 transportation 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 benefit 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 en-

vironment 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 public 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 im-

1 pacted or will negatively impact the environment and
2 public health:
3 (A) CLEAN WATER.—
4 (i) On May 9, 2002, the Environ-
5 mental Protection Agency (EPA) and the
6 Army Corps of Engineers put forth a final
7 rule that reconciled regulations imple-
8 menting section 404 of the Federal Water
9 Pollution Control Act by redefining the
10 term ''fill material'' and amending the def-
11 inition of the term ''discharge of fill mate-
12 rial'', reversing a 25-year-old regulation.
13 The new rule fails to restrict the dumping
14 of hardrock mining waste, construction de-
15 bris, and other industrial wastes into riv-
16 ers, streams, lakes, and wetlands. The rule
17 further allows destructive mountaintop re-
18 moval coal mining companies to dump
19 waste into streams and lakes, polluting the
20 surrounding natural habitat and poisoning
21 plants and animals that depend on those
22 water sources.
23 (ii) On February 12, 2003, the Envi-
24 ronmental Protection Agency published the
25 rule ''National Pollutant Discharge Elimi-

nation 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. Enviromental 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 defini-

tion 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 wild-

life 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 scientif-

ically 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. Enviromental 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.

1 "(iii) LOCATIONS.—On an annual
2 basis, the national fund manager shall col-
3 lect data and publish maps that show the
4 location of underserved areas.
5 "(4) PRIORITY PROJECTS.—
6 "(A) IN GENERAL.—Priority shall be given
7 to projects that—
8 "(i) are located in severely distressed
9 low-income communities, as defined by the
10 Community Development Financial Insti-
11 tutions Fund of the Department of the
12 Treasury; and
13 "(ii) include 1 or more of the fol-
14 lowing characteristics:
15 "(I) The project will create or re-
16 tain quality jobs in the community, as
17 determined in accordance with sub-
18 paragraph (B).
19 "(II) The project has community
20 support in terms of store quality, af-
21 fordability, site location, and coordina-
22 tion with local community plans or
23 other programs promoting community
24 and economic development.

"(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 estab-

lished 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.

1 "(d) DUTIES OF THE SECRETARY.—
2 "(1) IN GENERAL.—The Secretary shall—
3 "(A) designate a national fund manager to
4 manage national funds;
5 "(B) oversee the Initiative nationally;
6 "(C) work closely with the designated na-
7 tional fund manager—
8 "(i) to ensure that funds are used ap-
9 propriately and in the most effective man-
10 ner practicable; and
11 "(ii) to develop the program strategy
12 into a detailed work plan, program, and
13 operating budget;
14 "(D) review and approve the operating
15 budget for the national fund manager to ensure
16 that the administrative costs are—
17 "(i) reasonable (not more than 5 per-
18 cent of the total budget);
19 "(ii) connected to the costs of oper-
20 ations; and
21 "(iii) reflect efficient operations by the
22 national fund manager; and
23 "(E) make available to the public an an-
24 nual report, using data obtained from the De-
25 partment of Agriculture, the Department of

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 improving 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 se-

lected 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

1 administrative costs exceed 10 percent
2 of the Federal funds allocated.
3 "(C) USE OF THE NATIONAL FUNDS BY
4 THE NATIONAL FUND MANAGER.—The national
5 fund manager shall use national funds de-
6 scribed in subparagraph (A)(ii) to undertake fi-
7 nancing and other activities to enhance and
8 maximize the effectiveness of the Initiative, as
9 determined by the agreement with the Sec-
10 retary, including—
11 "(i) attracting other forms of financial
12 assistance to match or leverage the na-
13 tional funds;
14 "(ii) awarding national funds to part-
15 nerships in accordance with paragraph (3);
16 "(iii) creating and managing pools of
17 grant or loan capital that blend or leverage
18 national funds with other forms of finan-
19 cial assistance, including capital in the
20 form of tax credits under section 45D of
21 the Internal Revenue Code of 1986, for the
22 benefit of partnerships;
23 "(iv) creating and managing pools of
24 grant or loan capital that blend or leverage
25 the national funds with other forms of fi-

nancial 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 allocation 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 ac-

cordance 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.

"(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary to carry out this section $500,000,000, to remain available until expended.".

(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.

○