I

113TH CONGRESS
2D SESSION

H. R. 5294

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

IN THE HOUSE OF REPRESENTATIVES

JULY 30, 2014

Ms. ROYBAL-ALLARD (for herself, Ms. LEE of California, Mrs. CHRISTENSEN, Ms. BORDALLO, Ms. BROWN of Florida, Mr. BUTTERFIELD, Ms. CHU, Ms. CLARKE of New York, Mr. CÁRDENAS, Mr. CARSON of Indiana, Ms. CASTOR of Florida, Mr. CONYERS, Mr. CROWLEY, Mr. CUMMINGS, Mr. DANNY K. DAVIS of Illinois, Ms. DEGETTE, Ms. DELAURO, Ms. EDWARDS, Mr. ELLISON, Mr. FALEOMAVAEGA, Mr. FARR, Mr. FATTAH, Ms. FUDGE, Mr. GARCIA, Mr. GRIJALVA, Ms. MICHELLE LUJAN GRISHAM of New Mexico, Mr. GUTIÉRREZ, Ms. HAHN, Mr. HINOJOSA, Mr. HONDA, Ms. JACKSON LEE, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. JOHNSON of Georgia, Mr. LEWIS, Ms. LOFGREN, Mrs. LOWEY, Mr. BEN RAY LUJÁN of New Mexico, Ms. MATSUI, Ms. MCCOLLUM, Mr. MCGOVERN, Mrs. NEGRETE MCLEOD, Mr. MEEKS, Ms. MENG, Mrs. NAPOLITANO, Ms. NORTON, Mr. PASTOR of Arizona, Mr. PIERLUISI, Mr. RANGEL, Mr. RICHMOND, Mr. RUSH, Mr. SABLAN, Ms. LINDA T. SÁNCHEZ of California, Ms. LORETTA SANCHEZ of California, Ms. SCHAKOWSKY, Mr. SCHIFF, Mr. DAVID SCOTT of Georgia, Mr. SCOTT of Virginia, Mr. SERRANO, Mr. SIRES, Ms. SLAUGHTER, Mr. TAKANO, Mr. TONKO, Mr. VARGAS, Mr. VELA, Ms. VELÁZQUEZ, and Ms. WATERS) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Agriculture, Education and the Workforce, the Budget, Veterans' Affairs, Armed Services, 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.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Equity and Accountability Act of 2014''.

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

Subtitle E—HIV/AIDS

Subtitle F—Diabetes

Subtitle G—Lung Disease

Subtitle H—Osteoarthritis and Musculoskeletal Diseases

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, Healthy People 2020, and the National Health Care Quality Strategy, as well as critical resources such as the 2012 National Healthcare Quality and Disparities Reports, these comprehensive plans will work to increase the number of Americans who are healthy at every stage of life.

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

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

TITLE I—DATA COLLECTION AND REPORTING

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

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

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

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

"SEC. 3431. HEALTH DISPARITY DATA.

''(a) REQUIREMENTS.—

''(1) IN GENERAL.—Each health-related program operated by or that receives funding or 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 race and ethnicity categories outlined by the standards developed under section 3101;

"(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; or

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

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

disclosure of any such data by an individual pursuant to this title shall be strictly voluntary.

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

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

cioeconomic status data at the Federal, State, territorial, tribal, and local levels, including data to be collected under subsection (a), and to ensure that data collection activities carried out under this section are in compliance with the standards developed under section 3101. The Data Council of the Department of Health and Human Services, in consultation with the National Committee on Vital Health Statistics, the Office of Minority Health, Office on Women's Health, and other appropriate public and private entities, shall make recommendations to the Secretary concerning the development, implementation, and revision of the national plan. Such plan shall include recommendations on how to—

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

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

''(3) ensure that future patient record systems have data code sets for racial, ethnic, primary language, sexual orientation, disability status, gender identity, and socioeconomic status identifiers and that such identifiers can be retrieved from clinical records, including records transmitted electronically;

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

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

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

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

''(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 if such groups can be aggregated into the race and ethnicity categories outlined by the standards developed under section 3101;

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

''(D) develop educational programs to inform health insurance issuers, health plans,

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

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

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

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

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

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

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

''(g) PRIMARY LANGUAGE.—References in this section—

''(1) to primary language data, include spoken and written primary language data; and

''(2) to primary language data collection activities, include identifying, collecting, storing, tracking, and analyzing primary language data and information on the methods used to meet the language access needs of limited-English-proficient individuals.

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

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

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

''(i) 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 2015 through 2020.

"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 2014 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 con-

sortia 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 Commis-

sioner 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 race and ethnicity categories outlined by the standards developed under section 3101 of the Public Health Service Act; 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 2015 through 2020.''.

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 ''2020'';

(2) in paragraph (2), in the first sentence, by striking ''2003'' and inserting ''2020''; and

(3) in paragraph (3), by striking ''2002'' and inserting ''2020''.

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 2015 through 2020.''.

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 PRIMARY LANGUAGE 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 primary language 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, 2015, 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 primary language 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. 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. 112. 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 505E the following:

''SEC. 505F. 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:

''(cc) 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 505F.''.

(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 505F''.

SEC. 113. IMPROVING HEALTH DATA REGARDING NATIVE HAWAIIANS AND OTHER PACIFIC ISLANDERS.

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

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

''(a) 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 Islands, the Republic of Palau, or any other Pacific island.

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

''(b) NATIONAL STRATEGY.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the National Center for Health Statistics (referred to in this section as 'NCHS') of the Centers for Disease Control and Prevention, and other agencies within the Department of Health and Human Services as the Secretary determines appropriate, shall develop and implement an ongoing and sustainable national strategy for identifying and evaluating the health status and health care needs of NHOPI populations living in the continental United States, Hawaii, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam,

the Republic of Palau, and the Republic of the Marshall Islands.

''(2) CONSULTATION.—In developing and implementing a national strategy, as described in paragraph (1), not later than 180 days after the date of enactment of the Health Equity and Accountability Act of 2014, the Secretary—

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

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

''(c) PRELIMINARY HEALTH SURVEY.—

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

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

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

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

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

''(4) TIMEFRAME.—The survey required under this subsection shall be completed not later than 18 months after the date of enactment of the Health Equity and Accountability Act of 2014.

''(d) PROGRESS REPORT.—Not later than 2 years after the date of enactment of the Health Equity and Accountability Act of 2014, the Secretary shall submit to Congress a progress report, which shall include the national strategy described in subsection (b)(1).

''(e) STUDY AND REPORT BY THE IOM.—

''(1) IN GENERAL.—The Secretary shall enter 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 2014, 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 2015 through 2020.''.

SEC. 114. CLARIFICATION OF SIMPLIFIED ADMINISTRATIVE REPORTING REQUIREMENT.

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

''(5) SIMPLIFIED ADMINISTRATIVE REPORTING REQUIREMENT.—The administrative notification requirement under section 421(e)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1631(e)(2)) shall be satisfied by the submission by an agency of a report on the aggregate number of exceptions granted under such section by such agency in each year.''.

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 language 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 health care 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 language 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—

''(A) comprehends the source language and can communicate comprehensively in the target language to convey the meaning intended in the source language; and

''(B) 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 capture, 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—

''(A) comprehends the source language and can write or sign comprehensively in the target language to convey the meaning intended in the source language; and

''(B) 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 capture, to the greatest possible extent, all nuances intended in the source document.

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

''(A) the term 'cultural' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups, including lesbian, gay, bisexual, transgender, and intersex individuals, and individuals with physical and mental disabilities; and

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

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

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

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

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

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

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

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

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

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

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

''(18) MINORITY.—

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

''(B) POPULATIONS.—The term 'minority', with respect to populations, refers to racial and ethnic minority groups.

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

''(20) 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.

''(21) ONSITE INTERPRETATION.—The term 'onsite interpretation' means a method of inter-

preting 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.

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

''(23) SIGHT TRANSLATION.—The term 'sight translation' means the transmission of a written message in one language into a spoken or signed message in another language, or an alternative format in English or another language.

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

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

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

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

''(27) VIDEO INTERPRETATION.—The term 'video interpretation' means a method of interpreting/interpretation for which the interpreter is not in the physical presence of the provider of health care or related services and the limited-English-proficient recipient of such services but is connected via a video hook-up that includes both audio and video transmission.

''(28) VITAL DOCUMENT.—The term 'vital document' includes but is not limited to applications for government programs that provide health care services, medical or financial consent forms, financial assistance documents, letters containing important information regarding patient instructions (such as prescriptions, referrals to other providers, and discharge plans) and participation in a program (such as a Medicaid managed care program), notices per-

taining to the reduction, denial, or termination of services or benefits, notices of the right to appeal such actions, and notices advising limited-English-proficient individuals and individuals with communication disabilities of the availability of free language services, alternative formats, and other outreach materials.

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

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

''(1) to improve Federal agency performance regarding access to federally conducted and federally assisted programs and activities for individuals who are limited in their English proficiency;

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

''(3) to require each Federal agency to ensure that recipients of Federal financial assistance provide cultural competence and meaningful access to

their limited-English-proficient applicants and beneficiaries;

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

''(5) to ensure compliance with title VI of the Civil Rights Act of 1964 and that health care providers and organizations do not discriminate in the provision of services.

''(b) FEDERALLY CONDUCTED PROGRAMS AND ACTIVITIES.—

''(1) IN GENERAL.—Not later than 120 days after the date of enactment of this title, each Federal agency that carries out health-care-related activities shall prepare a plan to improve access cultural competence to the federally conducted, health-care-related programs and activities of the agency by limited-English-proficient individuals. Not later than one year after the date of enactment of this title,

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

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

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

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

''(C) the steps the agency will take for its federally conducted programs and activities to improve cultural competence to provide a range of language assistance options, notice to limited-English-proficient individuals of the right to competent language services, periodic training of staff, monitoring and quality assessment of the language services and, in appropriate circumstances, the translation of written materials;

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

"(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;

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

"(G) the resources the agency will provide to ensure that family, particularly minor children, and friends are not used to provide interpretation services, except—

"(i) in the case of a medical emergency where delay directly associated with

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

"(ii) on request of the patient, who has been informed in his or her preferred language of the availability of free interpretation services, if the health care services provider has determined that the family or friend can provide competent interpreter services as defined in section 3400.

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

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

"(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 fi-

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

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

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

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

''(d) CONSULTATIONS.—

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

''(a) APPLICABILITY.—This section applies to any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or any program or activity that is administered by an executive agency or any entity established under title I of the Patient Protection and Affordable Care Act (or amendments made thereby), as such programs, activities, agencies, and entities are described in section 1557(a) of the Patient Protection and Affordable Care Act.

''(b) STANDARDS.—The programs, activities, agencies, and entities described in subsection (a) shall—

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

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

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

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

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

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

''(B) except on request of the patient, who has been informed in his or her preferred language of the availability of free interpretation services if the health care services provider has determined that the family or friend can provide competent interpreter services as defined in section 3400;

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

''(A) easily understood patient-related materials, including print and multimedia materials;

''(B) information or notices about termination of benefits; and

''(C) signage;

''(7) develop and implement clear goals, policies, operational plans, and management, accountability, and oversight mechanisms to provide culturally and linguistically appropriate services and infuse them throughout the organization's planning and operations;

''(8) conduct initial and ongoing organizational assessments of culturally and linguistically appropriate services-related activities and integrate valid linguistic, competence-related National Standards for Culturally and Linguistically Appropriate Services (CLAS) measures into the internal audits, performance improvement programs, patient satisfaction assessments, continuous quality improvement

activities, and outcomes-based evaluations of the organization and develop ways to standardize the assessments;

''(9) ensure that, consistent with the privacy protections provided for under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, data on an individual required to be collected pursuant to section 3101, including the individual's alternative format preferences and policy modification needs, are—

''(A) collected in health records;

''(B) integrated into the organization's management information systems; and

''(C) periodically updated;

''(10) maintain a current demographic, cultural, and epidemiological profile of the community, conduct regular assessments of community health assets and needs, and use the results 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 com-

munity and patient involvement in designing, implementing, and evaluating policies and practices to ensure culturally and linguistically appropriate service-related activities;

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

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

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

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

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

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

''(1) INTERPRETATION SERVICES.—The Center shall provide resources via the Internet to identify and link health care providers to competent interpreter and translation services.

''(2) TRANSLATION OF WRITTEN MATERIAL.—

''(A) The Center shall provide, directly or through contract, vital documents from competent translation services for providers of health care and health-care-related services at no cost to such providers. Materials may be submitted for translation into non-English languages. Translation services shall be provided in a timely and reasonable manner. The quality of such translation services shall be monitored and reported publicly.

''(B) For each form developed or revised by the Secretary that will be used by LEP individuals in health care or health-care-related settings, the Center shall translate the form, at a minimum, into the top 15 non-English lan-

guages in the United States according to the most recent data from the American Community Survey or its replacement. The translation must be completed within 45 days of the Secretary receiving final approval of the form from the Office of Management and Budget.

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

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

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

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

''(4) HEALTH INFORMATION CLEARINGHOUSE.—

''(A) IN GENERAL.—The Center shall develop and maintain an information clearinghouse to facilitate the provision of language services by providers of health care and health-care-related services to reduce medical errors,

improve medical outcomes, to improve cultural competence, reduce health care costs caused by miscommunication with individuals with limited-English proficiency, and reduce or eliminate the duplication of effort to translate materials. The clearinghouse shall make such information available on the Internet and in print. Such information shall include the information described in the succeeding provisions of this paragraph.

''(B) DOCUMENT TEMPLATES.—The Center shall collect and evaluate for accuracy, develop, and make available templates for standard documents that are necessary for patients and consumers to access and make educated decisions about their health care, including the following:

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

''(I) intake forms;

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

''(III) forms informing patient of HIPAA compliance and consent; and

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

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

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

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

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

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

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

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

"(iv) facilitate access to these documents;

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

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

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

"(E) CULTURAL AND LINGUISTIC COMPETENCE MATERIALS.—The Center shall provide information relating to culturally and linguistically competent health care for minority populations residing in the United States to all health care providers and health-care-related

services at no cost. Such information shall include—

"(i) tenets of culturally and linguistically competent care;

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

"(iii) cultural and linguistic competence training tools;

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

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

"(F) INFORMATION ABOUT PROGRESS.—The Center shall regularly collect and make publicly available information about the progress of entities receiving grants under section 3404 regarding successful innovations in implementing the obligations under this subsection and provide public notice in the entities'

communities about the availability of this information.

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

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

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

''(e) 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 2015 through 2019.

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

''(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall award grants to eligible entities to enable such entities to design, implement, and evaluate innovative, cost-effective programs to improve cultural competence and language access in health care for individuals with limited-English proficiency. The Director of the Agency for Healthcare Research and Quality shall coordinate with, and ensure the participation of, other agencies including the Health Resources and Services Administration, the Center on Minority Health and Health Disparities at the National Institutes of Health, and the Office of Minority Health, regarding the design and evaluation of the grants program.

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

''(1) be—

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

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

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

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

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

''(F) a public hospital;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(12) develop, implement, and evaluate models of improving cultural competence; and

''(13) ensure that, consistent with the privacy protections provided for under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) and any applicable State privacy laws, data on the individual patient or recipi-

ent's race, ethnicity, and primary language are collected (and periodically updated) in health records and integrated into the organization's information management systems or any similar system used to store and retrieve data.

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

''(e) EVALUATION.—

''(1) BY GRANTEES.—An entity that receives a grant under this section shall submit to the Secretary an evaluation that describes, in the manner and to the extent required by the Secretary, the activities carried out with funds received under the grant, and how such activities improved access to health and health-care-related services and the quality of health care for individuals with limited-English proficiency. Such evaluation shall be collected and disseminated through the Robert T. Matsui Center for Cultural and Linguistic Competence in Health Care established under section 3403. The Director of the Agency for Healthcare Research and Quality shall notify grantees of the availability of technical

assistance for the evaluation and provide such assistance upon request.

''(2) BY SECRETARY.—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 2015 through 2019.

''SEC. 3405. RESEARCH ON CULTURAL AND LANGUAGE COMPETENCE.

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

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

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

''(1) To identify the barriers to mental and behavioral services that are faced by LEP individuals.

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

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

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

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

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

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

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

''(6) To evaluate the most effective ways in which the 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 flexi-

bility 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 2015 through 2019.".

SEC. 203. PILOT PROGRAM FOR IMPROVEMENT AND DEVELOPMENT OF STATE MEDICAL INTERPRETING SERVICES.

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

(b) GRANT PERIOD.—A grant awarded under this section is authorized for a period of three fiscal years beginning on October 1, 2014.

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

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

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

(3) that has a high growth rate of the population of LEP individuals, as determined by the Secretary; and

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

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

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

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

(A) a statewide health care information technology system that is designed to achieve

efficiencies and economies of scale with respect to onsite interpreter services provided to health care providers in the State participating in the State plan under Medicaid; and

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

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

(ii) procuring and scheduling interpreter services for LEP individuals seeking to enroll in the State plan under Medicaid;

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

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

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

(e) APPLICATION.—To receive a grant under this section, a State shall submit an application at such time and

containing such information as the Secretary may require, which shall include the following:

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

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

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

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

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

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

(f) DEFINITIONS.—In this section:

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

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

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

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

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

(g) FUNDING.—

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

(2) AVAILABILITY OF FUNDS.—The funds authorized by paragraph (1) shall be available without fiscal year limitation.

(3) INCREASED FEDERAL FINANCIAL PARTICIPATION.—Section 1903(a)(2)(E) of the Social Security Act (42 U.S.C. 1396b(a)(2)(E)), as amended by section 205(d)(1) of this Act, is further amended by inserting ''(or, in the case of a State receiving a grant under section 203 of the Health Equity and Accountability Act of 2014, 100 percent for each

quarter occurring during the grant period)'' after ''90 percent''.

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

SEC. 204. TRAINING TOMORROW'S DOCTORS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE: GRADUATE MEDICAL EDUCATION.

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

''(L) TREATMENT OF CULTURALLY COMPETENCY TRAINING.—In determining a hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program for education and training in cultural competency and linguistically appropriate service delivery shall be counted toward the determination of full-time equivalency.''.

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

1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

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

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

SEC. 205. FEDERAL REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES UNDER THE MEDICARE, MEDICAID, AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS.

(a) LANGUAGE ACCESS GRANTS FOR MEDICARE PROVIDERS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services, acting through the Centers for Medicare & Medicaid Services and in consultation with the Center for Medicare and Medicaid Innovation, shall establish a demonstration program under

which the Secretary shall award grants to eligible Medicare service providers to improve communication between such providers and limited-English-proficient Medicare beneficiaries, including beneficiaries who live in diverse and underserved communities.

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

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

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

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

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

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

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

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

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

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

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

(D) REPORTING.—In the case of a grantee that received a grant under this subsection in a previous year, such grantee is only eligible for continued payments under a grant under this

subsection if the grantee met the reporting requirements under paragraph (9) for such year. If a grantee fails to meet the requirement of such paragraph for the first year of a grant, the Secretary may terminate the grant and solicit applications from new grantees to participate in the demonstration program.

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

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

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

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

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

(4) CONSIDERATIONS IN AWARDING GRANTS.—

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

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

(ii) The grantees serve Medicare beneficiaries who speak different languages,

and who, as a population, have differing needs for language services.

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

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

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

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

(i) a community organization; or

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

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

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

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

(i) interpreter and translation services that—

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

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

(bb) if the grantee operates in a State that does not have statewide health care interpreter standards, utilizes competent interpreters who follow the National Council on Interpreting in

Health Care's Code of Ethics and Standards of Practice; and

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

(aa) onsite interpretation;

(bb) telephonic interpretation; or

(cc) video interpretation; and

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

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

(i) in the case of a Medicare beneficiary who is limited-English-proficient if—

(I) such beneficiary has been informed, in the beneficiary's primary language, of the availability of free interpreter and translation services and the beneficiary instead requests that a

family member, friend, or other person provide such services; and

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

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

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) MEDICARE ADVANTAGE ORGANIZATIONS AND PDP SPONSORS.—If a grantee is a Medicare Advantage organization offering a Medicare Advantage plan under part C of title XVIII of the Social Security Act or a PDP sponsor offering a prescription drug plan under part D of such title, such entity must provide

at least 50 percent of the grant funds that the entity receives under this subsection directly to the entity's network providers (including all health providers and pharmacists) for the purpose of providing support for such providers to provide competent language services to Medicare beneficiaries who are 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 Bu-

reau 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, as a condition of receiving a grant under this subsection—

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

(B) ensure the linguistic competence of bilingual providers;

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

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

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

(F) ensure that—

(i) primary language data are collected for recipients of language services and such data are consistent with standards developed under title XXXIV of the

Public Health Service Act, as added by section 202 of this Act, to the extent such standards are available upon the initiation of the demonstration program; and

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

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

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

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

(B) The primary languages of those Medicare beneficiaries.

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

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

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

(F) The costs of providing competent language services.

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

(10) EVALUATION AND REPORT TO CONGRESS.—Not later than 1 year after the completion of a 3-year grant under this subsection, the Secretary shall conduct an evaluation of the demonstration program under this subsection and shall submit to the Congress a report that includes the following:

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

(B) The effect of delivering language services on—

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

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

(iii) patient satisfaction;

(iv) health outcomes; and

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

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

other category as determined by the Secretary to ensure the provision of high-quality interpretation, translation, or other language services to Medicare beneficiaries if such services are expanded pursuant to subsection (c) of section 1907 of this Act.

(D) Recommendations, if any, regarding the extension of such project to the entire Medicare program, subject to the provisions 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 under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), $16,000,000 for each fiscal year of the demonstration program.

(b) LANGUAGE SERVICES UNDER THE MEDICARE PROGRAM.—

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

(A) in subsection (aa)(1)—

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

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

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

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

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

''Language Services and Related Terms

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

''(2) INTERPRETER SERVICES DEFINED.—For 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 language into a written message in another language that retains the intended meaning of the original message.

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

(2) COVERAGE.—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 paragraph (1) of section 1861(iii)) furnished by an

interpreter (as defined in paragraph (3) of such section) or translator.''.

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

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

(B) by redesignating paragraph (9) as paragraph (10); and

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

''(9) in the case of language services described in section 1861(iii)(1), 100 percent of the reasonable charges for such services, as determined in consultation with the Medicare Payment Advisory Commission; and''.

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

(c) MEDICARE PARTS C AND D.—

(1) IN GENERAL.—Medicare Advantage plans under part C of the Social Security Act and pre-

scription drug plans under part D of such Act shall comply with title VI of the Civil Rights Act of 1964 and section 1557 of the Patient Protection and Affordable Care Act to provide effective language services to enrollees of such plans.

(2) MEDICARE ADVANTAGE PLANS AND PRESCRIPTION DRUG PLANS REPORTING REQUIREMENT.—Section 1857(e) of the Social Security Act (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

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

''(A) The collection of data in a manner that meets the requirements of title I of the

Health Equity and Accountability Act of 2014, regarding the enrollee population.

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

''(C) Evaluation of the health plan's language services programs and services with respect to the plan's enrollee population, such as through analysis of complaints or satisfaction survey results.

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

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

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

(1) PAYMENTS TO STATES.—Section 1903(a)(2)(E) of the Social Security Act (42 U.S.C. 1396b(a)(2)(E)) 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) STATE PLAN REQUIREMENTS.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)) is amended by striking ''and (28)'' and inserting ''(28), and (29)''.

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

(A) in paragraph (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)(1), provided in a timely manner to limited-English-proficient individuals who need such services; and''.

(4) USE OF DEDUCTIONS AND COST SHARING.—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) CHIP COVERAGE REQUIREMENTS.—Section 2103 of the Social Security Act (42 U.S.C. 1397cc) is amended—

(A) in subsection (a), in the matter before paragraph (1), by striking ''and (7)'' and inserting ''(7), and (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)(1), 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) DEFINITION OF CHILD HEALTH ASSISTANCE.—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) STATE DATA COLLECTION.—Pursuant to the reporting requirement described in section 2107(b)(1) of the Social Security Act (42 U.S.C. 1397gg(b)(1)), the Secretary of Health and Human Services shall require that States collect data on—

(A) the primary language of individuals receiving child health assistance under title XXI of the Social Security Act; and

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

(8) CHIP PAYMENTS TO STATES.—Section 2105 of the Social Security Act (42 U.S.C. 1397ee(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 eligible entity's eligible costs 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 So-

cial Security Act, nor shall payments under such section be considered when determining uncompensated costs associated with the provision of language services.

(2) METHODOLOGY FOR PAYMENT OF CLAIMS.—

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

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

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

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

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

(5) REPORTING REQUIREMENTS.—

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

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

(6) DEFINITIONS.—In this subsection:

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

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

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

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

(i) is a Medicaid provider that is—

(I) a physician;

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

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

(ii) 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

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

(C) LANGUAGE SERVICES.—The term ''language services'' has the meaning given such term in section 1861(iii)(1) of the Social Security Act.

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

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided and subject to paragraph (2), the amendments made by this section shall take effect on January 1, 2013.

(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 206. INCREASING UNDERSTANDING OF AND IMPROVING HEALTH LITERACY.

(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and the Administrator of the Health Resources and Services Administration, in consultation with the Director

of the National Institute on Minority Health and Health Disparities and the Office of Minority Health, shall award grants to eligible entities to improve health care for patient populations that have low functional health literacy.

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

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

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

(c) USE OF FUNDS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

(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 2015 through 2019.

SEC. 207. ASSURANCES FOR RECEIVING FEDERAL FUNDS.

(a) IN GENERAL.—Any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, and any program or activity that is administered by an executive agency or any entity established under title I of the Patient Protection and Affordable Care Act (or amendments made thereby), as such programs, activities, agencies, and entities are described in section 1557(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18116), 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 lim-

ited-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, as defined in section 3400 of the Public Health Service Act.

(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 or her without charge, or of using his or 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.

(c) RULE OF CONSTRUCTION.—Subsection (b)(2) shall not be construed to mean that emergency rooms or

similar entities that regularly provide health care services in medical emergencies are exempt from legal or regulatory requirements related to competent interpreter services.

SEC. 208. 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 2015 through 2019.

SEC. 209. 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, 2015.

(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 2015 through 2018 $250,000,000 to carry out this section.

SEC. 210. 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. 211. 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.''.

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

tion 147.136(e) of title 45, Code of Federal Regulations, respectively, to require group health plans and health insurance issuers offering group or individual health insurance coverage to which such sections apply—

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

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

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

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

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

Exchange under title I of the Patient Protection and Affordable Care Act;

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

(3) require the Federal and State call centers established pursuant to section 1311(d)(4)(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(d)(4)(b)) to submit an annual report documenting the number of language assistance requests, the types of languages requested, the range and average wait time for a consumer to speak with an interpreter, and any steps the call center and language line have taken to actively address some of the consumer complaints.

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

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. NATIONAL WORKING GROUP ON WORKFORCE DIVERSITY.

''(a) IN GENERAL.—The Secretary, acting through the Bureau of Health Workforce 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 of the Department of Health and Human Services.

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

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

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

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

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

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

''(J) The Indian Health Service.

''(K) Minority-serving academic institutions.

''(L) Consumer organizations.

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

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

''(O) Health workforce accreditation entities.

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

''(Q) Local and State health departments.

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

for health profession schools pursuant to subsection (c)(8).

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

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

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

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

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

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

''(4) Draft a national strategic work plan for health workforce diversity, including recommendations for public and private sector initiatives.

''(5) Develop a framework and methods for the evaluation of current and future health workforce diversity initiatives.

''(6) Develop recommended standards for workforce diversity that could be applicable to all health professions programs and programs funded under this Act.

''(7) Develop guidelines to train health professionals to care for a diverse population.

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

''(9) Other activities determined appropriate by the Secretary.

''(d) ANNUAL REPORT.—Not later than 1 year after the establishment of the working group under subsection (a), and annually thereafter, the working group shall prepare and make available to the general public for comment, an annual report on the activities of the working group. Such report shall include the recommendations of the working group for improving health workforce diversity.

''(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 2015 through 2020.

"SEC. 3412. TECHNICAL CLEARINGHOUSE FOR HEALTH WORKFORCE DIVERSITY.

''(a) IN GENERAL.—The Secretary, acting through the Deputy Assistant Secretary for Minority Health, and in collaboration with the Bureau of Health Workforce within the Health Resources and Services Administration, the National Institute on Minority Health and Health Disparities, shall establish a technical clearinghouse on health workforce diversity within the Office of Minority Health and coordinate current and future clearinghouses.

''(b) INFORMATION AND SERVICES.—The clearinghouse established under subsection (a) shall offer the following information and services:

''(1) Information on the importance of health workforce diversity.

''(2) Statistical information relating to underrepresented minority representation in health and allied health professions and occupations.

''(3) Model health workforce diversity practices and programs, including integrated models of care.

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

''(5) Retainment policies that promote completion of health profession degrees for underserved populations.

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

''(7) Foundation and other large organizational initiatives relating to health workforce diversity.

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

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2015 through 2020.

''SEC. 3413. SUPPORT FOR INSTITUTIONS COMMITTED TO WORKFORCE DIVERSITY.

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

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

''(1) be an educational institution or entity that historically produces or trains meaningful numbers of underrepresented minority health professionals, including—

''(A) historically Black colleges and universities;

''(B) Hispanic-serving health professions schools;

''(C) Hispanic-serving institutions;

''(D) tribal colleges and universities;

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

''(F) institutions that have programs to recruit and retain underrepresented minority health professionals, in which a significant number of the enrolled participants are underrepresented minorities;

''(G) health professional associations, which may include underrepresented minority health professional associations; and

''(H) institutions—

''(i) located in communities with predominantly underrepresented minority populations;

''(ii) with whom partnerships have been formed for the purpose of increasing workforce diversity; and

''(iii) in which at least 20 percent of the enrolled participants are underrepresented minorities; and

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

''(c) USE OF FUNDS.—Amounts received under a grant under subsection (a) shall be used to expand existing workforce diversity programs, implement new workforce diversity programs, or evaluate existing or new workforce diversity programs, including with respect to mental health care professions. Such programs shall enhance diversity by considering minority status as part of an individualized consideration of qualifications. Possible activities may include—

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

''(2) scholarship, fellowship, grant, loan repayment, and loan cancellation programs;

''(3) postbaccalaureate programs;

''(4) academic enrichment programs, particularly targeting those who would not be competitive for health professions schools;

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

''(6) mentoring programs;

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

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

''(9) leadership training.

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

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

''(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 2015 through 2020.

"SEC. 3414. CAREER DEVELOPMENT FOR SCIENTISTS AND RESEARCHERS.

"(a) IN GENERAL.—The Secretary, acting through the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, the Commissioner of Food and Drugs, the Director of the Agency for Healthcare Research and Quality, and the Administrator of the Health Resources and Services Administration, shall award grants that expand existing opportunities for scientists and researchers and promote the inclusion of underrepresented minorities in the health professions.

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

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

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

''(d) STUDENT LOAN REIMBURSEMENT.—The Secretary shall establish a student loan reimbursement program to provide student loan reimbursement assistance to researchers who focus on racial and ethnic disparities in health. The Secretary shall promulgate regulations to define the scope and procedures for the program under this subsection.

''(e) STUDENT LOAN CANCELLATION.—The Secretary shall establish a student loan cancellation program to provide student loan cancellation assistance to researchers who focus on racial and ethnic disparities in health. Students participating in the program shall make a minimum 5-year commitment to work at an accredited health profession school. The Secretary shall promulgate additional regulations to define the scope and procedures for the program under this subsection.

''(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 2015 through 2020.

"SEC. 3415. CAREER SUPPORT FOR NONRESEARCH HEALTH PROFESSIONALS.

"(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, the Administrator of the Substance Abuse and Mental Health Services Administration, the Administrator of the Health Resources and Services Administration, and the Administrator of the Centers for Medicare & Medicaid Services, shall establish a program to award grants to eligible individuals for career support in nonresearch-related health and wellness professions.

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

"(1) be a student in a health professions school, a graduate of such a school who is working in a health profession, an individual working in a health or wellness profession (including mental and behavioral health), or a faculty member of such a school; and

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

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

''(1) support the individual's health activities or projects that involve underserved communities, including racial and ethnic minority communities;

''(2) support health-related career advancement activities;

''(3) to pay, or as reimbursement for payments of, student loans or training or credentialing costs for individuals who are health professionals and are focused on health issues affecting underserved communities, including racial and ethnic minority communities; and

''(4) to establish and promote leadership training programs to decrease health disparities and to increase cultural competence with the goal of increasing diversity in leadership positions.

''(d) DEFINITION.—In this section, the term 'career in nonresearch-related health and wellness professions' means employment or intended employment in the field of public health, health policy, health management, health administration, medicine, nursing, pharmacy, psychology, social work, psychiatry, other mental and behavioral health, allied health, community health, social work, or

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

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2015 through 2020.

"SEC. 3416. RESEARCH ON THE EFFECT OF WORKFORCE DIVERSITY ON QUALITY.

''(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, in collaboration with the Deputy Assistant Secretary for Minority Health and the Director of the National Institute on Minority Health and Health Disparities, shall award grants to eligible entities to expand research on the link between health workforce diversity and quality health care.

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

''(1) be a clinical, public health, or health services research entity or other entity determined appropriate by the Director; and

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

''(c) USE OF FUNDS.—Amounts received under a grant awarded under subsection (a) shall be used to sup-

port research that investigates the effect of health workforce diversity on—

"(1) language access;

"(2) cultural competence;

"(3) patient satisfaction;

"(4) timeliness of care;

"(5) safety of care;

"(6) effectiveness of care;

"(7) efficiency of care;

"(8) patient outcomes;

"(9) community engagement;

"(10) resource allocation;

"(11) organizational structure;

"(12) compliance of care; or

"(13) other topics determined appropriate by the Director.

"(d) PRIORITY.—In awarding grants under subsection (a), the Director shall give individualized consideration to all relevant aspects of the applicant's background. Consideration of prior research experience involving the health of underserved communities shall be such a factor.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2015 through 2020.

"SEC. 3417. HEALTH DISPARITIES EDUCATION PROGRAM.

''(a) ESTABLISHMENT.—The Secretary, acting through the National Institute on Minority Health and Health Disparities and in collaboration with the Office of Minority Health, the Office for Civil Rights, the Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services, the Health Resources and Services Administration, and other appropriate public and private entities, shall establish and coordinate a health and health care disparities education program to support, develop, and implement educational initiatives and outreach strategies that inform health care professionals and the public about the existence of and methods to reduce racial and ethnic disparities in health and health care.

''(b) ACTIVITIES.—The Secretary, through the education program established under subsection (a), shall, through the use of public awareness and outreach campaigns targeting the general public and the medical community at large—

''(1) disseminate scientific evidence for the existence and extent of racial and ethnic disparities in health care, including disparities that are not otherwise attributable to known factors such as access to care, patient preferences, or appropriateness of intervention, as described in the 2002 Institute of Medicine Report entitled 'Unequal Treatment: Con-

fronting 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 2015 through 2020.''.

SEC. 302. HISPANIC-SERVING HEALTH PROFESSIONS SCHOOLS.

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

''SEC. 742. HISPANIC-SERVING HEALTH PROFESSIONS SCHOOLS.

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

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

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

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

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

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

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

''(6) is a Regional Hispanic Center 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 at the end the following: ''$750,000 for fiscal year 2015, and such sums as may be necessary for each of the fiscal years 2016 through 2020''.

SEC. 304. COOPERATIVE AGREEMENTS FOR ONLINE DEGREE PROGRAMS AT SCHOOLS OF PUBLIC HEALTH AND SCHOOLS OF ALLIED HEALTH.

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

"SEC. 743. COOPERATIVE AGREEMENTS FOR ONLINE DEGREE PROGRAMS.

''(a) COOPERATIVE AGREEMENTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, in consultation with the Director of the Centers for Disease Control and Prevention, the Director of the Agency for Healthcare Research and Quality, and the Deputy Assistant Secretary for Minority Health, shall award cooperative agreements to schools of public health and schools of allied health to design and implement online degree programs.

''(b) PRIORITY.—In awarding cooperative agreements under this section, the Secretary shall give priority to any school of public health or school of allied health that has an established track record of serving medically underserved communities.

''(c) REQUIREMENTS.—Recipients of cooperative agreements under this section shall design and implement an online degree program that meets the following restrictions:

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

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

''(3) Achieving a high completion rate of enrolled underrepresented minority or disadvantaged students.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2015 through 2020.''.

SEC. 305. SENSE OF CONGRESS ON THE MISSION OF THE NATIONAL HEALTH CARE WORKFORCE COMMISSION.

It is the sense of Congress that the National Health Care Workforce Commission established by section 5101 of the Patient Protection and Affordable Care Act (42 U.S.C. 294q) should, in carrying out its assigned duties under that section, give attention to the needs of racial and ethnic minorities, individuals with lower socioeconomic status, individuals with mental, developmental, and physical disabilities, lesbian, gay, bisexual, and

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

SEC. 306. SCHOLARSHIP AND FELLOWSHIP PROGRAMS.

Subtitle A of title XXXIV of the Public Health Service Act, as added by section 301, is further amended by inserting after section 3417 the following:

"SEC. 3418. DAVID SATCHER PUBLIC HEALTH AND HEALTH SERVICES CORPS.

''(a) IN GENERAL.—The 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, career opportunities in the following health professions:

''(1) Medicine.

''(2) Nursing.

''(3) Public Health.

''(4) Pharmacy.

''(5) Health administration and management.

''(6) Health policy.

''(7) Psychology.

''(8) Dentistry.

''(9) International health.

''(10) Social work.

''(11) Allied health.

''(12) Psychiatry.

''(13) Hospice care.

''(14) Other professions deemed appropriate by the Director of the Centers for Disease Control and Prevention.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director of the Centers for Disease Control and Prevention shall give priority to those entities that—

''(1) serve a high proportion of individuals from disadvantaged backgrounds;

''(2) have experience in health disparity elimination programs;

''(3) facilitate the entry of disadvantaged individuals into institutions of higher education; and

''(4) provide counseling or other services designed to assist disadvantaged individuals in successfully completing their education at the postsecondary level.

''(e) STIPENDS.—The Secretary may approve stipends under this section for individuals for any period of education in student-enhancement programs (other than regular courses) at health professions schools, programs, or entities, except that such a stipend may not be provided to an individual for more than 6 months, and such a stipend may not exceed $20 per day (notwithstanding any other provision of law regarding the amount of stipends).

''(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 2015 through 2020.

"SEC. 3419. LOUIS STOKES PUBLIC HEALTH SCHOLARS PROGRAM.

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

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

''(1) have interest, knowledge, or skill in public health research or public health practice, or other health professions as determined appropriate by the Director of the Centers for Disease Control and Prevention;

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

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

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

''(5) comply with subsection (e); 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 public health professionals.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director shall give priority to those students that—

''(1) are from disadvantaged backgrounds;

''(2) have secured admissions to a minority-serving institution; and

''(3) have identified a health professional as a mentor at their school or institution and an academic advisor to assist in the completion of their baccalaureate degree.

''(e) SCHOLARSHIPS.—The Secretary may approve payment of scholarships under this section for such individuals for any period of education in student undergraduate tenure, except that such a scholarship may not be provided to an individual for more than 4 years, and such scholarships may not exceed $10,000 per academic year (notwithstanding any other provision of law regarding the amount of scholarship).

''(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 2015 through 2020.

"SEC. 3420. PATSY MINK HEALTH AND GENDER RESEARCH FELLOWSHIP PROGRAM.

''(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Deputy Assistant Secretary for Minority Health, the Administrator of the Substance Abuse and Mental Health Services Administration, and the Director of the Indian Health Services, shall award research fellowships to post-baccalaureate students to conduct research that will examine gender and health disparities and to pursue a career in the health professions.

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

''(1) have experience in health research or public health practice;

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

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

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

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

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

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

''(c) USE OF FUNDS.—Amounts received under an award under subsection (a) shall be used to support opportunities for students to become researchers and advance the research base on the intersection between gender and health.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director of the Centers for Disease Control and Prevention shall give priority to those applicants that—

''(1) are from disadvantaged backgrounds; and

''(2) have identified a mentor and academic advisor who will assist in the completion of their graduate or professional degree and have secured a research assistant position with a researcher working in the area of gender and health.

''(e) FELLOWSHIPS.—The Director of the Centers for Disease Control and Prevention may approve fellowships for individuals under this section for any period of edu-

cation in the student's graduate or health profession tenure, except that such a fellowship may not be provided to an individual for more than 3 years, and such a fellowship may not exceed $18,000 per academic year (notwithstanding any other provision of law regarding the amount of fellowship).

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2015 through 2020.

"SEC. 3420A. 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 (e); and

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

''(c) USE OF FUNDS.—Amounts received under an award under subsection (a) shall be used to support opportunities for students to become health professionals and to advance their knowledge about international issues relating to health care access and quality.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director shall give priority to those applicants that—

''(1) are from a disadvantaged background; and

''(2) have identified a mentor at a health professions school or institution, an academic advisor to assist in the completion of their graduate or professional degree, and an advisor from an international health non-governmental organization, private volunteer organization, or other international institution or program that focuses on increasing health care

access and quality for residents in developing countries.

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

''(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 2015 through 2020.

''SEC. 3420B. EDWARD R. ROYBAL HEALTH SCHOLAR PROGRAM.

''(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, the Director of the Centers for Medicare and Medicaid Services, and the Administrator for Health Resources and Services Administration, in collaboration with the Deputy Assistant Secretary for Minority Health, shall award grants to eligible entities to expose entering graduate students to the health professions.

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

''(1) be a clinical, public health, or health services organization, community-based, academic, or nonprofit entity, or other entity determined appropriate by the Director of the Agency for Healthcare Research and Quality;

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

''(3) work with students obtaining a degree in the health professions; and

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

''(c) USE OF FUNDS.—Amounts received under a grant awarded under subsection (a) shall be used to support opportunities that expose students to non-research-based health professions, including—

''(1) public health policy;

''(2) health care and pharmaceutical policy;

''(3) health care administration and management;

''(4) health economics; and

''(5) other professions determined appropriate by the Director of the Agency for Healthcare Re-

search and Quality, the Director of the Centers for Medicare and Medicaid Services, and the Administrator for Health Resources and Services Administration.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director of the Agency for Healthcare Research and Quality shall give priority to those entities that—

''(1) have experience with health disparity elimination programs;

''(2) facilitate training in the fields described in subsection (c); and

''(3) provide counseling or other services designed to assist such individuals in successfully completing their education at the postsecondary level.

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

''(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 2015 through 2020.''.

SEC. 307. MCNAIR POSTBACCALAUREATE ACHIEVEMENT PROGRAM.

Section 402E of the Higher Education Act of 1965 (20 U.S.C. 1070a–15) is amended by striking subsection (g) and inserting the following:

''(g) COLLABORATION IN HEALTH PROFESSION DIVERSITY TRAINING PROGRAMS.—The Secretary shall coordinate with the Secretary of Health and Human Services to ensure that there is collaboration between the goals of the program under this section and programs of the Health Resources and Services Administration that promote health workforce diversity. The Secretary of Education shall take such measures as may be necessary to encourage students participating in projects assisted under this section to consider health profession careers.

''(h) FUNDING.—From amounts appropriated pursuant to the authority of section 402A(g), the Secretary shall, to the extent practicable, allocate funds for projects authorized by this section in an amount which is not less than $31,000,000 for each of the fiscal years 2015 through 2021.''.

SEC. 308. RULES FOR DETERMINATION OF FULL-TIME EQUIVALENT RESIDENTS FOR COST-REPORTING PERIODS.

(a) DGME DETERMINATIONS.—Section 1886(h)(4) of the Social Security Act (42 U.S.C. 1395ww(h)(4)) is amended—

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

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

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

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

''(L) For purposes of cost-reporting periods beginning on or after October 1, 2014, in determining the hospital's number of full-time equivalent residents for purposes of this paragraph, all the time spent by an intern or resident in an approved medical residency training program shall be counted toward the determination of full-time equivalency if the hospital—

''(i) is recognized as a subsection (d) hospital;

''(ii) is recognized as a subsection (d) Puerto Rico hospital;

''(iii) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

''(iv) is a provider-based hospital outpatient department.''.

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B)(x) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(x)) is amended—

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

(2) in subclause (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. 309. 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 pipeline programs 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. 310. LOAN FORGIVENESS FOR MENTAL AND BEHAVIORAL HEALTH SOCIAL WORKERS.

Section 455 of the Higher Education Act of 1965 (20 U.S.C. 1087e) is amended by adding at the end the following new subsection:

''(r) 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, 2014, pursuant to any one or a combination of the following—

"(i) payments under an income-based repayment plan under section 493C;

"(ii) payments under a standard repayment plan under subsection (d)(1)(A), based on a 10-year repayment period;

"(iii) monthly payments under a repayment plan under subsection (d)(1) or (g) of not less than the monthly amount calculated under subsection (d)(1)(A), based on a 10-year repayment period; or

"(iv) payments under an income contingent repayment plan under subsection (d)(1)(D); and

"(B)(i) is employed as a mental health or behavioral health social worker, as defined by the Secretary by regulation, at the time of such forgiveness; and

"(ii) has been employed as such a mental health or behavioral health social worker during the period in which the borrower makes each of the 120 payments as described in subparagraph (A).

''(2) LOAN CANCELLATION AMOUNT.—After the conclusion of the employment period described in paragraph (1), the Secretary shall cancel the obligation to repay the balance of principal and interest due as of the time of such cancellation, on the eligible Federal Direct Loans made to the borrower under this part.

''(3) INELIGIBILITY FOR DOUBLE BENEFITS.—No borrower may, for the same employment as a mental heath or behavioral health social worker, receive a reduction of loan obligations under both this subsection and section 455(m), 428J, 428K, 428L, or 460.

''(4) DEFINITION OF ELIGIBLE FEDERAL DIRECT LOAN.—In this subsection, the term 'eligible Federal Direct Loan' means a Federal Direct Stafford Loan, Federal Direct PLUS Loan, Federal Direct Unsubsidized Stafford Loan, or a Federal Direct Consolidation Loan.''.

SEC. 311. HEALTH PROFESSIONS WORKFORCE FUND.

(a) PURPOSE.—It is the purpose of this section to establish a Health Professions Workforce Fund to be administered through the Health Resources and Services Administration within the Department of Health and Human Services to provide for expanded and sustained national

investment in the health professions and nursing workforce development programs under title VII and title VIII of the Public Health Service Act.

(b) ESTABLISHING THE HEALTH PROFESSIONS WORKFORCE FUND.—There is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, to the Health Professions Workforce Fund—

(1) $355,000,000 for fiscal year 2015;

(2) $375,000,000 for fiscal year 2016;

(3) $392,000,000 for fiscal year 2017;

(4) $412,000,000 for fiscal year 2018;

(5) $432,000,000 for fiscal year 2019;

(6) $454,000,000 for fiscal year 2020;

(7) $476,000,000 for fiscal year 2021;

(8) $500,000,000 for fiscal year 2022;

(9) $525,000,000 for fiscal year 2023; and

(10) $552,000,000 for fiscal year 2024.

(c) FUNDING.—

(1) For the purpose of carrying out health professions education programs authorized under title VII of the Public Health Service Act, in addition to any other amounts authorized to be appropriated for such purpose, there is authorized to be appropriated

out of any monies in the Health Professions Workforce Fund, the following:

(A) $240,000,000 for fiscal year 2015.

(B) $253,000,000 for fiscal year 2016.

(C) $265,000,000 for fiscal year 2017.

(D) $278,000,000 for fiscal year 2018.

(E) $292,000,000 for fiscal year 2019.

(F) $307,000,000 for fiscal year 2020.

(G) $322,000,000 for fiscal year 2021.

(H) $338,000,000 for fiscal year 2022.

(I) $355,000,000 for fiscal year 2023.

(J) $373,000,000 for fiscal year 2024.

(2) For the purpose of carrying out nursing workforce development programs authorized under Title VIII of the Public Health Service Act, in addition to any other amounts authorized to be appropriated for such purpose, there is authorized to be appropriated out of any monies in the Health Professions Workforce Fund, the following:

(A) $115,000,000 for fiscal year 2015.

(B) $122,000,000 for fiscal year 2016.

(C) $127,000,000 for fiscal year 2017.

(D) $134,000,000 for fiscal year 2018.

(E) $140,000,000 for fiscal year 2019.

(F) $147,000,000 for fiscal year 2020.

(G) $154,000,000 for fiscal year 2021.

(H) $162,000,000 for fiscal year 2022.

(I) $170,000,000 for fiscal year 2023.

(J) $179,000,000 for fiscal year 2024.

SEC. 312. FINDINGS; SENSE OF CONGRESS RELATING TO GRADUATE MEDICAL EDUCATION.

(a) FINDINGS.—Congress finds the following:

(1) Projections by the Association of American Medical Colleges (AAMC) and other expert entities, such as the Health Resources and Services Administration (HRSA), have indicated a nationwide shortage of up to 130,600 physicians, split evenly between primary care and specialists, by 2025.

(2) The coverage of an additional 25 million uninsured Americans under the Patient Protection and Affordable Care Act is expected to increase the projected shortage by 25 percent.

(3) The United States Census projects that the Nation's population will grow from 310 million in 2010 to 400 million in 2044, with the Nation becoming majority-minority in 2043, and the number of Medicare beneficiaries increasing from 50.7 million in 2012 to 90 million in 2045.

(4) One-third of currently practicing physicians are over 55 years of age and likely to retire in the next 20 years.

(5) A nationwide physician shortage will result in many Americans waiting longer and traveling farther for health care; seeking nonemergent care in emergency departments; and delaying treatment until their health care needs become more serious, complex, and costly.

(6) Changing demographics (such as an aging population), new health care delivery models (such as medical homes), and other factors (such as disaster preparedness) are contributing to a shortage of both generalist and specialist physicians.

(7) These shortages will have the most severe impact on vulnerable and underserved populations, including racial/ethnic minorities and the approximately 20 percent of Americans who live in rural or inner-city locations designated as health professional shortage areas.

(8) United States medical schools have committed to and have initiated a 30 percent increase in enrollment by 2017 to help reduce the Nation's shortage of quality physicians.

(9) An increase in United States medical school graduates must be accompanied by an increase of 4,000 graduate medical education (GME) training positions each year.

(10) Graduate medical education programs and teaching hospitals provide venues in which the next generation of physicians learns to work collaboratively with other physicians and health professionals, adopt more efficient care delivery models (such as care coordination and medical homes), incorporate health information technology and electronic health records in every aspect of their work, apply new methods of assuring quality and safety, and participate in groundbreaking clinical and public health research.

(11) The Medicare Program under title XVIII of the Social Security Act (having more beneficiaries than any other health care program), supports its ''fair share'' of the costs associated with graduate medical education (GME).

(12) In general, the level of support of graduate medical education by the Medicare Program has been capped since 1997 and has not been increased to support the expansion of graduate medical education programs needed to avert the projected physi-

cian shortage or to accommodate the increase in United States medical school graduates.

(b) SENSE OF CONGRESS.—It is the sense of Congress that eliminating the limit of the number of residency positions that receive some level of Medicare support under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)), also referred to as the Medical graduate medical education cap, is critical to—

(1) ensuring an appropriate supply of physicians to meet the Nation's health care needs;

(2) facilitating equitable access for all who seek health care; and

(3) mitigating disparities in health and health care.

SEC. 313. CAREER SUPPORT FOR SKILLED INTERNATIONALLY EDUCATED HEALTH PROFESSIONALS.

(a) FINDINGS.—Congress finds the following:

(1) According to the Association of Schools of Public Health, projections indicate a nationwide shortage of up to 250,000 public health workers needed by 2020.

(2) Similar trends are projected for other health professions indicating shortages across disciplines, including within the fields of nursing, dentistry,

pharmacy, mental and behavioral health, primary care, and community and allied health.

(3) A nationwide health workforce shortage will result in serious health threats and more severe and costly health care needs, due to, in part, a delayed response to food-borne outbreaks, emerging infectious diseases, and natural disasters, fewer cancer screenings and delayed treatment.

(4) Vulnerable and underserved populations and health professional shortage areas will be most severely impacted by the health workforce shortage.

(5) According to the Migration Policy Institute, over 2 million college-educated immigrants in the United States today are unemployed or underemployed in low- or semi-skilled jobs that fail to draw on their education and expertise.

(6) Approximately two out of every five internationally educated immigrants are unemployed or underemployed.

(7) According to Drexel University Center for Labor Markets and Policy, underemployment for internationally educated immigrant women is 28 percent higher than for their male counterparts.

(8) According to the Drexel University Center for Labor Markets and Policy, the mean annual

earnings of underemployed immigrants were $32,000, or 43 percent less than U.S.-born college graduates employed in the college labor market.

(9) According to Upwardly Global and the Welcome Back Initiative, with proper guidance and support underemployed skilled immigrants typically increase their income by 215 percent to 900 percent.

(10) According to the Brookings Institution and the Partnership for a New American Economy, immigrants working in the health workforce are, on average, better-educated than U.S.-born workers in the health workforce.

(b) GRANTS TO ELIGIBLE ENTITIES.—

(1) AUTHORITY TO PROVIDE GRANTS.—The Secretary of Health and Human Services, acting through the Bureau of Health Workforce within the Health Resources and Services Administration, the National Institute on Minority Health and Health Disparities, or the Office of Minority Health (in this section referred to as the ''Secretary''), may award grants to eligible entities to carry out activities described in subsection (c).

(2) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall—

(A) be a clinical, public health, or health services organization, a community-based or nonprofit entity, an academic institution, a faith-based organization, a State, county, or local government, a National Area Health Education Center, or another entity determined appropriate by the Secretary; and

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) AUTHORIZED ACTIVITIES.—A grant awarded under this section shall be used—

(1) to provide services to assist unemployed and underemployed skilled immigrants, residing in the United States, who have legal, permanent work authorization and who are internationally educated health professions, enter into the American health workforce with employment matching their health professional skills and education, and advance in employment to positions that better match their health professional education and expertise;

(2) to reduce disparities in incomes between skilled health professional immigrants and other workers in the health workforce;

(3) to reduce barriers to entry and advancement in the health workforce for internationally educated skilled immigrants; and

(4) to educate employers regarding the abilities and capacities of internationally educated health professionals.

(d) DEFINITIONS.—In this section:

(1) The term ''health professional'' means an individual trained for employment or intended employment in the field of public health, health management, dentistry, health administration, medicine, nursing, pharmacy, psychology, social work, psychiatry, other mental and behavioral health, allied health, community health, social work, or wellness work, including fitness and nutrition, or other fields as determined appropriate by the Secretary.

(2) The term ''underemployed'' means being employed at less skilled tasks than an employee's training or abilities would otherwise permit.

(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 2015 through 2019.

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 2014''.

SEC. 402. FINDINGS.

The Congress finds the following:

(1) Numerous studies and reports, including the 2012 National Healthcare Disparities Report of the Administration on Healthcare Research and Quality and the 2002 Unequal Treatment Report of the Institute of Medicine, document the extensiveness to which health disparities exist across the country.

(2) These studies have found that, on average, racial and ethnic minorities are disproportionately afflicted with chronic and acute conditions—such as cancer, diabetes, musculoskeletal disease, obesity, and hypertension—and suffer worse health outcomes, worse health status, and higher mortality rates than their White counterparts.

(3) Several recent studies also show that health disparities are a function of not only access to health

care, but also the social determinants of health—including the environment, the physical structure of communities, nutrition and food options, educational attainment, employment, race, ethnicity, geography, and language preference—that directly and indirectly affect the health, health care, and wellness of individuals and communities.

(4) Integrally involving and fully supporting the communities most affected by health inequities in the assessment, planning, launch, and evaluation of health disparity elimination efforts are among the leading recommendations made to adequately address and ultimately reduce health disparities.

(5) Recommendations also include supporting the efforts of community stakeholders from a broad cross section—including, but not limited to local businesses, local departments of commerce, education, labor, urban planning, and transportation, and community-based and other nonprofit organizations—to find areas of common ground around health disparity elimination and collaborate to 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 members of the target community, 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) The prevalence of disproportionate rates of certain illnesses or diseases including the following:

(i) Arthritis, osteoporosis, chronic back conditions, and other musculoskeletal diseases.

(ii) Cancer.

(iii) Chronic kidney disease.

(iv) Diabetes.

(v) Injury (intentional and unintentional).

(vi) Violence (intimate and non-intimate).

(vii) Maternal and paternal illnesses and diseases.

(viii) Infant mortality.

(ix) Mental illness and other disabilities.

(x) Substance abuse treatment and prevention, including underage drinking.

(xi) Nutrition, obesity, and overweight conditions.

(xii) Heart disease.

(xiii) Hypertension.

(xiv) Cerebrovascular disease or stroke.

(xv) Tuberculosis.

(xvi) HIV/AIDS and other sexually transmitted diseases.

(xvii) Viral hepatitis.

(xviii) Asthma.

(xix) Tooth decay and other oral health issues.

(C) Within the target community, the historical and persistent presence of conditions that have been found to contribute to health disparities including any such conditions respecting the following:

(i) Poverty.

(ii) Educational status and the quality of community schools.

(iii) Income.

(iv) Access to high-quality affordable health care.

(v) Work and work environment.

(vi) Environmental conditions in the community, including with respect to clean water, clean air, and the presence or absence of pollutants.

(vii) Language and English proficiency.

(viii) Access to affordable healthy food.

(ix) Access to ethnically and culturally diverse health and human service providers and practitioners.

(x) Access to culturally and linguistically competent health and human services and health and human service providers.

(xi) Health-supporting infrastructure.

(xii) Health insurance that is adequate and affordable.

(xiii) Race, racism, and bigotry (conscious and unconscious).

(xiv) Sexual orientation.

(xv) Health literacy.

(xvi) Place of residence (such as urban areas, rural areas, and tribal reservations).

(xvii) Stress.

(c) PROCEDURE.—

(1) REQUEST.—A request under subsection (a) shall—

(A) describe the bounds of the area to be designated as a health empowerment zone and the process used to select those bounds;

(B) demonstrate that the partnership submitting the request is an eligible community partnership described in subsection (b)(1);

(C) demonstrate that the area is an eligible area described in subsection (b)(2);

(D) include a comprehensive assessment of disparities in health status and health care experience by one or more communities in the area;

(E) set forth—

(i) a vision and a set of values for the area; and

(ii) a comprehensive and holistic set of goals to be achieved in the area through designation as a health empowerment zone; and

(F) include a strategic plan and an action plan for achieving the goals described in subparagraph (E)(ii).

(2) APPROVAL.—Not later than 60 days after the receipt of a request for designation of an area as a health empowerment zone under this section, the Secretary shall approve or disapprove the request.

(d) MINIMUM NUMBER.—The Secretary—

(1) shall designate not more than 110 health empowerment zones under this section; and

(2) shall designate at least one health empowerment zone in each of the several States, the District of Columbia, and each territory or possession of the United States.

SEC. 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 Na-

tional 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 2015.

Subtitle B—Other Improvements of Health Care Services

CHAPTER 1—EXPANSION OF COVERAGE

SEC. 411. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title XXXIV of the Public Health Service Act, as amended by titles I, II, III, and IX of this Act, is further amended by inserting after subtitle C the following:

"Subtitle D—Reconstruction and Improvement Grants for Public Health Care Facilities Serving Pacific Islanders and the Insular Areas

"SEC. 3451. GRANT SUPPORT FOR QUALITY IMPROVEMENT INITIATIVES.

''(a) IN GENERAL.—The Secretary, in collaboration with the Administrator of the Health Resources and Services Administration, the Director of the Agency for Healthcare Research and Quality, and the Administrator of the Centers for Medicare & Medicaid Services, shall

award grants to eligible entities for the conduct of demonstration projects to improve the quality of and access to health care.

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

''(1) be a health center, hospital, health plan, health system, community clinic. or other health entity determined appropriate by the Secretary—

''(A) that, by legal mandate or explicitly adopted mission, provides patients with access to services regardless of their ability to pay;

''(B) that provides care or treatment for a substantial number of patients who are uninsured, are receiving assistance under a State program under title XIX of the Social Security Act, or are members of vulnerable populations, as determined by the Secretary; and

''(C)(i) with respect to which, not less than 50 percent of the entity's patient population is made up of racial and ethnic minorities; or

''(ii) that—

''(I) serves a disproportionate percentage of local, minority racial and ethnic patients, or that has a patient population, at

least 50 percent of which is limited-English-proficient; and

''(II) provides an assurance that amounts received under the grant will be used only to support quality improvement activities in the racial and ethnic population served; and

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

''(c) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants under subsection (b)(2) that—

''(1) demonstrate an intent to operate as part of a health care partnership, network, collaborative, coalition, or alliance where each member entity contributes to the design, implementation, and evaluation of the proposed intervention; or

''(2) intend to use funds to carry out system-wide changes with respect to health care quality improvement, including—

''(A) improved systems for data collection and reporting;

"(B) innovative collaborative or similar processes;

"(C) group programs with behavioral or self-management interventions;

"(D) case management services;

"(E) physician or patient reminder systems;

"(F) educational interventions; or

"(G) other activities determined appropriate by the Secretary.

"(d) USE OF FUNDS.—An entity shall use amounts received under a grant under subsection (a) to support the implementation and evaluation of health care quality improvement activities or minority health and health care disparity reduction activities that include—

"(1) with respect to health care systems, activities relating to improving—

"(A) patient safety;

"(B) timeliness of care;

"(C) effectiveness of care;

"(D) efficiency of care;

"(E) patient centeredness; and

"(F) health information technology; and

"(2) with respect to patients, activities relating to—

''(A) staying healthy;

''(B) getting well, mentally and physically;

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

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

''(e) COMMON DATA SYSTEMS.—The Secretary shall provide financial and other technical assistance to grantees under this section for the development of common data systems.

''(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 2015 through 2020.

''SEC. 3452. CENTERS OF EXCELLENCE.

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

''(1) meet the requirements of section 3451(b)(1);

''(2) demonstrate excellence in providing care to minority populations; and

''(3) demonstrate excellence in reducing disparities in health and health care.

''(b) REQUIREMENTS.—A hospital or health system that serves as a center of excellence under subsection (a) shall—

''(1) design, implement, and evaluate programs and policies relating to the delivery of care in racially, ethnically, and linguistically diverse populations;

''(2) provide training and technical assistance to other hospitals and health systems relating to the provision of quality health care to minority populations; and

''(3) develop activities for graduate or continuing medical education that institutionalize a focus on cultural competence training for health care providers.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2015 through 2020.

"SEC. 3453. RECONSTRUCTION AND IMPROVEMENT GRANTS FOR PUBLIC HEALTH CARE FACILITIES SERVING PACIFIC ISLANDERS AND THE INSULAR AREAS.

''(a) IN GENERAL.—The Secretary shall provide direct financial assistance to designated health care pro-

viders and community health centers in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii for the purposes of reconstructing and improving health care facilities and services in a culturally competent and sustainable manner.

''(b) ELIGIBILITY.—To be eligible to receive direct financial assistance under subsection (a), an entity shall be a public health facility or community health center located in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, or Hawaii that—

''(1) is owned or operated by—

''(A) the Government of American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, or Hawaii or a unit of local government; or

''(B) a nonprofit organization; and

''(2)(A) provides care or treatment for a substantial number of patients who are uninsured, receiving assistance under a State program under a title XVIII of the Social Security Act, or a State program under title XIX of such Act, or who are

members of a vulnerable population, as determined by the Secretary; or

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

''(c) REPORT.—Not later than 180 days after the date of enactment of this title and annually thereafter, the Secretary shall submit to the Congress and the President a report that includes an assessment of health resources and facilities serving populations in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii. In preparing such report, the Secretary shall—

''(1) consult with and obtain information on all health care facilities needs from the entities described in subsection (b);

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

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

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

''(5) evaluate the effectiveness of the care provided by measuring patient outcomes and cost measures.

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

SEC. 412. REMOVING CITIZENSHIP AND IMMIGRATION BARRIERS TO ACCESS TO AFFORDABLE HEALTH CARE UNDER THE ACA.

(a) IN GENERAL.—

(1) PREMIUM TAX CREDITS.—Section 36B of the Internal Revenue Code of 1986 is amended—

(A) in subsection (c)(1)(B)—

(i) by amending the subparagraph heading to read as follows: ''SPECIAL RULE FOR CERTAIN INDIVIDUALS INELIGIBLE FOR MEDICAID DUE TO STATUS'', and

(ii) in clause (ii), by striking ''lawfully present in the United States, but'' and inserting ''who'', and

(B) by striking subsection (e).

(2) COST-SHARING REDUCTIONS.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is amended by striking subsection (e).

(3) PREEXISTING CONDITION INSURANCE PLAN.—Section 1101(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 18001(d)) is amended by striking paragraph (1) and redesignating paragraphs (2) and (3) as paragraphs (1) and (2), respectively.

(4) BASIC HEALTH PROGRAM ELIGIBILITY.—Section 1331(e)(1)(B) of the Patient Protection and Affordable Care Act (42 U.S.C. 18051(e)(1)(B)) is amended by striking ''lawfully present in the United States,''.

(5) RESTRICTIONS ON FEDERAL PAYMENTS.—Section 1412 of the Patient Protection and Affordable Care Act (42 U.S.C. 18082) is amended by striking subsection (d).

(6) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—Subsection (d) of section 5000A of the Internal Revenue Code of 1986 is amended by striking paragraph (3) and by redesignating paragraph (4) as paragraph (3).

(b) CONFORMING AMENDMENT.—

(1) Section 1411(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(a)) is amended by striking paragraph (1) and redesig-

nating paragraphs (2), (3), and (4) as paragraphs (1), (2), and (3), respectively.

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

(A) in the subsection heading, by striking ''employers;'' and all that follows through ''residents''; and

(B) by striking paragraph (3).

SEC. 413. STUDY ON THE UNINSURED.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall—

(1) conduct a study, in accordance with the standards under section 3101 of the Public Health Service Act (42 U.S.C. 300kk), on the demographic characteristics of the population of individuals who do not have health insurance coverage; and

(2) predict, based on such study, the demographic characteristics of the population of individuals who would remain without health insurance coverage after the end of open enrollment or any special enrollment period.

(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, age group, 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 preceding paragraph (1), by striking ''subsection (g)'' and inserting ''subsections (g) and (h)'';

(B) in subsection (g)(2), in the matter preceding subparagraph (A)—

(i) by striking ''Notwithstanding subsection (f) and subject to and'' and inserting ''Notwithstanding subsection (f) and subject to''; and

(ii) by striking ''paragraphs (3) and (5)'' and inserting '', paragraphs (3) and (5) of this subsection, and subsection (h)''.

(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 2015.''.

(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 2016.

(b) PARITY IN FMAP.—

(1) IN GENERAL.—Section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by inserting after ''and American Samoa shall be 55 percent,'' the following: ''(except that, beginning with fiscal year 2018, the Federal medical assistance percentage for Puerto Rico, the United States Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa shall be the Federal medical assistance percentage determined by the Secretary in consultation (for the United States Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa) with the Secretary of the Interior)''.

(2) 2-FISCAL-YEAR TRANSITION.—Notwithstanding any other provision of law, during fiscal years 2016 and 2017, the Federal medical assistance percentage established under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) for Puerto Rico, the United States Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa shall be the highest

such Federal medical assistance percentage applicable to any of the 50 States or the District of Columbia for the fiscal year involved.

(3) PER CAPITA INCOME DATA.—

(A) REPORT TO CONGRESS.—Not later than October 1, 2016, 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 United States 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''.

SEC. 415. EXTENSION OF MEDICARE SECONDARY PAYER.

(a) IN GENERAL.—Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence, by inserting '', and before January 1, 2015'' after ''prior to such date)''; and

(2) by adding at the end the following new sentence: ''Effective for items and services furnished on or after January 1, 2015 (with respect to periods

beginning on or after the date that is 42 months prior to such date), clauses (i) and (ii) shall be applied by substituting '42-month' for '12-month' each place it appears in the first sentence.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act. For purposes of determining an individual's status under section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)), as amended by subsection (a), an individual who is within the coordinating period as of the date of enactment of this Act shall have that period extended to the full 42 months described in the last sentence of such section, as added by the amendment made by subsection (a)(2).

SEC. 416. 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 grants to eligible entities to address priorities and recommendations to improve the health of border area residents that are established by—

(1) the United States members of the United States-Mexico Border Health Commission;

(2) the State border health offices; and

(3) the Secretary.

(c) APPLICATION.—An eligible entity that desires a grant under subsection (b) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(d) USE OF FUNDS.—An eligible entity that receives a grant under subsection (b) shall use the grant funds for—

(1) programs relating to—

(A) maternal and child health;

(B) primary care and preventative health;

(C) public health and public health infrastructure;

(D) musculoskeletal health and obesity;

(E) health education and promotion;

(F) oral health;

(G) mental and behavioral health;

(H) substance abuse;

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

(J) medical and health services research;

(K) workforce training and development;

(L) community health workers or promotoras;

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

(N) health disparities in the border area;

(O) environmental health; and

(P) outreach and enrollment services with respect to Federal programs (including programs authorized under titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 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 2015, and such sums as may be necessary for each succeeding fiscal year.

SEC. 417. REMOVING MEDICARE BARRIER TO HEALTH CARE.

(a) PART A.—Section 1818(a)(3) of the Social Security Act (42 U.S.C. 1395i–2(a)(3)) is amended by striking ''(B)'' and all that follows through ''under this section'' and inserting ''(B) an individual who is lawfully present in the United States''.

(b) PART B.—Section 1836(2) of the Social Security Act (42 U.S.C. 1395o(2)) is amended by striking ''(B)'' and all that follows through ''under this part'' and inserting ''(B) an individual who is lawfully present in the United States''.

SEC. 418. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED BY URBAN INDIAN HEALTH CENTERS.

(a) IN GENERAL.—The third sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396(b)), as amended by section 415(c), is further amended by inserting ''or are received through a program operated by an urban Indian organization through a grant or contract

under title V of such Act'' after ''(as defined in section 4 of the Indian Health Care Improvement Act)''.

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

SEC. 419. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) IN GENERAL.—The third sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), as amended by section 419, is amended by inserting ''; and, with respect to medical assistance provided to a Native Hawaiian (as defined in section 12(2) of the Native Hawaiian Health Care Improvement Act) through a federally qualified health center or a Native Hawaiian health care system (as defined in section 12(6) of such Act), whether directly, by referral, or under contract or other arrangement between such federally qualified health center or Native Hawaiian health care system and another health care provider'' before the period.

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

CHAPTER 2—EXPANSION OF ACCESS

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

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

(b) AUTHORITY TO AWARD GRANTS.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, shall award grants to eligible entities to assist in designing, implementing, and evaluating culturally and linguistically appropriate, science-based, and community-driven sustainable strategies to eliminate racial and ethnic health and health care disparities.

(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall—

(1) represent a coalition—

(A) whose principal purpose is to develop and implement interventions to reduce or eliminate a health or health care disparity in a targeted racial or ethnic minority group in the community served by the coalition; and

(B) that includes—

(i) members selected from among—

(I) public health departments;

(II) community-based organizations;

(III) university and research organizations;

(IV) American Indian tribal organizations, national American Indian organizations, Indian Health Service, or organizations serving Alaska Natives; and

(V) interested public or private health care providers or organizations as deemed appropriate by the Secretary; and

(ii) at least 1 member from a community-based organization that represents the targeted racial or ethnic minority group; and

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, which shall include—

(A) a description of the targeted racial or ethnic populations in the community to be served under the grant;

(B) a description of at least 1 health disparity that exists in the racial or ethnic targeted populations, including health issues such as infant mortality, breast and cervical cancer screening and management, musculoskeletal diseases and obesity, prostate cancer screening and management, cardiovascular disease, diabetes, child and adult immunization levels, or other health priority areas as designated by the Secretary; and

(C) a demonstration of a proven record of accomplishment of the coalition members in serving and working with the targeted community.

(d) SUSTAINABILITY.—The Secretary shall give priority to an eligible entity under this section if the entity agrees that, with respect to the costs to be incurred by the entity in carrying out the activities for which the grant was awarded, the entity (and each of the participating partners in the coalition represented by the entity) will maintain its expenditures of non-Federal funds for such activities at a level that is not less than the level of such

expenditures during the fiscal year immediately preceding the first fiscal year for which the grant is awarded.

(e) NONDUPLICATION.—Funds provided through this grant program should supplement, not supplant, existing Federal funding, and the funds should not be used to duplicate the activities of the other health disparity grant programs in this Act.

(f) TECHNICAL ASSISTANCE.—The Secretary may, either directly or by grant or contract, provide any entity that receives a grant under this section with technical and other nonfinancial assistance necessary to meet the requirements of this section.

(g) DISSEMINATION.—The Secretary shall encourage and enable grantees to share best practices, evaluation results, and reports with communities not affiliated with grantees using the Internet, conferences, and other pertinent information regarding the projects funded by this section, including the outreach efforts of the Office of Minority Health and Health Disparity Elimination and the Centers for Disease Control and Prevention.

(h) ADMINISTRATIVE BURDENS.—The Secretary shall make every effort to minimize duplicative or unnecessary administrative burdens on grantees.

(i) DEFINITION.—In this section, the term ''Secretary'' means the Secretary of Health and Human Services.

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

SEC. 422. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.

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

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

(A) in subparagraph (B)—

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

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

(B) by striking the comma at the end of subparagraph (B) and all that follows and inserting a period.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2015.

(b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT REQUIREMENT.—

(1) IN GENERAL.—Section 1820(c)(2) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)) is amended—

(A) in subparagraph (B)(iii), by striking ''provides not more than'' and inserting ''subject to subparagraph (F), provides not more than''; and

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

''(F) ALTERNATIVE TO 25 INPATIENT BED LIMIT REQUIREMENT.—

''(i) IN GENERAL.—A State may elect to treat a facility, with respect to the designation of the facility for a cost-reporting period, as satisfying the requirement of subparagraph (B)(iii) relating to a maximum number of acute care inpatient beds if the facility elects, in accordance with a method specified by the Secretary and before the beginning of the cost reporting period, to meet the requirement under clause (ii).

''(ii) ALTERNATE REQUIREMENT.—The requirement under this clause, with respect to a facility and a cost-reporting period, is that the total number of inpatient bed days described in subparagraph (B)(iii) during such period will not exceed 7,300. For purposes of this subparagraph, an individual who is an inpatient in a bed in the facility for a single day shall be counted as one inpatient bed day.

''(iii) WITHDRAWAL OF ELECTION.—The option described in clause (i) shall not apply to a facility for a cost-reporting period if the facility (for any two consecutive cost-reporting periods during the previous 5 cost-reporting periods) was treated under such option and had a total number of inpatient bed days for each of such two cost-reporting periods that exceeded the number specified in such clause.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to cost-reporting periods beginning on or after the date of the enactment of this Act.

SEC. 423. ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) PROGRAM.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 203(b)(1), is amended by adding at the end of the following new subsection:

''Rural Community Hospital; Rural Community Hospital Services

''(jjj)(1) The term 'rural community hospital' means a hospital (as defined in subsection (e)) that—

''(A) is located in a rural area (as defined in section 1886(d)(2)(D)) or treated as being so located pursuant to section 1886(d)(8)(E);

''(B) subject to paragraph (2), has less than 51 acute care inpatient beds, as reported in its most recent cost report;

''(C) makes available 24-hour emergency care services;

''(D) subject to paragraph (3), has a provider agreement in effect with the Secretary and is open to the public as of January 1, 2010; and

''(E) applies to the Secretary for such designation.

''(2) For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

''(3) Paragraph (1)(D) shall not be construed to prohibit any of the following from qualifying as a rural community hospital:

''(A) A replacement facility (as defined by the Secretary in regulations in effect on January 1, 2012) with the same service area (as defined by the Secretary in regulations in effect on such date).

''(B) A facility obtaining a new provider number pursuant to a change of ownership.

''(C) A facility which has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a building as of January 1, 2012.

''(4) Nothing in this subsection shall be construed as prohibiting a critical access hospital from qualifying as a rural community hospital if the critical access hospital meets the conditions otherwise applicable to hospitals under subsection (e) and section 1866.

''(5) Nothing in this subsection shall be construed as prohibiting a rural community hospital participating in the demonstration program under section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2313) from qualifying as a rural community hospital if the rural community hospital meets the conditions other-

wise applicable to hospitals under subsection (e) and section 1866.''.

(b) PAYMENT.—

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

''Payment for Inpatient Services Furnished in Rural Community Hospitals

''(m) The amount of payment under this part for inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is, at the election of the hospital in the application referred to in section 1861(jjj)(1)(E)—

''(1) 101 percent of the reasonable costs of providing such services, without regard to the amount of the customary or other charge, or

''(2) the amount of payment provided for under the prospective payment system for inpatient hospital services under section 1886(d).''.

(2) OUTPATIENT SERVICES.—Section 1834 of such Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(p) PAYMENT FOR OUTPATIENT SERVICES FURNISHED IN RURAL COMMUNITY HOSPITALS.—The amount of payment under this part for outpatient services furnished in a rural community hospital is, at the election of the hospital in the application referred to in section 1861(jjj)(1)(E)—

''(1) 101 percent of the reasonable costs of providing such services, without regard to the amount of the customary or other charge and any limitation under section 1861(v)(1)(U), or

''(2) the amount of payment provided for under the prospective payment system for covered OPD services under section 1833(t).''.

(3) EXEMPTION FROM 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 cost-sharing for outpatient services furnished in a rural community hospital under this part shall be as follows:

''(A) For items and services that would have been paid under section 1833(t) if provided by a hospital, the amount of cost-sharing determined under paragraph (8) of such section.

''(B) For items and services that would have been paid under section 1833(h) if furnished by a provider or supplier, no cost-sharing shall apply.

''(C) For all other items and services, the amount of cost-sharing that would apply to the item or service under the methodology that would be used to determine payment for such item or service if provided by a physician, provider, or supplier, as the case may be.''.

(d) CONFORMING AMENDMENTS.—

(1) PART A PAYMENT.—Section 1814(b) of such Act (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by inserting ''other than inpatient hospital services furnished by a rural community hospital,'' after ''critical access hospital services,''.

(2) PART B PAYMENT.—Section 1833(a) of such Act (42 U.S.C. 1395l(a)), as amended by section 203(b)(2), is amended—

(A) in paragraph (2), in the matter before subparagraph (A), by striking ''and (I)'' and inserting ''(I), and (K)'';

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

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

(D) by adding at the end the following:

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

(3) TECHNICAL AMENDMENTS.—

(A) CONSULTATION WITH STATE AGENCIES.—Section 1863 of such Act (42 U.S.C. 1395z) is amended by striking ''and (dd)(2)'' and inserting ''(dd)(2), (mm)(1), and (jjj)(1)''.

(B) PROVIDER AGREEMENTS.—Section 1866(a)(2)(A) of such Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting ''section 1834(p)(2),'' after ''section 1833(b),''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2014.

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).

(3) LIMITATION ON EXPENDITURES.—The Secretary shall limit incentive payments under this section in order to ensure that the aggregate expenditures under title XVIII of the Social Security Act (including incentive payments under this subsection) do not exceed the amount that the Secretary estimates would have been expended if the pilot projects under this section had not been implemented.

(d) WAIVER AUTHORITY.—The Secretary may waive such provisions of titles XI and XVIII of the Social Security Act as the Secretary determines to be appropriate for the conduct of the pilot projects under this section.

(e) REPORT TO CONGRESS.—Not later than 5 years after the date that the first pilot project under this section is implemented, the Secretary shall submit to Congress a report on the pilot projects. Such report shall contain a detailed description of issues related to the expansion of the projects under subsection (f) and recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(f) EXPANSION.—If the Secretary determines that any of the pilot projects under this section enhance health outcomes for Medicare beneficiaries and reduce expenditures under title XVIII of the Social Security Act, the 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-

mentation of a national plan for rural health quality improvement. The national plan shall—

(i) identify objectives for rural health quality improvement;

(ii) identify strategies to eliminate known gaps in rural health system capacity and improve rural health quality; and

(iii) provide for Federal programs to identify opportunities for strengthening and aligning policies and programs to improve rural health quality.

(B) DEMONSTRATION PROJECTS.—The Commission shall design demonstration projects to test alternative models for rural health quality improvement, including with respect to both personal and population health.

(C) MONITORING.—The Commission shall monitor progress toward the objectives identified pursuant to paragraph (1)(A).

(3) MEMBERSHIP.—

(A) NUMBER.—The Commission shall be composed of 11 members appointed by the Secretary.

(B) SELECTION.—The Secretary shall select the members of the Commission from

among individuals with significant rural health care and health care quality expertise, including expertise in clinical health care, health care quality research, population or public health, or purchaser organizations.

(4) CONTRACTING AUTHORITY.—Subject to the availability of funds, the Commission may enter into contracts and make other arrangements, as may be necessary to carry out the duties described in paragraph (2).

(5) STAFF.—Upon the request of the Commission, the Secretary may detail, on a reimbursable basis, any of the personnel of the Office of Rural Health Policy of the Health Resources and Services Administration, the Agency for Healthcare Quality and Research, or the Centers for Medicare & Medicaid Services to the Commission to assist in carrying out this subsection.

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

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

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

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

(b) RURAL HEALTH QUALITY DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Not later than 270 days after the date of the enactment of this section, the Secretary, in consultation with the Rural Health Quality Advisory Commission, the Office of Rural Health Policy of the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services, shall make grants to eligible entities for 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 2015 through 2019.

(2) AVAILABILITY.—

(A) IN GENERAL.—Funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year 2019.

(B) REPORT.—For purposes of carrying out subsection (b)(8), funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year 2020.

(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) GRANTS.—The Director of the Office of Rural Health Policy of the Health Resources and Services Administration may award grants to eligible entities to promote rural health care services outreach by expanding the delivery of health care services to include new and enhanced services in rural areas. The Director may award the grants for periods of not more than 3 years.

''(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection for a project, an entity—

''(A) shall be a rural public or rural nonprofit private entity, a facility that qualifies as a rural health clinic under title XVIII of the Social Security Act, a public or nonprofit entity existing exclusively to provide services to migrant and seasonal farm workers in rural areas, or a tribal government whose grant-funded activities will be conducted within federally recognized tribal areas;

''(B) shall represent a consortium composed of members—

''(i) that include 3 or more independently owned health care entities; and

"(ii) that may be nonprofit or for-profit entities; and

"(C) shall not previously have received a grant under this subsection for the same or a similar project, unless the entity is proposing to expand the scope of the project or the area that will be served through the project.

"(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—

"(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

"(B) a description of the manner in which the project funded under the grant will meet the health care needs of rural populations in the local community or region to be served;

"(C) a plan for quantifying how health care needs will be met through identification of the target population and benchmarks of service delivery or health status, such as—

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

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

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

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

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

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

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

"(c) RURAL HEALTH NETWORK DEVELOPMENT GRANTS.—

"(1) GRANTS.—

''(A) IN GENERAL.—The Director may award rural health network development grants to eligible entities to promote, through planning and implementation, the development of integrated health care networks that have combined the functions of the entities participating in the networks in order to—

''(i) achieve efficiencies and economies of scale;

''(ii) expand access to, coordinate, and improve the quality of the health care delivery system through development of organizational efficiencies;

''(iii) implement health information technology to achieve efficiencies, reduce medical errors, and improve quality;

''(iv) coordinate care and manage chronic illness; and

''(v) strengthen the rural health care system as a whole in such a manner as to show a quantifiable return on investment to the participants in the network.

''(B) GRANT PERIODS.—The Director may award such a rural health network development grant—

''(i) for a period of 3 years for implementation activities; or

''(ii) for a period of 1 year for planning activities to assist in the initial development of an integrated health care network, if the proposed participants in the network do not have a history of collaborative efforts and a 3-year grant would be inappropriate.

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

''(A) shall be a rural public or rural nonprofit private entity, a facility that qualifies as a rural health clinic under title XVIII of the Social Security Act, a public or nonprofit entity existing exclusively to provide services to migrant and seasonal farm workers in rural areas, or a tribal government whose grant-funded activities will be conducted within federally recognized tribal areas;

''(B) shall represent a network composed of participants—

''(i) that include 3 or more independently owned health care entities; and

"(ii) that may be nonprofit or for-profit entities; and

"(C) shall not previously have received a grant under this subsection (other than a 1-year grant for planning activities) for the same or a similar project.

"(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity, in consultation with the appropriate State office of rural health or another appropriate State entity, shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—

"(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

"(B) an explanation of the reasons why Federal assistance is required to carry out the project;

"(C) a description of—

"(i) the history of collaborative activities carried out by the participants in the network;

''(ii) the degree to which the participants are ready to integrate their functions; and

''(iii) how the local community or region to be served will benefit from and be involved in the activities carried out by the network;

''(D) a description of how the local community or region to be served will experience increased access to quality health care services across the continuum of care as a result of the integration activities carried out by the network, including a description of—

''(i) return on investment for the community and the network members; and

''(ii) other quantifiable performance measures that show the benefit of the network activities;

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

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

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

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

''(d) DELTA RURAL DISPARITIES AND HEALTH SYSTEMS DEVELOPMENT GRANTS.—

''(1) GRANTS.—The Director may award grants to eligible entities to support reduction of health disparities, improve access to health care, and enhance rural health system development in the Delta Region.

''(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection, an entity shall be a rural public or rural nonprofit private entity, a facility that qualifies as a rural health clinic under title XVIII of the Social Security Act, a public or nonprofit entity existing exclusively to provide services to migrant and seasonal farm workers in rural areas, or a tribal government whose grant-funded activities will be conducted within federally recognized tribal areas.

''(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—

"(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

"(B) an explanation of the reasons why Federal assistance is required to carry out the project;

"(C) a description of the manner in which the project funded under the grant will meet the health care needs of the Delta Region;

"(D) a description of how the local community or region to be served will experience increased access to quality health care services as a result of the activities carried out by the entity;

"(E) a description of how health disparities will be reduced or the health system will be improved;

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

"(G) a description of how the project will be evaluated including process and outcome measures related to the quality of care provided or how the health care system improves its performance;

''(H) a description of how the grantee will develop an advisory group made up of representatives of the communities to be served to provide guidance to the grantee to best meet community need; and

''(I) other such information as the Director determines to be appropriate.

''(e) SMALL RURAL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANTS.—

''(1) GRANTS.—The Director may award grants to provide for the planning and implementation of small rural health care provider quality improvement activities. The Director may award the grants for periods of 1 to 3 years.

''(2) ELIGIBILITY.—To be eligible for a grant under this subsection, an entity—

''(A) shall be—

''(i) a rural public or rural nonprofit private health care provider or provider of health care services, such as a rural health clinic; or

''(ii) another rural provider or network of small rural providers identified by the Director as a key source of local care; and

''(B) shall not previously have received a grant under this subsection for the same or a similar project.

''(3) PREFERENCE.—In awarding grants under this subsection, the Director shall give preference to facilities that qualify as rural health clinics under title XVIII of the Social Security Act.

''(4) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—

''(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

''(B) an explanation of the reasons why Federal assistance is required to carry out the project;

''(C) a description of the manner in which the project funded under the grant will assure continuous quality improvement in the provision of services by the entity;

''(D) a description of how the local community or region to be served will experience increased access to quality health care services as

a result of the activities carried out by the entity;

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

''(F) a description of how the project will be evaluated including process and outcome measures related to the quality of care provided; and

''(G) other such information as the Director determines to be appropriate.

''(f) GENERAL REQUIREMENTS.—

''(1) PROHIBITED USES OF FUNDS.—An entity that receives a grant under this section may not use funds provided through the grant—

''(A) to build or acquire real property; or

''(B) for construction.

''(2) COORDINATION WITH OTHER AGENCIES.—The Director shall coordinate activities carried out under grant programs described in this section, to the extent practicable, with Federal and State agencies and nonprofit organizations that are operating similar grant programs, to maximize the effect of public dollars in funding meritorious proposals.

''(g) REPORT.—Not later than September 30, 2016, the Secretary shall prepare and submit to the appropriate

committees of Congress a report on the progress and accomplishments of the grant programs described in subsections (b), (c), (d), and (e).

''(h) DEFINITIONS.—In this section:

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

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

''(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $40,000,000 for fiscal year 2015, and such sums as may be necessary for each of fiscal years 2016 through 2019.''.

SEC. 427. COMMUNITY HEALTH CENTER COLLABORATIVE ACCESS EXPANSION.

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

''(t) MISCELLANEOUS PROVISIONS.—

''(1) RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINICS.—Nothing in this section shall be construed to prevent a community health center from contracting with a federally cer-

tified rural health clinic (as defined by section 1861(aa)(2) of the Social Security Act) for the delivery of primary health care and other mental, dental, and physical health 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 and other mental, dental, and physical health services available in that rural health clinic.

''(2) ENABLING SERVICES.—To the extent possible, enabling services such as transportation and translation assistance shall be provided by rural health clinics described in paragraph (1).

''(3) ASSURANCES.—In order for a rural health clinic to receive funds under this section through a contract with a community health center for the delivery of primary health care and other services described in paragraph (1), such rural health clinic shall establish policies to ensure—

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

''(B) the establishment of a sliding fee scale for low-income patients; and

''(C) any such services should be subject to full reimbursement according to the Prospective Payment System scale.''.

SEC. 428. FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.

(a) IN GENERAL.—For purposes of expediting the provision of telehealth services, for which payment is made under the Medicare Program, across State lines, the Secretary of Health and Human Services shall, in consultation with representatives of States, physicians, health care practitioners, and patient advocates, encourage and facilitate the adoption of provisions allowing for multistate practitioner practice across State lines.

(b) DEFINITIONS.—In subsection (a):

(1) TELEHEALTH SERVICE.—The term ''telehealth service'' has the meaning given that term in subparagraph (F) of section 1834(m)(4) of the Social Security Act (42 U.S.C. 1395m(m)(4)).

(2) PHYSICIAN, PRACTITIONER.—The terms ''physician'' and ''practitioner'' have the meaning given those terms in subparagraphs (D) and (E), respectively, of such section.

(3) MEDICARE PROGRAM.—The term ''Medicare Program'' means the program of health insurance administered by the Secretary of Health and Human

Services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

SEC. 429. SCORING OF PREVENTIVE HEALTH SAVINGS.

Section 202 of the Congressional Budget and Impoundment Control Act of 1974 (2 U.S.C. 602) is amended by adding at the end the following new subsection:

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

''(1) DETERMINATION BY THE DIRECTOR.—Upon a request by the chairman or ranking minority member of the Committee on the Budget of the Senate, or by the chairman or ranking minority member of the Committee on the Budget of the House of Representatives, the Director shall determine if a proposed measure would result in reductions in budget outlays in budgetary outyears through the use of preventive health and preventive health services.

''(2) PROJECTIONS.—If the Director determines that a measure would result in substantial reductions in budget outlays as described in paragraph (1), the Director—

''(A) shall include, in any projection prepared by the Director, a description and estimate of the reductions in budget outlays in the

budgetary outyears and a description of the basis for such conclusions; and

"(B) may prepare a budget projection that includes some or all of the budgetary outyears, notwithstanding the time periods for projections described in subsection (e) and sections 308, 402, and 424.

"(3) DEFINITIONS.—As used in this subsection—

"(A) the term 'preventive health' means an action that focuses on the health of the public, individuals, and defined populations in order to protect, promote, and maintain health, wellness, and functional ability, and prevent disease, disability, and premature death that is demonstrated by credible and publicly available epidemiological projection models, incorporating clinical trials or observational studies in humans, to avoid future health care costs; and

"(B) the term 'budgetary outyears' means the 2 consecutive 10-year periods beginning with the first fiscal year that is 10 years after the budget year provided for in the most recently agreed to concurrent resolution on the budget.".

SEC. 430. SENSE OF CONGRESS.

It is the sense of the Congress that—

(1) the maintenance of effort 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 under title XIX of the Social Security Act and Children's Health Insurance Program under title XXI of such Act until the American Health Benefit Exchanges in the States are fully operational;

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

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

(4) the maintenance of effort provisions ensure the continued success of the Medicaid program and Children's Health Insurance Program 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 maintenance of effort provisions must be strictly enforced and proposals to weaken the maintenance of effort provisions must not be considered.

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) are each repealed.

(b) CONFORMING AMENDMENTS.—

(1) Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by amending paragraph (46) of subsection (a) to read as follows:

''(46) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act;'';

(B) in subsection (e)(13)(A)(i)—

(i) in the matter preceding subclause (I), by striking ''sections 1902(a)(46)(B) and 1137(d)'' and inserting ''section 1137(d)''; and

(ii) in subclause (IV), by striking ''1902(a)(46)(B) or''; and

(C) by striking subsection (ee).

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

(A) in subsection (i), by redesignating paragraphs (23) through (26) as paragraphs (22) through (25), respectively; and

(B) by redesignating subsections (y) and (z) as subsections (x) and (y), respectively.

(3) Subsection (c) of section 6036 of the Deficit Reduction Act of 2005 (42 U.S.C. 1396b note) 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:

''§ 7310. Office of Minority Health

''(a) ESTABLISHMENT.—There is established in the Department within the Office of the Under Secretary for

Health an office to be known as the 'Office of Minority Health' (in this section referred to as the 'Office').

''(b) HEAD.—The Director of the Office of Minority Health shall be the head of the Office. The Director of the Office of Minority Health shall be appointed by the Under Secretary of Health from among individuals qualified to perform the duties of the position.

''(c) FUNCTIONS.—The functions of the Office are as follows:

''(1) To establish short-range and long-range goals and objectives and coordinate all other activities within the Veterans Health Administration that relate to disease prevention, health promotion, health care services delivery, and health care research concerning veterans who are members of a racial or ethnic minority group.

''(2) To support research, demonstrations, and evaluations to test new and innovative models for the discharge of activities described in paragraph (1).

''(3) To increase knowledge and understanding of health risk factors for veterans who are members of a racial or ethnic minority group.

''(4) To develop mechanisms that support better health care information dissemination, education,

prevention, and services delivery to veterans from disadvantaged backgrounds, including veterans who are members of a racial or ethnic minority group.

''(5) To enter into contracts or agreements with appropriate public and nonprofit private entities to develop and carry out programs to provide bilingual or interpretive services to assist veterans who are members of a racial or ethnic minority group and who lack proficiency in speaking the English language in accessing and receiving health care services through the Veterans Health Administration.

''(6) To carry out programs to improve access to health care services through the Veterans Health Administration for veterans with limited proficiency in speaking the English language, including the development and evaluation of demonstration and pilot projects for that purpose.

''(7) To advise the Under Secretary of Health on matters relating to the development, implementation, and evaluation of health professions education in decreasing disparities in health care outcomes between veterans who are members of a racial or ethnic minority group and other veterans, including cultural competency as a method of eliminating such health disparities.

''(8) To perform such other functions and duties as the Secretary or the Under Secretary for Health considers appropriate.

''(d) DEFINITIONS.—In this section:

''(1) The term 'racial or ethnic minority group' means the following:

''(A) American Indians (including Alaska Natives, Eskimos, and Aleuts).

''(B) Asian-Americans.

''(C) Native Hawaiians and other Pacific Islanders.

''(D) Blacks.

''(E) Hispanics.

''(2) The term 'Hispanic' means individuals whose origin is Mexican, Puerto Rican, Cuban, Central or South American, or any other Spanish-speaking country.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 7309 the following new item:

''7310. Office of Minority Health.''.

SEC. 433. INDIAN DEFINED IN PPACA.

(a) DEFINITION OF INDIAN.—Section 1304 of the Patient Protection and Affordable Care Act (42 U.S.C. 18024) is amended by adding at the end the following:

''(f) INDIAN.—

''(1) IN GENERAL.—In this title, the term 'Indian' means any individual—

''(A) described in paragraph (13) or (28) of section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603);

''(B) who is eligible for health services provided by the Indian Health Service under section 809 of the Indian Health Care Improvement Act (25 U.S.C. 1679);

''(C) who is of Indian descent and belongs to the Indian community served by the local facilities and program of the Indian Health Service; or

''(D) who is described in paragraph (2).

''(2) INCLUDED INDIVIDUALS.—The following individuals shall be considered to be an 'Indian':

''(A) A member of a federally recognized Indian tribe.

''(B) A resident of an urban center who meets 1 or more of the following 4 criteria:

''(i) Membership in a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized as of the

date of enactment of the Health Equity and Accountability Act of 2014 or later by the State in which they reside, or being a descendant, in the first or second degree, of any such member.

''(ii) Is an Eskimo or Aleut or other Alaska Native.

''(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose.

''(iv) Is determined to be an Indian under regulations promulgated by the Secretary.

''(C) An individual who is considered by the Secretary of the Interior to be an Indian for any purpose.

''(D) An individual who is considered by the Secretary to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.''.

(b) CONFORMING AMENDMENTS.—

(1) AFFORDABLE CHOICES HEALTH BENEFIT PLANS.—Section 1311(c)(6)(D) of the Patient Protection and Affordable Care Act (42 U.S.C.

18031(c)(6)(D)) is amended by striking ''section 4 of the Indian Health Care Improvement Act'' and inserting ''section 1304(f)''.

(2) REDUCED COST-SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.—Section 1402(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 18071(d)) is amended—

(A) in paragraph (1), in the matter preceding subparagraph (A), by striking ''section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))'' and inserting ''section 1304(f)''; and

(B) in paragraph (2), in the matter preceding subparagraph (A), by striking ''(as so defined)'' and inserting ''(as defined in section 1304(f))''.

(3) EXEMPTION FROM PENALTY FOR NOT MAINTAINING MINIMUM ESSENTIAL COVERAGE.—Section 5000A(e) of the Internal Revenue Code of 1986 is amended by striking paragraph (3) and inserting the following:

''(3) INDIANS.—Any applicable individual who is an Indian (as defined in section 1304(f) of the Patient Protection and Affordable Care Act).''.

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

(a) IN GENERAL.—Not later than January 1, 2016, the Comptroller General of the United States shall conduct a study on how certain amendments made by the Patient Protection and Affordable Care Act (Public Law 111–148) to titles XVIII and XIX of the Social Security Act affect the timely access to health care services for low-income patients. Such study shall—

(1) evaluate and examine whether States electing to make medical assistance available under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) (including States making such an election through a waiver of the State plan) to individuals described in such section mitigates the need for payments to disproportionate share hospitals under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) and section 1923 of such Act (42 U.S.C. 1396r–4), including the impact of such States electing to make medical assistance available to such individuals on—

(A) the number of individuals in the United States who are without health insurance and the distribution of such individuals in rela-

tion to areas primarily served by disproportionate share hospitals; and

(B) the low-income utilization rate of such hospitals and the resulting fiscal sustainability of such hospitals;

(2) evaluate the appropriate level and distribution of such payments among disproportionate hospitals for purposes of—

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

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

(3) assess, with respect to disproportionate hospitals—

(A) the role played by such hospitals in providing critical access to emergency, inpatient, and outpatient health services, as well as the location of such hospitals in relation to medically underserved areas; and

(B) the extent to which such hospitals satisfy the requirements established for charitable hospital organizations under section 501(r) of the Internal Revenue Code of 1986 with respect

to community health needs assessments, financial assistance policy requirements, limitations on charges, and billing and collection requirements.

(b) REPORTS.—

(1) REPORT TO CONGRESS.—Not later than 180 days after the date on which the study under subsection (a) is completed, the Comptroller General of the United States shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report that contains—

(A) the results of the study;

(B) recommendations to Congress for any legislative changes to the payments to disproportionate share hospitals under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) and section 1923 of such Act (42 U.S.C. 1396r–4) that are needed to ensure access to health services for low-income patients that—

(i) are based on the number of individuals without health insurance, the amount of uncompensated care provided by

such hospitals, and the impact of reduced payments levels on low-income communities; and

(ii) takes into account any reports submitted by the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to Congressional committees regarding the costs incurred by charitable hospital organizations for charity care, bad debt, nonreimbursed expenses for services provided to individuals under the Medicare Program under title XVIII of the Social Security Act and the Medicaid Program under title XIX of such Act, and any community benefit activities provided by such organizations.

(2) REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES.—Not later than 180 days after the date on which the study under subsection (a) is completed, the Comptroller General of the United States shall submit to the Secretary of Health and Human Services a report that contains—

(A) the results of the study; and

(B) any recommendations for purposes of assisting in the development of the methodology for the adjustment of payments to disproportionate share hospitals, as required under section 1886(r) of the Social Security Act (42 U.S.C. 1395ww(r)) and the reduction of such payments section 1923(f)(7) of such Act (42 U.S.C. 1396r–4(f)(7)), taking into account the reports referred to in paragraph (1)(B)(ii).

SEC. 435. ASSISTANT SECRETARY OF THE INDIAN HEALTH SERVICE.

(a) REFERENCES.—Any reference in a law, regulation, document, paper, or other record of the United States to the Director of the Indian Health Service shall be deemed to be a reference to the Assistant Secretary of the Indian Health Service.

(b) EXECUTIVE SCHEDULE.—Section 5315 of title 5, United States Code, is amended in the matter relating to the Assistant Secretaries of Health and Human Services by striking ''(6)'' and inserting ''(7), 1 of whom shall be the Assistant Secretary of the Indian Health Service''.

(c) CONFORMING AMENDMENT.—Section 5316 of title 5, United States Code, is amended by striking ''Director, Indian Health Service, Department of Health and Human Services.''.

SEC. 436. REAUTHORIZATION OF THE NATIVE HAWAIIAN HEALTH CARE IMPROVEMENT ACT.

(a) NATIVE HAWAIIAN HEALTH CARE SYSTEMS.—Section 6(h)(1) of the Native Hawaiian Health Care Improvement Act (42 U.S.C. 11705(h)(1)) is amended by striking ''may be necessary for fiscal years 1993 through 2019'' and inserting ''are necessary''.

(b) ADMINISTRATIVE GRANT FOR PAPA OLA LOKAHI.—Section 7(b) of the Native Hawaiian Health Care Improvement Act (42 U.S.C. 11706(b)) is amended by striking ''may be necessary for fiscal years 1993 through 2019'' and inserting ''are necessary''.

(c) NATIVE HAWAIIAN HEALTH SCHOLARSHIPS.—Section 10(c) of the Native Hawaiian Health Care Improvement Act (42 U.S.C. 11709(c)) is amended by striking ''may be necessary for fiscal years 1993 through 2019'' and inserting ''are necessary''.

TITLE 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 Administrator of the Health Resources and Services Administration and other Federal officials determined appropriate by the Secretary, is authorized to award grants to eligible entities to promote positive health behaviors for women and children in target populations, especially racial and ethnic minority women and children in medically underserved communities.

''(b) USE OF FUNDS.—Grants awarded pursuant to subsection (a) may be used to support the activities of community health workers, including such activities—

''(1) to educate and provide outreach regarding enrollment in health insurance including the State Children's Health Insurance Program under title XXI of the Social Security Act, Medicare under title XVIII of such Act, and Medicaid under title XIX of such Act;

''(2) to educate, guide, and provide outreach in a community setting regarding health problems prevalent among women and children and especially among racial and ethnic minority women and children;

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

impede achieving healthy behaviors and good health outcomes, including—

"(A) poor nutrition;

"(B) physical inactivity;

"(C) being overweight or obese;

"(D) tobacco use;

"(E) alcohol and substance use;

"(F) injury and violence;

"(G) risky sexual behavior;

"(H) mental health problems;

"(I) musculoskeletal health and arthritis;

"(J) dental and oral health problems;

"(K) understanding informed consent; and

"(L) stigma;

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

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

"(6) to educate and refer target populations to appropriate health care agencies and community-based programs and organizations in order to increase access to quality health care services, including preventive health services.

"(c) APPLICATION.—

''(1) IN GENERAL.—Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

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

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

''(B) contain an assurance that, with respect to each community health worker program receiving funds under the grant awarded, such program provides in-language training and supervision to community health workers to enable such workers to provide authorized program activities in (at least) the most commonly used languages within a particular geographic region;

''(C) contain an assurance that the applicant will evaluate the effectiveness of community health worker programs receiving funds under the grant;

''(D) contain an assurance that each community health worker program receiving funds under the grant will provide culturally com-

petent services in the linguistic context most appropriate for the individuals served by the program;

"(E) contain a plan to document and disseminate project descriptions and results to other States and organizations as identified by the Secretary; and

"(F) describe plans to enhance the capacity of individuals to utilize health services and health-related social services under Federal, State, and local programs by—

"(i) assisting individuals in establishing eligibility under the programs and in receiving the services or other benefits of the programs; and

"(ii) providing other services, as the Secretary determines to be appropriate, which may include transportation and translation services.

"(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to those applicants—

"(1) who propose to target geographic areas that—

"(A)(i) have a high percentage of residents who are uninsured or underinsured (if the targeted geographic area is located in a State that has elected to make medical assistance available under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act to individuals described in such section); or

"(ii) have a high percentage of underinsured residents in a particular geographic area (if the targeted geographic area is located in a State that has not so elected); and

"(B) have a high percentage of families for whom English is not their primary language or including smaller limited-English-proficient communities within the region that are not otherwise reached by linguistically appropriate health services;

"(2) with experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

"(3) with documented community activity and experience with community health workers.

"(e) COLLABORATION WITH ACADEMIC INSTITUTIONS.—The Secretary shall encourage community health worker programs receiving funds under this section to col-

laborate with academic institutions, including minority-serving institutions. Nothing in this section shall be construed to require such collaboration.

''(f) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for ensuring the quality of the training and supervision of community health workers under the programs funded under this section and for ensuring the cost effectiveness of such programs.

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

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

''(i) REPORT TO CONGRESS.—

''(1) IN GENERAL.—Not later than 4 years after the date on which the Secretary first awards grants under subsection (a), the Secretary shall submit to Congress a report regarding the grant project.

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

''(A) A description of the programs for which grant funds were used.

''(B) The number of individuals served.

''(C) An evaluation of—

''(i) the effectiveness of these programs;

''(ii) the cost of these programs; and

''(iii) the impact of the project on the health outcomes of the community residents.

''(D) Recommendations for sustaining the community health worker programs developed or assisted under this section.

''(E) Recommendations regarding training to enhance career opportunities for community health workers.

''(j) DEFINITIONS.—In this section:

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

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

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

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

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

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

"(F) by taking into consideration the needs of the communities served, including the prevalence rates of risk factors that impede achieving healthy behaviors and good health outcomes among women and children, especially among racial and ethnic minority women and children; and

"(G) by providing referral and followup services.

"(2) COMMUNITY SETTING.—The term 'community setting' means a home or a community organization that serves a population.

"(3) ELIGIBLE ENTITY.—The term 'eligible entity' means—

"(A) a unit of State, territorial, local, or tribal government (including a federally recognized tribe or Alaska Native village); or

"(B) a community-based organization.

"(4) MEDICALLY UNDERSERVED COMMUNITY.—The term 'medically underserved community' means a community—

"(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3);

"(B) a significant portion of which is a health professional shortage area as designated under section 332; and

"(C) that includes populations that are linguistically isolated, such as geographic areas with a shortage of health professionals able to provide linguistically appropriate services.

"(5) SUPPORT.—The term 'support' means the provision of training, supervision, and materials needed to effectively deliver the services described in subsection (b), reimbursement for services, and other benefits.

"(6) TARGET POPULATION.—The term 'target population' means women of reproductive age, re-

gardless of their current childbearing status and children under 21 years of age.

''(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2015 through 2019.''.

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

(a) MEDICAID.—Section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)) is amended by striking paragraph (4) and inserting the following new paragraph:

''(4)(A) Notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and paragraph (1), payment shall be made to a State under this section for medical assistance furnished to an alien under this title (including an alien described in such paragraph) who meets any of the following conditions:

''(i) The alien is otherwise eligible for such assistance under the State plan approved under this title (other than the requirement of the receipt of aid or assistance under title IV, supplemental security income benefits under title

XVI, or a State supplementary payment) within either or both of the following eligibility categories:

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

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

"(ii) The alien is lawfully present in the United States.

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

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

"(J) Paragraph (4) of section 1903(v) (relating to coverage of categories of children,

pregnant women, and other lawfully present individuals).''.

(c) SUPPLEMENTAL NUTRITION ASSISTANCE.—Notwithstanding sections 401(a), 402(a), and 403(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(a); 1612(a); 1613(a)) and section 6(f) of the Food and Nutrition Act of 2008 (7 U.S.C. 2015(f)), persons who are lawfully present in the United States shall be not be ineligible for benefits under the supplemental nutrition assistance program on the basis of their immigration status or date of entry into the United States.

(d) ELIGIBILITY FOR FAMILIES WITH CHILDREN.—Section 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, pre-

maturity, 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 and targeting education to at-risk groups;

(3) modifying risk behaviors; or

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

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $5,000,000 for fiscal year 2015, $6,000,000 for fiscal year 2016, $7,000,000 for fiscal year 2017, $8,000,000 for fiscal year 2018, and $9,000,000 for fiscal year 2019.

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

(a) IN GENERAL.—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 2015 through 2021, 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 de-

scribed in subsection (b)(3), with respect to pregnancy-related deaths occurring within the State during such fiscal year;

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

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

"(2) CRITERIA.—The Secretary shall establish criteria for determining eligibility for and the amount of a grant awarded to a State under paragraph (1). Such criteria shall provide that in the case of a State that receives such a grant for a fiscal year and is determined by the Secretary to have not used such grant in accordance with this section, such State shall not be eligible for such a grant for any subsequent fiscal year.

"(3) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the grant program under this section, including for administrative purposes, there is authorized to be appropriated $10,000,000 for each of fiscal years 2015 through 2021.

"(b) PREGNANCY-RELATED DEATH REVIEW.—

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

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

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

"(ii) INDIVIDUALS AND ENTITIES DESCRIBED.—Individuals and entities described in this clause include each of the following:

"(I) Health care providers.

"(II) Medical examiners.

"(III) Medical coroners.

"(IV) Hospitals.

"(V) Free-standing birth centers.

"(VI) Federally qualified health centers.

"(VII) Other health care facilities.

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

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

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

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

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

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

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

"(C) DEVELOPMENT OF CASE-FINDING.—The State, through the vital statistics unit of the State, shall annually identify pregnancy-related and pregnancy-associated deaths occur-

ring in such State during the year involved by—

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

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

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

''(iv) any other methods the States may devise to identify maternal deaths, such as through review of a random sample of reported deaths of women of childbearing age to ascertain cases of pregnancy-related and pregnancy-associated deaths that are not discernable from a review of death certificates alone.

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

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

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

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

''(ii) medical records of the woman, including such records related to health care prior to pregnancy, prenatal and postnatal care, labor and delivery care, emergency room care, hospital discharge records including immunization status and screening status for prevalent diseases, 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 de-

fined 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 in-language when possible, 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, including experiences with intimate partner violence.

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

''(A) DUTIES.—

''(i) REQUIRED COMMITTEE ACTIVITIES.—For purposes of subsection (a), a maternal mortality review committee estab-

lished 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, nonmedical, and system-related factors that may have contributed to such pregnancy-related and

pregnancy-associated deaths and disparities.

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

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

wise improving the quality of care provided by the facilities.

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

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

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

''(I) representatives from medical specialties providing care to pregnant

and postpartum patients, including obstetricians (including generalists and maternal fetal medicine specialists), and family practice physicians;

''(II) representatives from midwifery specialties (including certified professional midwives and certified midwives);

''(III) advanced practice nurses;

''(IV) hospital-based nurses;

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

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

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

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

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

''(iii) ADDITIONAL MEMBERS.—Each such review committee may also include representatives from other relevant academic, health, social service, or policy professions, or community organizations, on an ongoing basis, or as needed, as determined beneficial by the review committee, including—

''(I) anesthesiologists;

''(II) emergency physicians;

''(III) pathologists;

''(IV) epidemiologists or biostatisticians;

''(V) intensivists;

''(VI) orthopedic surgeons and/or orthopedic physicians;

''(VII) vital statistics officers;

''(VIII) nutritionists;

''(IX) mental health professionals;

''(X) substance abuse treatment specialists;

''(XI) representatives of relevant advocacy groups;

''(XII) academics;

''(XIII) representatives of beneficiaries of the State plan under the Medicaid Program under title XIX;

''(XIV) paramedics;

''(XV) lawyers;

''(XVI) risk management specialists;

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

''(XVIII) policymakers.

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

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

tions, and from minority advocacy groups;

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

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

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

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

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

''(III) administrative staff.

''(C) OPTION FOR STATES TO FORM REGIONAL MATERNAL MORTALITY REVIEWS.—

States with a low rate of occurrence of pregnancy-associated or pregnancy-related deaths may choose to partner with one or more neighboring States to fulfill the activities described in paragraph (1)(C). In such a case, with respect to States in such a partnership, any requirement under this section relating to the 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 develop a uniform, comprehensive case abstraction form and make such form available to States for State maternal mortality review committees for use by such committees in order to—

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

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

''(2) PERMISSIBLE STATE MODIFICATION.—Each State may modify the form developed under paragraph (1) for implementation and use by such State or by the State maternal mortality review committee of such State by including on such form additional information to be collected, but may not alter the standard questions on such form, in order to en-

sure that the information can be collected and reviewed centrally at the Federal level.

''(d) TREATMENT AS PUBLIC HEALTH AUTHORITY FOR PURPOSES OF HIPAA.—For purposes of applying HIPAA privacy and security law (as defined in section 3009(a)(2) of the Public Health Service Act), a State maternal mortality review committee of a State established pursuant to this section to carry out activities described in subsection (b)(2)(A) shall be deemed to be a public health authority described in section 164.501 (and referenced in section 164.512(b)(1)(i)) of title 45, Code of Federal Regulations (or any successor regulation), carrying out public health activities and purposes described in such section 164.512(b)(1)(i) (or any such successor regulation).

''(e) PUBLIC DISCLOSURE OF INFORMATION.—

''(1) IN GENERAL.—For fiscal year 2015 or a subsequent fiscal year, each State receiving a grant under this section for such year shall, subject to paragraph (3), provide for the public disclosure, and submission to the information clearinghouse established under paragraph (2), of the information included in the report of the State under section 506(a)(2)(F) for such year (relating to the findings for such year of the State maternal mortality review

committee established by the State under this section).

''(2) INFORMATION CLEARINGHOUSE.—The Secretary of Health and Human Services shall establish an information clearinghouse, that shall be administered by the Director of the Centers for Disease Control and Prevention, that will maintain findings and recommendations submitted pursuant to paragraph (1) and provide such findings and recommendations for public review and research purposes by State health departments, maternal mortality review committees, and health providers and institutions.

''(3) CONFIDENTIALITY OF INFORMATION.—In no case shall any individually identifiable health information be provided to the public, or submitted to the information clearinghouse, under paragraph (1).

''(f) CONFIDENTIALITY OF REVIEW COMMITTEE PROCEEDINGS.—

''(1) IN GENERAL.—All proceedings and activities of a State maternal mortality review committee under this section, opinions of members of such a committee formed as a result of such proceedings and activities, and records obtained, created, or maintained pursuant to this section, including

records of interviews, written reports, and statements procured by the Department of Health and Human Services or by any other person, agency, or organization acting jointly with the Department, in connection with morbidity and mortality reviews under this section, shall be confidential, and not subject to discovery, subpoena, or introduction into evidence in any civil, criminal, legislative, or other proceeding. Such records shall not be open to public inspection.

''(2) TESTIMONY OF MEMBERS OF COMMITTEE.—

''(A) IN GENERAL.—Members of a State maternal mortality review committee under this section may not be questioned in any civil, criminal, legislative, or other proceeding regarding information presented in, or opinions formed as a result of, a meeting or communication of the committee.

''(B) CLARIFICATION.—Nothing in this subsection shall be construed to prevent a member of such a committee from testifying regarding information that was obtained independent of such member's participation on the committee, or that is public information.

''(3) AVAILABILITY OF INFORMATION FOR RESEARCH PURPOSES.—Nothing in this subsection shall prohibit the publishing by such a committee or the Department of Health and Human Services of statistical compilations and research reports that—

''(A) are based on confidential information, relating to morbidity and mortality review; and

''(B) do not contain identifying information or any other information that could be used to ultimately identify the individuals concerned.

''(g) DEFINITIONS.—For purposes of this section:

''(1) The term 'pregnancy-associated death' means the death of a woman while pregnant or during the one-year period following the date of the end of pregnancy, irrespective of the cause of such death.

''(2) The term 'pregnancy-related death' means the death of a woman while pregnant or during the one-year period following the date of the end of pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from any accidental or incidental cause.

''(3) The term 'woman of childbearing age' means a woman who is at least 10 years of age and not more than 54 years of age.''.

(b) INCLUSION OF FINDINGS OF REVIEW COMMITTEES IN REQUIRED REPORTS.—

(1) STATE TRIENNIAL REPORTS.—Paragraph (2) of section 506(a) of such Act (42 U.S.C. 706(a)) is amended by inserting after subparagraph (E) the following new subparagraph:

''(F) In the case of a State receiving a grant under section 514, beginning for the first fiscal year beginning after 3 years after the date of establishment of the State maternal mortality review committee established by the State pursuant to such grant and once every 3 years thereafter, information containing the findings and recommendations of such committee and information on the implementation of such recommendations during the period involved.''.

(2) ANNUAL REPORTS TO CONGRESS.—Paragraph (3) of such section is amended—

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

(B) in subparagraph (E), at the end, by striking the period and inserting ''; and''; and

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

''(F) For fiscal year 2015 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 (in consultation with the Deputy Assistant Secretary for Minority Health, the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, the Administrator of the Centers for Medicare & Medicaid

Services, and the Administrator of the Agency for Healthcare Research & Quality, and in consultation with relevant national stakeholder organizations such as national medical specialty organizations, national maternal child health organizations, national groups that represent minority populations, and national health disparity organizations) shall 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 types 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, 2015, and end on December 31, 2019.

''(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, 2020, the Secretary shall submit to Congress a report on the results of the demonstration project under subsection (a)(3).''.

SEC. 507. DECREASING THE RISK FACTORS FOR SUDDEN UNEXPECTED INFANT DEATH AND SUDDEN UNEXPLAINED DEATH IN CHILDHOOD.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health (in this section referred to as the ''Secretary''), shall establish and implement a culturally competent public health awareness and education campaign to provide information that is focused on decreasing the risk factors for sudden unexpected infant death and sudden unexplained death in childhood, including educating individuals about safe sleep environments, sleep positions, and reducing exposure to smoking during pregnancy and after birth.

(b) TARGETED POPULATIONS.—The campaign under subsection (a) shall be designed to reduce health disparities through the targeting of populations with high rates of sudden unexpected infant death and sudden unexplained death in childhood.

(c) CONSULTATION.—In establishing and implementing the campaign under subsection (a), the Secretary shall consult with national organizations representing health care providers, including nurses and physicians,

parents, child care providers, children's advocacy and safety organizations, maternal and child health programs, nutrition professionals focusing on women, infants, and children, and other individuals and groups determined necessary by the Secretary for such establishment and implementation.

(d) GRANTS.—

(1) IN GENERAL.—In carrying out the campaign under subsection (a), the Secretary shall award grants to national organizations, State and local health departments, and community-based organizations for the conduct of education and outreach programs for nurses, parents, child care providers, public health agencies, and community organizations.

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

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2015 through 2019.

SEC. 508. REDUCING UNINTENDED TEENAGE PREGNANCIES.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following 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 communities at disproportionate risk for unintended teen pregnancy (particularly youth in racial or ethnic minority or immigrant communities, youth in the foster care system, youth in the juvenile justice system, rural youth, and LGBT youth) the information and skills needed to prevent unintended teenage pregnancies, build healthy relationships, and improve overall health and well-being.

"SEC. 399OO–1. LIMITATION.

''No Federal funds provided under this Act may be used for health education programs or media awareness campaigns that—

''(1) deliberately withhold life-saving information about the human immunodeficiency virus (HIV);

''(2) undermine young people's confidence in the effectiveness of contraception;

''(3) are medically inaccurate or have been scientifically shown to be ineffective;

''(4) promote gender, racial, or ethnic stereotypes;

''(5) are insensitive and unresponsive to the needs of sexually active youth or LGBT youth;

''(6) are inconsistent with the ethical imperatives of medicine and public health; or

''(7) stigmatize and shame youth who are parenting or choose to parent.

"SEC. 399OO–2. DEMONSTRATION GRANTS TO REDUCE UNINTENDED TEENAGE PREGNANCIES.

''(a) IN GENERAL.—The Secretary shall award competitive grants to eligible entities for establishing or expanding programs to provide youth in communities at disproportionate risk for unintended teen pregnancy (particularly youth in racial or ethnic minority or immigrant communities, youth in the foster care system, youth in the juvenile justice system, rural youth, and LGBT youth) the information and skills needed to prevent unintended 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 communities at disproportionate risk for unintended teen pregnancy (particularly youth in racial or ethnic minority or immigrant communities, youth in the foster care system, youth in the juvenile justice system, rural youth, and LGBT youth);

''(2) that have a demonstrated history of effectively working with such targeted communities;

''(3) that have a demonstrated history of engaging in a meaningful and significant partnership with such targeted communities; or

''(4) that have an integrated approach that also promotes the skills necessary to build healthy relationships and recognize abusive or unhealthy behaviors.

''(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; afterschool programs; community-based programs; workforce development programs; and health care settings, including community health centers; or

''(2) in collaboration with systems that serve large numbers of at-risk youth such as juvenile justice or foster care systems.

''(d) PROJECT REQUIREMENTS.—As a condition of receipt of a grant under this section, an entity shall agree that, with respect to information and skills provided through the grant—

''(1) such information and skills will be—

''(A) age-appropriate;

''(B) evidence-based or evidence-informed;

''(C) provided in accordance with section 399OO–6(b); and

''(D) culturally sensitive and relevant to the target populations; and

''(2) any information provided about contraceptives shall include the health benefits and side effects of all contraceptives and barrier methods.

''(e) EVALUATION.—Of the total amount made available to carry out this section for a fiscal year, the Secretary, acting through the Director of the Centers for Disease Control and Prevention and other agencies as appropriate, shall allot up to 10 percent of such amount to carry out a rigorous, independent evaluation to determine the extent and the effectiveness of activities funded through this section during such fiscal year in changing attitudes

and behavior of teenagers with respect to healthy relationships and childbearing.

''(f) GRANTS FOR INDIAN TRIBES OR TRIBAL ORGANIZATIONS.—Of the total amount made available to carry out this section for a fiscal year, the Secretary shall reserve 5 percent of such amount to award grants under this section to Indian tribes and tribal organizations in such manner, and subject to such requirements, as the Secretary, in consultation with Indian tribes and tribal organizations, determines appropriate.

''(g) ELIGIBLE ENTITY DEFINED.—

''(1) IN GENERAL.—In this section, the term 'eligible entity' means a State, local, or tribal agency; a school or postsecondary institution; an afterschool program; a nonprofit organization; or a community or faith-based organization.

''(2) PREVENTING EXCLUSION OF SMALLER COMMUNITY-BASED ORGANIZATIONS.—In carrying out this section, the Secretary shall ensure that the amounts and requirements of grants provided under this section do not preclude receipt of such grants by community-based organizations with a demonstrated history of effectively working with adolescents in racial or ethnic minority or immigrant com-

munities or engaged in meaningful and significant partnership with such communities.

"SEC. 399OO–3. MULTIMEDIA CAMPAIGNS TO REDUCE UNINTENDED 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 unintended 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 communities at disproportionate risk for unintended teen pregnancy (particularly youth in racial or ethnic minority or immigrant communities, youth in the foster care system, youth in the juvenile justice system, rural youth, and LGBT youth).

"(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 unintended teenage pregnancy; and

''(B) healthy relationship development; and

''(2) may provide information on the prevention of dating violence and sexual assault.

"SEC. 399OO–4. RESEARCH ON REDUCING UNINTENDED 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 unintended 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 unintended teenage pregnancies and births, among all minority communities and subpopulations in which such data are not collected, including American Indian and Alaska Native youth;

''(B) sexual behavior, reproductive and sexual coercion, and teenage contraceptive use patterns at the State level, as appropriate;

''(C) unintended teenage pregnancies among youth in and aging out of foster care or juvenile justice systems and the underlying factors that lead to unintended teenage pregnancy among youth in foster care or juvenile justice systems; and

''(D) sexual and reproductive health, including teenage pregnancies and births, sexual behavior, reproductive and sexual coercion, and teenage contraceptive use among—

''(i) LGBT youth; and

''(ii) rural youth;

''(2) investigates—

''(A) the variance in the rates of unintended 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, based on the income of the family and education attainment;

"(B) factors affecting the risk for youth of unintended teenage pregnancy or dating violence, 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 unintended 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 in a culturally appropriate manner; and

"(F) the effectiveness of media campaigns in addressing healthy relationship development, dating violence prevention, and unintended teenage pregnancy; and

"(3) tests research-based strategies for addressing high rates of unintended teenage pregnancy through programs that emphasize healthy relationships and violence prevention.

''(b) PRIORITY.—In carrying out this section, the Secretary shall give priority to research that incorporates—

''(1) interdisciplinary approaches;

''(2) a strong emphasis on community-based participatory research; or

''(3) translational research.

"SEC. 399OO–5. HHS ADOLESCENT HEALTH WORK GROUP.

''(a) PURPOSE.—Not later than 30 days after the date of the enactment of this part, the Secretary shall direct the interagency adolescent health workgroup within the Office of Adolescent Health of the Department of Health and Human Services to—

''(1) include in the work of the group strategies for teenage dating violence prevention and healthy teenage relationships with a particular focus among racial or ethnic minority or immigrant communities; and

''(2) with respect to including such strategies, consult, to the greatest extent possible, with the Federal Interagency Workgroup on Teen Dating Violence formed under the leadership of the National Institute of Justice of the Department of Justice.

''(b) REPORT REQUIREMENT.—The Secretary, through the Office of Adolescent Health, shall periodically submit to Congress a report that—

''(1) includes a review of the evidence-based programs on preventing unintended teenage pregnancy, which are carried out and identified by the Office; and

''(2) identifies the programs of the Department of Health and Human Services that include teenage dating violence prevention and the promotion of healthy teenage relationships as part of a strategy to prevent unintended teenage pregnancy.

''SEC. 399OO–6. GENERAL GRANT PROVISIONS.

''(a) APPLICATIONS.—To seek a grant under this part, an entity shall submit an application to the Secretary in such form, in such manner, and containing such agreements, assurances, and information as the Secretary may require.

''(b) ADDITIONAL REQUIREMENTS.—A grant may be made under this part only if the applicant involved agrees that information, activities, and services provided under the grant—

''(1) will be evidence-based or evidence-informed;

''(2) will be factually and medically accurate and complete; and

''(3) if directed to a particular population group, will be provided in an appropriate language and cultural context.

''(c) TRAINING AND TECHNICAL ASSISTANCE.—

''(1) IN GENERAL.—Of the total amount made available to carry out this part for a fiscal year, the Secretary shall use 10 percent to provide, directly or through a competitive grant process, training and technical assistance to the grant recipients under this part, including by disseminating research and information regarding effective and promising practices, providing consultation and resources on a broad array of teenage and unintended pregnancy and violence prevention strategies, and developing resources and materials.

''(2) COLLABORATION.—In carrying out this subsection, the Secretary shall collaborate with entities that have expertise in the prevention of teenage pregnancy, healthy relationship development, minority health and health disparities, and violence prevention.

''SEC. 399OO–7. 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) LGBT YOUTH.—The term 'LGBT youth' means lesbian, gay, bisexual, and transgender youth.

''(3) 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.

''(4) REPRODUCTIVE AND SEXUAL COERCION.—The term 'reproductive and sexual coercion'—

''(A) means, with respect to a person, coercive behavior that interferes with the ability of such person to control the reproductive deci-

sionmaking of such person, such as intentionally exposing such person to sexually transmitted infections; in the case such person is a female, attempting to impregnate such person against her will; intentionally interfering with the person's birth control; or threatening or acting violent if the person does not comply with the perpetrator's wishes regarding contraception or the decision whether to terminate or continue a pregnancy; and

''(B) includes a range of behaviors that a partner may use related to sexual decision-making to pressure or coerce a person to have sex without using physical force, such as repeatedly pressuring a partner to have sex when he or she does not want to; threatening to end a relationship if a person does not have sex; and threatening retaliation if notified of a positive sexually transmitted disease test result.

''(5) YOUTH.—The term 'youth' means individuals who are 11 to 19 years of age.

"SEC. 399OO–8. 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, 2019, the Secretary shall submit to Congress a report on the impact of the programs under this part on reducing unintended teenage pregnancies.

''SEC. 399OO–9. 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 2015 through 2019.

''(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 enhance surveillance data and public health research on gestational diabetes.

''(2) AREAS TO BE ADDRESSED.—The research project developed under paragraph (1) shall address—

''(A) procedures to establish accurate and efficient systems for the collection of gestational diabetes data within each State and commonwealth, territory, or possession of the United States;

''(B) the progress of collaborative activities with the National Vital Statistics System, the National Center for Health Statistics, and State health departments with respect to the standard birth certificate, in order to improve surveillance of gestational diabetes;

''(C) postpartum methods of tracking women with gestational diabetes after delivery

as well as targeted interventions proven to lower the incidence of type 2 diabetes in that population;

"(D) variations in the distribution of diagnosed and undiagnosed gestational diabetes, and of impaired fasting glucose tolerance and impaired fasting glucose, within and among groups of women; and

"(E) factors and culturally sensitive interventions that influence risks and reduce the incidence of gestational diabetes and related complications during childbirth, including cultural, behavioral, racial, ethnic, geographic, demographic, socioeconomic, and genetic factors.

"(3) REPORT.—Not later than 2 years after the date of the enactment of this section, and annually thereafter, the Secretary shall generate a report on the findings and recommendations of the research project including prevalence of gestational diabetes in the multisite area and disseminate the report to the appropriate Federal and non-Federal agencies.

"(b) EXPANSION OF GESTATIONAL DIABETES RESEARCH.—

''(1) IN GENERAL.—The Secretary shall expand and intensify public health research regarding gestational diabetes. Such research may include—

''(A) developing and testing novel approaches for improving postpartum diabetes testing or screening and for preventing type 2 diabetes in women with a history of gestational diabetes; and

''(B) conducting public health research to further understanding of the epidemiologic, socioenvironmental, behavioral, translation, and biomedical factors and health systems that influence the risk of gestational diabetes and the development of type 2 diabetes in 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 2015 through 2019.

''(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 demonstra-

tion projects that implement evidence-based interventions to reduce the incidence of gestational diabetes, the recurrence of gestational diabetes in subsequent pregnancies, and the development of type 2 diabetes in women with a history of gestational diabetes.

''(2) PRIORITY.—In making grants under this subsection, the Secretary shall give priority to projects focusing on—

''(A) helping women who have 1 or more risk factors for developing gestational diabetes;

''(B) working with women with a history of gestational diabetes during a previous pregnancy;

''(C) providing postpartum care for women with gestational diabetes;

''(D) tracking cases where women with a history of gestational diabetes developed type 2 diabetes;

''(E) educating mothers with a history of gestational diabetes about the increased risk of their child developing diabetes;

''(F) working to prevent gestational diabetes and prevent or delay the development of

type 2 diabetes in women with a history of gestational diabetes; and

''(G) achieving outcomes designed to assess the efficacy and cost-effectiveness of interventions that can inform decisions on long-term sustainability, including third-party reimbursement.

''(3) APPLICATION.—An eligible entity desiring to receive a grant under this subsection shall submit to the Secretary—

''(A) an application at such time, in such manner, and containing such information as the Secretary may require; and

''(B) a plan to—

''(i) lower the rate of gestational diabetes during pregnancy; or

''(ii) develop methods of tracking women with a history of gestational diabetes and develop effective interventions to lower the incidence of the recurrence of gestational diabetes in subsequent pregnancies and the development of type 2 diabetes.

''(4) USES OF FUNDS.—An eligible entity receiving a grant under this subsection shall use the

grant funds to carry out demonstration projects described in paragraph (1), including—

"(A) expanding community-based health promotion education, activities, and incentives focused on the prevention of gestational diabetes and development of type 2 diabetes in women with a history of gestational diabetes;

"(B) aiding State- and tribal-based diabetes prevention and control programs to collect, analyze, disseminate, and report surveillance data on women with, and at risk for, gestational diabetes, the recurrence of gestational diabetes in subsequent pregnancies, and, for women with a history of gestational diabetes, the development of type 2 diabetes; and

"(C) training and encouraging health care providers—

"(i) to promote risk assessment, high-quality care, and self-management for gestational diabetes and the recurrence of 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 2015 through 2019.

''(d) POSTPARTUM FOLLOWUP REGARDING GESTATIONAL DIABETES.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall work with the State- and tribal-based diabetes prevention and control programs assisted by the Centers to encourage postpartum followup after gestational diabetes, as medically appropriate, for the purpose of reducing the incidence of gestational diabetes, the recurrence of

gestational diabetes in subsequent pregnancies, the development of type 2 diabetes in 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 2015 through 2019.

SEC. 511. SUPPORTING HEALTHY ADOLESCENT DEVELOPMENT.

(a) IN GENERAL.—The Secretary may award a grant to each eligible State to conduct programs of sex education

described in subsection (b), including education on both abstinence and contraception for the prevention of teenage pregnancy and sexually transmitted diseases, including HIV/AIDS and viral hepatitis.

(b) REQUIREMENTS FOR SEX EDUCATION PROGRAMS.—A program of sex education described in this subsection is a program that—

(1) is age appropriate and medically accurate;

(2) stresses the value of abstinence while not ignoring those young people who have been or are sexually active;

(3) includes information providing a factual understanding of male and female reproductive anatomy;

(4) provides information about the health benefits and side effects of contraceptive and barrier methods used—

(A) as a means to prevent pregnancy; and

(B) to reduce the risk of contracting sexually transmitted disease, including HIV/AIDS and viral hepatitis;

(5) encourages family communication between parent and child about sexuality;

(6) cultivates a respectful dialogue about sexuality, including sexual orientation and gender iden-

tity, and embraces the principles of nondiscrimination based on sexual orientation and gender identity;

(7) counters the perpetuation of narrow gender roles, including the sexualization of female children, adolescents, and adults;

(8) 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;

(9) develops healthy relationships, including the prevention of dating and sexual violence;

(10) teaches young people how alcohol and drug use can affect responsible decisionmaking; and

(11) 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—

(A) to ensure and protect their sexual and reproductive health from unintended pregnancy and sexually transmitted disease, including HIV/AIDS, throughout their lifespan;

(B) to be aware that certain racial and ethnic groups are more affected by certain sexually transmitted diseases; and

(C) to receive the education to prevent further transmission;

(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, evaluations shall be carried out in accordance with paragraphs (2) and (3).

(2) NATIONAL EVALUATION.—

(A) METHOD.—The Secretary shall provide for a national evaluation of a representative sample of programs of sex education carried out with grants under this section to determine—

(i) the effectiveness of such programs in helping to delay the initiation of sexual intercourse and other high-risk behaviors;

(ii) the effectiveness of such programs in preventing adolescent pregnancy;

(iii) the effectiveness of such programs in preventing sexually transmitted disease, including HIV/AIDS and viral hepatitis;

(iv) the effectiveness of such programs in increasing contraceptive knowledge and contraceptive behaviors when sexual intercourse occurs; and

(v) a list of best practices that—

(I) is based upon essential programmatic components of evaluated programs that have led to success described in clauses (i) through (iv); and

(II) documents the racial and ethnic minority populations that are recipients of grant funds under this section or are served by programs of sex education funded under this section.

(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 2015, an interim report on

the national evaluation under subparagraph (A); and

(ii) not later than March 31, 2020, 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 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 sub-

division 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 2015 through 2019.

SEC. 512. COMPASSIONATE ASSISTANCE FOR RAPE EMERGENCIES.

(a) MEDICARE.—

(1) LIMITATION ON PAYMENT.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

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

(B) in the subparagraph (W) added by section 3005(1)(C) of Public Law 111–148—

(i) by striking the period at the end and inserting a comma;

(ii) by moving the indentation 2 ems to the left; and

(iii) by moving such subparagraph to immediately follow subparagraph (V);

(C) in the subparagraph (W) added by section 6406(b)(3) of Public Law 111–148—

(i) by striking the period at the end and inserting ", and";

(ii) by moving the indentation 2 ems to the left;

(iii) by redesignating such subparagraph as subparagraph (X); and

(iv) by moving such subparagraph to immediately follow subparagraph (W), as moved under paragraph (2)(C); and

(D) by inserting after the subparagraph (X), as redesignated and moved under paragraph (3), the following:

"(Y) in the case of a hospital or critical access hospital, to adopt and enforce a policy to ensure compliance with the requirements of subsection (l) and to meet the requirements of such subsection.".

(2) ASSISTANCE TO VICTIMS.—Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is

amended by adding at the end the following new subsection:

''(l) COMPASSIONATE ASSISTANCE FOR RAPE EMERGENCIES.—

''(1) IN GENERAL.—For purposes of section 1866(a)(1)(Y), a hospital meets the requirements of this subsection if the hospital provides each of the services described in paragraph (2) to each female individual, whether or not eligible for benefits under this title or under any other form of health insurance. who comes to the hospital on or after January 1, 2015, and—

''(A) who states to hospital personnel that she is a victim of sexual assault;

''(B) who is accompanied by an individual who states to hospital personnel that the female individual is a victim of sexual assault; or

''(C) whom hospital personnel, during the course of treatment and care for the female individual, have reason to believe is a victim of sexual assault.

''(2) REQUIRED SERVICES DESCRIBED.—For purposes of paragraph (1), the services described in this subparagraph are the following:

"(A) Provision of medically and factually accurate and unbiased written and oral information about emergency contraception that—

"(i) is written in clear and concise language;

"(ii) is readily comprehensible;

"(iii) includes an explanation that—

"(I) emergency contraception has been approved by the Food and Drug Administration as an over-the-counter medication for female individuals, and is a safe and effective way to prevent pregnancy after unprotected intercourse or contraceptive failure if taken in a timely manner;

"(II) emergency contraception is more effective the sooner it is taken; and

"(III) emergency contraception does not cause an abortion and cannot interrupt an established pregnancy;

"(iv) meets such conditions regarding the provision of such information in languages other than English as the Secretary may establish; and

"(v) is provided without regard to the ability of the individual or her family to pay costs associated with the provision of such information to the individual.

"(B) Prompt offer to provide emergency contraception to the individual, and in the case that the individual accepts such offer, prompt provision of such contraception to such individual without regard to the inability of the individual or her family to pay costs associated with the offer and provision of such contraception.

"(3) DEFINITIONS.—For purposes of this paragraph:

"(A) The term 'emergency contraception' means a drug or device (as such terms are defined in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321)) or a drug regimen that—

"(i) is used postcoitally;

"(ii) prevents pregnancy primarily by preventing or delaying ovulation, and does not terminate an established pregnancy; and

''(iii) is approved by the Food and Drug Administration.

''(B) The term 'hospital' includes a critical access hospital, as defined in section 1861(mm)(1).

''(C) The term 'sexual assault' means coitus in which the individual involved does not consent or lacks the legal capacity to consent.''.

(b) LIMITATION ON PAYMENT UNDER MEDICAID.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended by inserting after paragraph (11) the following new paragraph:

''(12) with respect to any amount expended for care or services furnished under the plan by a hospital on or after January 1, 2015, unless such hospital meets the requirements specified in section 1866(l) for purposes of title XVIII.''.

SEC. 513. ACCESS TO BIRTH CONTROL DUTIES OF PHARMACIES TO ENSURE PROVISION OF FDA-APPROVED CONTRACEPTION.

Part B of title II of the Public Health Service Act (42 U.S.C. 238 et seq.) is amended by adding at the end the following:

"SEC. 249. DUTIES OF PHARMACIES TO ENSURE PROVISION OF FDA-APPROVED CONTRACEPTION.

"(a) IN GENERAL.—Subject to subsection (c), a pharmacy that receives Food and Drug Administration-approved drugs or devices in interstate commerce shall maintain compliance with the following:

"(1) If a customer requests a contraceptive that is in stock, the pharmacy shall ensure that the contraceptive is provided to the customer without delay.

"(2) If a customer requests a contraceptive that is not in stock and the pharmacy in the normal course of business stocks contraception, the pharmacy shall immediately inform the customer that the contraceptive is not in stock and without delay offer the customer the following options:

"(A) If the customer prefers to obtain the contraceptive through a referral or transfer, the pharmacy shall—

"(i) locate a pharmacy of the customer's choice or the closest pharmacy confirmed to have the contraceptive in stock; and

"(ii) refer the customer or transfer the prescription to that pharmacy.

"(B) If the customer prefers for the pharmacy to order the contraceptive, the pharmacy

shall obtain the contraceptive under the pharmacy's standard procedure for expedited ordering of medication and notify the customer when the contraceptive arrives.

"(3) The pharmacy shall ensure that its employees do not—

"(A) intimidate, threaten, or harass customers in the delivery of services relating to a request for contraception;

"(B) interfere with or obstruct the delivery of services relating to a request for contraception;

"(C) intentionally misrepresent or deceive customers about the availability of contraception or its mechanism of action;

"(D) breach medical confidentiality with respect to a request for contraception or threaten to breach such confidentiality; or

"(E) refuse to return a valid, lawful prescription for contraception upon customer request.

"(b) CONTRACEPTIVES NOT ORDINARILY STOCKED.—Nothing in subsection (a)(2) shall be construed to require any pharmacy to comply with such sub-

section if the pharmacy does not ordinarily stock contraceptives in the normal course of business.

''(c) REFUSALS PURSUANT TO STANDARD PHARMACY PRACTICE.—This section does not prohibit a pharmacy from refusing to provide a contraceptive to a customer in accordance with any of the following:

''(1) If it is unlawful to dispense the contraceptive to the customer without a valid, lawful prescription and no such prescription is presented.

''(2) If the customer is unable to pay for the contraceptive.

''(3) If the employee of the pharmacy refuses to provide the contraceptive on the basis of a professional clinical judgment.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to invalidate or limit rights, remedies, procedures, or legal standards under title VII of the Civil Rights Act of 1964.

''(e) PREEMPTION.—This section does not preempt any provision of State law or any professional obligation made applicable by a State board or other entity responsible for licensing or discipline of pharmacies or pharmacists, to the extent that such State law or professional obligation provides protections for customers that are greater than the protections provided by this section.

''(f) ENFORCEMENT.—

''(1) CIVIL PENALTY.—A pharmacy that violates a requirement of subsection (a) is liable to the United States for a civil penalty in an amount not exceeding $1,000 per day of violation, not to exceed $100,000 for all violations adjudicated in a single proceeding.

''(2) PRIVATE CAUSE OF ACTION.—Any person aggrieved as a result of a violation of a requirement of subsection (a) may, in any court of competent jurisdiction, commence a civil action against the pharmacy involved to obtain appropriate relief, including actual and punitive damages, injunctive relief, and a reasonable attorney's fee and cost.

''(3) LIMITATIONS.—A civil action under paragraph (1) or (2) may not be commenced against a pharmacy after the expiration of the 5-year period beginning on the date on which the pharmacy allegedly engaged in the violation involved.

''(g) DEFINITIONS.—In this section:

''(1) The term 'contraception' or 'contraceptive' means any drug or device approved by the Food and Drug Administration to prevent pregnancy.

''(2) The term 'employee' means a person hired, by contract or any other form of an agreement, by a pharmacy.

''(3) The term 'pharmacy' means an entity that—

''(A) is authorized by a State to engage in the business of selling prescription drugs at retail; and

''(B) employs one or more employees.

''(4) The term 'product' means a Food and Drug Administration-approved drug or device.

''(5) The term 'professional clinical judgment' means the use of professional knowledge and skills to form a clinical judgment, in accordance with prevailing medical standards.

''(6) The term 'without delay', with respect to a pharmacy providing, providing a referral for, or ordering contraception, or transferring the prescription for contraception, means within the usual and customary timeframe at the pharmacy for providing, providing a referral for, or ordering other products, or transferring the prescription for other products, respectively.

''(h) EFFECTIVE DATE.—This section shall take effect on the 31st day after the date of the enactment of

this section, without regard to whether the Secretary has issued any guidance or final rule regarding this section.''.

SEC. 514. ADDITIONAL FOCUS AREA FOR THE OFFICE ON WOMEN'S HEALTH.

Section 229(b) of the Public Health Service Act (42 U.S.C. 237a(b)) is amended—

(1) in paragraph (6), at the end, by striking ''and'';

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

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

''(8) facilitate policymakers, health system leaders and providers, consumers, and other stakeholders in understanding optimal maternity care and support for the provision of such care, including the priorities of—

''(A) protecting, promoting, and supporting the innate capacities of childbearing women and their newborns for childbirth, breastfeeding, and attachment;

''(B) using obstetric interventions only when such interventions are supported by strong, high-quality evidence, and minimizing overuse of maternity practices that have been

shown to have benefit in limited situations and that can expose women, infants, or both to risk of harm if used routinely and indiscriminately, including continuous electronic fetal monitoring, labor induction, epidural analgesia, primary cesarean section, and routine repeat cesarean birth;

''(C) reliably incorporating noninvasive, evidence-based practices that have documented correlation with considerable improvement in outcomes with no detrimental side effects, such as smoking cessation programs in pregnancy and proven models of group prenatal care that integrate health assessment, education, and support into a unified program;

''(D) a shared understanding of the qualifications of licensed providers of maternity care and the best evidence about the safety, satisfaction, outcomes, and costs of their care, and appropriate deployment of such caregivers within the maternity care workforce to address the needs of childbearing women and newborns and the growing shortage of maternity caregivers;

''(E) a shared understanding of the results of the best available research comparing hos-

pital, birth center, and planned home births, including information about each setting's safety, satisfaction, outcomes, and costs; and

''(F) high-quality, evidence-based childbirth education that promotes a natural, healthy, and safe approach to pregnancy, childbirth, and early parenting; is taught by certified educators, peer counselors, and health professionals; and promotes informed decisionmaking by childbearing women.''.

SEC. 515. INTERAGENCY COORDINATING COMMITTEE ON THE PROMOTION OF OPTIMAL MATERNITY OUTCOMES.

(a) IN GENERAL.—Part A of title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following new section:

''SEC. 229A. INTERAGENCY COORDINATING COMMITTEE ON THE PROMOTION OF OPTIMAL MATERNITY OUTCOMES.

''(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Deputy Assistant Secretary for Women's Health under section 229 and in collaboration with the Federal officials specified in subsection (b), shall establish the Interagency Coordinating

Committee on the Promotion of Optimal Maternity Outcomes (referred to in this subsection as the 'ICCPOM').

''(b) OTHER AGENCIES.—The officials specified in this subsection are the Secretary of Labor, the Secretary of Defense, the Secretary of Veterans Affairs, the Surgeon General, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Resources and Services Agency, the Administrator of the Centers for Medicare & Medicaid Services, the Director of the Indian Health Service, the Administrator of the Substance Abuse and Mental Health Services Administration, the Director of the National Institute on Child Health and Development, the Director of the Agency for Healthcare Research and Quality, the Assistant Secretary for Children and Families, the Deputy Assistant Secretary for Minority Health, the Director of the Office of Personnel Management, and such other Federal officials as the Secretary of Health and Human Services determines to be appropriate.

''(c) CHAIR.—The Deputy Assistant Secretary for Women's Health shall serve as the chair of the ICCPOM.

''(d) DUTIES.—The ICCPOM shall guide policy and program development across the Federal Government with respect to promotion of optimal maternity care, provided, however, that nothing in this section shall be construed

as transferring regulatory or program authority from an agency to the ICCPOM.

''(e) CONSULTATIONS.—The ICCPOM shall actively seek the input of, and shall consult with, all appropriate and interested stakeholders, including State health departments, public health research and interest groups, foundations, childbearing women and their advocates, and maternity care professional associations and organizations, reflecting racially, ethnically, demographically, and geographically diverse communities.

''(f) ANNUAL REPORT.—

''(1) IN GENERAL.—The Secretary, on behalf of the ICCPOM, shall annually submit to Congress a report that summarizes—

''(A) all programs and policies of Federal agencies (including the Medicare Program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act) designed to promote optimal maternity care, focusing particularly on programs and policies that support the adoption of evidence based maternity care, as defined by timely, scientifically sound systematic reviews;

''(B) all programs and policies of Federal agencies (including the Medicare Program

under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act) designed to address the problems of maternal mortality and morbidity, infant mortality, prematurity, and low birth weight, including such programs and policies designed to address racial and ethnic disparities with respect to each of such problems;

''(C) the extent of progress in reducing maternal mortality and infant mortality, low birth weight, and prematurity at State and national levels; and

''(D) such other information regarding optimal maternity care as the Secretary determines to be appropriate.

The information specified in subparagraph (C) shall be included in each such report in a manner that disaggregates such information by race, ethnicity, and indigenous status in order to determine the extent of progress in reducing racial and ethnic disparities and disparities related to indigenous status.

''(2) CERTAIN INFORMATION.—Each report under paragraph (1) shall include information (disaggregated by race, ethnicity, and indigenous

status, as applicable) on the following rates and costs by State:

"(A) The rate of primary cesarean deliveries and repeat cesarean deliveries.

"(B) The rate of vaginal births after cesarean.

"(C) The rate of vaginal breech births.

"(D) The rate of induction of labor.

"(E) The rate of freestanding birth center births.

"(F) The rate of planned and unplanned home birth.

"(G) The rate of attended births by provider, including by an obstetrician-gynecologist, family practice physician, obstetrician-gynecologist physician assistant, certified nurse-midwife, certified midwife, and certified professional midwife.

"(H) The cost of maternity care disaggregated by place of birth and provider of care, including—

"(i) uncomplicated vaginal birth;

"(ii) complicated vaginal birth;

"(iii) uncomplicated cesarean birth; and

''(iv) complicated cesarean birth.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, in addition to such amounts authorized to be appropriated under section 229(e), to carry out this section $1,000,000 for each of the fiscal years 2015 through 2019.''.

(b) CONFORMING AMENDMENTS.—

(1) INCLUSION AS DUTY OF HHS OFFICE ON WOMEN'S HEALTH.—Section 229(b) of such Act (42 U.S.C. 237a(b)), as amended, is amended—

(A) in paragraph (7), at the end, by striking ''and'';

(B) in paragraph (8), at the end, by striking the period and inserting ''; and''; and

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

''(9) establish the Interagency Coordinating Committee on the Promotion of Optimal Maternity Outcomes in accordance with section 229A.''.

(2) TREATMENT OF BIENNIAL REPORTS.—Section 229(d) of such Act (42 U.S.C. 237a(d)) is amended by inserting ''(other than under subsection (b)(9))'' after ''under this section''.

SEC. 516. CONSUMER EDUCATION CAMPAIGN.

Section 229 of the Public Health Service Act (42 U.S.C. 237a), as amended, is further amended in subsection (b)—

(1) in paragraph (8), at the end, by striking ''and'';

(2) in paragraph (9), at the end, by striking the period and inserting ''; and''; and

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

''(10) not later than one year after the date of the enactment of the Health Equity and Accountability Act of 2014, develop and implement a 4-year culturally and linguistically appropriate multimedia consumer education campaign that is designed to promote understanding and acceptance of evidence-based maternity practices and models of care for optimal maternity outcomes among women of childbearing ages and families of such women and that—

''(A) highlights the importance of protecting, promoting, and supporting the innate capacities of childbearing women and their newborns for childbirth, breastfeeding, and attachment;

''(B) promotes understanding of the importance of using obstetric interventions when

medically necessary and when supported by strong, high-quality evidence;

''(C) highlights the widespread overuse of maternity practices that have been shown to have benefit when used appropriately in situations of medical necessity, but which can expose women, infants, or both to risk of harm if used routinely and indiscriminately, including continuous fetal monitoring, labor induction, epidural anesthesia, elective primary cesarean section, and repeat cesarean delivery;

''(D) emphasizes the noninvasive maternity practices that have strong proven correlation or may be associated with considerable improvement in outcomes with no detrimental side effects, and are significantly underused in the United States, including smoking cessation programs in pregnancy, group model prenatal care, continuous labor support, nonsupine positions for birth, and external version to turn breech babies at term;

''(E) educates consumers about the qualifications of licensed providers of maternity care and the best evidence about their safety, satisfaction, outcomes, and costs;

"(F) informs consumers about the best available research comparing birth center births, planned home births, and hospital births, including information about each setting's safety, satisfaction, outcomes, and costs;

"(G) fosters participation in high-quality, evidence-based childbirth education that promotes a natural, healthy, and safe approach to pregnancy, childbirth, and early parenting; is taught by certified educators, peer counselors, and health professionals; and promotes informed decisionmaking by childbearing women; and

"(H) is pilot tested for consumer comprehension, cultural sensitivity, and acceptance of the messages across geographically, racially, ethnically, and linguistically diverse populations.".

SEC. 517. BIBLIOGRAPHIC DATABASE OF SYSTEMATIC REVIEWS FOR CARE OF CHILDBEARING WOMEN AND NEWBORNS.

(a) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services, through the Agency for Healthcare Research and Quality, shall—

(1) make publicly available an online bibliographic database identifying systematic reviews, including an explanation of the level and quality of evidence, for care of childbearing women and newborns; and

(2) initiate regular updates that incorporate newly issued and updated systematic reviews.

(b) SOURCES.—To aim for a comprehensive inventory of systematic reviews relevant to maternal and newborn care, the database shall identify reviews from diverse sources, including—

(1) scientific peer-reviewed journals;

(2) databases, including Cochrane Database of Systematic Reviews, Clinical Evidence, and Database of Abstracts of Reviews of Effects; and

(3) Internet Web sites of agencies and organizations throughout the world that produce such systematic reviews.

(c) FEATURES.—The database shall—

(1) provide bibliographic citations for each record within the database, and for each such citation include an explanation of the level and quality of evidence;

(2) include abstracts, as available;

(3) provide reference to companion documents as may exist for each review, such as evidence tables and guidelines or consumer educational materials developed from the review;

(4) provide links to the source of the full review and to any companion documents;

(5) provide links to the source of a previous version or update of the review;

(6) be searchable by intervention or other topic of the review, reported outcomes, author, title, and source; and

(7) offer to users periodic electronic notification of database updates relating to users' topics of interest.

(d) OUTREACH.—Not later than the first date the database is made publicly available and periodically thereafter, the Secretary of Health and Human Services shall publicize the availability, features, and uses of the database under this section to the stakeholders described in subsection (e).

(e) CONSULTATION.—For purposes of developing the database under this section and maintaining and updating such database, the Secretary of Health and Human Services shall convene and consult with an advisory committee composed of relevant stakeholders, including—

(1) Federal Medicaid administrators and State agencies administrating State plans under title XIX of the Social Security Act pursuant to section 1902(a)(5) of such Act (42 U.S.C. 1396a(a)(5));

(2) providers of maternity and newborn care from both academic and community-based settings, including obstetrician-gynecologists, family physicians, certified nurse midwives, certified midwives, certified professional midwives, physician assistants, perinatal nurses, pediatricians, and nurse practitioners;

(3) maternal-fetal medicine specialists;

(4) neonatologists;

(5) childbearing women and advocates for such women, including childbirth educators certified by a nationally accredited program, representing communities that are diverse in terms of race, ethnicity, indigenous status, and geographic area;

(6) employers and purchasers;

(7) health facility and system leaders, including both hospital and birth center facilities;

(8) journalists; and

(9) bibliographic informatics specialists.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $2,500,000 for each of the

fiscal years 2015 through 2017 for the purpose of developing the database and such sums as may be necessary for each subsequent fiscal year for updating the database and providing outreach and notification to users, as described in this section.

SEC. 518. MATERNITY CARE HEALTH PROFESSIONAL SHORTAGE AREAS.

Section 332 of the Public Health Service Act (42 U.S.C. 254e) is amended by adding at the end the following new subsection:

''(k)(1) The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall designate maternity care health professional shortage areas in the States, publish a descriptive list of the area's population groups, medical facilities, and other public facilities so designated, and at least annually review and, as necessary, revise such designations.

''(2) For purposes of paragraph (1), a complete descriptive list shall be published in the Federal Register not later than one year after the date of the enactment of the Health Equity and Accountability Act of 2014 and annually thereafter.

''(3) The provisions of subsections (b), (c), (e), (f), (g), (h), (i), and (j) (other than (j)(1)(B)) of this section shall apply to the designation of a maternity care health

professional shortage area in a similar manner and extent as such provisions apply to the designation of health professional shortage areas, except in applying subsection (b)(3), the reference in such subsection to 'physicians' shall be deemed to be a reference to nationally certified and State licensed obstetricians, family practice physicians who practice full-scope maternity care, certified nurse midwives, certified midwives, certified professional midwives, and physician's assistants who practice full scope maternity care.

''(4) For purposes of this subsection, the term 'maternity care health professional shortage area' means—

''(A) an area in an urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services) which the Secretary determines has a shortage of providers of maternity care health services including those referenced in paragraph (3) or an urban or rural area that the Secretary determines has lost a significant number of such providers during the 10-year period beginning with 2004 or has no obstetrical providers licensed to provide operative obstetrical services;

''(B) an area in an urban or rural area (which need not conform to the geographic boundaries of a

political subdivision and which is a rational area for the delivery of health services) which the Secretary determines has a shortage of hospital or labor and delivery units, hospital birth center units, or free-standing birth centers or an area that lost a significant number of these units during the 10-year period beginning with 2004; or

''(C) a population group which the Secretary determines has such a shortage of providers or facilities.''.

SEC. 519. EXPANSION OF CDC PREVENTION RESEARCH CENTERS PROGRAM TO INCLUDE CENTERS ON OPTIMAL MATERNITY OUTCOMES.

(a) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services, shall support the establishment of additional Prevention Research Centers under the Prevention Research Center Program administered by the Centers for Disease Control and Prevention. Such additional centers shall each be known as a Center for Excellence on Optimal Maternity Outcomes.

(b) RESEARCH.—Each Center for Excellence on Optimal Maternity Outcomes shall—

(1) conduct at least one focused program of research to improve maternity outcomes, including the

reduction of cesarean birth rates, elective inductions, prematurity rates, and low birth weight rates within an underserved population that has a disproportionately large burden of suboptimal maternity outcomes, including maternal mortality and morbidity, infant mortality, prematurity, or low birth weight;

(2) work with partners on special interest projects, as specified by the Centers for Disease Control and Prevention and other relevant agencies within the Department of Health and Human Services, and on projects funded by other sources; and

(3) involve a minimum of two distinct birth setting models, such as a hospital labor and delivery model and freestanding birth center model; or a hospital labor and delivery model and planned home birth model.

(c) INTERDISCIPLINARY PROVIDERS.—Each Center for Excellence on Optimal Maternity Outcomes shall include the following interdisciplinary providers of maternity care:

(1) Obstetrician-gynecologists.

(2) At least two of the following providers:

(A) Family practice physicians.

(B) Nurse practitioners.

(C) Physician assistants.

(D) Certified professional midwives.

(d) SERVICES.—Research conducted by each Center for Excellence on Optimal Maternity Outcomes shall include at least 2 (and preferably more) of the following supportive provider services:

(1) Mental health.

(2) Doula labor support.

(3) Nutrition education.

(4) Childbirth education.

(5) Social work.

(6) Physical therapy or occupation therapy.

(7) Substance abuse services.

(8) Home visiting.

(e) COORDINATION.—The programs of research at each of the two Centers of Excellence on Optimal Maternity Outcomes shall compliment and not replicate the work of the other.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,000,000 for each of the fiscal years 2015 through 2019.

SEC. 520. EXPANDING MODELS ALLOWED TO BE TESTED BY CENTER FOR MEDICARE AND MEDICAID INNOVATION TO INCLUDE MATERNITY CARE MODELS.

Section 1115A(b)(2)(B) of the Social Security Act (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the end the following new clause:

''(xxi) Promoting evidence-based models of care that have been associated with reductions in maternal and infant health disparities, including incorporating the use of doula and promotoras support for pregnant and childbearing women into evidence-based models of prenatal care, labor and delivery, and postpartum care, and supporting the appropriate use of out-of-hospital birth models, including births at home and in freestanding birth centers.''.

SEC. 521. DEVELOPMENT OF INTERPROFESSIONAL MATERNITY CARE EDUCATIONAL MODELS AND TOOLS.

(a) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services, acting in conjunction with the Administrator of Health Resources and Services Administration, shall convene, for a 1-year period, an Interprofes-

sional Maternity Provider Education Commission to discuss and make recommendations for—

(1) a consensus standard physiologic maternity care curriculum that takes into account the core competencies for basic midwifery practice such as those developed by the American College of Nurse Midwives and the North American Registry of Midwives, and the educational objectives for physicians practicing in obstetrics and gynecology as determined by the Council on Resident Education in Obstetrics and Gynecology;

(2) suggestions for multidisciplinary use of the consensus physiologic curriculum;

(3) strategies to integrate and coordinate education across maternity care disciplines, including recommendations to increase medical and midwifery student exposure to out-of-hospital birth; and

(4) pilot demonstrations of interprofessional educational models.

(b) PARTICIPANTS.—The Commission shall include maternity care educators, curriculum developers, service leaders, certification leaders, and accreditation leaders from the various professions that provide maternity care in this country. Such professions shall include obstetrician gynecologists, certified nurse midwives or certified mid-

wives, family practice physicians, nurse practitioners, physician assistants, certified professional midwives, and perinatal nurses. Additionally, the Commission shall include representation from maternity care consumer advocates.

(c) CURRICULUM.—The consensus standard physiologic maternity care curriculum described in subsection (a)(1) shall—

(1) have a public health focus with a foundation in health promotion and disease prevention;

(2) foster physiologic childbearing and woman and family centered care;

(3) integrate strategies to reduce maternal and infant morbidity and mortality;

(4) incorporate recommendations to ensure respectful, safe, and seamless consultation, referral, transport, and transfer of care when necessary; and

(5) include cultural sensitivity and strategies to decrease disparities in maternity outcomes.

(d) REPORT.—Not later than 6 months after the final meeting of the Commission, the Secretary of Health and Human Services shall—

(1) submit to Congress a report containing the recommendations made by the Commission under this section; and

(2) make such report publicly available.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,000,000 for each of the fiscal years 2015 and 2016, and such sums as are necessary for each of the fiscal years 2017 through 2019.

SEC. 522. INCLUDING WITHIN INPATIENT HOSPITAL SERVICES UNDER MEDICARE SERVICES FURNISHED BY CERTAIN STUDENTS, INTERNS, AND RESIDENTS SUPERVISED BY CERTIFIED NURSE MIDWIVES.

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

(1) in paragraph (6), by striking ''; or'' and inserting '', or in the case of services in a hospital or osteopathic hospital by a student midwife or an intern or resident-in-training under a teaching program previously described in this paragraph who is in the field of obstetrics and gynecology, if such student midwife, intern, or resident-in-training is supervised by a certified nurse-midwife to the extent permitted under applicable State law and as may be authorized by the hospital;'';

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

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

''(8) a certified nurse-midwife where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all certified nurse-midwives in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after the date of the enactment of this Act.

SEC. 523. GRANTS TO PROFESSIONAL ORGANIZATIONS TO INCREASE DIVERSITY IN MATERNITY CARE PROFESSIONALS.

(a) IN GENERAL.—The Secretary of Health and Human Services, through the Administrator of the Health Resources and Services Administration, shall carry out a grant program under which the Secretary may make to eligible health professional organizations—

(1) for fiscal year 2015, planning grants described in subsection (b); and

(2) for the subsequent 4-year period, implementation grants described in subsection (c).

(b) PLANNING GRANTS.—

(1) IN GENERAL.—Planning grants described in this subsection are grants for the following purposes:

(A) To collect data and identify any workforce disparities, with respect to a health profession, at each of the following areas along the health professional continuum:

(i) Pipeline availability with respect to students at the high school and college or university levels considering and working toward entrance in the profession.

(ii) Entrance into the training program for the profession.

(iii) Graduation from such training program.

(iv) Entrance into practice.

(v) Retention in practice for more than a 5-year period.

(B) To develop one or more strategies to address the workforce disparities within the health profession, as identified under (and in response to the findings pursuant to) subparagraph (A).

(2) APPLICATION.—To be eligible to receive a grant under this subsection, an eligible health professional organization shall submit to the Secretary of Health and Human Services an application in such form and manner and containing such information as specified by the Secretary.

(3) AMOUNT.—Each grant awarded under this subsection shall be for an amount not to exceed $300,000.

(4) REPORT.—Each recipient of a grant under this subsection shall submit to the Secretary of Health and Human Services a report containing—

(A) information on the extent and distribution of workforce disparities identified through the grant; and

(B) reasonable objectives and strategies developed to address such disparities within a 5-, 10-, and 25-year period.

(c) IMPLEMENTATION GRANTS.—

(1) IN GENERAL.—Implementation grants described in this subsection are grants to implement one or more of the strategies developed pursuant to a planning grant awarded under subsection (b).

(2) APPLICATION.—To be eligible to receive a grant under this subsection, an eligible health pro-

fessional organization shall submit to the Secretary of Health and Human Services an application in such form and manner as specified by the Secretary. Each such application shall contain information on the capability of the organization to carry out a strategy described in paragraph (1), involvement of partners or coalitions, plans for developing sustainability of the efforts after the culmination of the grant cycle, and any other information specified by the Secretary.

(3) AMOUNT.—Each grant awarded under this subsection shall be for an amount not to exceed $500,000 each year during the 4-year period of the grant.

(4) REPORTS.—For each of the first 3 years for which an eligible health professional organization is awarded a grant under this subsection, the organization shall submit to the Secretary of Health and Human Services a report on the activities carried out by such organization through the grant during such year and objectives for the subsequent year. For the fourth year for which an eligible health professional organization is awarded a grant under this subsection, the organization shall submit to the Secretary a report that includes an analysis of all the

activities carried out by the organization through the grant and a detailed plan for continuation of outreach efforts.

(d) ELIGIBLE HEALTH PROFESSIONAL ORGANIZATION DEFINED.—For purposes of this section, the term ''eligible health professional organization'' means a professional organization representing obstetrician-gynecologists, certified nurse midwives, certified midwives, family practice physicians, nurse practitioners whose scope of practice includes maternity care, physician assistants whose scope of practice includes obstetrical care, or certified professional midwives.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,000,000 for fiscal year 2015 and $3,000,000 for each of the fiscal years 2016 through 2019.

TITLE VI—MENTAL HEALTH

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

(a) COVERAGE OF SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) 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)) and substance abuse counselor services (as defined in subsection (kkk)(5));''.

(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:

''Marriage and Family Therapist Services; Marriage and Family Therapist; Mental Health Counselor Services; Mental Health Counselor

''(kkk)(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the mar-

riage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'marriage and family therapist' means an individual who—

''(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

''(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

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

''(3) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (4)) for the diagnosis and treatment

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

''(5) The term 'substance abuse counselor services' means services performed by a substance abuse counselor (as defined in paragraph (6)) for the diagnosis and treatment of substance abuse and addiction which the substance abuse counselor is legally authorized to perform

under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(6) The term 'substance abuse counselor' means an individual who—

''(A) has performed at least 2 years of supervised substance abuse counselor practice;

''(B) in the case of an individual performing services in a State that provides for licensure or certification of substance abuse counselors or professional counselors, is licensed or certified as a substance abuse counselor or professional counselor in such State; or

''(C) the individual is a drug and alcohol counselor as defined in section 40.281 of title 49, Code of Federal Regulations.''.

(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, mental health counselor services, and substance abuse 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, mental health counselor services, and substance abuse 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 COUNSELOR SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of such Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting "marriage and family therapist services (as defined in section 1861(kkk)(1)), mental health counselor serv-

ices (as defined in section 1861(kkk)(3)),'' after ''qualified psychologist services,''.

(6) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS, MENTAL HEALTH COUNSELORS, AND SUBSTANCE ABUSE COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of such Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clauses:

''(vii) A marriage and family therapist (as defined in section 1861(kkk)(2)).

''(viii) A mental health counselor (as defined in section 1861(kkk)(4)).

''(ix) A substance abuse counselor (as defined in section 1861 (kkk)(6)).''.

(b) COVERAGE OF CERTAIN MENTAL HEALTH SERVICES PROVIDED IN CERTAIN SETTINGS.—

(1) RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ''or by a clinical social worker (as defined in subsection (hh)(1)),'' and inserting '', by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection

(kkk)(2)), or by a mental health counselor (as defined in subsection (kkk)(4)), or by a substance abuse counselor (as defined in section 1861 (kkk)(6)).''.

(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, 2015.

SEC. 602. MINORITY FELLOWSHIP PROGRAM.

Title V of the Public Health Service Act is amended by inserting after section 506B of such Act (42 U.S.C. 290aa–5b) the following:

''SEC. 506C. MINORITY FELLOWSHIP PROGRAM.

''(a) FELLOWSHIPS.—The Administrator shall maintain a program, to be known as the Minority Fellowship

Program, under which the Administrator awards grants or contracts to national associations or other appropriate entities for the financial support of graduate students, postdoctoral fellows, and residents in the professions of psychology, psychiatry, social work, psychiatric advance-practice nursing, marriage and family therapy, and professional counseling 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 2015 through 2019.''.

SEC. 603. INTEGRATED HEALTH CARE DEMONSTRATION PROGRAM.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.) is amended by adding at the end the following:

"SEC. 544. INTERPROFESSIONAL HEALTH CARE TEAMS FOR PROVISION OF BEHAVIORAL HEALTH CARE IN PRIMARY CARE SETTINGS.

''(a) GRANTS.—The Secretary, acting through the Deputy Assistant Secretary for Minority Health, 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 2014 through 2016.''.

SEC. 604. ADDRESSING RACIAL AND ETHNIC MINORITY MENTAL HEALTH DISPARITIES RESEARCH GAPS.

Not later than 6 months after the date of the enactment of this Act, the Director of the National Institute on Minority Health and Health Disparities shall enter into

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

(1) to conduct a study with respect to mental and behavioral health disparities in racial and ethnic minority groups (as defined in section 1707(g) of the Public Health Service Act (42 U.S.C. 300u–6(g)); and

(2) to submit to the Congress a report on the results of such study, including—

(A) a compilation of information on the dynamics of mental disorders in such racial and ethnic minority groups;

(B) an identification of gaps in knowledge and research needs; and

(C) recommendations for an interprofessional research agenda at the National Institutes of Health aimed at reducing and ultimately eliminating mental and behavioral health disparities in such racial and ethnic minority groups.

SEC. 605. HEALTH PROFESSIONS COMPETENCIES TO ADDRESS RACIAL AND ETHNIC MINORITY MENTAL HEALTH DISPARITIES.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Substance Abuse and Mental Health Services Administration, shall award grants to qualified national organizations for the purpose of developing, and disseminating to health professional educational programs, curricula or core competencies addressing mental health disparities among racial and ethnic minority groups.

(b) USE OF FUNDS.—Organizations receiving funds under subsection (a) shall use the funds to develop and disseminate curricula or core competencies, as described in such subsection, for use in the training of students in the professions of social work, psychology, psychiatry, marriage and family therapy, mental health counseling, and substance abuse counseling.

(c) ALLOWABLE ACTIVITIES.—Organizations receiving funds under subsection (a) may use the funds to engage in the following activities related to the development and dissemination of curricula or core competencies:

(1) Formation of committees or working groups comprised of experts from accredited health professions schools to identify core competencies relating

to mental health disparities among racial and ethnic minority groups.

(2) Planning of workshops in national fora to allow for public input into the educational needs associated with mental health disparities among racial and ethnic minority groups.

(3) Dissemination and promotion of the use of curricula or core competencies in undergraduate and graduate health professions training programs nationwide.

(d) DEFINITIONS.—In this section:

(1) The term ''qualified national organization'' means a national organization that focuses on the education of students in programs of social work, psychology, psychiatry, and marriage and family therapy.

(2) The term ''racial and ethnic minority group'' has the meaning given to such term in section 1707(g) of the Public Health Service Act (42 U.S.C. 300u–6(g)).

(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 2014 through 2018.

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 2014''.

(b) FINDINGS.—Congress makes the following findings:

(1) Lung cancer is the leading cause of cancer death for both men and women, accounting for 28 percent of all cancer deaths.

(2) Lung cancer kills more people annually than breast cancer, prostate cancer, colon cancer, liver cancer, melanoma, and kidney cancer combined.

(3) Since the National Cancer Act of 1971 (Public Law 92–218; 85 Stat. 778), coordinated and comprehensive research has raised the 5-year survival rates for breast cancer to 88 percent, for prostate cancer to 99 percent, and for colon cancer to 64 percent.

(4) However, the 5-year survival rate for lung cancer is still only 15 percent and a similar coordinated and comprehensive research effort is required to achieve increases in lung cancer survivability rates.

(5) Sixty percent of lung cancer cases are now diagnosed nonsmokers or former smokers.

(6) Two-thirds of nonsmokers diagnosed with lung cancer are women.

(7) Certain minority populations, such as African-American males, have disproportionately high rates of lung cancer incidence and mortality, notwithstanding their similar smoking rate.

(8) Members of the baby boomer generation are entering their sixties, the most common age at which people develop lung cancer.

(9) Tobacco addiction and exposure to other lung cancer carcinogens such as Agent Orange and other herbicides and battlefield emissions are serious problems among military personnel and war veterans.

(10) Significant and rapid improvements in lung cancer mortality can be expected through greater use and access to lung cancer screening tests for at-risk individuals.

(11) Additional strategies are necessary to further enhance the existing tests and therapies available to diagnose and treat lung cancer in the future.

(12) The August 2001 Report of the Lung Cancer Progress Review Group of the National Can-

cer 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 701 of the Health Equity and Accountability Act of 2014, shall implement a comprehensive program, to be known as the Lung Cancer Mortality Reduction Program, to achieve a reduction of at least 25 percent in the mortality rate of lung cancer by 2020.

''(b) REQUIREMENTS.—The Program shall include at least the following:

''(1) With respect to the National Institutes of Health—

''(A) a strategic review and prioritization by the National Cancer Institute of research grants to achieve the goal of the Lung Cancer Mortality Reduction Program in reducing lung cancer mortality;

''(B) the provision of funds to enable the Airway Biology and Disease Branch of the National Heart, Lung, and Blood Institute to expand its research programs to include predispositions to lung cancer, the interrelationship between lung cancer and other pulmonary and cardiac disease, and the diagnosis and treatment of 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 530 of the Federal Food, Drug, and Cosmetic Act; and

''(B) activities under section 561 of the Federal Food, Drug, and Cosmetic Act to expand access to investigational drugs and devices for the diagnosis, monitoring, or treatment of lung cancer.

''(3) With respect to the Centers for Disease Control and Prevention, the establishment of an early disease research and management program under section 1511.

''(4) With respect to the Agency for Healthcare Research and Quality, the conduct of a biannual review of lung cancer screening, diagnostic, and treatment protocols, and the issuance of updated guidelines.

''(5) The cooperation and coordination of all minority and health disparity programs within the Department of Health and Human Services to en-

sure that all aspects of the Lung Cancer Mortality Reduction Program under this section adequately address the burden of lung cancer on minority and rural populations.

''(6) The cooperation and coordination of all tobacco control and cessation programs within agencies of the Department of Health and Human Services to achieve the goals of the Lung Cancer Mortality Reduction Program under this section with particular emphasis on the coordination of drug and other cessation treatments with early detection protocols.''.

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

''DRUGS RELATING TO LUNG CANCER

''SEC. 530. (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 Health Equity and Accountability Act of 2014 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 530, 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 Advi-

sory Board (referred to in this section as the ''Board'')—

(A) to monitor the programs established under this section (and the amendments made by this section); and

(B) to provide annual reports to the Congress concerning benchmarks, expenditures, lung cancer statistics, and the public health impact of such programs.

(2) COMPOSITION.—The Board shall be composed of—

(A) the Secretary of Health and Human Services;

(B) the Secretary of Defense;

(C) the Secretary of Veterans Affairs; and

(D) two representatives each from the fields of clinical medicine focused on lung cancer, lung cancer research, imaging, drug development, and lung cancer advocacy, to be appointed by the Secretary of Health and Human Services.

(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 2015 through 2019.

(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 2015, and such sums as may be necessary for each of fiscal years 2016 through 2019, 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 2015, and such sums as may be necessary for each of fiscal years 2016 through 2019, for the activities described in section 417H(b)(1)(C) of such Act;

(C) $10,000,000 for fiscal year 2015, and such sums as may be necessary for each of fiscal years 2016 through 2019, for the activities described in section 417H(b)(1)(D) of such Act; and

(D) $15,000,000 for fiscal year 2015, and such sums as may be necessary for each of fiscal years 2016 through 2019, 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 2014'' or the ''PROSTATE Act''.

(b) FINDINGS.—Congress makes the following findings:

(1) Prostate cancer is the second leading cause of cancer death among men.

(2) In 2010, more than 217,730 new patients were diagnosed with prostate cancer and more than 32,000 men died from this disease.

(3) Roughly 2,000,000 Americans are living with a diagnosis of prostate cancer and its consequences.

(4) While prostate cancer generally affects older individuals, younger men are also at risk for the disease, and when prostate cancer appears in early middle age it frequently takes on a more aggressive form.

(5) There are significant racial and ethnic disparities that demand attention, namely African-Americans have prostate cancer mortality rates that are more than double those in the White population.

(6) Underserved rural populations have higher rates of mortality compared to their urban counterparts, and innovative and cost-efficient methods to improve rural access to high quality care should take advantage of advances in telehealth to diagnose and treat prostate cancer when appropriate.

(7) Certain veterans populations may have nearly twice the incidence of prostate cancer as the general population of the United States.

(8) Urologists may constitute the specialists who diagnose and treat the vast majority of prostate cancer patients.

(9) Although much basic and translational research has been completed and much is currently known, there are still many unanswered questions. For example, it is not fully understood how much of known disparities are attributable to disease etiology, access to care, or education and awareness in the community.

(10) Causes of prostate cancer are not known. There is not good information regarding how to differentiate accurately, early on, between aggressive and indolent forms of the disease. As a result, there is significant overtreatment in prostate cancer. There are no treatments that can durably arrest

growth or cure prostate cancer once it has metastasized.

(11) A significant proportion (roughly 23 to 54 percent) of cases may be clinically indolent and ''overdiagnosed'', resulting in significant overtreatment. More accurate tests will allow men and their families to face less physical, psychological, financial, and emotional trauma and billions of dollars could be saved in private and public health care systems in an area that has been identified by the Medicare Program as one of eight high-volume, high-cost areas in the Resource Utilization Report Program authorized by Congress under the Medicare Improvements for Patients and Providers Act of 2008.

(12) Prostate cancer research and health care programs across Federal agencies should be coordinated to improve accountability and actively encourage the translation of research into practice, to identify and implement best practices, in order to foster an integrated and consistent focus on effective prevention, diagnosis, and treatment of this disease.

(c) PROSTATE CANCER COORDINATION AND EDUCATION.—

(1) INTERAGENCY PROSTATE CANCER COORDINATION AND EDUCATION TASK FORCE.—Not later

than 180 days after the date of the enactment of this section, the Secretary of Veterans Affairs, in cooperation with the Secretary of Defense and the Secretary of Health and Human Services, shall establish an Interagency Prostate Cancer Coordination and Education Task Force (in this section referred to as the ''Prostate Cancer Task Force'').

(2) DUTIES.—The Prostate Cancer Task Force shall—

(A) develop a summary of advances in prostate cancer research supported or conducted by Federal agencies relevant to the diagnosis, prevention, and treatment of prostate cancer, including psychosocial impairments related to prostate cancer treatment, and compile a list of best practices that warrant broader adoption in health care programs;

(B) consider establishing, and advocating for, a guidance to enable physicians to allow screening of men who are over age 74, on a case-by-case basis, taking into account quality of life and family history of prostate cancer;

(C) share and coordinate information on Federal research and health care program activities, including activities related to—

(i) determining how to improve research and health care programs, including psychosocial impairments related to prostate cancer treatment;

(ii) identifying any gaps in the overall research inventory and in health care programs;

(iii) identifying opportunities to promote translation of research into practice; and

(iv) maximizing the effects of Federal efforts by identifying opportunities for collaboration and leveraging of resources in research and health care programs that serve those susceptible to or diagnosed with prostate cancer;

(D) develop a comprehensive interagency strategy and advise relevant Federal agencies in the solicitation of proposals for collaborative, multidisciplinary research and health care programs, including proposals to evaluate factors that may be related to the etiology of prostate cancer, that would—

(i) result in innovative approaches to study emerging scientific opportunities or

eliminate knowledge gaps in research to improve the prostate cancer research portfolio of the Federal Government;

(ii) outline key research questions, methodologies, and knowledge gaps; and

(iii) ensure consistent action, as outlined by section 402(b) of the Public Health Service Act;

(E) develop a coordinated message related to screening and treatment for prostate cancer to be reflected in educational and beneficiary materials for Federal health programs as such documents are updated; and

(F) not later than 2 years after the date of the establishment of the Prostate Cancer Task Force, submit to the Expert Advisory Panel to be reviewed and returned within 30 days, and then within 90 days submitted to Congress recommendations—

(i) regarding any appropriate changes to research and health care programs, including recommendations to improve the research portfolio of the Department of Veterans Affairs, Department of Defense, National Institutes of Health, and other

Federal agencies to ensure that scientifically based strategic planning is implemented in support of research and health care program priorities;

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

(iii) regarding public participation in decisions relating to prostate cancer research and health care programs to increase the involvement of patient advocates, community organizations, and medical associations representing a broad geographical area;

(iv) on how to best disseminate information on prostate cancer research and progress achieved by health care programs;

(v) about how to expand partnerships between public entities, including Federal agencies, and private entities to encourage

collaborative, cross-cutting research and health care delivery;

(vi) assessing any cost savings and efficiencies realized through the efforts identified and supported in this section and recommending expansion of those efforts that have proved most promising while also ensuring against any conflicts in directives from other congressional or statutory mandates or enabling statutes;

(vii) identifying key priority action items from among the recommendations; and

(viii) with respect to the level of funding needed by each agency to implement the recommendations contained in the report.

(3) MEMBERS OF THE PROSTATE CANCER TASK FORCE.—The Prostate Cancer Task Force described in 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 Com-

mittee Act (5 U.S.C. App.) shall apply to the Prostate Cancer Task Force.

(B) EXCEPTION.—Section 14(a)(2)(B) of such Act (relating to the termination of advisory committees) shall not apply to the Prostate Cancer Task Force.

(8) SUNSET DATE.—The Prostate Cancer Task Force shall terminate at the end of fiscal year 2019.

(d) PROSTATE CANCER RESEARCH.—

(1) RESEARCH COORDINATION.—The Secretary of Veterans Affairs, in coordination with the Secretaries of Defense and of Health and Human Services, shall establish and carry out a program to coordinate and intensify prostate cancer research as needed. Specifically, such research program shall—

(A) develop advances in diagnostic and prognostic methods and tests, including biomarkers and an improved prostate cancer screening blood test, including improvements or alternatives to the prostate specific antigen test and additional tests to distinguish indolent from aggressive disease;

(B) better understand the etiology of the disease (including an analysis of lifestyle factors proven to be involved in higher rates of prostate

cancer, such as obesity and diet, and in different ethnic, racial, and socioeconomic groups, such as the African-American, Latino or Hispanic, and American Indian populations and men with a family history of prostate cancer) to improve prevention efforts;

(C) expand basic research into prostate cancer, including studies of fundamental molecular and cellular mechanisms;

(D) identify and provide clinical testing of novel agents for the prevention and treatment of prostate cancer;

(E) establish clinical registries for prostate cancer;

(F) use the National Institute of Biomedical Imaging and Bioengineering and the National Cancer Institute for assessment of appropriate imaging modalities; and

(G) address such other matters relating to prostate cancer research as may be identified by the Federal agencies participating in the program under this section.

(2) PROSTATE CANCER ADVISORY BOARD.—There is established in the Office of the Chief Scientist of the Food and Drug Administration a Pros-

tate Cancer Scientific Advisory Board. Such board shall be responsible for accelerating real-time sharing of the latest research data and accelerating movement of new medicines to patients.

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

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

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

(C) recognize and address—

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

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

(iii) 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, Latino or Hispanic, American Indians/Alaska Natives, and those in rural areas. Such projects shall promote efficient use of specialist care through better coordination of primary care and physician extender teams in underserved areas and more effectively employ tumor boards to better counsel patients.

(2) ELIGIBLE ENTITIES.—

(A) IN GENERAL.—The Secretaries shall select eligible entities to participate in the pilot projects under this section.

(B) PRIORITY.—In selecting eligible entities to participate in the pilot projects under this section, the Secretaries shall give priority to such entities located in medically underserved areas, particularly those that include African-Americans, Latinos and Hispanics, and facilities of the Indian Health Service, including Indian Health Service operated facilities, tribally operated facilities, and Urban Indian Clinics, and those in rural areas.

(3) EVALUATION.—The Secretaries shall, through the pilot projects, evaluate—

(A) the effective and economic delivery of care in diagnosing and treating prostate cancer with the use of telehealth services in medically underserved and tribal areas including collaborative uses of health professionals and integration of the range of telehealth and other technologies;

(B) the effectiveness of improving the capacity of nonmedical providers and nonspecialized medical providers to provide health services

for prostate cancer in medically underserved and tribal areas, including the exploration of innovative medical home models with collaboration between urologists, other relevant medical specialists, including oncologists, radiologists, and primary care teams and coordination of care through the efficient use of primary care teams and physician extenders; and

(C) the effectiveness of using telehealth services to provide prostate cancer treatment in medically underserved areas, including the use of tumor boards to facilitate better patient counseling.

(4) REPORT.—Not later than 12 months after the completion of the pilot projects under this subsection, the Secretaries shall submit to Congress a report describing the outcomes of such pilot projects, including any cost savings and efficiencies realized, and providing recommendations, if any, for expanding the use of telehealth services.

(f) EDUCATION AND AWARENESS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall develop a national education campaign for prostate cancer. Such campaign shall involve the use of written educational materials and public serv-

ice 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 2015 through 2019 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 2015 through 2019 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 2015, payment for medical assistance for individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII) shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), (3), and (5) of this subsection) to such commonwealth or territory for such fiscal year.''.

(2) TECHNICAL AMENDMENT.—Such section is further amended by striking ''(3), and (4)'' and inserting ''(3), and (5)''.

(b) APPLICATION OF ENHANCED FMAP FOR HIGHEST STATE.—Section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by adding at the end the following: ''Notwithstanding the first sentence of this subsection, with respect to medical assistance described in clause (4) of such sentence that is furnished in Puerto Rico, the 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, 2014.

SEC. 704. CANCER PREVENTION AND TREATMENT DEMONSTRATION FOR ETHNIC AND RACIAL MINORITIES.

(a) DEMONSTRATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct demonstration projects (in this section referred to as ''demonstration projects'') for the purpose of developing models and evaluating methods that—

(A) improve the quality of items and services provided to target individuals in order to facilitate reduced disparities in early detection and treatment of cancer;

(B) improve clinical outcomes, satisfaction, quality of life, appropriate use of items and services covered under the Medicare Program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), and referral patterns with respect to target individuals with cancer;

(C) eliminate disparities in the rate of preventive cancer screening measures, such as Pap smears, prostate cancer screenings, colon cancer screenings, breast cancer screenings, and computed tomography (CT) scans, for lung cancer among target individuals;

(D) promote collaboration with community-based organizations to ensure cultural competency of health care professionals and lin-

guistic access for target individuals who are persons with limited-English proficiency; and

(E) encourage the incorporation of community health workers to increase the efficiency and appropriateness of cancer screening programs.

(2) COMMUNITY HEALTH WORKER DEFINED.—In this section, the term ''community health worker'' includes a community health advocate, a lay health worker, a community health representative, a peer health promotor, a community health outreach worker, and a promotore de salud, who promotes health or nutrition within the community in which the individual resides.

(3) TARGET INDIVIDUAL DEFINED.—In this section, the term ''target individual'' means an individual of a racial and ethnic minority group, as defined in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)), who is entitled to benefits under part A, and enrolled under part B, of title XVIII of the Social Security Act.

(b) PROGRAM DESIGN.—

(1) INITIAL DESIGN.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall evaluate best practices in the private

sector, community programs, and academic research of methods that reduce disparities among individuals of racial and ethnic minority groups in the prevention and treatment of cancer and shall design the demonstration projects based on such evaluation.

(2) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall implement at least nine demonstration projects, including the following:

(A) Two projects, each of which shall target different ethnic subpopulations, 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) Latinos or Hispanics.

(v) Native Hawaiians and other Pacific Islanders.

(B) One project within the Pacific Islands or United States insular areas.

(C) At least one project 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 (42 U.S.C. 1395 et seq.); 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 Medicare 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 (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

SEC. 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 sec-

tion referred to as the ''Secretary'') shall enter into an agreement with an entity that specializes in developing quality measures for cancer care under which the entity shall develop a uniform set of measures to evaluate disparities in the quality of cancer care and annually update such set of measures.

(2) MEASURES TO BE INCLUDED.—Such set of measures shall include, with respect to the treatment of cancer, measures of patient outcomes, the process for delivering medical care related to such treatment, patient counseling and engagement in decisionmaking, patient experience of care, resource use, and practice capabilities, such as care coordination.

(b) ESTABLISHMENT OF REPORTING PROCESS.—

(1) IN GENERAL.—The Secretary shall establish a reporting process that requires and provides for a method for health care providers specified under paragraph (2) to submit to the Secretary and make public data on the performance of such providers during each reporting period through use of the measures developed pursuant to subsection (a). Such data shall be submitted in a form and manner and at a time specified by the Secretary.

(2) SPECIFICATION OF PROVIDERS TO REPORT ON MEASURES.—The Secretary shall specify the

classes of Medicare providers of services and suppliers, including hospitals, cancer centers, physicians, primary care providers, and specialty providers, that will be required under such process to publicly report on the measures specified under subsection (a).

(3) ASSESSMENT OF CHANGES.—Under such reporting process, the Secretary shall establish a format that assesses changes in both the absolute and relative disparities in cancer care over time. These measures shall be presented in an easily comprehensible format, such as those presented in the final publications relating to Healthy People 2010 or the National Healthcare Disparities Report.

(4) INITIAL IMPLEMENTATION.—The Secretary shall implement the reporting process under this subsection for reporting periods beginning not later than 6 months after the date that measures are first established under subsection (a).

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 2014''.

(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. At least 15,000 deaths per year in the United States can be attributed to chronic HBV and HCV. Chronic HCV is also a leading cause of death in Americans living with HIV/AIDS, many of those living with HIV/

AIDS are coinfected with chronic HBV, chronic HCV, or both.

(3) According to the Centers for Disease Control and Prevention (referred to in this section as the ''CDC''), approximately 2 percent of the population of the United States is living with chronic HBV, chronic HCV, or both. The CDC has recognized HCV as the Nation's most common chronic bloodborne virus infection and HBV as the deadliest vaccine-preventable disease.

(4) HBV is easily transmitted and is 100 times more infectious than HIV. According to the CDC, HBV is transmitted through contact with infectious blood, semen, or other body fluids. HCV is transmitted by contact with infectious blood, particularly through percutaneous exposures (i.e. puncture through the skin).

(5) The CDC conservatively estimates that in 2010 approximately 17,000 Americans were newly infected with HCV and more than 35,000 Americans were newly infected with HBV. These estimates could be much higher due to many reasons, including lack of screening education and awareness, and perceived marginalization of the populations at risk.

(6) In 2012, CDC released new guidelines recommending every person born between 1945 and 1965 receive a one-time test. Among the estimated 102 million (1.6 million chronically HCV-infected) eligible for screening, birth-cohort screening leads to 84,000 fewer cases of decompensated cirrhosis, 46,000 fewer cases of hepatocellular carcinoma, 10,000 fewer liver transplants, and 78,000 fewer HCV-related deaths gained versus risk-based screening.

(7) In 2013, the United States Preventive Task Force (USPSTF) issued a Grade B rating for screening for the hepatitis C virus (HCV) infection in persons at high risk for infection and adults born between 1945 and 1965. In 2014, the USPSTF issued a Grade B for screening for the hepatitis B virus (HBV) in persons at high-risk of hepatitis B infection. In 2009, the USPSTF issued a Grade A for screening pregnant women for the hepatitis B virus (HBV) during their first prenatal visit.

(8) There were 35 outbreaks (19 of HBV, 16 of HCV) reported to CDC for investigation from 2008 through 2012 related to health care acquired infection of HBV and HCV, 33 of which occurred in

nonhospital settings. There were more than 99,975 patients potentially exposed to one of the viruses.

(9) Chronic HBV and chronic HCV usually do not cause symptoms early in the course of the disease, but after many years of a clinically ''silent'' phase, CDC estimates show more than 33 percent of infected individuals will develop cirrhosis, end-stage liver disease, or liver cancer. Since most individuals with chronic HBV, HCV, or both are unaware of their infection, they do not know to take precautions to prevent the spread of their infection and can unknowingly exacerbate their own disease progression.

(10) HBV and HCV disproportionately affect certain populations in the United States. Although representing only 6 percent of the population, Asian-Americans and Pacific Islanders account for over half of the 1,400,000 domestic chronic HBV cases. Baby boomers (those born between 1945 and 1965) account for more than half of domestic chronic hepatitis C cases. In addition, African-Americans, Latinos (Latinas), and American Indian/Native Alaskans are among the groups which have disproportionately high rates of HBV and/or HCV infections in the United States.

(11) For both chronic HBV and chronic HCV, behavioral changes can slow disease progression if diagnosis is made early. Early diagnosis, which is determined through simple blood tests, can reduce the risk of transmission and disease progression through education and vaccination of household members and other susceptible persons at risk.

(12) Advancements have led to the development of improved diagnostic tests for viral hepatitis. These tests, including rapid, point of care testing and others in development, can facilitate testing, notification of results and post-test counseling, and referral to care at the time of the testing visit. In particular, these tests are also advantageous because they can be used simultaneously with HIV rapid testing for persons at risk for both HCV and HIV infections.

(13) For those chronically infected with HBV or HCV, regular monitoring can lead to the early detection of liver cancer at a stage where a cure is still possible. Liver cancer is the second deadliest cancer in the United States; however, liver cancer has received little funding for research, prevention, or treatment.

(14) Treatment for chronic HCV can eradicate the disease in approximately 75 percent of those currently treated. The treatment of chronic HBV can effectively suppress viral replication in the overwhelming majority (over 80 percent) 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.

(15) To combat the viral hepatitis epidemic 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 produced a 2010 report 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.

(16) The annual health care costs attributable to HBV and HCV in the United States are signifi-

cant. For HBV, it is estimated to be approximately $2,500,000,000 ($2,000 per infected person). In 2000, the lifetime cost of HBV—-before the availability of most current therapies—-was approximately $80,000 per chronically infected person, totaling more than $100,000,000,000. For HCV, medical costs for patients are expected to increase from $30,000,000,000 in 2009 to over $85,000,000,000 in 2024. Avoiding these costs by screening and diagnosing individuals earlier—and connecting them to appropriate treatment and care, will save lives and critical health care dollars. Currently, without a comprehensive screening, testing, and diagnosis program, most patients are diagnosed too late when they need a liver transplant costing at least $314,000 for uncomplicated cases or when they have liver cancer or end stage liver disease which costs $30,980 to $110,576 per hospital admission. As health care costs continue to grow, it is critical that the Federal Government invests in effective mechanisms to avoid documented cost drivers.

(17) According to the IOM report in 2010 (described in paragraph (15)), chronic HBV and HCV infections cause substantial morbidity and mortality despite being preventable and treatable. Deficiencies

in the implementation of established guidelines for the prevention, diagnosis, and medical management of chronic HBV and HCV infections perpetuate personal and economic burdens. Existing grants are not sufficient for the scale of the health burden presented by HBV and HCV.

(18) Screening and testing for HBV and HCV is aligned with the Healthy People 2020 goal to increase immunization rates and reduce preventable infectious diseases. Awareness of disease and access to prevention and treatment remain essential components for reducing infectious disease transmission.

(19) Federal support is necessary to increase knowledge and awareness of HBV and HCV and to assist State and local prevention and control efforts in reducing the morbidity and mortality of these epidemics.

(20) The Secretary of Health and Human Services has the discretion to carry out this Act directly and through whichever of the agencies of the Public Health Service the Secretary determines to be appropriate, which may (in the Secretary's discretion) include the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Serv-

ices Administration, the National Institutes of Health (including the National Institute on Minority Health and Health Disparities), and other agencies of such Service.

(c) BIENNIAL ASSESSMENT OF HHS HEPATITIS B AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH, AND MEDICAL MANAGEMENT PLAN.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended—

(1) by striking section 317N (42 U.S.C. 247b–15); and

(2) by adding at the end the following:

"PART W—BIENNIAL ASSESSMENT OF HHS HEPATITIS B AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH, AND MEDICAL MANAGEMENT PLAN

"SEC. 399NN. BIENNIAL UPDATE OF THE PLAN.

''(a) IN GENERAL.—The Secretary shall conduct a biennial assessment of the Secretary's plan for the prevention, control, and medical management of, and education and research relating to, hepatitis B and hepatitis C, for the purposes of—

''(1) incorporating into such plan new knowledge or observations relating to hepatitis B and hepatitis C (such as knowledge and observations that

may be derived from clinical, laboratory, and epidemiological research and disease detection, prevention, and surveillance outcomes);

''(2) addressing gaps in the coverage or effectiveness of the plan; and

''(3) evaluating and, if appropriate, updating recommendations, guidelines, or educational materials of the Centers for Disease Control and Prevention or the National Institutes of Health for health care providers or the public on viral hepatitis in order to be consistent with the plan.

''(b) PUBLICATION OF NOTICE OF ASSESSMENTS.—Not later than October 1 of the first even-numbered year beginning after the date of the enactment of this part, and October 1 of each even-numbered year thereafter, the Secretary shall publish in the Federal Register a notice of the results of the assessments conducted under paragraph (1). Such notice shall include—

''(1) a description of any revisions to the plan referred to in subsection (a) as a result of the assessment;

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

''(3) in the case of a determination by the Secretary that the plan does not need revision, an explanation of the basis for such determination.

"SEC. 399NN–1. ELEMENTS OF PROGRAM.

''(a) EDUCATION AND AWARENESS PROGRAMS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Resources and Services Administration, and the Administrator of the Substance Abuse and Mental Health Services Administration, and in accordance with the plan referred to in section 399NN(a), shall implement programs to increase awareness and enhance knowledge and understanding of hepatitis B and hepatitis C. Such programs shall include—

''(1) the conduct of culturally and language appropriate health education in primary and secondary schools, college campuses, public awareness campaigns, and community outreach activities (especially to the ethnic communities with high rates of chronic hepatitis B and chronic hepatitis C and other high-risk groups) to promote public awareness and knowledge about the value of hepatitis A and hepatitis B immunization, risk factors, the transmission and prevention of hepatitis B and hepatitis C, the value of screening for the early detection of hepatitis B

and hepatitis C, and options available for the treatment of chronic hepatitis B and chronic hepatitis C;

''(2) the promotion of immunization programs that increase awareness and access to hepatitis A and hepatitis B vaccines for susceptible adults and children;

''(3) the training of health care professionals regarding the importance of vaccinating individuals infected with hepatitis C and individuals who are at risk for hepatitis C infection against hepatitis A and hepatitis B;

''(4) the training of health care professionals regarding the importance of vaccinating individuals chronically infected with hepatitis B and individuals who are at risk for chronic hepatitis B infection against the hepatitis A virus;

''(5) the training of health care professionals and health educators to make them aware of the high rates of chronic hepatitis B and chronic hepatitis C in certain adult ethnic populations, and the importance of prevention, detection, and medical management of hepatitis B and hepatitis C and of liver cancer screening;

''(6) the development and distribution of health education curricula (including information relating

to the special needs of individuals infected with hepatitis B and hepatitis C, such as the importance of prevention and early intervention, regular monitoring, the recognition of psychosocial needs, appropriate treatment, and liver cancer screening) for individuals providing hepatitis B and hepatitis C counseling; and

''(7) support for the implementation curricula described in paragraph (6) by State and local public health agencies.

''(b) IMMUNIZATION, PREVENTION, AND CONTROL PROGRAMS.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall support the integration of activities described in paragraph (3) into existing clinical and public health programs at State, local, territorial, and tribal levels (including community health clinics, programs for the prevention and treatment of HIV/AIDS, sexually transmitted diseases, and substance abuse, and programs for individuals in correctional settings).

''(2) COORDINATION OF DEVELOPMENT OF FEDERAL SCREENING GUIDELINES.—

''(A) REFERENCES.—For purposes of this subsection, the term 'CDC Director' means the Director of the Centers for Disease Control and Prevention, and the term 'AHRQ Director' means the Director of the Agency for Healthcare Research and Quality.

''(B) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.—Due to the rapidly evolving standard of care associated with diagnosing and treating viral hepatitis infection, the AHRQ Director shall convene the Preventive Services Task Force under section 915(a) of the Public Health Service Act to review its recommendation for screening for HBV and HCV infection every 3 years.

''(3) ACTIVITIES.—

''(A) VOLUNTARY TESTING PROGRAMS.—

''(i) IN GENERAL.—The Secretary shall establish a mechanism by which to support and promote the development of State, local, territorial, and tribal voluntary hepatitis B and hepatitis C testing programs to screen the high-prevalence populations to aid in the early identification of chronically infected individuals.

"(ii) CONFIDENTIALITY OF THE TEST RESULTS.—The Secretary shall prohibit the use of the results of a hepatitis B or hepatitis C test conducted by a testing program developed or supported under this subparagraph for any of the following:

"(I) Issues relating to health insurance.

"(II) To screen or determine suitability for employment.

"(III) To discharge a person from employment.

"(B) COUNSELING REGARDING VIRAL HEPATITIS.—The Secretary shall support State, local, territorial, and tribal programs in a wide variety of settings, including those providing primary and specialty health care services in nonprofit private and public sectors, to—

"(i) provide individuals with ongoing risk factors for hepatitis B and hepatitis C infection with client-centered education and counseling which concentrates on—

"(I) promoting testing of individuals that have been exposed to their

blood, family members, and their sexual partners; and

"(II) changing behaviors that place individuals at risk for infection;

"(ii) provide individuals chronically infected with hepatitis B or hepatitis C with education, health information, and counseling to reduce their risk of—

"(I) dying from end-stage liver disease and liver cancer; and

"(II) transmitting viral hepatitis to others; and

"(iii) provide women chronically infected with hepatitis B or hepatitis C who are pregnant or of childbearing age with culturally and language appropriate health information, such as how to prevent hepatitis B perinatal infection, and to alleviate fears associated with pregnancy or raising a family.

"(C) IMMUNIZATION.—The Secretary shall support State, local, territorial, and tribal efforts to expand the current vaccination programs to protect every child in the country and all susceptible adults, particularly those infected

with hepatitis C and high-prevalence ethnic populations and other high-risk groups, from the risks of acute and chronic hepatitis B infection by—

''(i) ensuring continued funding for hepatitis B vaccination for all children 19 years of age or younger through the Vaccines for Children Program;

''(ii) ensuring that the recommendations of the Advisory Committee on Immunization Practices are followed regarding the birth dose of hepatitis B vaccinations for newborns;

''(iii) requiring proof of hepatitis B vaccination for entry into public or private daycare, preschool, elementary school, secondary school, and institutions of higher education;

''(iv) expanding the availability of hepatitis B vaccination for all susceptible adults to protect them from becoming acutely or chronically infected, including ethnic and other populations with high prevalence rates of chronic hepatitis B infection;

"(v) expanding the availability of hepatitis B vaccination for all susceptible adults, particularly those in their reproductive age (women and men less than 45 years of age), to protect them from the risk of hepatitis B infection;

"(vi) ensuring the vaccination of individuals infected, or at risk for infection, with hepatitis C against hepatitis A, hepatitis B, and other infectious diseases, as appropriate, for which such individuals may be at increased risk; and

"(vii) ensuring the vaccination of individuals infected, or at risk for infection, with hepatitis B against hepatitis A virus and other infectious diseases, as appropriate, for which such individuals may be at increased risk.

"(D) MEDICAL REFERRAL.—The Secretary shall support State, local, territorial, and tribal programs that support—

"(i) referral of persons chronically infected with hepatitis B or hepatitis C—

"(I) for medical evaluation to determine the appropriateness for

antiviral treatment to reduce the risk of progression to cirrhosis and liver cancer; and

''(II) for ongoing medical management including regular monitoring of liver function and screening for liver cancer; and

''(ii) referral of persons infected with acute or chronic hepatitis B infection or acute or chronic hepatitis C infection for drug and alcohol abuse treatment where appropriate.

''(4) INCREASED SUPPORT FOR ADULT VIRAL HEPATITIS COORDINATORS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall provide increased support to Adult Viral Hepatitis Coordinators in State, local, territorial, and tribal health departments in order to enhance the additional management, networking, and technical expertise needed to ensure successful integration of hepatitis B and hepatitis C prevention and control activities into existing public health programs.

''(c) EPIDEMIOLOGICAL SURVEILLANCE.—

"(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall support the establishment and maintenance of a national chronic and acute hepatitis B and hepatitis C surveillance program, in order to identify—

"(A) trends in the incidence of acute and chronic hepatitis B and acute and chronic hepatitis C;

"(B) trends in the prevalence of acute and chronic hepatitis B and acute and chronic hepatitis C infection among groups that may be disproportionately affected; and

"(C) trends in liver cancer and end-stage liver disease incidence and deaths, caused by chronic hepatitis B and chronic hepatitis C in the high-risk ethnic populations.

"(2) SEROPREVALENCE AND LIVER CANCER STUDIES.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall prepare a report outlining the population-based seroprevalence studies currently underway, future planned studies, the criteria involved in determining which seroprevalence studies to conduct, defer, or suspend, and the scope of those studies, the

economic and clinical impact of hepatitis B and hepatitis C, and the impact of chronic hepatitis B and chronic hepatitis C infections on the quality of life. Not later than one year after the date of the enactment of this part, the Secretary shall submit the report to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate.

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

''(d) RESEARCH.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, the Director of the National Cancer Institute, and the Director of the National Institutes of Health, shall—

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

''(2) conduct research on hepatitis B and hepatitis C natural history, pathophysiology, improved

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

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

''(4) conduct research comparing the effectiveness of screening, diagnostic, management, and treatment approaches for chronic hepatitis B, chronic hepatitis C, and liver cancer in the affected communities.

''(e) UNDERSERVED AND DISPROPORTIONATELY AFFECTED POPULATIONS.—In carrying out this section, the Secretary shall provide expanded support for individuals with limited access to health education, testing, and health care services and groups that may be disproportionately affected by hepatitis B and hepatitis C.

''(f) EVALUATION OF PROGRAM.—The Secretary shall develop benchmarks for evaluating the effectiveness of the programs and activities conducted under this section and make determinations as to whether such benchmarks have been achieved.

"SEC. 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 2015, $90,000,000 for fiscal year 2016, $110,000,000 for fiscal year 2017, $130,000,000 for fiscal year 2018, and $150,000,000 for fiscal year 2019.".

(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 2014''.

(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 Latino or Hispanic populations.

(6) The National Heart, Lung, and Blood Institute and the National Cancer Institute have conducted important research into the causes of and treatments for acquired bone marrow failure diseases.

(7) The National Marrow Donor Program Registry has made significant contributions to the fight against bone marrow failure diseases by connecting millions of potential marrow donors with individuals and families suffering from these conditions.

(8) Despite these advances, a more comprehensive Federal strategic effort among numerous Federal agencies is needed to discover a cure for acquired bone marrow failure disorders.

(9) Greater Federal surveillance of acquired bone marrow failure diseases is needed to gain a better understanding of the causes of acquired bone marrow failure diseases.

(10) The Federal Government should increase its research support for and engage with public and private organizations in developing a comprehensive approach to combat and cure acquired bone marrow failure diseases.

(c) NATIONAL ACQUIRED BONE MARROW FAILURE DISEASE REGISTRY.—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).

''(3) PURPOSES OF REGISTRY.—The National Acquired Bone Marrow Failure Disease Registry—

''(A) shall identify the incidence and prevalence of acquired bone marrow failure diseases in the United States;

''(B) shall be used to collect and store data on acquired bone marrow failure diseases, including data concerning—

''(i) the age, race or ethnicity, general geographic location, sex, and family history of individuals who are diagnosed with acquired bone marrow failure diseases, and any other characteristics of such individuals determined appropriate by the Secretary;

''(ii) the genetic and environmental factors that may be associated with developing acquired bone marrow failure diseases;

''(iii) treatment approaches for dealing with acquired bone marrow failure diseases;

''(iv) outcomes for individuals treated for acquired bone marrow failure diseases, including outcomes for recipients of stem

cell therapeutic products as contained in the database established pursuant to section 379A; and

''(v) any other factors pertaining to acquired bone marrow failure diseases determined appropriate by the Secretary; and

''(C) shall be made available—

''(i) to the general public; and

''(ii) to researchers to facilitate further research into the causes of, and treatments for, acquired bone marrow failure diseases in accordance with standard practices of the Centers for Disease Control and Preventions.

''(b) ADVISORY COMMITTEE.—

''(1) ESTABLISHMENT.—Not later than 6 months after the date of the enactment of this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an advisory committee, to be known as the Advisory Committee on Acquired Bone Marrow Failure Diseases.

''(2) MEMBERS.—The members of the Advisory Committee on Acquired Bone Marrow Failure Diseases shall be appointed by the Secretary, acting

through the Director of the Centers for Disease Control and Prevention, and shall include at least one representative from each of the following:

''(A) A national patient advocacy organization with experience advocating on behalf of patients suffering from acquired bone marrow failure diseases.

''(B) The National Institutes of Health, including at least one representative from each of—

''(i) the National Cancer Institute;

''(ii) the National Heart, Lung, and Blood Institute; and

''(iii) the Office of Rare Diseases.

''(C) The Centers for Disease Control and Prevention.

''(D) Clinicians with experience in—

''(i) diagnosing or treating acquired bone marrow failure diseases; and

''(ii) medical data registries.

''(E) Epidemiologists who have experience with data registries.

''(F) Publicly or privately funded researchers who have experience researching acquired bone marrow failure diseases.

"(G) The entity operating the C.W. Bill Young Cell Transplantation Program established pursuant to section 379 and the entity operating the C.W. Bill Young Cell Transplantation Program Outcomes Database.

"(3) RESPONSIBILITIES.—The Advisory Committee on Acquired Bone Marrow Failure Diseases shall provide recommendations to the Secretary on the establishment and maintenance of the National Acquired Bone Marrow Failure Disease Registry, including recommendations on the collection, maintenance, and dissemination of data.

"(4) PUBLIC AVAILABILITY.—The Secretary shall make the recommendations of the Advisory Committee on Acquired Bone Marrow Failure Disease publicly available.

"(c) GRANTS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may award grants to, and enter into contracts and cooperative agreements with, public or private nonprofit entities for the management of, as well as the collection, analysis, and reporting of data to be included in, the National Acquired Bone Marrow Failure Disease Registry.

"(d) DEFINITION.—In this section, the term 'acquired bone marrow failure disease' means—

''(1) myelodysplastic syndromes (MDS);

''(2) aplastic anemia;

''(3) paroxysmal nocturnal hemoglobinuria (PNH);

''(4) pure red cell aplasia;

''(5) acute myeloid leukemia that has progressed from myelodysplastic syndromes; or

''(6) large granular lymphocytic leukemia.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $3,000,000 for each of fiscal years 2015 through 2019.''.

(d) PILOT STUDIES THROUGH THE AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY.—

(1) PILOT STUDIES.—The Secretary of Health and Human Services, acting through the Administrator of the Agency for Toxic Substances and Disease Registry, shall conduct pilot studies to determine which environmental factors, including exposure to toxins, may cause acquired bone marrow failure diseases.

(2) COLLABORATION WITH THE RADIATION INJURY TREATMENT NETWORK.—In carrying out the directives of this section, the Secretary may collaborate with the Radiation Injury Treatment Network of the C.W. Bill Young Cell Transplantation 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 2015 through 2019.

(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-

geted to minority populations affected by acquired bone marrow failure diseases.

''(2) PROGRAM REQUIREMENTS.—Minority-focused outreach and informational programs authorized by this section—

''(A) shall make information about treatment options and clinical trials for acquired bone marrow failure diseases publicly available, and

''(B) shall provide referral services for treatment options and clinical trials,

at the National Minority Health Resource Center supported under section 1707(b)(8) (including by means of the Center's Web site, through appropriate locations such as the Center's knowledge center, and through appropriate programs such as the Center's resource persons network) and through minority health consultants located at each Department of Health and Human Services regional office.

''(b) HISPANIC AND ASIAN-AMERICAN AND PACIFIC ISLANDER OUTREACH.—

''(1) IN GENERAL.—The Secretary, acting through the Deputy Assistant Secretary for Minority Health, shall undertake a coordinated outreach effort to connect Hispanic, Asian-American, and Pa-

cific Islander communities with comprehensive services focused on treatment of, and information about, acquired bone marrow failure diseases.

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

''(c) GRANTS AND COOPERATIVE AGREEMENTS.—

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

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

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

''(d) DEFINITION.—In this section, the term 'acquired bone marrow failure disease' has the meaning given to such term in section 317X(d).

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,000,000 for each of fiscal years 2015 through 2019.''.

(f) DIAGNOSIS AND QUALITY OF CARE FOR ACQUIRED BONE MARROW FAILURE DISEASES.—

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

(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,000,000 for each of fiscal years 2015 through 2019.

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

(1) myelodysplastic syndromes (MDS);

(2) aplastic anemia;

(3) paroxysmal nocturnal hemoglobinuria (PNH);

(4) pure red cell aplasia;

(5) acute myeloid leukemia that progressed from myelodysplastic syndromes; or

(6) large granular lymphocytic leukemia.

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

SEC. 731. GUIDELINES FOR DISEASE SCREENING FOR MINORITY PATIENTS.

(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall convene a series of meetings to develop guidelines for disease screening for minority patient populations which have a higher than average risk for many chronic diseases and cancers.

(b) PARTICIPANTS.—In convening meetings under subsection (a), the Secretary shall ensure that meeting participants include representatives of—

(1) professional societies and associations;

(2) minority health organizations;

(3) health care researchers and providers, including those with expertise in minority health;

(4) Federal health agencies, including the Office of Minority Health, the National Institute on Minority Health and Health Disparities, and the National Institutes of Health; and

(5) other experts determined appropriate by the Secretary.

(c) DISEASES.—Screening guidelines for minority populations shall be developed as appropriate under subsection (a) for—

(1) hypertension;

(2) hypercholesterolemia;

(3) diabetes;

(4) cardiovascular disease;

(5) cancers, including breast, prostate, colon, cervical, and lung cancer;

(6) asthma;

(7) diabetes;

(8) kidney diseases;

(9) eye diseases and disorders, including glaucoma;

(10) HIV/AIDS and sexually transmitted diseases;

(11) uterine fibroids;

(12) autoimmune disease;

(13) mental health conditions;

(14) dental health conditions and oral diseases, including oral cancer;

(15) environmental and related health illnesses and conditions;

(16) Sickle cell disease;

(17) violence and injury prevention and control;

(18) genetic and related conditions;

(19) heart disease and stroke;

(20) tuberculosis;

(21) chronic obstructive pulmonary disease;

(22) musculoskeletal diseases, arthritis, and obesity; and

(23) 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 2015 through 2019.

SEC. 732. CDC WISEWOMAN SCREENING PROGRAM.

Section 1509 of the Public Health Service Act (42 U.S.C. 300n–4a) is amended—

(1) in subsection (a)—

(A) by striking the heading and inserting ''IN GENERAL.—''; and

(B) in the matter preceding paragraph (1), by striking ''may make grants'' and all that follows through ''purpose'' and inserting the following: ''may make grants to such States for the purpose''; and

(2) in subsection (d)(1), by striking ''there are authorized'' and all that follows through the period and inserting ''there are authorized to be appropriated $23,000,000 for fiscal year 2015, $25,300,000 for fiscal year 2016, $27,800,000 for fiscal year 2017, $30,800,000 for fiscal year 2018, and $34,000,000 for fiscal year 2019.''.

SEC. 733. REPORT ON CARDIOVASCULAR CARE FOR WOMEN AND MINORITIES.

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

''SEC. 399V–6. REPORT ON CARDIOVASCULAR CARE FOR WOMEN AND MINORITIES.

''Not later than September 30, 2015, 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 improv-

ing the treatment of, heart disease, stroke, and other cardiovascular diseases in women, racial and ethnic minorities, those for whom English is not their primary language, and individuals with disabilities.''.

SEC. 734. COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES IN MEDICAID.

(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 COST SHARING.—Section 1916A(b)(3)(B) of such Act (42 U.S.C. 1396o–1(b)(3)(B)42 U.S.C. 1396o–1(b)(3)(B)) is amended—

(A) in clause (iii), by striking '', and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb))''; and

(B) by adding at the end the following:

''(xi) Counseling and pharmacotherapy for cessation of tobacco use (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation in accord-

ance 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, 2014.

SEC. 735. CLINICAL RESEARCH FUNDING FOR ORAL HEALTH.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expand and intensify the conduct and support of the research activities of the National Institutes of Health and the National Institute of Dental and Craniofacial Research to improve the oral health of the population through the prevention and management of oral diseases and conditions.

(b) INCLUDED RESEARCH ACTIVITIES.—Research activities under subsection (a) shall include—

(1) comparative effectiveness research and clinical disease management research addressing early childhood caries and oral cancer; and

(2) awarding of grants and contracts to support the training and development of health services researchers, comparative effectiveness researchers, and clinical researchers whose research improves the oral health of the population.

SEC. 736. PARTICIPATION BY MEDICAID BENEFICIARIES IN APPROVED CLINICAL TRIALS.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1943 the following new section:

"SEC. 1944. PARTICIPATION IN AN APPROVED CLINICAL TRIAL.

''(a) COVERAGE OF ROUTINE PATIENT COSTS ASSOCIATED WITH APPROVED CLINICAL TRIALS.—

''(1) INCLUSION.—Subject to paragraph (2), routine patient costs shall include all items and services consistent with the medical assistance provided under the State plan that would otherwise be provided to the individual under such State plan if such individual was not enrolled in an approved clinical trial, including any items or services related to the prevention, detection, and treatment of any medical complications that arise as a result of participation in the approved clinical trial.

''(2) EXCLUSION.—For purposes of paragraph (1), routine patient costs does not include—

''(A) the investigational item, device, or service itself;

''(B) items and services that are provided solely to satisfy data collection and analysis

needs and that are not used in the direct clinical management of the patient; or

"(C) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

"(3) INFORMATION CONCERNING CLINICAL TRIALS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary, in consultation with relevant stakeholders, shall develop a single standardized electronic form for use by the individual or the referring health care provider to submit to the State agency administering the State plan in order to verify that the clinical trial meets the conditions established for an approved clinical trial (as defined in subsection (c)).

"(B) EXCLUDED INFORMATION.—For purposes of subparagraph (A) or any such request by the State agency for information regarding a clinical trial, an individual or referring health care provider shall not be required to submit—

"(i) the clinical protocol document for the clinical trial; or

"(ii) subject to subparagraph (C), any additional information other than such information as is required pursuant to the form described in subparagraph (A).

"(C) OPTIONAL INFORMATION.—For purposes of subparagraphs (A) and (B)(ii), the form may include a requirement that the referring health care provider attest that the individual is eligible to participate in the clinical trial pursuant to the trial protocol and that their participation in such trial would be appropriate.

"(D) REVIEW OF INFORMATION.—

"(i) IN GENERAL.—A State plan under this title shall establish a process for timely review by the State agency of the form and information submitted pursuant to subparagraph (A) and, not later than 48 hours after receipt of such form, confirmation that the information provided in such form satisfies the requirements established under such subparagraph, with such process to include establishment and operation of a 24-hour, toll-free telephone num-

ber and e-mail address to provide for expedited communication.

''(ii) FAILURE TO RESPOND.—If an individual or the referring health care provider does not receive a response or request for additional information from the State agency following the 48-hour period described in clause (i), the information provided in the form may be presumed to satisfy the requirements established under this paragraph.

''(b) ENCOURAGEMENT OF PARTICIPATION IN APPROVED CLINICAL TRIALS.—

''(1) REASONABLY ACCESSIBLE PROVIDER.—For purposes of participation in an approved clinical trial by an individual eligible for medical assistance under this title, the State agency administering the State plan shall make reasonable efforts to ensure that the individual is provided with access to a provider who is—

''(A) participating in the approved clinical trial;

''(B) located not more than 25 miles from the residence of the individual (or, if no such

provider is available, as close as possible to the residence of the individual); and

"(C) a participating provider under the State plan or has been deemed to be a participating provider under the State plan for purposes of providing medical assistance to the individual during their participation in the approved clinical trial.

"(2) INFORMATIONAL MATERIALS.—The State agency administering the plan approved under this title shall develop informational materials and programs to encourage participating providers to make appropriate referrals to physicians and other appropriate health care professionals who can provide individuals with access to approved clinical trials.

"(c) DEFINITION OF APPROVED CLINICAL TRIAL.—The term 'approved clinical trial' has the same meaning as provided under section 2709(d) of the Public Health Service Act.".

(b) CONFORMING AMENDMENT.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (77) the following new paragraph:

"(78) provide that participation in an approved clinical trial and coverage of routine patient costs associated with such trial for an individual eligible

for medical assistance under this title is conducted in accordance with the requirements under section 1944;''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to calendar quarters beginning on or after October 1, 2014.

(2) DELAY PERMITTED FOR STATE PLAN AMENDMENT.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be

deemed to be a separate regular session of the State legislature.

Subtitle E—HIV/AIDS

SEC. 741. STATEMENT OF POLICY.

It is the policy of the United States to achieve an AIDS-free generation, and to—

(1) expand access to lifesaving antiretroviral therapy for people living with HIV/AIDS and immediately link people to continuous and coordinated high-quality care when they learn they are infected with HIV;

(2) expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches, including routine HIV screening, and universal access to HIV prevention tools in the communities where HIV/AIDS is most heavily concentrated, particularly communities of color;

(3) ensure laws, policies, and regulations do not impede access to prevention, treatment, and care for people living with HIV/AIDS or at risk for acquiring HIV;

(4) accelerate research for more efficacious HIV prevention and treatments tools, a cure, and a vaccine; and

(5) respect the human rights and dignity of persons living with HIV/AIDS.

SEC. 742. 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, 18 percent of whom are unaware of their HIV-positive status.

(2) Annually there are over 50,000 new HIV infections and 20,000 deaths in people with an HIV diagnoses in 50 States and 6 dependent areas of the United States.

(3) The Centers for Disease Control and Prevention estimates that in 2011 there were approximately 50,199 people newly diagnosed 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 (MSM) who, in 2010, accounted for 45 percent of new HIV infections among black MSM and 55 percent of HIV infections among young MSM overall.

(4) HIV disproportionately affects certain populations in the United States. Though African-Ameri-

cans represent less than 13 percent of the population, African-Americans account for almost half (44 percent) of all people living with HIV in the United States. Men who have sex with men (MSM) make up approximately 4 percent of the population, but account for 63 percent of all new HIV infections and are the only risk group in which HIV infections continue to increase.

(5) Disparities exist among Latinos/Hispanics; they make up 16 percent of US population and 22 percent of new infections (2011).

(6) Though American Indians/Alaska Natives represent less than 2 percent of the total number of HIV/AIDS cases, American Indians and Alaska Natives rank fifth in rates of HIV/AIDS diagnosis, still higher than their White counterparts.

(7) While Asian-Americans, Native Hawaiians, and Pacific Islanders HIV/AIDS cases account for approximately 1 percent of cases nationally, between 2010 and 2011, the rate of new HIV diagnoses increased for Asian-Americans by 22 percent.

(8) The latest data from the CDC (2013) indicate that women account for 1 in 5 (20 percent) new HIV infections in the United States women of color, particularly Black women, have been especially hard

hit and represent the majority of women living with the disease and women newly infected. In addition, Black women accounted for nearly two-thirds (64 percent) of all estimated new HIV infections among women, while only accounting for 13 percent of the female population; White women accounted for 18 percent and Latinas 15 percent of new infections.

(9) The history of HIV shows that culturally relevant and gender-responsive supportive services, including psychosocial support, treatment literacy, case management, and transportation are necessary strategies to reach and engage women and girls in medical care.

(10) The limited data available on transgender individuals point to a disproportionate burden of HIV infection.

(11) Stigma and discrimination contribute to these disparities.

(12) The Centers for Disease Control and Prevention has determined that increasing the proportion of people who know their HIV status is an essential component of comprehensive HIV/AIDS treatment and prevention efforts and that early diagnosis is critical in order for people with HIV/AIDS to receive life-extending therapy. Additionally,

the Centers for Disease Control and Prevention recommend routine HIV screening in health care settings for all patients aged 13 to 64, regardless of risk.

(13) In 1998, Congress created the National Minority AIDS Initiative to provide technical assistance, build capacity, and strengthen outreach efforts among local institutions and community-based organizations that serve racial and ethnic minorities living with or vulnerable to HIV/AIDS.

(14) 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, gender identity, or socioeconomic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.''.

(15) In recent years, several thousand people across the country were waiting to receive AIDS

treatment through the AIDS Drug Assistance Program authorized by the provisions popularly known as the Ryan White CARE Act.

(16) At present, 34 States and 2 United States territories have criminal statutes based on ''exposure'' to HIV. Most of these laws were adopted before the availability of effective antiretroviral treatment for HIV/AIDS.

(17) 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 annually. Preventing 40,000 new infections in the United States each year would save $12.8 billion annually.

(18) 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.

(19) 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, the District of Columbia, and the cities of New York, San Francisco, Los Angeles, Washington, DC, and Philadelphia allow condom distribution in their correctional facilities. However, these States and cities operate fewer than 1 percent of all correctional facilities.

(20) Many correctional facilities in the United States do not provide comprehensive testing and treatment programs to reduce the spread of STIs. Fewer than half of correctional facilities provide counseling to HIV-positive incarcerated persons.

(21) 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.

(22) Research shows that stable housing leads to better health outcomes for those living with HIV. Inadequate or unstable housing is not only a barrier to effective treatment, but also increases the likelihood of engaging in risky behaviors leading to HIV

infection. Insecure housing puts people with HIV/AIDS at risk of premature death from exposure to other diseases, poor nutrition, and lack of medical care.

(23) Due to advances in treatment, many people living with HIV/AIDS (PLWHA) today are living healthy lives and have the ability and desire to fully participate in all aspects of community life, including employment. Research associates being employed with tremendous economic, social, and health benefits for many people living with HIV/AIDS.

(24) The common benefits associated with employment include income, autonomy, productivity, and status within society, daily structure, making a contribution to one's community, and increased skills and self-esteem. Research also indicates that many people with disabilities, including PLWHA, report perceiving themselves as being less disabled or not disabled at all, when working. Furthermore, some studies link working with better physical and mental health outcomes for PLWHA when compared to those who are not working. Preliminary data also suggest that transitioning to employment is associated with reduced HIV-related health risk behavior for many people.

(25) On July 16, 2012, the Food and Drug Administration approved the first drug to reduce the risk of HIV infection in uninfected individuals who are at high risk of HIV infection and who may engage in sexual activity with HIV-infected partners.

SEC. 743. ADDITIONAL FUNDING FOR AIDS DRUG ASSISTANCE PROGRAM TREATMENTS.

Section 2623 of the Public Health Service Act (42 U.S.C. 300ff–31b) is amended by adding at the end the following:

''(c) ADDITIONAL FUNDING FOR AIDS DRUG ASSISTANCE PROGRAM TREATMENTS.—In addition to amounts otherwise authorized to be appropriated for carrying out this subpart, there are authorized to be appropriated such sums as may be necessary to carry out sections 2612(b)(3)(B) and 2616 for each of fiscal years 2015 through 2017.''.

SEC. 744. ENHANCING THE NATIONAL HIV SURVEILLANCE SYSTEM.

(a) GRANTS.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall make grants to States to support integration of public health surveillance systems into all electronic health records in order to allow

rapid communications between the clinical setting and health departments, by means that include—

(1) providing technical assistance and policy guidance to State and local health departments, clinical providers, and other agencies serving individuals with HIV to improve the interoperability of data systems relevant to monitoring HIV care and supportive services;

(2) capturing longitudinal data pertaining to the initiation and ongoing prescription or dispensing of antiretroviral therapy for individuals diagnosed with HIV (such as through pharmacy-based reporting);

(3) obtaining information—

(A) on a voluntary basis, on sexual orientation and gender identity; and

(B) on sources of coverage (or the lack thereof) for medical treatment (including coverage through Medicaid, Medicare, the program under title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.; commonly referred to as the ''Ryan White HIV/AIDS Program''), other public funding, private insurance, and health maintenance organizations); and

(4) obtaining and using current geographic markers of residence (such as current address, zip code, partial zip code, and census block).

(b) PRIVACY AND SECURITY SAFEGUARDS.—In carrying out this section, the Secretary of Health and Human Services shall ensure that appropriate privacy and security safeguards are met to prevent unauthorized disclosure of protected health information and compliance with the HIPAA privacy and security law (as defined in section 3009 of the Public Health Service Act (42 U.S.C. 300jj–19)) and other relevant laws and regulations.

(c) PROHIBITION AGAINST IMPROPER USE OF DATA.—No grant under this section may be used to allow or facilitate the collection or use of surveillance or clinical data or records—

(1) for punitive measures of any kind, civil or criminal, against the subject of such data or records; or

(2) for imposing any requirement or restriction with respect to an individual without the individual's written consent.

(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2015 through 2019.

SEC. 745. EVIDENCE-BASED STRATEGIES FOR IMPROVING LINKAGE TO AND RETENTION IN APPROPRIATE CARE.

(a) STRATEGIES.—The Secretary of Health and Human Services, in collaboration with the Director of the Centers for Disease Control and Prevention, the Administrator of the Substance Abuse and Mental Health Services Administration, the Director of the Office of AIDS Research, the Administrator of the Health Resources and Services Administration, and the Administrator of the Centers for Medicare & Medicaid Services, shall—

(1) identify evidence-based strategies most effective at addressing the multifaceted issues that impede disease status awareness and linkage to and retention in appropriate care, taking into consideration health care systems issues, clinic and provider issues, and individual psychosocial, environmental, and other contextual factors;

(2) support the wide-scale implementation of the evidence-based strategies identified pursuant to paragraph (1), including through incorporating such strategies into health care coverage supported by the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), the program under title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.; commonly referred to

as the ''Ryan White HIV/AIDS Program''), and health plans purchased through an American Health Benefit Exchange established pursuant to section 1311 of the Patient Protection and Affordable Care Act (42 U.S.C. 18031); and

(3) not later than 12 months after the date of the enactment of this Act, submit a report to the Congress on the status of activities under paragraphs (1) and (2).

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2015 through 2019.

SEC. 746. IMPROVING ENTRY INTO AND RETENTION IN CARE AND ANTIRETROVIRAL ADHERENCE FOR PERSONS WITH HIV.

(a) SENSE OF CONGRESS.—It is the sense of the Congress that AIDS research has led to scientific advancements that have—

(1) saved the lives of millions of people with HIV/AIDS;

(2) prevented millions of people from being infected; and

(3) had broad benefits that extend far beyond helping people at risk for or living with HIV.

(b) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the National Institutes of Health, shall expand, intensify, and coordinate operational and translational research and other activities of the National Institutes of Health regarding methods—

(1) to increase adoption of evidence-based adherence strategies within HIV care and treatment programs;

(2) to increase HIV testing and case detection rates;

(3) to reduce HIV-related health disparities;

(4) to ensure that research to improve adherence to HIV care and treatment programs address the unique concerns of women;

(5) to integrate HIV/AIDS prevention and care services with mental health and substance use prevention and treatment delivery systems; and

(6) to increase knowledge on the implementation of preexposure prophylaxis (PrEP), including with respect to—

(A) who can benefit most from PrEP;

(B) how to provide PrEP safely and efficiently;

(C) how to integrate PrEP with other essential prevention methods such as condoms; and

(D) how to ensure high levels of adherence.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2015 through 2019.

SEC. 747. 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 Secretary, acting through the Deputy Assistant Secretary for Minority Health, may make grants to public health agencies and faith-based organizations to conduct—

(1) outreach activities related to HIV/AIDS prevention and testing activities;

(2) HIV/AIDS prevention activities; and

(3) HIV/AIDS testing activities.

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $50,000,000 for fiscal year 2015, and such sums as may be necessary for fiscal years 2016 through 2019.

SEC. 748. MINORITY AIDS INITIATIVE.

(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) men who have sex with men;

(2) youth;

(3) persons who engage in intravenous drug abuse;

(4) women;

(5) homeless individuals; and

(6) individuals incarcerated or in the penal system.

(d) AUTHORIZATION OF APPROPRIATIONS.—For carrying out this section, there are authorized to be appropriated $610,000,0000 for fiscal year 2015 and such sums as may be necessary for each of fiscal years 2016 through 2019.

SEC. 749. HEALTH CARE PROFESSIONALS TREATING INDIVIDUALS WITH HIV/AIDS.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, shall expand, intensify, and coordinate workforce initiatives of the Health Resources and Services Administration to increase the capacity of the health workforce focusing primarily on HIV/AIDS to meet the demand for culturally competent care, and may award grants for any of the following:

(1) Development of curricula for training primary care providers in HIV/AIDS prevention and care, including routine HIV testing.

(2) Support to expand access to culturally and linguistically accessible benefits counselors, trained peer navigators, and mental and behavioral health professionals with expertise in HIV/AIDS.

(3) Training health care professionals to provide care to individuals with HIV/AIDS.

(4) Development by grant recipients under title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.; commonly referred to as the Ryan White HIV/AIDS Program) and other persons, of policies for providing culturally relevant and sensitive treatment to individuals with HIV/AIDS, with particular emphasis on treatment to racial and ethnic minorities, men who have sex with men, and women, young people, and children with HIV/AIDS.

(5) Development and implementation of programs to increase the use of telehealth to respond to HIV/AIDS-specific health care needs in rural and minority communities, with particular emphasis given to medically underserved communities and insular areas.

(6) Evaluating interdisciplinary medical provider care team models that promote high quality care, with particular emphasis on care to racial and ethnic minorities.

(7) Training health care professionals to make them aware of the high rates of chronic hepatitis B and chronic hepatitis C in adult racial and ethnic populations, and the importance of prevention, detection, and medical management of hepatitis B and hepatitis C and of liver cancer screening.

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2015 through 2019.

SEC. 750. HIV/AIDS PROVIDER LOAN REPAYMENT PROGRAM.

(a) IN GENERAL.—The Secretary may enter into an agreement with any physician, nurse practitioner, or physician assistant under which—

(1) the physician, nurse practitioner, or physician assistant agrees to serve as a medical provider for a period of not less than 2 years—

(A) at a Ryan White-funded or title X-funded facility with a critical shortage of doctors (as determined by the Secretary); or

(B) in an area with a high incidence of HIV/AIDS; and

(2) the Secretary agrees to make payments in accordance with subsection (b) on the professional

education loans of the physician, nurse practitioner, or physician assistant.

(b) MANNER OF PAYMENTS.—The payments described in subsection (a) shall be made by the Secretary as follows:

(1) Upon completion by the physician, nurse practitioner, or physician assistant for whom the payments are to be made of the first year of the service specified in the agreement entered into with the Secretary under subsection (a), the Secretary shall pay 30 percent of the principal of and the interest on the individual's professional education loans.

(2) Upon completion by the physician, nurse practitioner, or physician assistant of the second year of such service, the Secretary shall pay another 30 percent of the principal of and the interest on such loans.

(3) Upon completion by that individual of a third year of such service, the Secretary shall pay another 25 percent of the principal of and the interest on such loans.

(c) APPLICABILITY OF CERTAIN PROVISIONS.—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 physicians, nurse practitioners, and physician assistants enrolled in the program.

(2) The number and amount of loan repayments.

(3) The placement location of loan repayment recipients at facilities described in subsection (a)(1).

(4) The default rate and actions required.

(5) The amount of outstanding default funds.

(6) To the extent that it can be determined, the reason for the default.

(7) The demographics of individuals participating in the program.

(8) An evaluation of the overall costs and benefits of the program.

(e) DEFINITIONS.—In this section:

(1) The term ''HIV/AIDS'' means human immunodeficiency virus and acquired immune deficiency syndrome.

(2) The term ''nurse practitioner'' means a registered nurse who has completed an accredited graduate degree program in advanced nurse practice and has successfully passed a national certification exam.

(3) The term ''physician'' means a graduate of a school of medicine who has completed postgraduate training in general or pediatric medicine.

(4) The term ''physician assistant'' means a medical provider who completed an accredited physician assistant training program and successfully passed the Physician Assistant National Certifying Examination.

(5) The term ''professional education loan''—

(A) means a loan that is incurred for the cost of attendance (including tuition, other reasonable educational expenses, and reasonable living costs) at a school of medicine, nursing, or physician assistant training program; and

(B) includes only the portion of the loan that is outstanding on the date the physician, nurse practitioner, or physician assistant in-

volved begins the service specified in the agreement under subsection (a).

(6) The term ''Ryan White-funded'' means, with respect to a facility, receiving funds under title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.).

(7) The term ''Secretary'' means the Secretary of Health and Human Services.

(8) The term ''school of medicine'' has the meaning given to that term in section 799B of the Public Health Service Act (42 U.S.C. 295p).

(9) The term ''title X-funded'' means, with respect to a facility, receiving funds under title X of the Public Health Service Act (42 U.S.C. 300 et seq.).

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2015 through 2019.

SEC. 751. 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 2015 through 2019.

SEC. 752. REDUCING NEW HIV INFECTIONS AMONG INJECTING DRUG USERS.

(a) SENSE OF CONGRESS.—It is the sense of the Congress that providing sterile syringes and sterilized equipment to injecting drug users substantially reduces risk of HIV infection, increases the probability that they will initiate drug treatment, and does not increase drug use.

(b) IN GENERAL.—The Secretary of Health and Human Services may provide grants and technical assistance for the purpose of reducing the rate of HIV infections among injecting drug users through a comprehensive package of services for such users, including the provision of sterile syringes, education and outreach, access to infectious disease testing, overdose prevention, and treatment for drug dependence.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2015 through 2019.

SEC. 753. SUPPORT FOR EXPANSION OF COMPREHENSIVE SEXUAL HEALTH AND EDUCATION PROGRAMS.

(a) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) federally funded sex education programs should aim to—

(A) reduce unintended pregnancy and sexually transmitted infections, including HIV;

(B) promote safe and healthy relationships;

(C) use, and be informed by, the best scientific information available;

(D) be built on characteristics of effective programs;

(E) expand the existing body of evidence on comprehensive sex education programs through program evaluation;

(F) expand training programs for teachers of comprehensive sex education;

(G) build on the personal responsibility education programs funded under section 513 of the Social Security Act (42 U.S.C. 713) and the President's Teen Pregnancy Prevention program, funded under title II of the Consolidated

Appropriations Act, 2010 (Public Law 111–117; 123 Stat. 3253); and

(H) promote and uphold the rights of young people to information in order to make healthy and responsible decisions about their sexual health; and

(2) no Federal funds should be used for health education programs that—

(A) deliberately withhold life-saving information about HIV;

(B) are medically inaccurate or have been scientifically shown to be ineffective;

(C) promote gender stereotypes;

(D) are insensitive and unresponsive to the needs of sexually active adolescents;

(E) are insensitive and unresponsive to the needs of lesbian, gay, bisexual, or transgender youth; or

(F) are inconsistent with the ethical imperatives of medicine and public health.

(b) GRANTS FOR COMPREHENSIVE SEX EDUCATION FOR ADOLESCENTS.—

(1) PROGRAM AUTHORIZED.—The Secretary, in coordination with the Director of the Office of Adolescent Health, shall award grants, on a competitive

basis, to eligible entities to enable such eligible entities to carry out programs that provide adolescents with comprehensive sex education, as described in paragraph (6).

(2) DURATION.—Grants awarded under this subsection shall be for a period of 5 years.

(3) ELIGIBLE ENTITY.—In this subsection, the term ''eligible entity'' means a public or private entity that focuses on adolescent health or education or has experience working with adolescents, which may include—

(A) a State educational agency;

(B) a local educational agency;

(C) a tribe or tribal organization, as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b);

(D) a State or local department of health;

(E) a State or local department of education;

(F) a nonprofit organization;

(G) a nonprofit or public institution of higher education; or

(H) a hospital.

(4) APPLICATIONS.—An eligible entity desiring a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including the evaluation plan described in paragraph (7)(A).

(5) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to eligible entities that—

(A) are State or local public entities, with an additional priority for State or local educational agencies; and

(B) address health disparities among young people that are at highest risk for not less than 1 of the following:

(i) Unintended pregnancies.

(ii) Sexually transmitted infections, including HIV.

(iii) Dating violence and sexual assault.

(6) USE OF FUNDS.—

(A) IN GENERAL.—Each eligible entity that receives a grant under this subsection shall use grant funds to carry out a program that

provides adolescents with comprehensive sex education that—

(i) replicates evidence-based sex education programs;

(ii) substantially incorporates elements of evidence-based sex education programs; or

(iii) creates a demonstration project based on generally accepted characteristics of effective sex education programs.

(B) CONTENTS OF SEX EDUCATION PROGRAMS.—The sex education programs funded under this subsection shall include curricula and program materials that address—

(i) abstinence and delaying sexual initiation;

(ii) the health benefits and side effects of all contraceptive and barrier methods as a means to prevent pregnancy and sexually transmitted infections, including HIV;

(iii) healthy relationships, including the development of healthy attitudes and skills necessary for understanding—

(I) healthy relationships between oneself and family, others, and society; and

(II) the prevention of sexual abuse, teen dating violence, bullying, harassment, and suicide;

(iv) healthy life skills including goal-setting, decisionmaking, interpersonal skills (such as communication, assertiveness, and peer refusal skills), critical thinking, self-esteem and self-efficacy, and stress management;

(v) how to make responsible decisions about sex and sexuality, including—

(I) how to avoid, and how to avoid making, unwanted verbal, physical, and sexual advances; and

(II) how alcohol and drug use can affect responsible decisionmaking;

(vi) the development of healthy attitudes and values about such topics as adolescent growth and development, body image, gender roles and gender identity, racial and ethnic diversity, and sexual orientation; and

(vii) referral services for local health clinics and services where adolescents can obtain additional information and services related to sexual and reproductive health, dating violence and sexual assault, and suicide prevention.

(7) EVALUATION; REPORT.—

(A) INDEPENDENT EVALUATION.—Each eligible entity applying for a grant under this subsection shall develop and submit to the Secretary a plan for a rigorous independent evaluation of such grant program. The plan shall describe an independent evaluation that—

(i) uses sound statistical methods and techniques relating to the behavioral sciences, including random assignment methodologies, whenever possible;

(ii) uses quantitative data for assessments and impact evaluations, whenever possible; and

(iii) is carried out by an entity independent from such eligible entity.

(B) SELECTION OF EVALUATED PROGRAMS; BUDGET.—

(i) SELECTION OF EVALUATED PROGRAMS.—The Secretary shall select, at random, a subset of the eligible entities that the Secretary has selected to receive a grant under this subsection to receive additional funding to carry out the evaluation plan described in subparagraph (A).

(ii) BUDGET FOR EVALUATION ACTIVITIES.—The Secretary, in coordination with the Director of the Office of Adolescent Health, shall establish a budget for each eligible entity selected under clause (i) for the costs of carrying out the evaluation plan described in subparagraph (A).

(C) FUNDS FOR EVALUATION.—The Secretary shall provide eligible entities who are selected under subparagraph (B)(i) with additional funds, in accordance with the budget described in subparagraph (B)(ii), to carry out and report to the Secretary on the evaluation plan described in subparagraph (A).

(D) PERFORMANCE MEASURES.—The Secretary, in coordination with the Director of the Centers for Disease Control and Prevention, shall establish a common set of performance

measures to assess the implementation and impact of grant programs funded under this subsection. Such performance measures shall include—

(i) output measures, such as the number of individuals served and the number of hours of service delivery;

(ii) outcome measures, including measures relating to—

(I) the knowledge that youth participating in the grant program have gained about—

(aa) adolescent growth and development;

(bb) relationship dynamics;

(cc) ways to prevent unintended pregnancy and sexually transmitted infections, including HIV; and

(dd) sexual health;

(II) the skills that adolescents participating in the grant program have gained regarding—

(aa) negotiation and communication;

(bb) decisionmaking and goal-setting;

(cc) interpersonal skills and healthy relationships; and

(dd) condom use; and

(III) the behaviors of adolescents participating in the grant program, including data about—

(aa) age of first intercourse;

(bb) number of sexual partners;

(cc) condom and contraceptive use at first intercourse;

(dd) recent condom and contraceptive use; and

(ee) dating abuse and lifetime history of domestic violence, sexual assault, dating violence, bullying, harassment, and stalking.

(E) REPORT TO THE SECRETARY.—Eligible entities receiving a grant under this subsection who have been selected to receive funds to carry out the evaluation plan described in subparagraph (A), in accordance with subpara-

graph (B)(i), shall collect and report to the Secretary—

(i) the results of the independent evaluation described in subparagraph (A); and

(ii) information about the performance measures described in subparagraph (B).

(F) EFFECTIVE PROGRAMS.—The Secretary, in coordination with the Director of the Centers for Disease Control and Prevention, shall publish on the Web site of the Centers for Disease Control and Prevention, a list of programs funded under this subsection that the Secretary has determined to be effective programs.

(c) GRANTS FOR COMPREHENSIVE SEX EDUCATION AT INSTITUTIONS OF HIGHER EDUCATION.—

(1) PROGRAM AUTHORIZED.—The Secretary, in coordination with the Office of Adolescent Health and the Secretary of Education, shall award grants, on a competitive basis, to institutions of higher education to enable such institutions to provide young people with comprehensive sex education, described in paragraph (5)(B), with an emphasis on reducing

HIV, other sexually transmitted infections, and unintended pregnancy through instruction about—

(A) abstinence and contraception;

(B) reducing dating violence, sexual assault, bullying, and harassment;

(C) increasing healthy relationships; and

(D) academic achievement.

(2) DURATION.—Grants awarded under this subsection shall be for a period of 5 years.

(3) APPLICATIONS.—An institution of higher education desiring a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(4) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to an institution of higher education that—

(A) has an enrollment of needy students as defined in section 318(b) of the Higher Education Act of 1965 (20 U.S.C. 1059e(b));

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

(C) is a Tribal College or University, as defined in section 316(b) of such Act (20 U.S.C. 1059c(b));

(D) is an Alaska Native-serving institution, as defined in section 317(b) of such Act (20 U.S.C. 1059d(b));

(E) is a Native Hawaiian-serving institution, as defined in section 317(b) of such Act (20 U.S.C. 1059d(b));

(F) is a Predominately Black Institution, as defined in section 318(b) of such Act (20 U.S.C. 1059e(b));

(G) is a Native American-serving, nontribal institution, as defined in section 319(b) of such Act (20 U.S.C. 1059f(b));

(H) is an Asian American and Native American Pacific Islander-serving institution, as defined in section 320(b) of such Act (20 U.S.C. 1059g(b)); or

(I) is a minority institution, as defined in section 365 of such Act (20 U.S.C. 1067k), with an enrollment of needy students, as defined in section 312 of such Act (20 U.S.C. 1058).

(5) USES OF FUNDS.—

(A) IN GENERAL.—An institution of higher education receiving a grant under this subsection may use grant funds to integrate issues relating to comprehensive sex education into the academic or support sectors of the institution of higher education in order to reach a large number of students, by carrying out 1 or more of the following activities:

(i) Developing educational content for issues relating to comprehensive sex education that will be incorporated into first-year orientation or core courses.

(ii) Developing and employing schoolwide educational programming outside of class that delivers elements of comprehensive sex education programs to students, faculty, and staff.

(iii) Creating innovative technology-based approaches to deliver sex education to students, faculty, and staff.

(iv) Developing and employing peer-outreach and education programs to generate discussion, educate, and raise awareness among students about issues relating to comprehensive sex education.

(B) CONTENTS OF SEX EDUCATION PROGRAMS.—Each institution of higher education's program of comprehensive sex education funded under this subsection shall include curricula and program materials that address information about—

(i) safe and responsible sexual behavior with respect to the prevention of pregnancy and sexually transmitted infections, including HIV, including through—

(I) abstinence;

(II) a reduced number of sexual partners; and

(III) the use of condoms and contraception;

(ii) healthy relationships, including the development of healthy attitudes and insights necessary for understanding—

(I) relationships between oneself, family, partners, others, and society; and

(II) the prevention of sexual abuse, dating violence, bullying, harassment, and suicide; and

(iii) referral services to local health clinics where young people can obtain additional information and services related to sexual and reproductive health, dating violence and sexual assault, and suicide prevention.

(C) OPTIONAL COMPONENTS OF SEX EDUCATION.—Each institution of higher education's program of comprehensive sex education may also include information and skills development relating to—

(i) how to make responsible decisions about sex and sexuality, including—

(I) how to avoid, and avoid making, unwanted verbal, physical, and sexual advances; and

(II) how alcohol and drug use can affect responsible decisionmaking;

(ii) healthy life skills, including—

(I) goal-setting and decisionmaking;

(II) interpersonal skills, such as communication, assertiveness, and peer refusal skills;

(III) critical thinking;

(IV) self-esteem and self-efficacy; and

(V) stress management;

(iii) the development of healthy attitudes and values about such topics as body image, gender roles and gender identity, racial and ethnic diversity, and sexual orientation; and

(iv) the responsibilities of parenting and the skills necessary to parent well.

(6) EVALUATION; REPORT.—The requirements described in section 125B(g) shall also apply to eligible entities receiving a grant under this subsection in the same manner as such requirements apply to eligible entities receiving grants under section 125B.

(d) GRANTS FOR PRE-SERVICE AND IN-SERVICE TEACHER TRAINING.—

(1) PROGRAM AUTHORIZED.—The Secretary, in coordination with the Director of the Centers for Disease Control and Prevention and the Secretary of Education, shall award grants, on a competitive basis, to eligible entities to enable such eligible entities to carry out the activities described in paragraph (5).

(2) DURATION.—Grants awarded under this subsection shall be for a period of 5 years.

(3) ELIGIBLE ENTITY.—In this subsection, the term ''eligible entity'' means—

(A) a State educational agency;

(B) a local educational agency;

(C) a tribe or tribal organization, as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b);

(D) a State or local department of health;

(E) a State or local department of education;

(F) a nonprofit institution of higher education;

(G) a national or statewide nonprofit organization that has as its primary purpose the improvement of provision of comprehensive sex education through effective teaching of comprehensive sex education; or

(H) a consortium of nonprofit organizations that has as its primary purpose the improvement of provision of comprehensive sex education through effective teaching of comprehensive sex education.

(4) APPLICATION.—An eligible entity desiring a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(5) AUTHORIZED ACTIVITIES.—

(A) REQUIRED ACTIVITY.—Each eligible entity receiving a grant under this subsection shall use grant funds to train targeted faculty and staff, in order to increase effective teaching of comprehensive sex education for elementary school and secondary school students.

(B) PERMISSIBLE ACTIVITIES.—Each eligible entity receiving a grant under this subsection may use grant funds to—

(i) strengthen and expand the eligible entity's relationships with—

(I) institutions of higher education;

(II) State educational agencies;

(III) local educational agencies; or

(IV) other public and private organizations with a commitment to comprehensive sex education and the

benefits of comprehensive sex education;

(ii) support and promote research-based training of teachers of comprehensive sex education and related disciplines in elementary schools and secondary schools as a means of broadening student knowledge about issues related to human development, relationships, personal skills, sexual behavior, sexual health, and society and culture;

(iii) support the dissemination of information on effective practices and research findings concerning the teaching of comprehensive sex education;

(iv) support research on—

(I) effective comprehensive sex education teaching practices; and

(II) the development of assessment instruments and strategies to document—

(aa) student understanding of comprehensive sex education; and

(bb) the effects of comprehensive sex education;

(v) convene national conferences on comprehensive sex education, in order to effectively train teachers in the provision of comprehensive sex education; and

(vi) develop and disseminate appropriate research-based materials to foster comprehensive sex education.

(C) SUBGRANTS.—Each eligible entity receiving a grant under this subsection may award subgrants to nonprofit organizations, State educational agencies, or local educational agencies to enable such organizations or agencies to—

(i) train teachers in comprehensive sex education;

(ii) support Internet or distance learning related to comprehensive sex education;

(iii) promote rigorous academic standards and assessment techniques to guide and measure student performance in comprehensive sex education;

(iv) encourage replication of best practices and model programs to promote comprehensive sex education;

(v) develop and disseminate effective, research-based comprehensive sex education learning materials;

(vi) develop academic courses on the pedagogy of sex education at institutions of higher education; or

(vii) convene State-based conferences to train teachers in comprehensive sex education and to identify strategies for improvement.

(e) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter for a period of 5 years, the Secretary shall prepare and submit to the appropriate committees of Congress a report on the activities to provide adolescents and young people with comprehensive sex education funded under this section.

(2) REPORT ELEMENTS.—The report described in paragraph (1) shall include information about—

(A) the number of eligible entities and institutions of higher education that are receiving grant funds under subsections (b) and (c);

(B) the specific activities supported by grant funds awarded under subsections (b) and (c);

(C) the number of adolescents served by grant programs funded under subsection (b);

(D) the number of young people served by grant programs funded under subsection (c); and

(E) the status of program evaluations described under subsections (b) and (c).

(f) LIMITATION.—No Federal funds provided under this section may be used for health education programs that—

(1) deliberately withhold life-saving information about HIV;

(2) are medically inaccurate or have been scientifically shown to be ineffective;

(3) promote gender stereotypes;

(4) are insensitive and unresponsive to the needs of sexually active youth or lesbian, gay, bisexual, or transgender youth; or

(5) are inconsistent with the ethical imperatives of medicine and public health.

(g) DEFINITIONS.—In this section:

(1) ESEA DEFINITIONS.—The terms ''elementary school'', ''local educational agency'', ''secondary school'', and ''State educational agency'' have the meanings given the terms in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(2) AGE AND DEVELOPMENTALLY APPROPRIATE.—The term ''age and developmentally appropriate'' means suitable for a particular age or age group of children and adolescents, based on developing cognitive, emotional, and behavioral capacity typical for that age or age group.

(3) ADOLESCENTS.—The term ''adolescents'' means individuals who are ages 10 through 19 at the time of commencement of participation in a program supported under this section.

(4) CHARACTERISTICS OF EFFECTIVE PROGRAMS.—The term ''characteristics of effective programs'' means the aspects of evidence-based programs, including development, content, and implementation of such programs, that—

(A) have been shown to be effective in terms of increasing knowledge, clarifying values and attitudes, increasing skills, and impacting upon behavior; and

(B) are widely recognized by leading medical and public health agencies to be effective in changing sexual behaviors that lead to sexually transmitted infections, including HIV, unintended pregnancy, and dating violence and sexual assault among young people.

(5) COMPREHENSIVE SEX EDUCATION.—The term ''comprehensive sex education'' means a program that—

(A) includes age- and developmentally appropriate, culturally and linguistically relevant information on a broad set of topics related to sexuality including human development, relationships, decisionmaking, communication, abstinence, contraception, and disease and pregnancy prevention;

(B) provides students with opportunities for developing skills as well as learning information;

(C) is inclusive of lesbian, gay, bisexual, transgender, and heterosexual young people; and

(D) aims to—

(i) provide scientifically accurate and realistic information about human sexuality;

(ii) provide opportunities for individuals to understand their own, their families', and their communities' values, attitudes, and insights about sexuality;

(iii) help individuals develop healthy relationships and interpersonal skills; and

(iv) help individuals exercise responsibility regarding sexual relationships, which includes addressing abstinence, pressures to become prematurely involved in sexual intercourse, and the use of contraception and other sexual health measures.

(6) EVIDENCE-BASED PROGRAM.—The term ''evidence-based program'' means a sex education program that has been proven through rigorous evaluation to be effective in changing sexual behavior or incorporates elements of other sex education pro-

grams that have been proven to be effective in changing sexual behavior.

(7) INSTITUTION OF HIGHER EDUCATION.—The term ''institution of higher education'' has the meaning given the term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

(8) MEDICALLY ACCURATE AND COMPLETE.—The term ''medically accurate and complete'', when used with respect to a sex education program, means that—

(A) the information provided through the program is verified or supported by the weight of research conducted in compliance with accepted scientific methods and is published in peer-reviewed journals, where applicable; or

(B)(i) the program contains information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete; and

(ii) the program does not withhold information about the effectiveness and benefits of correct and consistent use of condoms and other contraceptives.

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

(10) YOUNG PEOPLE.—The term ''young people'' means individuals who are ages 10 through 24 at the time of commencement of participation in a program supported under this section.

(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2015 through 2019.

SEC. 754. ELIMINATION OF 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 fiscal years 2013 and 2014 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 ''$75,000,000 for each of fiscal years 2011 through 2015'' and inserting ''$75,000,000 for each of fiscal years 2011

through 2014, an amount for fiscal year 2015 equal to $75,000,000 increased by an amount equal to the unobligated portion of funds appropriated for fiscal year 2014 and 2015 under section 510(d) that are rescinded by section 754(b) of the Health Equity and Accountability Act of 2014, and $125,000,000 for each of fiscal years 2016 and 2017''.

SEC. 755. REPORT ON IMPACT OF HIV/AIDS IN VULNERABLE POPULATIONS.

(a) IN GENERAL.—The Secretary shall submit to the Congress and the President an annual report on the impact of HIV/AIDS for racial and ethnic minority communities, women, and youth aged 24 and younger.

(b) CONTENTS.—The report under subsection (a) shall include information on the—

(1) progress that has been made in reducing the impact of HIV/AIDS in such communities;

(2) opportunities that exist to make additional progress in reducing the impact of HIV/AIDS in such communities;

(3) challenges that may impede such additional progress; and

(4) Federal funding necessary to achieve substantial reductions in HIV/AIDS in racial and ethnic minority communities.

SEC. 756. NATIONAL HIV/AIDS OBSERVANCE DAYS.

(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 American HIV/AIDS Awareness Day.

(5) Caribbean-American HIV/AIDS Awareness Day.

(6) National Youth HIV/AIDS Awareness Day.

(7) National Black Clergy HIV/AIDS Awareness Sunday.

(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 preven-

tive measures, be tested for HIV/AIDS, and seek care when appropriate.

SEC. 757. REVIEW OF ALL FEDERAL AND STATE LAWS, POLICIES, AND REGULATIONS REGARDING THE CRIMINAL PROSECUTION OF INDIVIDUALS FOR HIV-RELATED OFFENSES.

(a) DEFINITIONS.—

(1) HIV AND HIV/AIDS.—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).

(2) STATE.—The term ''State'' includes the District of Columbia, American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the United States Virgin Islands.

(b) SENSE OF CONGRESS REGARDING LAWS OR REGULATIONS DIRECTED AT PEOPLE LIVING WITH HIV/AIDS.—It is the sense of the Congress that Federal and State laws, policies, and regulations regarding people living with HIV/AIDS—

(1) should not place unique or additional burdens on such individuals solely as a result of their HIV status; and

(2) should instead demonstrate a public health-oriented, evidence-based, medically accurate, and contemporary understanding of—

(A) the multiple factors that lead to HIV transmission;

(B) the relative risk of HIV transmission routes;

(C) the current health implications of living with HIV;

(D) the associated benefits of treatment and support services for people living with HIV; and

(E) the impact of punitive HIV-specific laws and policies on public health, on people living with or affected by HIV, and on their families and communities.

(c) REVIEW OF ALL FEDERAL AND STATE LAWS, POLICIES, AND REGULATIONS REGARDING THE CRIMINAL PROSECUTION OF INDIVIDUALS FOR HIV-RELATED OFFENSES.—

(1) REVIEW OF FEDERAL AND STATE LAWS.—

(A) IN GENERAL.—No later than 90 days after the date of the enactment of this Act, the Attorney General, the Secretary of Health and Human Services, and the Secretary of Defense

acting jointly (in this paragraph and paragraph (2) referred to as the ''designated officials'') shall initiate a national review of Federal and State laws, policies, regulations, and judicial precedents and decisions regarding criminal and related civil commitment cases involving people living with HIV/AIDS, including in regards to the Uniform Code of Military Justice.

(B) CONSULTATION.—In carrying out the review under subparagraph (A), the designated officials shall ensure diverse participation and consultation from each State, including with—

(i) State attorneys general (or their representatives);

(ii) State public health officials (or their representatives);

(iii) State judicial and court system officers, including judges, district attorneys, prosecutors, defense attorneys, law enforcement, and correctional officers;

(iv) members of the United States Armed Forces, including members of other Federal services subject to the Uniform Code of Military Justice;

(v) people living with HIV/AIDS, particularly those who have been subject to HIV-related prosecution or who are from communities whose members have been disproportionately subject to HIV-specific arrests and prosecutions;

(vi) legal advocacy and HIV/AIDS service organizations that work with people living with HIV/AIDS;

(vii) nongovernmental health organizations that work on behalf of people living with HIV/AIDS; and

(viii) trade organizations or associations representing persons or entities described in clauses (i) through (vii).

(C) RELATION TO OTHER REVIEWS.—In carrying out the review under subparagraph (A), the designated officials may utilize other existing reviews of criminal and related civil commitment cases involving people living with HIV/AIDS, including any such review conducted by any Federal or State agency or any public health, legal advocacy, or trade organization or association if the designated officials determine that such reviews were conducted in ac-

cordance with the principles set forth in subsection (b).

(2) REPORT.—No later than 180 days after initiating the review required by paragraph (1), the Attorney General shall transmit to the Congress and make publicly available a report containing the results of the review, which includes the following:

(A) For each State and for the Uniform Code of Military Justice, a summary of the relevant laws, policies, regulations, and judicial precedents and decisions regarding criminal cases involving people living with HIV/AIDS, including, if applicable, the following:

(i) A determination of whether such laws, policies, regulations, and judicial precedents and decisions place any unique or additional burdens upon people living with HIV/AIDS.

(ii) A determination of whether such laws, policies, regulations, and judicial precedents and decisions demonstrate a public health-oriented, evidence-based, medically accurate, and contemporary understanding of—

(I) the multiple factors that lead to HIV transmission;

(II) the relative risk of HIV transmission routes;

(III) the current health implications of living with HIV;

(IV) the associated benefits of treatment and support services for people living with HIV; and

(V) the impact of punitive HIV-specific laws and policies on public health, on people living with or affected by HIV, and on their families and communities.

(iii) An analysis of the public health and legal implications of such laws, policies, regulations, and judicial precedents, including an analysis of the consequences of having a similar penal scheme applied to comparable situations involving other communicable diseases.

(iv) An analysis of the proportionality of punishments imposed under HIV-specific laws, policies, regulations, and judicial precedents, taking into consideration pen-

alties attached to violation of State laws against similar degrees of endangerment or harm, such as driving while intoxicated (DWI) or transmission of other communicable diseases, or more serious harms, such as vehicular manslaughter offenses.

(B) An analysis of common elements shared among State laws, policies, regulations, and judicial precedents.

(C) A set of best practice recommendations directed to State governments, including State attorneys general, public health officials, and judicial officers, in order to ensure that laws, policies, regulations, and judicial precedents regarding people living with HIV/AIDS are in accordance with the principles set forth in subsection (b).

(D) Recommendations for adjustments to the Uniform Code of Military Justice, as may be necessary, in order to ensure that laws, policies, regulations, and judicial precedents regarding people living with HIV/AIDS are in accordance with the principles set forth in subsection (b).

(3) GUIDANCE.—Within 90 days of the release of the report required by paragraph (2), the Attorney General and the Secretary of Health and Human Services, acting jointly, shall develop and publicly release updated guidance for States based on the set of best practice recommendations required by paragraph (2)(C) in order to assist States dealing with criminal and related civil commitment cases regarding people living with HIV/AIDS.

(4) MONITORING AND EVALUATION SYSTEM.—Within 60 days of the release of the guidance required by paragraph (3), the Attorney General and the Secretary of Health and Human Services, acting jointly, shall establish an integrated monitoring and evaluation system which includes, where appropriate, objective and quantifiable performance goals and indicators to measure progress toward statewide implementation in each State of the best practice recommendations required in paragraph (2)(C), including to monitor, track, and evaluate the effectiveness of assistance provided pursuant to subsection (d).

(5) ADJUSTMENTS TO FEDERAL LAWS, POLICIES, OR REGULATIONS.—Within 90 days of the release of the report required by paragraph (2), the Attorney General, the Secretary of Health and

Human Services, and the Secretary of Defense, acting jointly, shall develop and transmit to the President and the Congress, and make publicly available, such proposals as may be necessary to implement adjustments to Federal laws, policies, or regulations, including to the Uniform Code of Military Justice, based on the recommendations required by paragraph (2)(D), either through Executive order or through changes to statutory law.

(6) AUTHORIZATION OF APPROPRIATIONS.—

(A) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary for the purpose of carrying out this subsection. Amounts authorized to be appropriated by the preceding sentence are in addition to amounts otherwise authorized to be appropriated for such purpose.

(B) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to the authorization of appropriations in subparagraph (A) are authorized to remain available until expended.

(d) AUTHORIZATION TO PROVIDE GRANTS.—

(1) GRANTS BY ATTORNEY GENERAL.—

(A) IN GENERAL.—The Attorney General may provide assistance to eligible State and

local entities and eligible nongovernmental organizations for the purpose of incorporating the best practice recommendations developed under subsection (c)(2)(C) within relevant State laws, policies, regulations, and judicial decisions regarding people living with HIV/AIDS.

(B) AUTHORIZED ACTIVITIES.—The assistance authorized by subparagraph (A) may include—

(i) direct technical assistance to eligible State and local entities in order to develop, disseminate, or implement State laws, policies, regulations, or judicial decisions that conform with the best practice recommendations developed under subsection (c)(2)(C);

(ii) direct technical assistance to eligible nongovernmental organizations in order to provide education and training, including through classes, conferences, meetings, and other educational activities, to eligible State and local entities; and

(iii) subcontracting authority to allow eligible State and local entities and eligible nongovernmental organizations to seek

technical assistance from legal and public health experts with a demonstrated understanding of the principles underlying the best practice recommendations developed under subsection (c)(2)(C).

(2) GRANTS BY SECRETARY OF HEALTH AND HUMAN SERVICES.—

(A) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, may provide assistance to State and local public health departments and eligible nongovernmental organizations for the purpose of supporting eligible State and local entities to incorporate the best practice recommendations developed under subsection (c)(2)(C) within relevant State laws, policies, regulations, and judicial decisions regarding people living with HIV/AIDS.

(B) AUTHORIZED ACTIVITIES.—The assistance authorized by subparagraph (A) may include—

(i) direct technical assistance to State and local public health departments in order to support the development, dissemi-

nation, or implementation of State laws, policies, regulations, or judicial decisions that conform with the set of best practice recommendations developed under subsection (c)(2)(C);

(ii) direct technical assistance to eligible nongovernmental organizations in order to provide education and training, including through classes, conferences, meetings, and other educational activities, to State and local public health departments; and

(iii) subcontracting authority to allow State and local public health departments and eligible nongovernmental organizations to seek technical assistance from legal and public health experts with a demonstrated understanding of the principles underlying the best practice recommendations developed under subsection (c)(2)(C).

(3) LIMITATION.—As a condition of receiving assistance through this subsection, eligible State and local entities, State and local public health departments, and eligible nongovernmental organizations shall agree—

(A) not to place any unique or additional burdens on people living with HIV/AIDS solely as a result of their HIV status; and

(B) that if the entity, department, or organization promulgates any laws, policies, regulations, or judicial decisions regarding people living with HIV/AIDS, such actions shall demonstrate a public health-oriented, evidence-based, medically accurate, and contemporary understanding of—

(i) the multiple factors that lead to HIV transmission;

(ii) the relative risk of HIV transmission routes;

(iii) the current health implications of living with HIV;

(iv) the associated benefits of treatment and support services for people living with HIV; and

(v) the impact of punitive HIV-specific laws and policies on public health, on people living with or affected by HIV, and on their families and communities.

(4) REPORT.—No later than 1 year after the date of the enactment of this Act, and annually

thereafter, the Attorney General and the Secretary of Health and Human Services, acting jointly, shall transmit to Congress and make publicly available a report describing, for each State, the impact and effectiveness of the assistance provided through this Act. Each such report shall include—

(A) a detailed description of the progress each State has made, if any, in implementing the best practice recommendations developed under subsection (c)(2)(C) as a result of the assistance provided under this subsection, and based on the performance goals and indicators established as part of the monitoring and evaluation system in subsection (c)(4);

(B) a brief summary of any outreach efforts undertaken during the prior year by the Attorney General and the Secretary of Health and Human Services to encourage States to seek assistance under this subsection in order to implement the best practice recommendations developed under subsection (c)(2)(C);

(C) a summary of how assistance provided through this subsection is being utilized by eligible State and local entities, State and local public health departments, and eligible non-

governmental organizations and, if applicable, any contractors, including with respect to non-governmental organizations, the type of technical assistance provided, and an evaluation of the impact of such assistance on eligible State and local entities; and

(D) a summary and description of eligible State and local entities, State and local public health departments, and eligible nongovernmental organizations receiving assistance through this subsection, including if applicable, a summary and description of any contractors selected to assist in implementing such assistance.

(5) DEFINITIONS.—For the purposes of this subsection:

(A) ELIGIBLE STATE AND LOCAL ENTITIES.—The term ''eligible State and local entities'' means the relevant individuals, offices, or organizations that directly participate in the development, dissemination, or implementation of State laws, policies, regulations, or judicial decisions, including—

(i) State governments, including State attorneys general, State departments of

justice, and State National Guards, or their equivalents;

(ii) State judicial and court systems, including trial courts, appellate courts, State supreme courts and courts of appeal, and State correctional facilities, or their equivalents; and

(iii) local governments, including city and county governments, district attorneys, and local law enforcement departments, or their equivalents.

(B) STATE AND LOCAL PUBLIC HEALTH DEPARTMENTS.—The term ''State and local public health departments'' means the following:

(i) State public health departments, or their equivalents, including the chief officer of such departments and infectious disease and communicable disease specialists within such departments.

(ii) Local public health departments, or their equivalents, including city and county public health departments, the chief officer of such departments, and infectious

disease and communicable disease specialists within such departments.

(iii) Public health departments or officials, or their equivalents, within State or local correctional facilities.

(iv) Public health departments or officials, or their equivalents, within State National Guards.

(v) Any other recognized State or local public health organization or entity charged with carrying out official State or local public health duties.

(C) ELIGIBLE NONGOVERNMENTAL ORGANIZATIONS.—The term ''eligible nongovernmental organizations'' means the following:

(i) Nongovernmental organizations, including trade organizations or associations that represent—

(I) State attorneys general, or their equivalents;

(II) State public health officials, or their equivalents;

(III) State judicial and court officers, including judges, district attorneys, prosecutors, defense attorneys,

law enforcement, and correctional officers;

(IV) State National Guards;

(V) people living with HIV/AIDS;

(VI) legal advocacy and HIV/AIDS service organizations that work with people living with HIV/AIDS; and

(VII) nongovernmental health organizations that work on behalf of people living with HIV/AIDS.

(ii) Nongovernmental organizations, including trade organizations or associations that demonstrate a public-health oriented, evidence-based, medically accurate, and contemporary understanding of—

(I) the multiple factors that lead to HIV transmission;

(II) the relative risk of HIV transmission routes;

(III) the current health implications of living with HIV;

(IV) the associated benefits of treatment and support services for people living with HIV; and

(V) the impact of punitive HIV-specific laws and policies on public health, on people living with or affected by HIV, and on their families and communities.

(6) AUTHORIZATION OF APPROPRIATIONS.—

(A) IN GENERAL.—In addition to amounts otherwise made available, there are authorized to be appropriated to the Attorney General and the Secretary of Health and Human Services such sums as may be necessary to carry out this subsection for each of the fiscal years 2015 through 2019.

(B) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to the authorizations of appropriations in subparagraph (A) are authorized to remain available until expended.

SEC. 758. REPEAL OF LIMITATION AGAINST USE OF FUNDS FOR EDUCATION OR INFORMATION DESIGNED TO PROMOTE OR ENCOURAGE, DIRECTLY, HOMOSEXUAL OR HETEROSEXUAL ACTIVITY OR INTRAVENOUS SUBSTANCE ABUSE.

Section 2500 of the Public Health Service Act (42 U.S.C. 300ee) is amended—

(1) by striking subsection (c); and

(2) by redesignating subsection (d) as subsection (c).

SEC. 759. EXPANDING SUPPORT FOR CONDOMS IN PRISONS.

(a) AUTHORITY TO ALLOW COMMUNITY ORGANIZATIONS TO PROVIDE STI COUNSELING, STI PREVENTION EDUCATION, AND SEXUAL BARRIER PROTECTION DEVICES IN FEDERAL CORRECTIONAL FACILITIES.—

(1) DIRECTIVE TO ATTORNEY GENERAL.—Not later than 30 days after the date of enactment of this Act, the Attorney General shall direct the Bureau of Prisons to allow community organizations to distribute sexual barrier protection devices and to engage in STI counseling and STI prevention education in Federal correctional facilities. These activities shall be subject to all relevant Federal laws and regulations which govern visitation in correctional facilities.

(2) INFORMATION REQUIREMENT.—Any community organization permitted to distribute sexual barrier protection devices under paragraph (1) shall ensure that the persons to whom the devices are distributed are informed about the proper use and disposal of sexual barrier protection devices in accord-

ance with established public health practices. Any community organization conducting STI counseling or STI prevention education under paragraph (1) shall offer comprehensive sexuality education.

(3) POSSESSION OF DEVICE PROTECTED.—No Federal correctional facility may, because of the possession or use of a sexual barrier protection device—

(A) take adverse action against an incarcerated person; or

(B) consider possession or use as evidence of prohibited activity for the purpose of any Federal correctional facility administrative proceeding.

(4) IMPLEMENTATION.—The Attorney General and Bureau of Prisons shall implement this section according to established public health practices in a manner that protects the health, safety, and privacy of incarcerated persons and of correctional facility staff.

(b) SENSE OF CONGRESS REGARDING DISTRIBUTION OF SEXUAL BARRIER PROTECTION DEVICES IN STATE PRISON SYSTEMS.—It is the sense of the Congress that States should allow for the legal distribution of sexual barrier protection devices in State correctional facilities to reduce the prevalence and spread of STIs in those facilities.

(c) SURVEY OF AND REPORT ON CORRECTIONAL FACILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF STIS.—

(1) SURVEY.—The Attorney General, after consulting with the Secretary of Health and Human Services, State officials, and community organizations, shall, to the maximum extent practicable, conduct a survey of all Federal and State correctional facilities, not later than 180 days after the date of enactment of this Act and annually thereafter for 5 years, to determine the following:

(A) 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.

(B) ACCESS TO SEXUAL BARRIER PROTECTION DEVICES.—Whether incarcerated persons can—

(i) possess sexual barrier protection devices;

(ii) purchase sexual barrier protection devices;

(iii) purchase sexual barrier protection devices at a reduced cost; and

(iv) obtain sexual barrier protection devices without cost.

(C) INCIDENCE OF SEXUAL VIOLENCE.—The incidence of sexual violence and assault committed by incarcerated persons and by correctional facility staff.

(D) PREVENTION EDUCATION OFFERED.—The type of prevention education, information, or training offered to incarcerated persons and correctional facility staff regarding sexual violence and the spread of STIs, including whether such education, information, or training—

(i) constitutes comprehensive sexuality education;

(ii) is compulsory for new incarcerated persons and for new staff; and

(iii) is offered on an ongoing basis.

(E) STI TESTING.—Whether the correctional facility tests incarcerated persons for STIs or gives them the option to undergo such testing—

(i) at intake;

(ii) on a regular basis; and

(iii) prior to release.

(F) STI TEST RESULTS.—The number of incarcerated persons who are tested for STIs and the outcome of such tests at each correctional facility, disaggregated to include results for—

(i) the type of sexually transmitted infection tested for;

(ii) the race and/or ethnicity of individuals tested;

(iii) the age of individuals tested; and

(iv) the gender of individuals tested.

(G) PRERELEASE REFERRAL POLICY.—Whether incarcerated persons are informed prior to release about STI-related services or other health services in their communities, including free and low-cost counseling and treatment options.

(H) PRERELEASE REFERRALS MADE.—The number of referrals to community-based organizations or public health facilities offering STI-related or other health services provided to incarcerated persons prior to release, and the type of counseling or treatment for which the referral was made.

(I) REINSTATEMENT OF MEDICAID BENEFITS.—Whether the correctional facility assists incarcerated persons that were enrolled in the State Medicaid program prior to their incarceration, in reinstating their enrollment upon release and whether such individuals receive referrals as provided by subparagraph (G) to entities that accept the State Medicaid program, including if applicable—

(i) the number of such individuals, including those diagnosed with 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.

(d) 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 (c)(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 information and training on sexual violence and the spread of STIs, and comprehensive sexuality education.

(B) SEXUAL BARRIER PROTECTION DEVICE ACCESS.—A plan for expanding access to sexual barrier protection devices in correctional facilities.

(C) SEXUAL VIOLENCE REDUCTION.—A plan for reducing the incidence of sexual violence among incarcerated persons and correctional facility staff, developed in consultation with the National Prison Rape Elimination Commission.

(D) COUNSELING AND SUPPORTIVE SERVICES.—A plan for expanding access to counseling and supportive services related to STIs in correctional facilities.

(E) TESTING.—A plan for testing incarcerated persons for STIs during intake, during regular health exams, and prior to release, and that—

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

(ii) includes pretest counseling;

(iii) requires that incarcerated persons are notified of their option to decline testing at any time;

(iv) requires that incarcerated persons are confidentially notified of their test results in a timely manner; and

(v) ensures that incarcerated persons testing positive for STIs receive post-test counseling, care, treatment, and supportive services.

(F) TREATMENT.—A plan for ensuring that correctional facilities have the necessary medicine and equipment to treat and monitor STIs and for ensuring that incarcerated persons living with or testing positive for STIs receive and have access to care and treatment services.

(G) STRATEGIES FOR DEMOGRAPHIC GROUPS.—A plan for developing and implementing culturally appropriate, sensitive, and specific strategies to reduce the spread of STIs among demographic groups heavily impacted by STIs.

(H) LINKAGES WITH COMMUNITIES AND FACILITIES.—A plan for establishing and strengthening linkages to local communities and health facilities that—

(i) provide counseling, testing, care, and treatment services;

(ii) may receive persons recently released from incarceration who are living with STIs; and

(iii) accept payment through the State Medicaid program.

(I) ENROLLMENT IN STATE MEDICAID PROGRAMS.—Plans to ensure that incarcerated persons who were—

(i) enrolled in their State Medicaid program prior to incarceration in a correctional facility are automatically re-enrolled in such program upon their release; and

(ii) not enrolled in their State Medicaid program prior to incarceration, but who are diagnosed with the human immunodeficiency virus while incarcerated in a correctional facility, are automatically enrolled in such program upon their release.

(J) OTHER PLANS.—Any other plans developed by the Attorney General for reducing the spread of STIs or improving the quality of health care in correctional facilities.

(K) MONITORING SYSTEM.—A monitoring system that establishes performance goals related to reducing the prevalence and spread of STIs in correctional facilities and which, where feasible, expresses such goals in quantifiable form.

(L) MONITORING SYSTEM PERFORMANCE INDICATORS.—Performance indicators that measure or assess the achievement of the performance goals described in subparagraph (K).

(M) COST ESTIMATE.—A detailed estimate of the funding necessary to implement the strategy at the Federal and State levels for all 5 years, including the amount of funds required

by community organizations to implement the parts of the strategy in which they take part.

(3) REPORT.—The Attorney General shall transmit to Congress and make publicly available an annual progress report regarding the implementation and effectiveness of the strategy described in paragraph (1). The progress report shall include an evaluation of the implementation of the strategy using the monitoring system and performance indicators provided for in subparagraphs (K) and (L) of paragraph (2).

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out this section for each of fiscal years 2015 through 2020.

(2) AVAILABILITY OF FUNDS.—Amounts made available under paragraph (1) are authorized to remain available until expended.

(f) DEFINITIONS.—For the purposes of this section:

(1) COMMUNITY ORGANIZATION.—The term ''community organization'' means a public health care facility or a nonprofit organization which provides health- or STI-related services according to established public health standards.

(2) COMPREHENSIVE SEXUALITY EDUCATION.—The term ''comprehensive sexuality education'' means sexuality education that includes information about abstinence and about the proper use and disposal of sexual barrier protection devices and which is—

(A) evidence-based;

(B) medically accurate;

(C) age and developmentally appropriate;

(D) gender and identity sensitive;

(E) culturally and linguistically appropriate; and

(F) structured to promote critical thinking, self-esteem, respect for others, and the development of healthy attitudes and relationships.

(3) CORRECTIONAL FACILITY.—The term ''correctional facility'' means any prison, penitentiary, adult detention facility, juvenile detention facility, jail, or other facility to which persons may be sent after conviction of a crime or act of juvenile delinquency within the United States.

(4) INCARCERATED PERSON.—The term ''incarcerated person'' means any person who is serving a sentence in a correctional facility after conviction of a crime.

(5) SEXUALLY TRANSMITTED INFECTION.—The term ''sexually transmitted infection'' or ''STI'' means any disease or infection that is commonly transmitted through sexual activity, including HIV/AIDS, gonorrhea, chlamydia, syphilis, genital herpes, viral hepatitis, and human papillomavirus.

(6) SEXUAL BARRIER PROTECTION DEVICE.—The term ''sexual barrier protection device'' means any FDA-approved physical device which has not been tampered with and which reduces the probability of STI transmission or infection between sexual partners, including female condoms, male condoms, and dental dams.

(7) STATE.—The term ''State'' includes the District of Columbia, American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the United States Virgin Islands.

SEC. 760. AUTOMATIC REINSTATEMENT OR ENROLLMENT IN MEDICAID FOR PEOPLE WHO TEST POSITIVE FOR HIV BEFORE REENTERING COMMUNITIES.

(a) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

''(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—

"(I) if such individual is scheduled to be released from a public institution due to the completion of sentence, not less than 30 days prior to the scheduled date of the release; and

"(II) if such individual is to be released from a public institution on parole or on probation, as soon as possible after the date on which the determination to release such individual was made, and before the date such individual is released.

"(ii) EXCEPTION.—If a State makes a determination that an individual is not eligible to be enrolled under the State plan—

"(I) on or before the date by which the individual would be enrolled under clause (i), such clause shall not apply to such individual; or

"(II) after such date, the State may terminate the enrollment of such individual.

"(B) RELATIONSHIP OF ENROLLMENT TO PAYMENT FOR SERVICES.—

"(i) IN GENERAL.—Subject to subparagraph (A)(ii), an eligible individual who is enrolled, or whose enrollment is reinstated, under subparagraph (A) shall be eligible for medical assistance that is provided after the date that the eligible individual is released from the public institution.

"(ii) RELATIONSHIP TO PAYMENT PROHIBITION FOR INMATES.—No provision of this paragraph may be construed to permit payment for care or services for which payment is excluded under the subdivision (A) that follows paragraph (29) of section 1905(a).

"(C) TREATMENT OF CONTINUOUS ELIGIBILITY.—

"(i) SUSPENSION FOR INMATES.—Any period of continuous eligibility under this title shall be suspended on the date an in-

dividual enrolled under this title becomes an inmate of a public institution (except as a patient of a medical institution).

''(ii) DETERMINATION OF REMAINING PERIOD.—Notwithstanding any changes to State law related to continuous eligibility during the time that an individual is an inmate of a public institution (except as a patient of a medical institution), subject to clause (iii), with respect to an eligible individual who was subject to a suspension under clause (i), on the date that such individual is released from a public institution the suspension of continuous eligibility under such clause shall be lifted for a period that is equal to the time remaining in the period of continuous eligibility for such individual on the date that such period was suspended under such clause.

''(iii) EXCEPTION.—If a State makes a determination that an individual is not eligible to be enrolled under the State plan—

''(I) on or before the date that the suspension of continuous eligibility

is lifted under clause (ii), such clause shall not apply to such individual; or

"(II) after such date, the State may terminate the enrollment of such individual.

"(D) AUTOMATIC ENROLLMENT OR REINSTATEMENT OF ENROLLMENT DEFINED.—For purposes of this paragraph, the term 'automatic enrollment or reinstatement of enrollment' means that the State determines eligibility for medical assistance under the State plan without a program application from, or on behalf of, the eligible individual, but an individual can only be automatically enrolled in the State Medicaid plan if the individual affirmatively consents to being enrolled through affirmation in writing, by telephone, orally, through electronic signature, or through any other means specified by the Secretary.

"(E) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this paragraph, the term 'eligible individual' means an individual who is an inmate of a public institution (except as a patient in a medical institution)—

"(i) who was enrolled under the State plan for medical assistance immediately before becoming an inmate of such an institution; or

"(ii) is diagnosed with human immunodeficiency virus.".

(b) SUPPLEMENTAL FUNDING FOR STATE IMPLEMENTATION OF AUTOMATIC REINSTATEMENT OF MEDICAID BENEFITS.—

(1) 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) or a period of one year.

(2) USE OF FUNDS.—A State may only use increased matching payments authorized under paragraph (1)—

(A) 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 subparagraph (E) of paragraph (15) of section 1902(e) of the Social Security Act (as amended by subsection (a))); and

(B) for medical assistance (as such term is defined in section 1905(a) of the Social Security Act) provided to such eligible individuals.

(3) APPLICATION AND AGREEMENT.—The Secretary may only make payments to a State in the increased amount if—

(A) the State has amended the State plan under section 1902(e) of the Social Security Act to incorporate the requirements of paragraph (15) of such section (as added by subsection (a));

(B) 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);

(C) the State's application meets the satisfaction of the Secretary; and

(D) 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 contains the information required under paragraph (4).

(4) REQUIRED REPORT INFORMATION.—The information that is required in the report under paragraph (3)(D)(ii) includes—

(A) 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 from public institutions into the Medicaid program;

(B) 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

(C) any other information that is required by the Secretary.

(5) 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 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.

(6) LIMITATIONS.—

(A) 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.

(B) MAINTENANCE OF ELIGIBILITY.—

(i) IN GENERAL.—Subject to clause (ii), a State is not eligible for an increase

in its Federal matching payments under paragraph (1), or an increase in a cap amount under paragraph (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 subparagraph (A) beginning with the first calendar quarter in which the State has reinstated eligibility standards, methodologies, or procedures that are no more restrictive than

the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on such date.

(C) NO WAIVER AUTHORITY.—The Secretary may not waive the application of this subsection under section 1115 of the Social Security Act or otherwise.

(D) 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.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by subsection (a) shall take effect 180 days after the date of the enactment of this Act and shall apply to services furnished on or after such date.

(2) RULE FOR CHANGES REQUIRING STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the

amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 761. STOP AIDS IN PRISON.

(a) SHORT TITLE.—This section may be cited as the ''Stop AIDS in Prison Act''.

(b) 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.

(c) PURPOSE.—The purposes of this policy shall be as follows:

(1) To stop the spread of HIV/AIDS among inmates.

(2) To protect prison guards and other personnel from HIV/AIDS infection.

(3) To provide comprehensive medical treatment to inmates who are living with HIV/AIDS.

(4) To promote HIV/AIDS awareness and prevention among inmates.

(5) To encourage inmates to take personal responsibility for their health.

(6) To reduce the risk that inmates will transmit HIV/AIDS to other persons in the community following their release from prison.

(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 this policy.

(e) TIME LIMIT.—The Bureau shall draft appropriate regulations to implement this policy not later than 1 year after the date of the enactment of this Act.

(f) REQUIREMENTS FOR POLICY.—The policy created under subsection (b) shall provide for the following:

(1) TESTING AND COUNSELING UPON INTAKE.—

(A) Health care personnel shall provide routine HIV testing to all inmates as a part of a comprehensive medical examination immediately following admission to a facility. (Health care personnel need not provide routine HIV testing to an inmate who is transferred to a facility from another facility if the inmate's medical records are transferred with the inmate and indicate that the inmate has been tested previously.)

(B) To all inmates admitted to a facility prior to the effective date of this policy, health care personnel shall provide routine HIV testing within no more than 6 months. HIV testing for these inmates may be performed in conjunction with other health services provided to these inmates by health care personnel.

(C) All HIV tests under this paragraph shall comply with the opt-out provision.

(2) PRE-TEST AND POST-TEST COUNSELING.—Health care personnel shall provide confidential pre-test and post-test counseling to all inmates who are tested for HIV. Counseling may be included with other general health counseling provided to inmates by health care personnel.

(3) HIV/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.

(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 audiovisual materials shall be made available to all inmates.

(C)(i) The HIV/AIDS educational programs and materials under this paragraph shall include information on—

(I) modes of transmission, including transmission through tattooing, sexual contact, and intravenous drug use;

(II) prevention methods;

(III) treatment; and

(IV) disease progression.

(ii) The programs and materials shall be culturally sensitive, written or designed for low-literacy levels, available in a variety of lan-

guages, and present scientifically accurate information in a clear and understandable manner.

(4) HIV TESTING UPON REQUEST.—

(A) Health care personnel shall allow inmates to obtain HIV tests upon request once per year or whenever an inmate has a reason to believe the inmate may have been exposed to HIV. Health care personnel shall, both orally and in writing, inform inmates, during orientation and periodically throughout incarceration, of their right to obtain HIV tests.

(B) Health care personnel shall encourage inmates to request HIV tests if the inmate is sexually active, has been raped, uses intravenous drugs, receives a tattoo, or if the inmate is concerned that the inmate may have been exposed to HIV/AIDS.

(C) An inmate's request for an HIV test shall not be considered an indication that the inmate has put him/herself at risk of infection and/or committed a violation of prison rules.

(5) HIV TESTING OF PREGNANT WOMAN.—

(A) Health care personnel shall provide routine HIV testing to all inmates who become pregnant.

(B) All HIV tests under this paragraph shall comply with the opt-out provision.

(6) COMPREHENSIVE TREATMENT.—

(A) Health care personnel shall provide all inmates who test positive for HIV—

(i) timely, comprehensive medical treatment;

(ii) confidential counseling on managing their medical condition and preventing its transmission to other persons; and

(iii) voluntary partner notification services.

(B) Health care provided under this paragraph shall be consistent with current Department of Health and Human Services guidelines and standard medical practice. Health care personnel shall discuss treatment options, the importance of adherence to antiretroviral therapy, and the side effects of medications with inmates receiving treatment.

(C) Health care personnel and pharmacy personnel shall ensure that the facility formulary contains all Food and Drug Administration-approved medications necessary to provide comprehensive treatment for inmates living with HIV/AIDS, and that the facility maintains adequate supplies of such medications to meet inmates' medical needs. Health care personnel and pharmacy personnel shall also develop and implement automatic renewal systems for these medications to prevent interruptions in care.

(D) Correctional staff, health care personnel, and pharmacy personnel shall develop and implement distribution procedures to ensure timely and confidential access to medications.

(7) PROTECTION OF CONFIDENTIALITY.—

(A) Health care personnel shall develop and implement procedures to ensure the confidentiality of inmate tests, diagnoses, and treatment. Health care personnel and correctional staff shall receive regular training on the implementation of these procedures. Penalties for violations of inmate confidentiality by health

care personnel or correctional staff shall be specified and strictly enforced.

(B) HIV testing, counseling, and treatment shall be provided in a confidential setting where other routine health services are provided and in a manner that allows the inmate to request and obtain these services as routine medical services.

(8) TESTING, COUNSELING, AND REFERRAL PRIOR TO REENTRY.—

(A) Health care personnel shall provide routine HIV testing to all inmates no more than 3 months prior to their release and reentry into the community. (Inmates who are already known to be infected need not be tested again.) This requirement may be waived if an inmate's release occurs without sufficient notice to the Bureau to allow health care personnel to perform a routine HIV test and notify the inmate of the results.

(B) All HIV tests under this paragraph shall comply with the opt-out provision.

(C) To all inmates who test positive for HIV and all inmates who already are known to

have HIV/AIDS, health care personnel shall provide—

(i) confidential prerelease counseling on managing their medical condition in the community, accessing appropriate treatment and services in the community, and preventing the transmission of their condition to family members and other persons in the community;

(ii) referrals to appropriate health care providers and social service agencies in the community that meet the inmate's individual needs, including voluntary partner notification services and prevention counseling services for people living with HIV/AIDS; and

(iii) a 30-day supply of any medically necessary medications the inmate is currently receiving.

(9) OPT-OUT PROVISION.—Inmates shall have the right to refuse routine HIV testing. Inmates shall be informed both orally and in writing of this right. Oral and written disclosure of this right may be included with other general health information and counseling provided to inmates by health care

personnel. If an inmate refuses a routine test for HIV, health care personnel shall make a note of the inmate's refusal in the inmate's confidential medical records. However, the inmate's refusal shall not be considered a violation of prison rules or result in disciplinary action. Any reference in this section to the ''opt-out provision'' shall be deemed a reference to the requirement of this paragraph.

(10) EXCLUSION OF TESTS PERFORMED UNDER SECTION 4014(b) FROM THE DEFINITION OF ROUTINE HIV TESTING.—HIV testing of an inmate under section 4014(b) of title 18, United States Code, is not routine HIV testing for the purposes of the opt-out provision. Health care personnel shall document the reason for testing under section 4014(b) of title 18, United States Code, in the inmate's confidential medical records.

(11) TIMELY NOTIFICATION OF TEST RESULTS.—Health care personnel shall provide timely notification to inmates of the results of HIV tests.

(g) CHANGES IN EXISTING LAW.—

(1) SCREENING IN GENERA.—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" after "under this section".

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

(h) REPORTING REQUIREMENTS.—

(1) REPORT ON HEPATITIS 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 proce-

dures to provide testing, treatment, and prevention education programs for hepatitis and other diseases transmitted through sexual activity and intravenous drug use. The Bureau shall consult with appropriate officials of the Department of Health and Human Services, the Office of National Drug Control Policy, the Office of National AIDS Policy, and the Centers for Disease Control and Prevention regarding the development of this report.

(2) ANNUAL REPORTS.—

(A) GENERALLY.—Not later than 2 years after the date of the enactment of this Act, and then annually thereafter, the Bureau shall report to Congress on the incidence among inmates of diseases transmitted through sexual activity and intravenous drug use.

(B) MATTERS PERTAINING TO VARIOUS DISEASES.—Reports under paragraph (1) shall discuss—

(i) the incidence among inmates of HIV/AIDS, hepatitis, and other diseases transmitted through sexual activity and intravenous drug use; and

(ii) updates on Bureau testing, treatment, and prevention education programs for these diseases.

(C) MATTERS PERTAINING TO HIV/AIDS ONLY.—Reports under paragraph (1) shall also include—

(i) the number of inmates who tested positive for HIV upon intake;

(ii) the number of inmates who tested positive prior to reentry;

(iii) the number of inmates who were not tested prior to reentry because they were released without sufficient notice;

(ix) the number of inmates who opted-out of taking the test;

(x) the number of inmates who were tested under section 4014(b) of title 18, United States Code; and

(xi) 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 Dis-

ease Control and Prevention regarding the development of reports under paragraph (1).

SEC. 762. SUPPORT DATA SYSTEM REVIEW AND INDICATORS FOR MONITORING HIV CARE.

The Secretary of Health and Human Services, in collaboration with the Assistant Secretary for Health, the Director of the Office of HIV/AIDS and Infectious Disease Policy, the Director of the Centers for Disease Control and Prevention, the Administrator of the Substance Abuse and Mental Health Services Administration, the Director of the Department of Housing and Urban Development, the Director of the Office of AIDS Research, the Administrator of the Health Resources and Services Administration, and the Administrator of the Centers for Medicare & Medicaid Services, shall expand and coordinate efforts to align metrics across agencies and modify Federal data systems, to—

(1) adopt the Institute of Medicine's clinical HIV care indicators as the core metrics for monitoring the quality of HIV care, mental health, substance abuse, and supportive services;

(2) better enable assessment of the impact of the National HIV/AIDS Strategy and the Patient Protection and Affordable Care Act on improving

HIV/AIDS care and access to supportive services for individuals with HIV;

(3) expand the demographic data elements to be captured by Federal data systems relevant to HIV care to permit calculation of the indicators for subgroups of the population of people with diagnosed HIV infection, including—

(A) age;

(B) race;

(C) ethnicity;

(D) sex (assigned at birth);

(E) gender identity;

(F) sexual orientation;

(G) current geographic marker of residence;

(H) income or poverty level; and

(I) primary means of reimbursement for medical services (including Medicaid, Medicare, the Ryan White HIV/AIDS Program, private insurance, health maintenance organizations, and no coverage); and

(4) streamline data collection and systematically review all existing reporting requirements for federally funded HIV/AIDS programs to ensure that only essential data are collected.

SEC. 763. TRANSFER OF FUNDS FOR IMPLEMENTATION OF NATIONAL HIV/AIDS STRATEGY.

Title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by inserting after section 241 the following:

"SEC. 241A. TRANSFER OF FUNDS FOR IMPLEMENTATION OF NATIONAL HIV/AIDS STRATEGY.

''(a) TRANSFER AUTHORIZATION.—Of the discretionary appropriations made available to the Department of Health and Human Services for any fiscal year for programs and activities that, as determined by the Secretary of Health and Human Services, pertain to HIV/AIDS, the Secretary, in coordination with the Director of the Office of National HIV/AIDS Policy, may transfer up to 1 percent of such appropriations to the Office of the Assistant Secretary for Health for implementation of the National HIV/AIDS Strategy.

''(b) CONGRESSIONAL NOTIFICATION.—Not less than 30 days before making any transfer under this section, the Secretary shall give notice of the transfer to the Congress.

''(c) DEFINITIONS.—In this section:

''(1) The term 'HIV/AIDS' has the meaning given to such term in section 2689.

''(2) The term 'National HIV/AIDS Strategy' means the National HIV/AIDS Strategy for the

United States issued by the President in July 2010 and includes any subsequent revisions to such Strategy.''.

SEC. 764. HIV INTEGRATED SERVICES DELIVERY MODEL DEMONSTRATION.

(a) IN GENERAL.—Consistent with the National HIV/AIDS Strategy for the United States and in accordance with this section, the Secretary of Health and Human Services acting through the Center for Medicare & Medicaid Innovation and in cooperation with CDC, HRSA, SAMHSA, and HUD, shall conduct a 3-year demonstration project that is designed to integrate services and funding under the Medicare and Medicaid programs, under HIV-related programs conducted by the CDC, and under the Ryan White HIV/AIDS Program, to reduce new HIV infections, to increase the proportion of people who know their status, to increase access to care, to improve health outcomes, to reduce HIV-related health disparities among Medicaid and Medicare beneficiaries, and to reduce the cost of care provided to HIV positive Medicare and Medicaid beneficiaries.

(b) OBJECTIVES.—The objectives of the demonstration are the following:

(1) To ensure the early identification of HIV positive beneficiaries to reduce costly HIV-related

clinical conditions through HIV screening and rapid linkage to high quality HIV medical care.

(2) To reduce new HIV infections among Medicaid and Medicare beneficiaries through routine HIV testing, prevention services for HIV negative beneficiaries, and intensive ''prevention for positive'' services for HIV positive beneficiaries.

(3) To reduce morbidity, mortality, and high cost inpatient and specialty care among HIV positive beneficiaries by ensuring access to high quality HIV medical care, HIV medications, and support services.

(4) To promote HIV treatment adherence and retention in care through intensive case management, treatment education, and outreach services.

(5) To effectively treat behavioral health conditions among HIV positive beneficiaries that impair their HIV treatment adherence and lead to secondary HIV infections through services funded under Medicare and Medicaid and programs administered by SAMHSA.

(6) To promote independence, treatment adherence, and stable housing for HIV positive beneficiaries through highly coordinated HIV health, housing, and support services funded by HRSA and HUD.

(c) DEMONSTRATION DESIGN.—

(1) IN GENERAL.—The Secretary shall design the demonstration to test both—

(A) the service delivery model described in paragraph (2); and

(B) the payment model described in paragraph (3).

(2) SERVICE DELIVERY MODEL.—

(A) IN GENERAL.—Under the service delivery model described in this paragraph, the demonstration shall test comprehensive HIV testing, linkage to care, HIV medical care, and ancillary services to individuals enrolled under Medicare, Medicaid, or both. The service delivery model will integrate services furnished under Medicare and Medicaid with prevention services funded by CDC for HIV positive beneficiaries, intensive case management services funded by HRSA, behavioral services funded by SAMHSA, and housing assistance services funded through HUD.

(B) CORE ELEMENTS.—The model under this paragraph shall have the following 8 core elements:

(i) HIV testing services that apply the CDC's 2006 recommendations for universal opt-out testing among Medicare and Medicaid beneficiary populations.

(ii) Rapid linkage from HIV testing settings to treatment for HIV positive beneficiaries to ensure they are engaged in care in a timely basis.

(iii) Access to high quality HIV experienced medical care, laboratory monitoring, HIV medications, and other required services.

(iv) Routine screening and treatment for HIV-related and other chronic conditions, including behavioral health.

(v) Prevention and treatment education services, including an adapted Medication Therapy Management (MTM) program model, to optimize the benefit of HIV therapeutics.

(vi) Risk-stratified medical case management.

(vii) Provision of preventive care, including counseling to prevent secondary HIV infection.

(viii) Wrap-around support and housing services.

(3) PAYMENT MODEL.—Under the payment model described in this paragraph, the demonstration shall test the following:

(A) A prepaid capitated payment model that adjusts payment for HIV and behavioral health acuity, to be applied under contracts with managed care organizations with demonstrated HIV experience.

(B) Use of funds under the Ryan White HIV/AIDS Program to purchase capitated services from the contracted managed care organizations.

(C) Provision of additional funds to support services to the extent that Medicaid and Medicare coverage is limited, including for services such as HIV testing (for Medicaid beneficiaries), medical case management, prevention case management, treatment education, case finding, behavioral health services, and housing assistance.

(d) BENEFICIARY CRITERIA.—Beneficiaries eligible for participation in the demonstration are the following:

(1) MEDICAID FFS BENEFICIARIES.—Fee-for-service Medicaid beneficiaries 18 years of age or older.

(2) DUAL ELIGIBLES.—Individuals who are—

(A) entitled to medical assistance under Medicaid; and

(B) entitled to benefits under part A, and enrolled under part B, of Medicare but are not enrolled under a Medicare Advantage plan under Medicare.

(e) ROLES AND RESPONSIBILITIES IN DEMONSTRATION.—

(1) IN GENERAL.—Consistent with the National HIV/AIDS Strategy for the United States, Federal agencies shall coordinate their funding for the selected States or cities covered under the demonstration to provide resources to fund the delivery of services within the demonstration.

(2) HHS.—In carrying out the demonstration, the Secretary shall—

(A) design the application process;

(B) solicit applications from 5 to 7 State Medicaid agencies to host the demonstration;

(C) with respect to the service delivery model described in subsection (c)(2), collaborate

with the CDC, HRSA, and the National Institutes of Health to design a minimum service delivery model that reflects the current standard of care as established by the Public Health Service and CDC guidelines and recommendations; and

(D) fund an evaluation of the demonstration to ensure collection of system, provider, and beneficiary-level data to address their routine reporting requirements.

The Secretary may carry out the Secretary's authority under this paragraph through CMMI.

(3) CDC.—The CDC shall collaborate with the Secretary and CDC-funded HIV prevention grantees in the selected States and cities to provide technical assistance to design cost-effective HIV and sexually transmitted infection (STI) screening and testing services for Medicaid and Medicare beneficiaries, including partner notification services and communicable disease reporting. CDC and CMS shall determine the extent to which testing funds shall be supported jointly or separately by these agencies.

(4) HRSA.—HRSA shall allocate funds available through the Special Projects of National Significance (SPNS) Initiative Program (under subpart

I of part F of the Ryan White HIV/AIDS Program) to support wrap-around core and support services not covered under Medicare or Medicaid and shall authorize the use of Ryan White HIV/AIDS Program funds to purchase services through capitated managed care programs that meet or exceed the services covered by the Ryan White HIV/AIDS Program at rates that are no greater than current per capita expenditures. HRSA is authorized to use funds under SPNS, and to waive such requirements of SPNS as may be necessary, to carry out the demonstration.

(5) SAMHSA.—SAMHSA shall allocate funds through the Minority HIV/AIDS Initiative or other programs to support behavioral health services not covered under Medicare or Medicaid.

(6) HOPWA.—HUD shall directly allocate funds under the Housing Opportunities for People With AIDS (HOPWA) program to the States or cities participating in the demonstration to provide supportive housing and other housing assistance to beneficiaries who otherwise meet HOPWA eligibility criteria. HUD is authorized to use such HOPWA funds, and to waive such requirements under

HOPWA as may be necessary, to carry out the demonstration.

(7) STATE MEDICAID AGENCIES.—Single State agencies responsible for administration of the Medicaid program for individuals who are accepted to participate in the demonstration shall—

(A) collaborate with CMS to design or refine a prepaid capitated payment model, to allocate and award contracts with capitated managed care plans, to ensure such plans meet State statutory or regulatory requirements, to contract with a coordinating agency to organize and deliver integrated HIV testing, medical care, support, and housing services funded under Medicare and Medicaid, other Federal, State, and local government sponsors, and to coordinate their activities with the State HIV/AIDS program; and

(B) identify and contract with a coordinating agency to organize the demonstration in the State, to establish a coordinating body representing State, local, and provider agencies participating in the demonstration, to establish systems of care that integrate HIV prevention, testing, treatment, support, and housing serv-

ices, to establish mechanisms to gather evaluation data for reporting to CMMI and other participating Federal agencies, and to establish a quality management program to monitor provider performance in delivering the services provided to participating beneficiaries under the demonstration.

(8) MANAGED CARE ORGANIZATIONS.—Capitated managed care organizations participating in the demonstration shall organize and deliver services as specified by the minimum service delivery model established by CMMI through a network of providers with demonstrated HIV experience, high quality, and sufficient provider capacity.

(f) DEFINITIONS.—In this section:

(1) CDC.—The term ''CDC'' means the Director of the Centers for Disease Control and Prevention.

(2) CMMI.—The term ''CMMI'' means the Director of the Center for Medicare & Medicaid Innovation.

(3) CMS.—The term ''CMS'' means the Administrator of the Centers for Medicare & Medicaid Services.

(4) DEMONSTRATION.—The term ''demonstration'' means the demonstration conducted under this section.

(5) HRSA.—The term ''HRSA'' means the Administrator of the Health Resources and Services Administration.

(6) HUD.—The term ''HUD'' means the Secretary of Housing and Urban Development.

(7) MEDICARE; MEDICAID.—The terms ''Medicare'' and ''Medicaid'' mean the programs under titles XVIII and XIX, respectively, of the Social Security Act.

(8) NATIONAL HIV/AIDS STRATEGY FOR THE UNITED STATES.—The term ''National HIV/AIDS Strategy for the United States'' has the meaning given such term under section 241A(b) of the Public Health Service Act.

(9) RYAN WHITE HIV/AIDS PROGRAM.—The term ''Ryan White HIV/AIDS Program'' means the program under title XXVI of the Public Health Service Act.

(10) SAMHSA.—The term ''SAMHSA'' means the Substance Abuse and Mental Health Services Administration.

(11) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through CMMI.

SEC. 765. REPORT ON THE IMPLEMENTATION OF GOAL 4 (IMPROVED COORDINATION) OF THE NATIONAL HIV/AIDS STRATEGY.

(a) REPORT REQUIRED.—The President, in consultation with the heads of all relevant Federal departments and 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 Veteran Affairs, and the Social Security Administration, shall transmit to the Congress and make publicly available a report on the status of implementation of Goal 4 of the National HIV/AIDS Strategy.

(b) CONTENTS.—The report required by subsection (a) shall include a description, an analysis, and an evaluation of—

(1) the extent to which the National HIV/AIDS Strategy has improved coordination of efforts, enhanced capacity, and strengthened infrastructure in order 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; and

(2) 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.

(c) DEFINITION.—In this section, the term ''National HIV/AIDS Strategy'' means the National HIV/AIDS Strategy for the United States issued by the President in July 2010 and includes any subsequent revisions to such Strategy.

Subtitle F—Diabetes

SEC. 771. RESEARCH, TREATMENT, AND EDUCATION.

Subpart 3 of part C of title IV of the Public Health Service Act (42 U.S.C. 285c et seq.) is amended by adding at the end the following new section:

"SEC. 434B. DIABETES IN MINORITY POPULATIONS.

''(a) IN GENERAL.—The Director of NIH shall expand, intensify, and support ongoing research and other activities with respect to prediabetes and diabetes, particularly type 2, in minority populations.

''(b) RESEARCH.—

''(1) DESCRIPTION.—Research under subsection (a) shall include investigation into—

''(A) the causes of diabetes, including socioeconomic, geographic, clinical, environmental, genetic, and other factors that may contribute to increased rates of diabetes in minority populations; and

''(B) the causes of increased incidence of diabetes complications in minority populations, and possible interventions to decrease such incidence.

''(2) INCLUSION OF MINORITY PARTICIPANTS.—In conducting and supporting research described in subsection (a), the Director of NIH shall seek to in-

clude minority participants as study subjects in clinical trials.

''(c) REPORT; COMPREHENSIVE PLAN.—

''(1) IN GENERAL.—The Diabetes Mellitus Interagency Coordinating Committee shall—

''(A) prepare and submit to the Congress, not later than 6 months after the date of enactment of this section, a report on Federal research and public health activities with respect to prediabetes and diabetes in minority populations; and

''(B) develop and submit to the Congress, not later than 1 year after the date of enactment of this section, an effective and comprehensive Federal plan (including all appropriate Federal health programs) to address prediabetes and diabetes in minority populations.

''(2) CONTENTS.—The report under paragraph (1)(A) shall at minimum address each of the following:

''(A) Research on diabetes and prediabetes in minority populations, including such research on—

''(i) genetic, behavioral, and environmental factors; and

''(ii) prevention and complications among individuals within these populations who have already developed diabetes.

''(B) Surveillance and data collection on diabetes and prediabetes in minority populations, including with respect to—

''(i) efforts to better determine the prevalence of diabetes among Asian-American and Pacific Islander subgroups; and

''(ii) efforts to coordinate data collection on the American Indian population.

''(C) Community-based interventions to address diabetes and prediabetes targeting minority populations, including—

''(i) the evidence base for such interventions;

''(ii) the cultural appropriateness of such interventions; and

''(iii) efforts to educate the public on the causes and consequences of diabetes.

''(D) Education and training programs for health professionals (including community health workers) on the prevention and manage-

ment of diabetes and its related complications that is supported by the Health Resources and Services Administration, including such programs supported by—

"(i) the National Health Service Corps; or

"(ii) the community health centers program under section 330.

"(d) EDUCATION.—The Director of NIH shall—

"(1) through the National Institute on Minority Health and Health Disparities and the National Diabetes Education Program—

"(A) make grants to programs funded under section 464z–4 (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.

''(e) DEFINITIONS.—For purposes of this section:

''(1) The 'Diabetes Mellitus Interagency Coordinating Committee' means the Diabetes Mellitus Interagency Coordinating Committee established under section 429.

''(2) The term 'minority population' means a racial and ethnic minority group, as defined in section 1707.''.

SEC. 772. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.

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

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

''(a) RESEARCH AND OTHER ACTIVITIES.—

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

''(2) CERTAIN ACTIVITIES.—Activities under paragraph (1) regarding diabetes in minority populations shall include the following:

''(A) Further enhancing the National Health and Nutrition Examination Survey by over-sampling Asian-American, Native Hawaiian, and Other Pacific Islanders in appropriate geographic areas to better determine the prevalence of diabetes in such populations as well as to improve the data collection of diabetes penetration disaggregated into major ethnic groups within such populations. The Secretary shall ensure that any such oversampling does not reduce the oversampling of other minority populations including African-American and Latino populations.

''(B) Through the Division of Diabetes Translation—

''(i) providing for prevention research to better understand how to influence health care systems changes to improve quality of care being delivered to such populations;

''(ii) carrying out model demonstration projects to design, implement, and evaluate effective diabetes prevention and control interventions for minority popu-

lations, including culturally appropriate community-based interventions;

''(iii) developing and implementing a strategic plan to reduce diabetes in minority populations through applied research to reduce disparities and culturally and linguistically appropriate community-based interventions;

''(iv) supporting, through the national diabetes prevention program under section 399V–3, diabetes prevention program sites in underserved regions highly impacted by diabetes; and

''(v) implementing, through the national diabetes prevention program under section 399V–3, a demonstration program developing new metrics measuring health outcomes related to diabetes that can be stratified by specific minority populations.

''(b) EDUCATION.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall direct the Division of Diabetes Translation to conduct and support both programs to educate the public on diabetes in minority populations and programs to

educate minority populations about the causes and effects of diabetes.

''(c) DIABETES; HEALTH PROMOTION, PREVENTION ACTIVITIES, AND ACCESS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and the National Diabetes Education Program, shall conduct and support programs to educate specific minority populations through culturally appropriate and linguistically appropriate information campaigns about prevention of, and managing, diabetes.

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

SEC. 773. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.

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

''SEC. 399V–7. PROGRAMS TO EDUCATE HEALTH PROVIDERS ON THE CAUSES AND EFFECTS OF DIABETES IN MINORITY POPULATIONS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Health Resources and Services Administration, shall conduct and support programs described in subsection (b) to educate health professionals on the causes and effects of diabetes in minority populations.

''(b) PROGRAMS.—Programs described in this subsection, with respect to education on diabetes in minority populations, shall include the following:

''(1) Giving priority, under the primary care training and enhancement program under section 747—

''(A) to awarding grants to focus on or address diabetes; and

''(B) adding minority populations to the list of vulnerable populations that should be served by such grants.

''(2) Providing additional funds for the Health Careers Opportunity Program, Centers for Excellence, and the Minority Faculty Fellowship Program to partner with the Office of Minority Health under section 1707 and the National Institutes of Health to strengthen programs for career opportunities focused on diabetes treatment and care within underserved regions highly impacted by diabetes.

''(3) Developing a diabetes focus within, and providing additional funds for, the National Health Service Corps Scholarship Program—

''(A) to place individuals in areas that are disproportionately affected by diabetes and to

provide diabetes treatment and care in such areas; and

''(B) to provide such individuals continuing medical education specific to diabetes care.''.

SEC. 774. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.

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

''SEC. 399V–8. RESEARCH, EDUCATION, AND OTHER ACTIVITIES REGARDING DIABETES IN AMERICAN INDIAN POPULATIONS.

''In addition to activities under sections 317V–6 and 434B, the Secretary, acting through the Indian Health Service and in collaboration with other appropriate Federal agencies, shall—

''(1) conduct and support research and other activities with respect to diabetes; and

''(2) coordinate the collection of data on clinically and culturally appropriate diabetes treatment, care, prevention, and services by health care professionals to the American Indian population.''.

SEC. 775. UPDATED REPORT ON HEALTH DISPARITIES.

The Secretary of Health and Human Services shall seek to enter into an arrangement with the Institute of Medicine under which the Institute will—

(1) not later than 1 year after the date of enactment of this Act, submit to the Congress an updated version of the Institute's 2002 report entitled ''Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care''; and

(2) in such updated version, address how racial and ethnic health disparities have changed since the publication of the original report.

Subtitle G—Lung Disease

SEC. 776. EXPANSION OF THE NATIONAL ASTHMA EDUCATION AND PREVENTION PROGRAM.

(a) IN GENERAL.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall convene a working group comprised of patient groups, nonprofit organizations, medical societies, and other relevant governmental and nongovernmental entities, including those that participate in the National Asthma Education and Prevention Program, to develop a report to Congress that—

(1) catalogs, with respect to asthma prevention, management, and surveillance—

(A) the activities of the Federal Government, including identifying all Federal programs that carry out asthma-related activities, as well as assessment of the progress of the

Federal Government and States, with respect to achieving the goals of the Healthy People 2020 initiative; and

(B) the activities of other entities that participate in the program, including nonprofit organizations, patient advocacy groups, and medical societies; and

(2) makes recommendations for the future direction of asthma activities, in consultation with researchers from the National Institutes of Health and other member bodies of the National Asthma Education and Prevention Program who are qualified to review and analyze data and evaluate interventions, including—

(A) description of how the Federal Government may better coordinate and improve its response to asthma including identifying any barriers that may exist;

(B) description of how the Federal Government may continue, expand, and improve its private-public partnerships with respect to asthma including identifying any barriers that may exist;

(C) identification of steps that may be taken to reduce the—

(i) morbidity, mortality, and overall prevalence of asthma;

(ii) financial burden of asthma on society;

(iii) burden of asthma on disproportionately affected areas, particularly those in medically underserved populations (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))); and

(iv) burden of asthma as a chronic disease;

(D) identification of programs and policies that have achieved the steps described in subparagraph (C), and steps that may be taken to expand such programs and policies to benefit larger populations; and

(E) recommendations for future research and interventions.

(b) REPORT TO CONGRESS.—At the end of the 5-year period following the submission of the report under subsection (a), the National Asthma Education and Prevention Program shall evaluate the analyses and recommendations under such report and determine whether

a new report to the Congress is necessary, and make appropriate recommendations to the Congress.

SEC. 777. ASTHMA-RELATED ACTIVITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

Section 317I of the Public Health Service Act (42 U.S.C. 247b–10) is amended to read as follows:

"SEC. 317I. ASTHMA-RELATED ACTIVITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

''(a) PROGRAM FOR PROVIDING INFORMATION AND EDUCATION TO THE PUBLIC.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall collaborate with State and local health departments to conduct activities, including the provision of information and education to the public regarding asthma including—

''(1) deterring the harmful consequences of uncontrolled asthma; and

''(2) disseminating health education and information regarding prevention of asthma episodes and strategies for managing asthma.

''(b) DEVELOPMENT OF STATE ASTHMA PLANS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall collaborate with State and local health departments to develop State plans incorporating public health responses to reduce the burden

of asthma, particularly regarding disproportionately affected populations.

''(c) COMPILATION OF DATA.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall, in cooperation with State and local public health officials—

''(1) conduct asthma surveillance activities to collect data on the prevalence and severity of asthma, the effectiveness of public health asthma interventions, and the quality of asthma management, including—

''(A) collection of household data on the local burden of asthma;

''(B) surveillance of health care facilities; and

''(C) collection of data not containing individually identifiable information from electronic health records or other electronic communications;

''(2) compile and annually publish data regarding the prevalence and incidence of childhood asthma, the child mortality rate, and the number of hospital admissions and emergency department visits by children associated with asthma nationally and in each State and at the county level by age, sex, race,

and ethnicity, as well as lifetime and current prevalence; and

''(3) compile and annually publish data regarding the prevalence and incidence of adult asthma, the adult mortality rate, and the number of hospital admissions and emergency department visits by adults associated with asthma nationally and in each State and at the county level by age, sex, race, ethnicity, industry, and occupation, as well as lifetime and current prevalence.

''(d) COORDINATION OF DATA COLLECTION.—The Director of the Centers for Disease Control and Prevention, in conjunction with State and local health departments, shall coordinate data collection activities under subsection (c)(2) so as to maximize comparability of results.

''(e) COLLABORATION.—The Centers for Disease Control and Prevention are encouraged to collaborate with national, State, and local nonprofit organizations to provide information and education about asthma, and to strengthen such collaborations when possible.

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

to be appropriated to such Centers such sums as may be necessary for each of fiscal years 2015 through 2019 for the purpose of carrying out this section.''.

SEC. 778. INFLUENZA AND PNEUMONIA VACCINATION CAMPAIGN.

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

(1) enhance the annual campaign by the Department of Health and Human Services to increase the number of people vaccinated each year for influenza and pneumonia; and

(2) include in such campaign the use of written educational materials, public service announcements, physician education, and any other means which the Secretary deems effective.

(b) MATERIALS AND ANNOUNCEMENTS.—In carrying out the annual campaign described in subsection (a), the Secretary of Health and Human Services shall ensure that—

(1) educational materials and public service announcements are readily and widely available in communities experiencing disparities in the incidence and mortality rates of influenza and pneumonia; and

(2) the campaign uses targeted, culturally appropriate messages and messengers to reach underserved communities.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2015 through 2019.

SEC. 779. 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 2015 through 2019.

Subtitle H—Osteoarthritis and Musculoskeletal Diseases

SEC. 781. FINDINGS.

The Congress finds as follows:

(1) Eighty percent of African-American women and nearly 74 percent of Hispanic men are either overweight or obese, speeding the onset and progression of arthritis.

(2) Arthritis affects 46 million Americans, and that number will rise to 67 million by the year 2030.

(3) Twenty-seven million Americans suffer from osteoarthritis, the most common form of arthritis, making it the leading cause of disability in the United States. Osteoarthritis is sometimes referred to as degenerative joint disease.

(4) Obesity accelerates the onset of arthritis: 70 percent of obese adults with mild osteoarthritis of the knee at age 60 will develop advanced end-stage disease by age 80. In contrast, just 43 percent of non-obese adults will have end-stage disease over the same time period.

(5) Arthritis affects one in five Americans, and is the single greatest cause of chronic pain and disability in the United States.

(6) Women, African-Americans, and Hispanics have more severe arthritis and functional limitations. These same individuals are more likely to be obese, diabetic, and have higher incidence of heart disease—medical conditions that can be improved with physical activity. Instead of moving; however, these groups have an inactivity rate of 40 to 50 percent, which continues to increase.

(7) Arthritis costs $128 billion a year, including $81 billion in direct costs (medical) and $47 billion in indirect costs (lost earnings). Each year, $309 bil-

lion in direct and indirect costs is lost due to disparities in osteoarthritis and musculoskeletal diseases.

(8) Obesity and other chronic health conditions exacerbate the debilitating impact of arthritis, leading to inactivity, loss of independence, and a perpetual cycle of comorbid chronic conditions.

(9) Sixty-one percent of arthritis sufferers are women, and women represent 64 percent of an estimated 43 million annual visits to physicians' offices and outpatient clinics where arthritis was the primary diagnosis. Women also represented 60 percent of approximately 1 million hospitalizations that occurred in 2003 for which arthritis was the primary diagnosis.

(10) Women ages 65 and older have up to 2½ times more disabilities than men of the same age. Higher rates of obesity and arthritis among this group explained up to 48 percent of the gender gap in disability, above all other common chronic health conditions.

(11) The primary indication for total knee arthroplasty (TKA), also known as knee replacement, is relief of significant, disabling pain caused by severe arthritis.

(12) Knee replacement is surgery for people with severe knee damage. Knee replacement can relieve pain and allow you to be more active. When you have a total knee replacement, the surgeon removes damaged cartilage and bone from the surface of your knee joint and replaces them with a man-made surface of metal and plastic. In a partial knee replacement, the surgeon only replaces one part of your knee joint.

(13) Total hip replacement, also called total hip arthroplasty (THA), is used if your hip pain interferes with daily activities and more-conservative treatments have not helped. Arthritis damage is the most common reason to need hip replacement.

(14) The odds of a family practice physician recommending TKA to a male patient with moderate arthritis are twice that of a female patient, while the odds of an orthopaedic surgeon recommending TKA to a male patient with moderate arthritis are 22 times that of a female patient.

(15) African-Americans with doctor-diagnosed arthritis have a higher prevalence of severe pain attributable to arthritis, compared with Whites (34.0 percent versus 22.6 percent). African-Americans, compared to Whites, report a higher proportion of

work limitations (39.5 percent versus 28.0 percent) and a higher prevalence of arthritis-attributable work limitation (6.6 percent versus 4.6 percent).

(16) Hispanics are 50 percent more likely than non-Hispanic Whites to report needing assistance with at least one instrumental activity of daily living and to have difficulty walking.

(17) African-Americans and Hispanics were 1.3 times more likely to have activity limitation, 1.6 times more likely to have work limitations, and 1.9 times more likely to have severe joint pain than Whites.

(18) In 2003, the Institute of Medicine reported that the rates of TKA and THA among African-American and Hispanic patients are significantly lower than for Whites—even for those with equitable health care coverage such as through Medicare or the Department of Veterans Affairs.

(19) According to the Centers for Disease Control and Prevention, in 2000, African-American Medicare enrollees were 37 percent less likely than White Medicare enrollees to undergo total knee replacements. In 2006, the disparity increased to 39 percent.

(20) Even after adjusting for insurance and health access, Hispanics and African-Americans are almost 50 percent less likely to undergo total knee replacement than Whites.

SEC. 782. OSTEOARTHRITIS AND OTHER MUSCULOSKELETAL HEALTH-RELATED ACTIVITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

(a) EDUCATION AND AWARENESS ACTIVITIES.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall direct the National Center for Chronic Disease Prevention and Health Promotion to conduct and expand the Health Community Program and Arthritis Program to educate the public on—

(1) the causes of, preventive health actions for, and effects of arthritis and other musculoskeletal conditions in minority patient populations; and

(2) the effects of such conditions on other comorbidities including obesity, hypertension, and cardiovascular disease.

(b) PROGRAMS ON ARTHRITIS AND MUSCULOSKELETAL CONDITIONS.—Education and awareness programs of the Centers for Disease Control and Prevention

on arthritis and other musculoskeletal conditions in minority communities shall—

(1) be culturally and linguistically appropriate to minority patients, targeting musculoskeletal health promotion and prevention programs of each major ethnic group, including—

(A) Native Americans and Alaska Natives;

(B) Asian-Americans;

(C) African-Americans/Blacks;

(D) Hispanic/Latino-Americans; and

(E) Native Hawaiians and Pacific Islanders; and

(2) include public awareness campaigns directed toward these patient populations that emphasize the importance of musculoskeletal health, physical activity, diet and healthy lifestyle, and weight reduction for overweight and obese patients.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as necessary for fiscal year 2015 and each subsequent fiscal year.

Subtitle I—Sleep and Circadian Rhythm Disorders

SEC. 791. SHORT TITLE; FINDINGS.

(a) SHORT TITLE.—This subtitle may be cited as the ''Sleep and Circadian Rhythm Disorders Health Disparities Act''.

(b) FINDINGS.—The Congress finds the following:

(1) Decrements in sleep health such as sleep apnea, insufficient sleep time, and insomnia, affect 50–70 million United States adults. Twelve to eighteen million United States adults have sleep apnea, a chronic disorder characterized by one or more pauses in breathing which can last from a few seconds to minutes. They may occur 30 times or more an hour, disrupting sleep and resulting in excessive daytime sleepiness and loss in productivity.

(2) Seventy percent of high school students are not getting enough sleep on school nights, while 33 percent of Americans get fewer than 7 hours of sleep per night and roughly 6,000 fatal motor vehicle crashes are caused by drowsy drivers.

(3) Insufficient sleep and insomnia are more prevalent in women. Women who are pregnant and have sleep apnea are at an increased risk of cardiovascular complications during pregnancy. The im-

pact of disparities in sleep health is associated with a growing number of health problems, including the following:

(A) Hypertension.

(B) Cancer.

(C) Stroke.

(D) Cardiac arrhythmia.

(E) Chronic heart failure and heart disease.

(F) Diabetes.

(G) Cognitive functioning and behavior.

(H) Depression and bipolar disorder.

(I) Substance abuse.

(4) A ''sleep disparity'' exists in that poor sleep quality is strongly associated with poverty and race. Factors such as employment, education, and health status, amongst others, significantly mediated this effect only in poor subjects, suggesting a differential vulnerability to these factors in poor relative to non-poor individuals in the context of sleep quality.

(5) African-Americans sleep worse than Caucasian Americans. African-Americans take longer to fall asleep, report poorer sleep quality, have more light and less deep sleep, and nap more often and longer.

(6) African-Americans and individuals in lower socioeconomic status groups may be at an increased risk for sleep disturbances and associated health consequences.

(7) Among young African-Americans, the likelihood of having sleep disordered breathing and exhibiting risk factors for poor sleep is twice that in young Caucasians. Frequent snoring is more common among African-American and Hispanic women and Hispanic men compared to non-Hispanic Caucasians, independent of other factors including obesity.

(8) African-Americans with sleep disordered breathing develop symptoms at a younger age than Caucasians but appear less likely to be diagnosed and treated in a timely manner. This delay may at least in part be due to reduced access to care.

(9) Sleep loss contributes to increased risk for chronic conditions such as obesity, diabetes, and hypertension, all of which have increased prevalence in underserved, underrepresented minorities. Racial and ethnic disparities related to obesity may also contribute to disparities in health outcomes related to sleep disordered breathing.

(10) Non-Caucasian adults report an insomnia rate of 12.9 percent compared to only 6.6 percent for Caucasians.

(11) African-American women have a higher incidence of insomnia than African-American men, perhaps related in part to higher risk for chronic persisting symptoms.

SEC. 792. SLEEP AND CIRCADIAN RHYTHM DISORDERS RESEARCH ACTIVITIES OF THE NATIONAL INSTITUTES OF HEALTH.

(a) IN GENERAL.—The Director of the National Institutes of Health, acting through the Director of the National Heart, Lung, and Blood Institute, shall—

(1) continue to expand research activities addressing sleep health disparities; and

(2) continue implementation of the ''NIH Sleep Disorders Research Plan'' across all institutes and centers of the National Institutes of Health to improve treatment and prevention of sleep health disparities.

(b) REQUIRED RESEARCH ACTIVITIES.—In conducting or supporting research relating to sleep and circadian rhythm, the Director of the National Heart, Lung, and Blood Institute shall—

(1) advance epidemiology and clinical research to achieve a more complete understanding of disparities in domains of sleep health and across population subgroups for which cardiovascular and metabolic health disparities exist, including—

(A) prevalence and severity of sleep apnea;

(B) habitual sleep duration;

(C) sleep timing and regularity; and

(D) insomnia;

(2) develop study designs and analytical approaches to explain and predict multilevel and life-course determinants of sleep health and to elucidate the sleep-related causes of cardiovascular and metabolic health disparities across the age spectrum, including such determinants and causes that are—

(A) environmental;

(B) biological or genetic;

(C) psychosocial;

(D) societal;

(E) political; or

(F) economic;

(3) determine the contribution of sleep impairments such as sleep apnea, insufficient sleep duration, irregular sleep schedules, and insomnia to un-

explained disparities in cardiovascular and metabolic risk and disease outcomes;

(4) develop study designs, data sampling and collection tools, and analytical approaches to optimize understanding of mediating and moderating factors, and feedback mechanisms coupling sleep to cardiovascular and metabolic health disparities;

(5) advance research to understand cultural and linguistic barriers (on the person, provider, or system level) to access to care, medical diagnosis, and treatment of sleep disorders in diverse population groups;

(6) develop and test multilevel interventions (including sleep health education in diverse communities) to reduce disparities in sleep health that will impact ability to improve disparities in cardiovascular and metabolic risk or disease;

(7) create opportunities to integrate sleep and health disparity science by strategically utilizing resources (existing or anticipated cohorts), exchanging scientific data and ideas (cross-over into scientific meetings), and develop multidisciplinary investigator-initiated grant applications; and

(8) enhance the diversity and foster career development of young investigators involved in sleep and health disparities science.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal year 2015 and each subsequent fiscal year.

SEC. 793. SLEEP AND CIRCADIAN RHYTHM HEALTH DISPARITIES-RELATED ACTIVITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention shall conduct, support, and expand public health strategies and prevention, diagnosis, surveillance, and public and professional awareness activities regarding sleep and circadian rhythm disorders.

(b) FINDINGS.—The Congress finds as follows:

(1) Sleep disorders and sleep deficiency unrelated to a primary sleep disorder are underdiagnosed and are increasingly detrimental to health status.

(2) The consequences to society include additional diseases, motor vehicle accidents, decreased longevity, elevated direct medical costs, and indirect costs related to work absenteeism and property damage.

(c) REQUIRED SURVEILLANCE AND EDUCATION AWARENESS ACTIVITIES.—In conducting or supporting research relating to sleep and circadian rhythm disorders surveillance and education awareness activities, the Director of the Centers for Disease Control and Prevention shall—

(1) ensure that such activities are culturally and linguistically appropriate to minority patients, targeting sleep and circadian rhythm health promotion and prevention programs of each major ethnic group, including—

(A) Native Americans and Alaska Natives;

(B) Asian-Americans;

(C) African-Americans/Blacks;

(D) Hispanic/Latino-Americans; and

(E) Native Hawaiians and Pacific Islanders;

(2) collect and compile national and State surveillance data on sleep disorders health disparities;

(3) continue to develop and implement new sleep questions in public health surveillance systems to increase public awareness of sleep health and sleep disorders and their impact on health;

(4) publish monthly reports highlighting geographic, racial, and ethnic disparities in sleep health,

as well as relationships between insufficient sleep and chronic disease, health risk behaviors, and other outcomes as determined necessary by the Director; and

(5) include public awareness campaigns that inform patient populations from major ethnic groups about the prevalence of sleep and circadian rhythm disorders and emphasize the importance of sleep health.

(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal year 2015 and each subsequent fiscal year.

TITLE VIII—HEALTH INFORMATION TECHNOLOGY

SEC. 800. DEFINITIONS.

In this title:

(1) The term ''certified EHR technology'' has the meaning given to that term in section 3000 of the Public Health Service Act (42 U.S.C. 300jj).

(2) The term ''EHR'' means an electronic health record.

Subtitle A—Reducing Health Disparities Through Health IT

SEC. 801. HRSA ASSISTANCE TO HEALTH CENTERS FOR PROMOTION OF HEALTH IT.

The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, shall expand and intensify the programs and activities of the Administration (directly or through grants or contracts) to provide technical assistance and resources to health centers (as defined in section 330(a) of the Public Health Service Act (42 U.S.C. 254b(a)) to adopt and meaningfully use certified EHR technology for the management of chronic diseases and health conditions and reduction of health disparities.

SEC. 802. ASSESSMENT OF IMPACT OF HEALTH IT ON RACIAL AND ETHNIC MINORITY COMMUNITIES; OUTREACH AND ADOPTION OF HEALTH IT IN SUCH COMMUNITIES.

(a) NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY.—

(1) IN GENERAL.—The National Coordinator for Health Information Technology shall conduct an evaluation of the level of use and accessibility of electronic health records in racial and ethnic minority communities focusing on whether patients in

those communities have providers with EHRs, stratified by disparity variables.

(2) CONTENT.—In conducting the evaluation under paragraph (1), the National Coordinator shall publish the results of a study regarding the 100,000 providers recruited by the Regional Extension Center established under section 3012 of the Public Health Service Act (42 U.S.C. 300jj–32), including the race and ethnicity of such providers and the populations served by such providers, with the populations stratified by disparity variables.

(b) NATIONAL CENTER FOR HEALTH STATISTICS.—As soon as practicable after the date of enactment of this Act, the Director of the National Center for Health Statistics shall provide to Congress a more detailed analysis of the data presented in the Data Brief 79 published by such Center in November 2011 (entitled ''Electronic Health Record Systems and Intent to Apply for Meaningful Use Incentives Among Office-Based Physician Practices'').

(c) INSTITUTE OF MEDICINE.—The Secretary of Health and Human Services may enter into an agreement with the Institute of Medicine of the National Academies that provides such Institute will—

(1) evaluate the impact of health information technology in racial and ethnic minority communities; and

(2) publish a report regarding such evaluation.

(d) CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) IN GENERAL.—As part of the process of collecting information, with respect to a provider, at registration and attestation for purposes of the Medicare and Medicaid Electronic Health Records Incentive Programs, the Secretary of Health and Human Services shall collect the race and ethnicity of such provider.

(2) MEDICARE AND MEDICAID ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAMS DEFINED.—For purposes of paragraph (1), the term ''Medicare and Medicaid Electronic Health Records Incentive Programs'' means the incentive programs under section 1814(l)(3), subsections (a)(7) and (o) of section 1848, subsections (l) and (m) of section 1853, subsections (b)(3)(B)(ix)(I) and (n) of section 1886, and subsections (a)(3)(F) and (t) of section 1903 of the Social Security Act (42 U.S.C. 1395f(l)(3), 1395w–4, 1395w–23, 1395ww, and 1396b).

(e) NATIONAL COORDINATOR'S ASSESSMENT OF IMPACT OF HIT.—Section 3001(c)(6)(C) of the Public Health Service Act (42 U.S.C. 300jj–11(c)(6)(C)) is amended—

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

(2) by inserting ", in communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)), including people with disabilities in these groups," after "communities with health disparities"; 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, States, and private entities to expand outreach for and the adoption of certified EHR technology in communities with a high proportion of individuals from racial and ethnic minority groups (as so defined), while also maintaining the accessibility requirements of section 508 of the Rehabilitation Act 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 report required by section 832 of the Health Equity and Accountability Act of 2014, establish criteria for evaluating the impact of health information technology on communities with a high proportion of individuals from racial and ethnic minority groups (as so defined) taking into account the findings in such report; and

''(ii) not later than 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, at least one patient or family caregiver,

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)).''.

SEC. 814. AUTHORIZATION OF APPROPRIATIONS.

Section 3018 of the Public Health Service Act (42 U.S.C. 300jj–38) is amended by striking ''fiscal years 2009 through 2013'' and inserting ''fiscal years 2014 through 2021''.

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 en-

tity described in this clause is a historically Black college or university, a Hispanic-serving institution, a tribal college or university, or an Asian-American-, Native American-, and Pacific Islander-serving institution with an accredited public health, health policy, or health services research program.''.

SEC. 832. STUDY OF HEALTH INFORMATION TECHNOLOGY IN MEDICALLY UNDERSERVED COMMUNITIES.

(a) IN GENERAL.—Not later than 24 months after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) enter into an agreement with the Institute of Medicine of the National Academies (or, if the Institute of Medicine declines, another appropriate public or nonprofit private entity) to conduct a study on the development, implementation, and effectiveness of health information technology within medically underserved areas (as described in subsection (c)); and

(2) submit a report to Congress describing the results of such study, including any recommendations for legislative or administrative action.

(b) STUDY.—The study described in subsection (a)(1) shall—

(1) identify barriers to successful implementation of health information technology in medically underserved areas;

(2) examine the impact of health information technology on providing quality care and reducing the cost of care to individuals in such areas, including the impact of such technology on improved health outcomes for individuals, including which technology worked for which population and how it improved health outcomes for that population;

(3) examine the impact of health information technology on improving health-care-related decisions by both patients and providers in such areas;

(4) identify specific best practices for using health information technology to foster the consistent provision of physical accessibility and reasonable policy accommodations in health care to individuals with disabilities in such areas;

(5) assess the feasibility and costs associated with the use of health information technology in such areas;

(6) evaluate whether the adoption and use of qualified electronic health records (as described in

section 3000(13) of the Public Health Service Act (42 U.S.C. 300jj(13)) is effective in reducing health disparities, including analysis of clinical quality measures reported by Medicare and Medicaid providers pursuant to programs to encourage the adoption and use of certified EHR technology;

(7) identify providers in medically underserved areas that are not electing to adopt and use electronic health records and determine what barriers are preventing those providers from adopting and using such records; and

(8) examine urban and rural community health systems and determine the impact that health information technology may have on the capacity of primary health providers in those systems.

(c) MEDICALLY UNDERSERVED AREA.—The term ''medically underserved area'' means—

(1) a population that has been designated as a medically underserved population under section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3));

(2) an area that has been designated as a health professional shortage area under section 332 of the Public Health Service Act (42 U.S.C. 254e);

(3) an area or population that has been designated as a medically underserved community under section 799B(6) of the Public Health Service Act (42 U.S.C. 295p(6)); or

(4) an area or population that—

(A) is not described in paragraphs (1) through (3) of this subsection;

(B) experiences significant barriers to accessing quality health services; and

(C) has a high prevalence of diseases or conditions described in title VII of this Act, with such diseases or conditions having a disproportionate impact on racial and ethnic minority groups (as defined in section 1707(g) of the Public Health Service Act (42 U.S.C. 300u-6(g))) or a subgroup of people with disabilities who have specific functional impairments.

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 insert-

ing ''hospital that is a subsection (d) hospital or a subsection (d) Puerto Rico hospital''.

(b) OFFSETTING REDUCTION.—Subsection (n)(2) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) 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 2014; 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 amend-

ments 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 REHABILITATION FACILITIES, 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 inserting after clause (ii) the following new clauses:

"(iii) a rehabilitation facility (as defined in section 1886(j)(1)) that furnishes acute or subacute rehabilitation services;

"(iv) a long-term care hospital (as defined in section 1886(d)(1)(B)(iv)(I)); or

"(v) 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 to read as follows:

''(v) physician assistant, in the case that the assistant is a primary care provider, including an assistant who practices in a rural health clinic that is led by a physician assistant or practices in a federally qualified health center that is so led.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to amounts expended under section 1903(a)(3)(F) of the Social Security Act (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters beginning on or after the date of the enactment of this Act.

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, MARITAL STATUS, FAMILIAL STATUS, SEXUAL ORIENTATION, GENDER IDENTITY, OR DISABILITY STATUS.

(a) IN GENERAL.—No person in the United States shall, on the basis of sex, race, color, national origin, marital status, familial status, sexual orientation, gender identity, or disability status, be excluded from participation in, be denied the benefits of, or be subjected to discrimina-

tion under any health program or activity, including any health research program or activity, receiving Federal financial assistance.

(b) DEFINITION.—In this section, the term ''familial status'' means, with respect to one or more individuals—

(1) being domiciled with any individual related by blood or affinity whose close association with the individual is the equivalent of a family relationship;

(2) being in the process of securing legal custody of any individual; or

(3) being pregnant.

SEC. 902. TREATMENT OF MEDICARE PAYMENTS UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964.

A payment to a provider of services, physician, or other supplier under part B, C, or D of title XVIII of the Social Security Act shall be deemed a grant, and not a contract of insurance or guaranty, for the purposes of title VI of the Civil Rights Act of 1964.

SEC. 903. ACCOUNTABILITY AND TRANSPARENCY WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Title XXXIV of the Public Health Service Act, as amended by titles I, II, and III of this Act, is further amended by inserting after subtitle B the following:

"Subtitle C—Strengthening Accountability

"SEC. 3441. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.

''(a) IN GENERAL.—The Secretary shall establish within the Office for Civil Rights an Office of Health Disparities, which shall be headed by a director to be appointed by the Secretary.

''(b) PURPOSE.—The Office of Health Disparities shall ensure that the health programs, activities, and operations of health entities which receive Federal financial assistance are in compliance with title VI of the Civil Rights Act, which prohibits discrimination on the basis of race, color, or national origin. The activities of the Office shall include the following:

''(1) The development and implementation of an action plan to address racial and ethnic health care disparities, which shall address concerns relating to the Office for Civil Rights as released by the United States Commission on Civil Rights in the report entitled 'Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equity' (September 1999) in conjunction with the reports by the Institute of Medicine entitled 'Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care', 'Crossing the Quality

Chasm: A New Health System for the 21st Century', 'In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce', 'The National Partnership for Action to End Health Disparities', and 'The Health of Lesbian, Gay, Bisexual, and Transgender People', and other related reports by the Institute of Medicine. This plan shall be publicly disclosed for review and comment and the final plan shall address any comments or concerns that are received by the Office.

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

''(3) The review of racial, ethnic, gender identity, sexual orientation, sex, disability status, socioeconomic status, and primary language health data collected by Federal health agencies to assess health care disparities related to intentional discrimination and policies and practices that have a disparate impact on minorities.

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

''(5) The provision of technical assistance for health entities to facilitate compliance with title VI of the Civil Rights Act.

''(6) Coordination and oversight of activities of the civil rights compliance offices established under section 3442.

''(7) Ensuring—

''(A) at a minimum, compliance with the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity; and

''(B) consideration of available data and language standards such as—

''(i) the standards for collecting and reporting data under section 3101; and

''(ii) the National Standards on Culturally and Linguistically Appropriate Services of the Office of Minority Health within the Department of Health and Human Services.

''(c) FUNDING AND STAFF.—The Secretary shall ensure the effectiveness of the Office of Health Disparities by ensuring that the Office is provided with—

''(1) adequate funding to enable the Office to carry out its duties under this section; and

''(2) staff with expertise in—

''(A) epidemiology;

''(B) statistics;

''(C) health quality assurance;

''(D) minority health and health disparities;

''(E) cultural and linguistic competency;

''(F) civil rights; and

''(G) social, behavioral, and economic determinants of health.

''(d) REPORT.—Not later than December 31, 2015, and annually thereafter, the Secretary, in collaboration with the Director of the Office for Civil Rights and the Deputy Assistant Secretary for Minority Health, shall submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives that includes—

''(1) the number of cases filed, broken down by category;

''(2) the number of cases investigated and closed by the office;

''(3) the outcomes of cases investigated;

''(4) the staffing levels of the office including staff credentials;

''(5) the number of other lingering and emerging cases in which civil rights inequities can be demonstrated; and

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

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2015 through 2020.

''SEC. 3442. ESTABLISHMENT OF HEALTH PROGRAM OFFICES FOR CIVIL RIGHTS WITHIN FEDERAL HEALTH AND HUMAN SERVICES AGENCIES.

''(a) IN GENERAL.—The Secretary shall establish civil rights compliance offices in each agency within the Department of Health and Human Services that administers health programs.

''(b) PURPOSE OF OFFICES.—Each office established under subsection (a) shall ensure that recipients of Federal financial assistance under Federal health programs administer their programs, services, and activities in a manner that—

''(1) does not discriminate, either intentionally or in effect, on the basis of race, national origin, language, ethnicity, sex, age, disability, sexual orientation, and gender identity; and

''(2) promotes the reduction and elimination of disparities in health and health care based on race, national origin, language, ethnicity, sex, age, disability, sexual orientation, and gender identity.

''(c) POWERS AND DUTIES.—The offices established in subsection (a) shall have the following powers and duties:

''(1) The establishment of compliance and program participation standards for recipients of Federal financial assistance under each program administered by an agency within the Department of Health and Human Services including the establishment of disparity reduction standards to encompass disparities in health and health care related to race, national origin, language, ethnicity, sex, age, disability, sexual orientation, and gender identity.

''(2) The development and implementation of program-specific guidelines that interpret and apply Department of Health and Human Services guidance under title VI of the Civil Rights Act of 1964 and section 1557 of the Patient Protection and Affordable Care Act to each Federal health program administered by the agency.

''(3) The development of a disparity-reduction impact analysis methodology that shall be applied to

every rule issued by the agency and published as part of the formal rulemaking process under sections 555, 556, and 557 of title 5, United States Code.

''(4) Oversight of data collection, analysis, and publication requirements for all recipients of Federal financial assistance under each Federal health program administered by the agency; compliance with, at a minimum, the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity; and consideration of available data and language standards such as—

''(A) the standards for collecting and reporting data under section 3101; and

''(B) the National Standards on Culturally and Linguistically Appropriate Services of the Office of Minority Health within the Department of Health and Human Services.

''(5) The conduct of publicly available studies regarding discrimination within Federal health programs administered by the agency as well as disparity reduction initiatives by recipients of Federal financial assistance under Federal health programs.

''(6) Annual reports to the Committee on Health, Education, Labor, and Pensions and the

Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives on the progress in reducing disparities in health and health care through the Federal programs administered by the agency.

''(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS IN THE DEPARTMENT OF JUSTICE.—

''(1) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Office for Civil Rights in the Department of Health and Human Services shall provide standard-setting and compliance review investigation support services to the Civil Rights Compliance Office for each agency.

''(2) DEPARTMENT OF JUSTICE.—The Office for Civil Rights in the Department of Justice shall continue to maintain the power to institute formal proceedings when an agency Office for Civil Rights determines that a recipient of Federal financial assistance is not in compliance with the disparity reduction standards of the agency.

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

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

''(2) under this Act that provide Federal financial assistance for health care, biomedical research, health services research, and programs designed to improve the public's health, including health service programs.''.

SEC. 904. UNITED STATES COMMISSION ON CIVIL RIGHTS.

(a) COORDINATION WITHIN DEPARTMENT OF JUSTICE OF ACTIVITIES REGARDING HEALTH DISPARITIES.—Section 3(a) of the Civil Rights Commission Act of 1983 (42 U.S.C. 1975a(a)) is amended—

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

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

(3) by adding at the end the following:

''(3) shall, with respect to activities carried out in health care and correctional facilities toward the goal of eliminating health disparities between the general population and members of 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 2015, and such sums as may be necessary for each of the fiscal years 2016 through 2020.''.

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) Lesbian, gay, bisexual and transgender (LGBT) populations experience significant personal and structural barriers to obtaining high-quality health care.

(4) Efforts to improve minority health have been limited by inadequate resources (funding, staffing, and stewardship) and lack of accountability.

(b) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) funding should be doubled by fiscal year 2016 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 2016, and subsequent funding increases, should be provided for health and human service professions training programs, the Racial and Ethnic Approaches to Com-

munity Health (REACH) Initiative 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 fully restored to the Racial and Ethnic Approaches to Community Health (REACH) Initiative at the Centers for Disease Control and Prevention, which has been a successful program at the community health level, and efforts should continue to place a strong emphasis on building community capacity to secure financial resources and technical assistance to eliminate health disparities;

(4) adequate funding for fiscal year 2016 and increased funding for future years should be provided for the REACH Initiative's United States Risk Factor Survey to ensure adequate data collection to track health disparities, and there should be appropriate avenues provided to disseminate findings to the general public;

(5) 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 2016; and

(6) stewardship and accountability should be provided to the Congress and the President for measurable and sustainable progress toward health disparity elimination.

SEC. 906. GAO AND NIH REPORTS.

(a) GAO REPORT ON NIH GRANT RACIAL AND ETHNIC DIVERSITY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on the racial and ethnic diversity among the following groups:

(A) All applicants for grants, contracts, and cooperative agreements awarded by the National Institutes of Health during the period beginning on January 1, 1990, and ending December 31, 2013.

(B) All recipients of such grants, contracts, and cooperative agreements.

(C) All members of the peer review panels of such applicants and recipients, respectively.

(2) REPORT.—Not later than six months after the date of the enactment of this Act, the Comptroller General shall complete the study under para-

graph (1) and submit to Congress a report containing the results of such study.

(b) NIH REPORT ON CERTAIN AUTHORITY OF NATIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH DISPARITIES.—Not later than six months after the date of the enactment of this Act, and biennially thereafter, the Director of the National Institutes of Health, in collaboration with the Director of the National Institute on Minority Health and Health Disparities, shall submit to Congress a report that details and evaluates—

(1) the steps taken during the applicable report period by the Director of the National Institutes of Health to enforce the expanded planning, coordination, review, and evaluation authority provided the National Institute on Minority Health and Health Disparities under section 464z–3(h) of the Public Health Service Act (42 U.S.C. 285(h)), as added by section 10334(c) of the Patient Protection and Affordable Care Act, over all minority health and health disparity research that is conducted or supported by the Institutes and Centers at the National Institutes of Health; and

(2) the outcomes of such steps.

(c) GAO REPORT RELATED TO RECIPIENTS OF PPACA FUNDING.—Not later than one year after the

date of the enactment of this Act and biennially thereafter until 2024, 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. DEFINITIONS.

(a) DETERMINANTS OF HEALTH.—The term ''determinants of health''—

(1) refers to the range of personal, social, economic, and environmental factors that influence health status; and

(2) includes social determinants of health (which are sometimes referred to as ''social and economic determinants of health'' or ''socioeconomic de-

terminants of health''), environmental determinants of health, and personal determinants of health.

(b) ENVIRONMENTAL DETERMINANTS OF HEALTH.—The term ''environmental determinants of health'' refers to the broad physical, psychological, social, and aesthetic environment.

(c) PERSONAL DETERMINANTS OF HEALTH.—The term ''personal determinants of health'' refers to an individual's behavior, biology, and genetics.

(d) SOCIAL DETERMINANTS OF HEALTH .—The term ''social determinants of health'' refers to a subset of determinants of the health of individuals and environments (such as communities, neighborhoods, and societies) that describe people's social identity, describe the social and economic resources to which people have access, and describe the conditions in which people work, live, and play.

SEC. 1002. FINDINGS.

The Congress finds as follows:

(1) There are more opportunities to improve health for everyone when we understand that health starts, first, not in a medical setting, but in our families, in our schools and workplaces, in our neighborhoods, and in the air we breathe and water we drink.

(2) The social determinants of health are the largest predictors of health outcomes.

(3) Healthy People 2020 identifies health and health care quality as a function of not only access to health care, but also the social determinants of health, categorized into the following: neighborhoods and the built environment; social and community context; education; and economic stability. The following examples illustrate the nexus between the unequal distribution of the social determinants of health and health disparities:

(A) The built environment influences residents' level of physical activity. Neighborhoods with high levels of poverty are significantly less likely to have places where children can be physically active, such as parks, green spaces, and bike paths and lanes. Neighborhoods and communities can provide opportunities for physical activity and support active lifestyles through accessible and safe parks and open spaces and through land use policy, zoning, and healthy community design.

(B) Emotional and physical health and well-being are directly impacted by perceived levels of safety, such as unlit streets at night.

Community members have expressed that safety is not only a barrier to accessing programs and services that increase quality of life but they are also not able to access physical activity in their community through the built environment.

(C) In many workplace environments, toxic chemicals have lasting detrimental effects on employees' health. The hazardous compounds found in most nail salon products affect the respiratory system, reproductive system, and central nervous system, and also cause kidney and liver damage. Recognizing the importance of addressing occupational hazards as a matter of public health, especially for Asian-American women who constitute 40 percent of nail salon technicians—with Vietnamese-American women accounting for 37 percent of this—the White House Initiative on Asian American Pacific Islanders has created an interagency working group to coordinate efforts by the Environmental Protection Agency, Occupational and Safety Health Administration, Food and Drug Administration, and other Federal agencies to create programming, draft regulations, and con-

duct more outreach on educating workers on health and safety issues.

(D) Historical and institutional discrimination against certain racial groups in the United States has shaped the way in which social and economic resources and exposure to health promoting environments are distributed. Income, education, occupation, neighborhood conditions, schools, workplaces, the use of and health and social services, and experiences with the criminal justice system are all highly patterned by race, with racial minorities (compared to Whites) experiencing more that is health harming. Finding ways to uncouple the link between race and access to resources and healthy environments is a principal means of reducing health disparities. Additionally, the anticipation of racism itself causes higher psychological and cardiovascular stress levels that are linked to poor health outcomes. Remedying discriminatory practices at the individual and systemic levels will likely reduce health disparities caused by this unequal distribution of stress.

(E) Poor health among Native Americans has largely been driven by post-colonial oppres-

sion and historical trauma. The expropriation of native lands and territories to the American state had severe consequences on Native American health. This resulted in the deprivation of traditional food sources—and nutrients—for Native Americans and also the destruction of traditional economies and community organization. Today, Native Americans have twice the rate of diabetes than non-Hispanic Whites. Recognition of the origins of the diabetes as having a social and community context, rather than just individual responsibility and genetic predisposition, will shape better policy to provide food security.

(F) In the context of prisons, overcrowding has led to the deterioration of the physical and mental health of individuals after they leave prison. In particular, the mass incarceration of African-American males as a result of unequal contact with and treatment in the criminal justice system has contributed to an overburdening of certain infectious diseases within the African-American community. As a social institution, incarceration amplifies existing adverse health conditions by concentrating diseases and harm

health behaviors such as tobacco use, drug use, and violence.

(G) Educational attainment is the strongest predictor of adult mortality. It is a basic component of socioeconomic status by shaping earning potential to access resources that promote health. People with more education are less likely to report that they are in poor health, and are also less likely to have diabetes and other chronic diseases.

(H) Similarly, reading ability is a strong predictor of adult health status and is often correlated with other child health issues, such as developmental problems, vision and hearing impairments, and frequent school absence due to illness.

(I) Individuals with lower levels of educational attainment are much more likely to report to be current smokers. In 2011, smoking prevalence was 45.3 percent among adults with a GED diploma, 34.6 percent with nine to 11 years of education, and 23.8 percent with a high school diploma, while dropping significantly to 9.3 percent among adults with an un-

dergraduate college degree and 5.0 percent with a postgraduate college degree.

(J) Social class differences account for a large part of health disparities. For example, children living in poverty experience poorer housing conditions, increased exposure to indoor allergens and toxins (such as pesticides, lead, mercury, radon, air pollution, and carcinogens), and more psychological stress. These experiences culminate in worse adult health as compared with children with higher socioeconomic status. Specifically, children living in socioeconomic neighborhoods have higher rates of asthma due to higher rates of psychological stress resulting from higher rates of violence.

(K) Lesbian, gay, bisexual, and transgender (LGBT) individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights. Discrimination against LGBT individuals has been associated with high rates of psychiatric disorders, substance abuse, and suicide. Experiences of violence and victimization are frequent for LGBT individuals, and have long-lasting effects on the individual and the community. Per-

sonal, family, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBT individuals.

(4) Laws and regulations that improve opportunities to live in safe neighborhoods, with more social cohesion, attain higher education, sustain stable employment, and bridge class differences help foster the health and safety of individuals.

(5) The global public health community has reached consensus through the Rio Political Declaration of Social Determinants of Health that ''[c]ollaboration in coordinated and intersectoral policy actions has proven to be effective. Health in All Policies, together with intersectoral cooperation and action, is one promising approach to enhance accountability in other sectors of health, as well as the promotion of health equity and more inclusive and productive societies.''

SEC. 1003. HEALTH IMPACT ASSESSMENTS.

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

(1) Health Impact Assessment is a tool to help planners, health officials, decisionmakers, and the public make more informed decisions about the po-

tential health effects of proposed plans, policies, programs, and projects in order to maximize health benefits and minimize harms.

(2) Health Impact Assessments can be done at a fraction of the cost and time typically required for other planning and permitting reviews.

(3) Health Impact Assessments can build community support and reduce opposition to a project or policy, thereby facilitating economic growth by aiding the development of consensus regarding new development proposals.

(4) Health Impact Assessments facilitate collaboration across sectors.

(b) PURPOSES.—It is the purpose of this section to—

(1) provide more information about the potential human health effects of policy decisions and the distribution of those effects;

(2) improve how health is considered in planning and decisionmaking processes; and

(3) build stronger, healthier communities through the use of Health Impact Assessment.

(c) HEALTH IMPACT ASSESSMENTS.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended, is further amended by adding at the end the following:

"SEC. 399V–9. HEALTH IMPACT ASSESSMENTS.

''(a) DEFINITIONS.—In this section and section 399V–10:

''(1) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Environmental Protection Agency.

''(2) BUILT ENVIRONMENT.—The term 'built environment' means the components of the environment, and the location of these components in a geographically defined space, that are created or modified by individuals to form the physical and social characteristics of a community or enhance quality of human life, including—

''(A) homes, schools, and places of work and worship;

''(B) parks, recreation areas, and greenways;

''(C) transportation systems;

''(D) business, industry, and agriculture; and

''(E) land-use plans, projects, and policies that impact the physical or social characteristics of a community, including access to services and amenities.

''(3) DIRECTOR.—The term 'Director' means the Director of the Centers for Disease Control and Prevention.

''(4) ELIGIBLE ENTITY.—The term 'eligible entity' means a unit of State or tribal government the jurisdiction of which includes individuals or populations the health of which are, or will be, affected by an activity or a proposed activity.

''(5) ELIGIBLE INSTITUTION.—The term 'eligible institution' means a public agency or private nonprofit institution that submits to the Secretary, in consultation with the Administrator, an application for a grant authorized under such section at such time, in such manner, and containing such agreements, assurances, and information as the Secretary and Administrator may require.

''(6) HEALTH IMPACT ASSESSMENT.—The term 'Health Impact Assessment' means a systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a population and the distribution of those effects within the population. Such term includes identifying and recommending appropriate actions on monitoring

and maximizing potential benefits and minimizing the potential harms.

''(7) HEALTH DISPARITIES.—The term 'health disparities' are a particular type of health differences that are closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characterisitics historically linked to discrimination or exclusion.

''(8) PROPOSED ACTIVITY.—The term 'proposed activity' means a proposed policy, program, plan, or project currently under consideration by a local, State, tribal, or Federal agency or government.

''(b) ESTABLISHMENT.—The Secretary, acting through the Director and in collaboration with the Administrator, shall carry out the following:

''(1) Establish a program at the National Center for Environmental Health at the Centers for Disease Control and Prevention focused on advancing the field of Health Impact Assessment. In devel-

oping and implementing the program, the Director of the National Center for Environmental Health shall consult with the Director of the National Center for Chronic Disease Prevention and Health Promotion as well as relevant offices within the Department of Housing and Urban Development, the Department of Transportation, and the Department of Agriculture. The program shall include—

''(A) collecting and disseminating best practices;

''(B) administering capacity building grants to States to support grantees in initiating Health Impact Assessments, in accordance with subsection (d);

''(C) providing technical assistance;

''(D) developing training tools and providing training on conducting Health Impact Assessment and the implementation of built environment and health indicators;

''(E) making information available, as appropriate, regarding the existence of other community healthy living tools, checklists, and indices that help connect public health to other sectors, and tools to help examine the effect of the

indoor built environment and building codes on population health;

"(F) conducting research and evaluations of Health Impact Assessments; and

"(G) awarding competitive extramural research grants.

"(2) In accordance with subsection (c), develop guidance and guidelines to conduct Health Impact Assessments.

"(3) In accordance with subsection (d), establish a grant program to allow States to fund eligible entities to conduct Health Impact Assessments.

"(c) GUIDANCE.—The Director, in consultation with the Director of the National Center for Environmental Health and, the Director of the National Center for Chronic Disease Prevention and Health Promotion, and relevant offices within the Department of Housing and Urban Development, the Department of Transportation, and the Department of Agriculture, shall—

"(1) develop guidance for conducting Health Impact Assessment, including—

"(A) background on national and international efforts to bridge urban planning and public health institutions and disciplines, in-

cluding a review of Health Impact Assessment best practices internationally;

''(B) evidence-based direct and indirect pathways that link land-use planning, transportation, and housing policy and objectives to human health outcomes;

''(C) data resources and quantitative and qualitative forecasting methods to evaluate both the status of health determinants and health effects, including identification of existing programs that can disseminate these resources;

''(D) best practices for inclusive public involvement in conducting Health Impact Assessments; and

''(E) technical assistance for other agencies seeking to develop their own guidelines and procedures for Health Impact Assessment;

''(2) in developing the guidance, consider available international Health Impact Assessment guidance, North American Health Impact Assessment Practice Standards, and recommendations from the National Academy of Science; and

''(3) not later than 1 year after the date of enactment of this section, publish the guidance.

''(d) GRANT PROGRAM.—The Secretary, acting through the Director and in collaboration with the Administrator, shall establish a program under which the Secretary shall award grants to States to fund eligible entities for capacity building or to prepare Health Impact Assessments, and shall ensure that States receiving a grant under this subsection further support training and technical assistance for grantees under the program by funding and overseeing appropriate local, State, tribal, Federal, university, or nonprofit Health Impact Assessment experts to provide technical assistance. Such assessments shall—

''(1) ensure that appropriate health factors are taken into consideration as early as practicable during the planning, review, or decisionmaking processes;

''(2) assess the effect on the health of individuals and populations of proposed policies, projects, or plans that result in modifications to the built environment; and

''(3) assess the distribution of health effects across various factors, such as race, income, ethnicity, age, disability status, gender, and geography.

''(e) APPLICATIONS.—

''(1) IN GENERAL.—To be eligible to receive a grant under this section, an eligible entity shall submit to the Secretary an application in accordance with this subsection, at such time, in such manner, and containing such additional information as the Secretary may require.

''(2) INCLUSION.—An application under this subsection shall include a list of proposed activities that require or would benefit from conducting a Health Impact Assessment within six months of awarding funds. The list should be accompanied by supporting documentation, including letters of support, from potential conductors of Health Impact Assessments for the listed proposed activities. Each application should also include an assessment by the eligible entity of the health of the population of its jurisdiction and describe potential adverse or positive effects on health that the proposed activities may create.

''(3) PREFERENCE.—Preference in awarding funds under this section may be given to eligible entities that demonstrate the potential to significantly improve population health or lower health care costs as a result of potential Health Impact Assessment work.

''(f) USE OF FUNDS.—

''(1) IN GENERAL.—An eligible entity shall use amounts provided under a grant under this section to conduct Health Impact Assessment capacity building or to conduct or fund subgrantees to conduct a Health Impact Assessment for a proposed activity in accordance with this subsection.

''(2) PURPOSES.—The purposes of a Health Impact Assessment under this subsection are—

''(A) to facilitate the involvement of tribal, State, and local public health officials in community planning, transportation, housing, and land use decisions and other decisions affecting the built environment to identify any potential health concern or health benefit relating to an activity or proposed activity;

''(B) to provide for an investigation of any health-related issue of concern raised in a planning process, an environmental impact assessment process, or policy appraisal relating to a proposed activity;

''(C) to describe and compare alternatives (including no-action alternatives) to a proposed activity to provide clarification with respect to the potential health outcomes associated with

the proposed activity and, where appropriate, to the related benefit-cost or cost-effectiveness of the proposed activity and alternatives;

''(D) to contribute, when applicable, to the findings of a planning process, policy appraisal, or an environmental impact statement with respect to the terms and conditions of implementing a proposed activity or related mitigation recommendations, as necessary;

''(E) to ensure that the disproportionate distribution of negative impacts among vulnerable populations is minimized as much as possible;

''(F) to engage affected community members and ensure adequate opportunity for public comment on all stages of the Health Impact Assessment; and

''(G) where appropriate, to consult with local and county health departments and appropriate organizations, including planning, transportation, and housing organizations and providing them with information and tools regarding how to conduct and integrate Health Impact Assessment into their work.

''(3) ELIGIBLE ACTIVITIES.—

''(A) IN GENERAL.—Eligible entities funded under this subsection shall conduct an evaluation of any proposed activity to determine whether it will have a significant adverse or positive effect on the health of the affected population in the jurisdiction of the eligible entity, based on the criteria described in subparagraph (B).

''(B) CRITERIA.—The criteria described in this subparagraph include, as applicable to the proposed activity, the following:

''(i) Any substantial adverse effect or significant health benefit on health outcomes or factors known to influence health, including the following:

''(I) Physical activity.

''(II) Injury.

''(III) Mental health.

''(IV) Accessibility to health-promoting goods and services.

''(V) Respiratory health.

''(VI) Chronic disease.

''(VII) Nutrition.

''(VIII) Land use changes that promote local, sustainable food sources.

''(IX) Infectious disease.

''(X) Health disparities.

''(XI) Existing air quality, ground or surface water quality or quantity, or noise levels; and

''(ii) Other factors that may be considered, including—

''(I) the potential for a proposed activity to result in systems failure that leads to a public health emergency;

''(II) the probability that the proposed activity will result in a significant increase in tourism, economic development, or employment in the jurisdiction of the eligible entity;

''(III) any other significant potential hazard or enhancement to human health, as determined by the eligible entity; or

''(IV) whether the evaluation of a proposed activity would duplicate an-

other analysis or study being undertaken in conjunction with the proposed activity.

''(C) FACTORS FOR CONSIDERATION.—In evaluating a proposed activity under subparagraph (A), an eligible entity may take into consideration any reasonable, direct, indirect, or cumulative effect that can be clearly related to potential health effects and that is related to the proposed activity, including the effect of any action that is—

''(i) included in the long-range plan relating to the proposed activity;

''(ii) likely to be carried out in coordination with the proposed activity;

''(iii) dependent on the occurrence of the proposed activity; or

''(iv) likely to have a disproportionate impact on high-risk or vulnerable populations.

''(4) REQUIREMENTS.—A Health Impact Assessment prepared with funds awarded under this subsection shall incorporate the following, after conducting the screening phase (identifying projects or policies for which a Health Impact Assessment

would be valuable and feasible) through the application process:

"(A) SCOPING.—Identifying which health effects to consider and the research methods to be utilized.

"(B) ASSESSING RISKS AND BENEFITS.—Assessing the baseline health status and factors known to influence the health status in the affected community, which may include aggregating and synthesizing existing health assessment evidence and data from the community.

"(C) DEVELOPING RECOMMENDATIONS.—Suggesting changes to proposals to promote positive or mitigate adverse health effects.

"(D) REPORTING.—Synthesizing the assessment and recommendations and communicating the results to decisionmakers.

"(E) MONITORING AND EVALUATING.—Tracking the decision and implementation effect on health determinants and health status.

"(5) PLAN.—An eligible entity that is awarded a grant under this section shall develop and implement a plan, to be approved by the Director, for meaningful and inclusive stakeholder involvement in all phases of the Health Impact Assessment. Stake-

holders may include community-based organizations, youth-serving organizations, planners, public health experts, State and local public health departments and officials, health care experts or officials, housing experts or officials, and transportation experts or officials.

''(6) SUBMISSION OF FINDINGS.—An eligible entity that is awarded a grant under this section shall submit the findings of any funded Health Impact Assessment activities to the Secretary and make these findings publicly available.

''(7) ASSESSMENT OF IMPACTS.—An eligible entity that is awarded a grant under this section shall ensure the assessment of the distribution of health impacts (related to the proposed activity) across race, ethnicity, income, age, gender, disability status, and geography.

''(8) CONDUCT OF ASSESSMENT.—To the greatest extent feasible, a Health Impact Assessment shall be conducted under this section in a manner that respects the needs and timing of the decision-making process it evaluates.

''(9) METHODOLOGY.—In preparing a Health Impact Assessment under this subsection, an eligible

entity or partner shall follow the guidance published under subsection (c).

''(g) HEALTH IMPACT ASSESSMENT DATABASE.—The Secretary, acting through the Director and in collaboration with the Administrator, shall establish, maintain, and make publicly available a Health Impact Assessment database, including—

''(1) a catalog of Health Impact Assessments received under this section;

''(2) an inventory of tools used by eligible entities to conduct Health Impact Assessments; and

''(3) guidance for eligible entities with respect to the selection of appropriate tools described in paragraph (2).

''(h) EVALUATION OF GRANTEE ACTIVITIES.—The Secretary shall award competitive grants to Prevention Research Centers, or nonprofit organizations or academic institutions with expertise in Health Impact Assessments to—

''(1) assist grantees with the provision of training and technical assistance in the conducting of Health Impact Assessments;

''(2) evaluate the activities carried out with grants under subsection (d); and

''(3) assist the Secretary in disseminating evidence, best practices, and lessons learned from grantees.

''(i) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of this section, the Secretary shall submit to Congress a report concerning the evaluation of the programs under this section, including recommendations as to how lessons learned from such programs can be incorporated into future guidance documents developed and provided by the Secretary and other Federal agencies, as appropriate.

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

''SEC. 399V–10. ADDITIONAL RESEARCH ON THE RELATIONSHIP BETWEEN THE BUILT ENVIRONMENT AND HEALTH OUTCOMES.

''(a) RESEARCH GRANT PROGRAM.—

''(1) GRANTS.—The Secretary, in collaboration with the Administrator, shall award grants to eligible institutions to conduct and coordinate research on the built environment and its influence on human health. Factors that influence health that may be considered include—

''(A) levels of physical activity;

''(B) consumption of nutritional foods;

''(C) rates of crime;

''(D) air, water, and soil quality;

''(E) risk or rate of injury;

''(F) accessibility to health-promoting goods and services;

''(G) chronic disease rates;

''(H) community design;

''(I) housing; and

''(J) other indicators as determined appropriate by the Secretary.

''(2) RESEARCH.—The Secretary, in consultation with the Administrator, shall support research under this section that—

''(A) investigates and defines links between the built environment and human health and identifies causal relationships;

''(B) examines—

''(i) the scope and intensity of the impact that the built environment (including the various characteristics of the built environment) has on the human health; or

''(ii) the distribution of such impacts by—

''(I) location; and

"(II) population subgroup;

"(C) is used to develop—

"(i) measures and indicators to address health impacts and the connection of health to the built environment;

"(ii) efforts to link the measures to transportation, land use, and health databases; and

"(iii) efforts to enhance the collection of built environment surveillance data;

"(D) distinguishes carefully between personal attitudes and choices and external influences on behavior to determine how much the association between the built environment and the health of residents, versus the lifestyle preferences of the people that choose to live in the neighborhood, reflects the physical characteristics of the neighborhood; and

"(E)(i) identifies or develops effective intervention strategies focusing on enhancements to the built environment that promote increased use physical activity, access to nutritious foods, or other health-promoting activities by residents; and

"(ii) in developing the intervention strategies under clause (i), ensures that the intervention strategies will reach out to high-risk or vulnerable populations, including low-income urban and rural communities and aging populations, in addition to the general population.

"(3) SURVEYS.—The Secretary may use funds appropriated under this section to support the expansion of national surveys and data tracking systems to provide more detailed information about the connection between the built environment and health.

"(4) PRIORITY.—In providing assistance under the grant program under this section, the Secretary and the Administrator shall give priority to research that incorporates—

"(A) interdisciplinary approaches; or

"(B) the expertise of the public health, physical activity, urban planning, land use, and transportation research communities in the United States and abroad.

"(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section. Not to exceed 20 percent of amounts appropriated for each fiscal year under

this subsection may be used for the research component of the program under this section.''.

SEC. 1004. 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 help them identify potential environmental justice problems and involving environ-

mental 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 timeframes 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 put into operation environmental justice in the Agency's daily activities.

(3) The recommendation that the Agency ensure the comprehensive training program currently under development includes standard and consistent definitions of the key environmental justice concepts (such as ''low-income'', ''minority'', and ''disproportionately impacted'') and instructions for implementation of those concepts.

The Administrator shall submit an initial report to Congress within 6 months after the enactment of this Act regarding the Administrator's strategy for implementing the recommendations referred to in paragraphs (1), (2), and (3). Thereafter, the Administrator shall provide semiannual reports to Congress regarding the Administrator's progress in implementing such recommendations and modifying the Administrator's emergency management

procedures to incorporate environmental justice in the Agency's Incident Command Structure (in accordance with the December 18, 2006, letter from the Deputy Administrator to the Acting Inspector General of the Agency).

(d) FEDERAL ACTION PLAN FOR SAVING LIVES, PROTECTING PEOPLE AND THEIR FAMILIES FROM RADON.—

(1) IN GENERAL.—Because radon is a naturally occurring radioactive gas that is recognized as the leading cause of lung cancer among nonsmokers and is a particular environmental threat for low-income and minority individuals because of the lack of information about radon levels in their own homes, the Administrator of the Environmental Protection Agency shall within 6 months after the date of the enactment of this Act, implement the action plan entitled ''Protecting People and Families from Radon: A Federal Action Plan for Saving Lives'' (June 20, 2011), working with the Secretary of Health and Human Services acting through the Director of the Centers for Disease Control and Prevention, and with the other Federal agencies mentioned in and as set forth in the action plan.

(2) SPECIFIC STEPS.—In carrying out paragraph (1), the Administrator shall take steps to achieve each of the following:

(A) The recommendation that the workgroup comprised of the Federal agencies participating in the development of the action plan referred to in paragraph (1) implement specific steps within the current authority and activities of each Federal agency to reduce exposure to radon.

(B) The recommendation that such workgroup meet on the 1-year anniversary of the plan to assess and recognize achievements of the plan.

(3) REPORT.—The Administrator shall report to the Congress on the 1-year assessment of the plan's implementation, including the challenges remaining and the progress in reducing radon exposure particularly to low-income and minority families.

SEC. 1005. GRANT PROGRAM TO CONDUCT ENVIRONMENTAL HEALTH IMPROVEMENT ACTIVITIES AND TO IMPROVE SOCIAL DETERMINANTS OF HEALTH.

(a) DEFINITIONS.—In this section:

(1) DIRECTOR.—The term ''Director'' means the Director of the Centers for Disease Control and Prevention, acting in collaboration with the Administrator of the Environmental Protection Agency and the Director of the National Institute of Environmental Health Sciences.

(2) ELIGIBLE ENTITY.—The term ''eligible entity'' means a State or local community that—

(A) bears a disproportionate burden of exposure to environmental health hazards;

(B) bears a disproportionate burden of exposure to unhealthy living conditions, low standard housing conditions, low socioeconomic status, poor nutrition, less opportunity for educational attainment, disproportionate unemployment rates, or lower literacy levels;

(C) has established a coalition—

(i) with not less than 1 community-based organization or demonstration program; and

(ii) with not less than 1—

(I) public health entity;

(II) health care provider organization;

(III) academic institution, including any minority-serving institution (including a Hispanic-serving institution, a historically Black college or university, and a tribal college or university); or

(IV) child-serving institution;

(D) ensures planned activities and funding streams are coordinated to improve community health; and

(E) submits an application in accordance with subsection (c).

(b) ESTABLISHMENT.—The Director shall establish a grant program under which eligible entities shall receive grants to conduct environmental health improvement activities and to improve social determinants of health.

(c) APPLICATION.—To receive a grant under this section, an eligible entity shall submit an application to the Director at such time, in such manner, and accompanied by such information as the Director may require.

(d) COOPERATIVE AGREEMENTS.—An eligible entity may use a grant under this section—

(1) to promote environmental health;

(2) to address environmental health disparities among all populations, including children; and

(3) to address racial and ethnic disparities in social determinants of health.

(e) AMOUNT OF COOPERATIVE AGREEMENT.—

(1) IN GENERAL.—The Director shall award grants to eligible entities at the 3 different funding levels described in this subsection.

(2) LEVEL 1 COOPERATIVE AGREEMENTS.—

(A) IN GENERAL.—An eligible entity awarded a grant under this paragraph shall use the funds to identify environmental health problems and solutions by—

(i) establishing a planning and prioritizing council in accordance with subparagraph (B); and

(ii) conducting an environmental health assessment in accordance with subparagraph (C).

(B) PLANNING AND PRIORITIZING COUNCIL.—

(i) IN GENERAL.—A prioritizing and planning council established under subparagraph (A)(i) (referred to in this paragraph as a ''PPC'') shall assist the environmental health assessment process and

environmental health promotion activities of the eligible entity.

(ii) MEMBERSHIP.—Membership of a PPC shall consist of representatives from various organizations within public health, planning, development, and environmental services and shall include stakeholders from vulnerable groups such as children, the elderly, disabled, and minority ethnic groups that are often not actively involved in democratic or decisionmaking processes.

(iii) DUTIES.—A PPC shall—

(I) identify key stakeholders and engage and coordinate potential partners in the planning process;

(II) establish a formal advisory group to plan for the establishment of services;

(III) conduct an in-depth review of the nature and extent of the need for an environmental health assessment, including a local epidemiological profile, an evaluation of the service provider capacity of the community,

and a profile of any target populations; and

(IV) define the components of care and form essential programmatic linkages with related providers in the community.

(C) ENVIRONMENTAL HEALTH ASSESSMENT.—

(i) IN GENERAL.—A PPC shall carry out an environmental health assessment to identify environmental health concerns.

(ii) ASSESSMENT PROCESS.—The PPC shall—

(I) define the goals of the assessment;

(II) generate the environmental health issue list;

(III) analyze issues with a systems framework;

(IV) develop appropriate community environmental health indicators;

(V) rank the environmental health issues;

(VI) set priorities for action;

(VII) develop an action plan;

(VIII) implement the plan; and

(IX) evaluate progress and planning for the future.

(D) EVALUATION.—Each eligible entity that receives a grant under this paragraph shall evaluate, report, and disseminate program findings and outcomes.

(E) TECHNICAL ASSISTANCE.—The Director may provide such technical and other nonfinancial assistance to eligible entities as the Director determines to be necessary.

(3) LEVEL 2 COOPERATIVE AGREEMENTS.—

(A) ELIGIBILITY.—

(i) IN GENERAL.—The Director shall award grants under this paragraph to eligible entities that have already—

(I) established broad-based collaborative partnerships; and

(II) completed environmental assessments.

(ii) NO LEVEL 1 REQUIREMENT.—To be eligible to receive a grant under this paragraph, an eligible entity is not required to have successfully completed a

Level 1 Cooperative Agreement (as described in paragraph (2)).

(B) USE OF GRANT FUNDS.—An eligible entity awarded a grant under this paragraph shall use the funds to further activities to carry out environmental health improvement activities, including—

(i) addressing community environmental health priorities in accordance with paragraph (2)(C)(ii), including—

(I) geography;

(II) the built environment;

(III) air quality;

(IV) water quality;

(V) land use;

(VI) solid waste;

(VII) housing;

(VIII) crime;

(IX) socioeconomic status;

(X) ethnicity, social construct and language preference;

(XI) educational attainment;

(XII) employment;

(XIII) food safety;

(XIV) nutrition;

(XV) health care services; and

(XVI) injuries;

(ii) building partnerships between planning, public health, and other sectors, including child-serving institutions, to address how the built environment impacts food availability and access and physical activity to promote healthy behaviors and lifestyles and reduce overweight and obesity, musculoskeletal diseases, respiratory conditions, dental, oral and mental health conditions, poverty, and related comorbidities;

(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, lower limb prostheses, and hip,

knee, and other joint replacements; and

(iv) convening intervention and demonstration programs that examine the role of the social environment in connection with the physical and chemical environment in—

(I) determining access to nutritional food; and

(II) improving physical activity to reduce overweight, obesity, and comorbidities and increase quality of life.

(4) LEVEL 3 COOPERATIVE AGREEMENTS.—

(A) IN GENERAL.—An eligible entity awarded a grant under this paragraph shall use the funds to identify and address racial and ethnic disparities in social determinants of health by creating demonstration programs that assess the feasibility of establishing a federally funded comprehensive program and describe key outcomes that address racial and ethnic disparities in social determinants of health.

(B) PROGRAM DESIGN.—

(i) EVALUATION.—No later than 1 year after enactment of this Act, the Director shall evaluate the best practices of existing programs from the private, public, community based, and academically supported initiatives focused on reducing disparities in the social determinants of health for racial and ethnic populations.

(ii) DEMONSTRATION PROJECTS.—Not later than two years after the date of enactment of this Act, the Director shall implement at least ten demonstration projects including at least one project for each major racial and ethnic minority group, each of which is unique to the cultural and linguistic needs of each of the following groups:

(I) Native Americans and Alaska Natives.

(II) Asian-Americans.

(III) African-Americans/Blacks.

(IV) Hispanic/Latino-Americans.

(V) Native Hawaiians and Pacific Islanders.

(iii) REPORT TO CONGRESS.—No later than 2 years after the implementation of the initial demonstration projects, the Director shall submit to Congress a report which includes—

(I) a description of each demonstration project and design;

(II) an evaluation of the cost effectiveness of each project's prevention and treatment efforts;

(III) an evaluation of the cultural and linguistic appropriateness of each project by racial and ethnic group; and

(IV) an evaluation of the beneficiary's health status improvement under the demonstration project.

(iv) ANY OTHER INFORMATION DEEMED APPROPRIATE BY THE DIRECTOR.—The Director shall require any other information deemed appropriate to be shared by or developed by eligible entities awarded a grant under this paragraph, including the following:

(I) Developing models and evaluating methods that improve the cultural and linguistically appropriate services provided through the Centers for Disease Control and Prevention to target individuals impacted by health disparities based on their race, ethnicity, and gender.

(II) Promoting the collaboration between primary and specialty care health care providers and patients, to ensure patients impacted by health disparities based on race, ethnicity, and gender are receiving comprehensive and organized treatment and care.

(III) Educating health care professionals on the causes and effects of disparities in the social determinants of health as it relates to minority and racial and ethnic communities and the need for culturally and linguistically appropriate care in the prevention and treatment of high-impact diseases.

(IV) Encouraging collaboration among community and patient-based organizations which work to address disparities in the social determinants of health as it relates to high-impact diseases in minority and racial and ethnic populations.

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

(1) $25,000,000 for fiscal year 2015; and

(2) such sums as may be necessary for fiscal years 2016 through 2018.

SEC. 1006. ADDITIONAL RESEARCH ON THE RELATIONSHIP BETWEEN THE BUILT ENVIRONMENT AND THE HEALTH OF COMMUNITY RESIDENTS.

(a) DEFINITION OF ELIGIBLE INSTITUTION.—In this section, the term ''eligible institution'' means a public or private nonprofit institution that submits to the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') and the Administrator of the Environmental Protection Agency (in this section referred to as the ''Administrator'') an application for a grant under the grant program authorized under subsection (b)(2) at such time, in such manner, and containing such agree-

ments, assurances, and information as the Secretary and Administrator may require.

(b) RESEARCH GRANT PROGRAM.—

(1) DEFINITION OF HEALTH.—In this section, the term ''health'' includes—

(A) levels of physical activity;

(B) degree of mobility due to factors such as musculoskeletal diseases, arthritis, and obesity;

(C) consumption of nutritional foods;

(D) rates of crime;

(E) air, water, and soil quality;

(F) risk of injury;

(G) accessibility to health care services;

(H) levels of educational attainment; and

(I) other indicators as determined appropriate by the Secretary.

(2) GRANTS.—The Secretary, in collaboration with the Administrator, shall provide grants to eligible institutions to conduct and coordinate research on the built environment and its influence on individual and population-based health.

(3) RESEARCH.—The Secretary shall support research that—

(A) investigates and defines the causal links between all aspects of the built environment and the health of residents;

(B) examines—

(i) the extent of the impact of the built environment (including the various characteristics of the built environment) on the health of residents;

(ii) the variance in the health of residents by—

(I) location (such as inner cities, inner suburbs, and outer suburbs); and

(II) population subgroup (including children, the elderly, the disadvantaged); or

(iii) the importance of the built environment to the total health of residents, which is the primary variable of interest from a public health perspective;

(C) is used to develop—

(i) measures to address health and the connection of health to the built environment; and

(ii) efforts to link the measures to travel and health databases; 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, low-income urban and rural communities, and children.

(4) PRIORITY.—In providing assistance under the grant program authorized under paragraph (2),

the Secretary and the Administrator shall give priority to research that incorporates—

(A) minority-serving institutions as grantees;

(B) interdisciplinary approaches; or

(C) the expertise of the public health, physical activity, nutrition and health care (including child health), urban planning, and transportation research communities in the United States and abroad.

SEC. 1007. ENVIRONMENT AND PUBLIC HEALTH RESTORATION.

(a) FINDINGS.—

(1) GENERAL FINDINGS.—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 environment for the benefit of public health, to maintain air quality and water quality, to sustain wildlife, and to protect the environment.

(F) Such laws include the Antiquities Act of 1906 (16 U.S.C. 431 et seq.) initiated by President Theodore Roosevelt to create the national park system, the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.), the Clean Air Act (42 U.S.C. 7401 et seq.), the Federal Water Pollution Control Act (33 U.S.C.

1251 et seq.), the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (Public Law 96–510), the Endangered Species Act of 1973 (Public Law 93–205), and the National Forest Management Act of 1976 (Public Law 94–588).

(G) Attempts to repeal or weaken key environmental safeguards pose dangers to the 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 impacted or will negatively impact the environment and public health:

(A) CLEAN WATER.—

(i) On May 9, 2002, the Environmental Protection Agency (EPA) and the Army Corps of Engineers put forth a final rule that reconciled regulations implementing section 404 of the Federal Water Pollution Control Act by redefining the term ''fill material'' and amending the definition of the term ''discharge of fill mate-

rial'', reversing a 25-year-old regulation. The new rule fails to restrict the dumping of hardrock mining waste, construction debris, and other industrial wastes into rivers, streams, lakes, and wetlands. The rule further allows destructive mountaintop removal coal mining companies to dump waste into streams and lakes, polluting the surrounding natural habitat and poisoning plants and animals that depend on those water sources.

(ii) On February 12, 2003, the Environmental Protection Agency published the rule ''National Pollutant Discharge Elimination System Permit Regulation and Effluent Limitation Guidelines and Standards for Concentrated Animal Feeding Operations'', new livestock waste regulations that aimed to control factory farm pollution but which would severely undermine existing protections under the Federal Water Pollution Control Act. This regulation allows large-scale animal factories to foul the Nation's waters with animal waste, allows livestock owners to draft

their own pollution-management plans and avoid ground water monitoring, legalizes the discharge of contaminated runoff water rich in nitrogen, phosphorus, bacteria, and metals, and ensures that large factory farms are not held liable for the environmental damage they cause. In a 2005 Federal court decision (''Waterkeeper Alliance, et al. v. 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 max-

imum 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 cleanup plans and is allowing States to avoid cleaning polluted waters entirely by dropping them from their cleanup 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 Ju-

risdiction Following the U.S. Supreme Court's Decision in Rapanos v. United States & Carabell v. United States''. This new guidance dictates enforcement actions under the Federal Water Pollution Control Act and calls for a complicated ''case-by-case'' analysis to determine jurisdiction for waterways that do not flow all year. Such actions endanger small streams and wetlands that serve as important habitats for aquatic life, which play a fundamental role in safeguarding sources of clean drinking water and mitigate the risks and effects of floods and droughts. Further, the definition provided therein for ''waters of the United States'' is applicable to the Federal Water Pollution Control Act as a whole, potentially affecting programs that control industrial pollution and sewage levels, prevent oil spills, and set water quality standards for all waters in the United States protected under the Federal Water Pollution Control Act.

(B) FORESTS AND LAND MANAGEMENT.—

(i) On December 3, 2003, the President signed into law the Healthy Forests Restoration Act of 2003 (Public Law 108–148; 16 U.S.C. 6501 et seq.). Although the law attempts to reduce the risk of catastrophic forest fires, it provides a boon to timber companies by accelerating the aggressive thinning of backcountry forests that are far from at-risk communities. The law allows for increased logging of large, fire-resistant trees that are not in close proximity of homes and communities; it undermines critical protections for endangered species by exempting Federal land management agencies from consulting with the United States Fish and Wildlife Service before approving any action that could harm endangered plants or wildlife; and it limits public participation by reducing the number of environmental project reviews.

(ii) On April 21, 2008, the Department of Agriculture issued a Final Planning Rule and Record of Decision for National Forest System Land Management Planning. Similar to rules enacted by the

Administration on January 5, 2005, later remanded back to the agency in Federal district court for violating the National Environmental Policy Act of 1969, the Endangered Species Act of 1973, and the Administrative Procedure Act (''Citizens for Better Forestry v. United States Department of Agriculture'', 481 F. Supp. 2d 1059 (N.D. Cal. 2007)), this revised rule eliminates strict forest planning standards established in 1982, and opens millions of acres of public lands to damaging and invasive logging, mining, and drilling operations. These regulations would reverse more than 20 years of protection for wildlife and national forests by removing the overall goal of ensuring ecological sustainability in managing the national forest system, weakening the National Forest Management Act of 1976, and effectively ending the review of forest management plans under the National Environmental Policy Act of 1969.

(iii) On September 20, 2006, the District Court for the Northern District of

California vacated the Protection of Inventoried Roadless Areas rule, enacted on May 13, 2005, which gave State Governors 18 months to petition the Federal Government to either restore the previous rule for their States, or submit a new management and development plan for national forest areas inventoried under the rule. Despite the enjoinment of the Administration's 2005 rule, and the subsequent restoration of the original Roadless Area Conservation Rule, the United States Forest Service has continued to allow States to petition for a special rule under the authority of the Administrative Procedure Act, publishing a final special rule for Idaho on October 16, 2008. As a result, 58.5 million acres of wild national forests are still vulnerable to logging, road building, and other developments that may fragment natural habitats and negatively impact fish and wildlife.

(iv) On November 17, 2008, the Department of the Interior's Bureau of Land Management (BLM) signed the Record of Decision (ROD) amending 12 resource

management plans in Colorado, Utah, and Wyoming, opening 2,000,000 acres of public lands to commercial tar sands and oil shale exploration and development. On November 18, 2008, the BLM published a final rule for Oil Shale Management setting the policies and procedures for a commercial leasing program for the management of federally owned oil shale in those three States. Previously barred by a congressional moratorium on the commercial leasing regulations for oil shale until September 30, 2008, the development of oil shale on public lands poses a serious threat to land conservation, endangered and threatened species, and critical habitat. Domestic shale oil production allowed by these regulations is highly water and energy intensive, the impacts of which will intensify existing water scarcity in the arid Western Region and potentially degrade air and water quality for surrounding populations.

(C) SCIENTIFIC REVIEW.—On December 16, 2008, the United States Fish and Wildlife

Service of the Department of the Interior and the National Oceanic and Atmospheric Administration of the Department of Commerce jointly issued a new rule amending regulations governing interagency cooperation under section 7 of the Endangered Species Act of 1973 (ESA). This rule undermines the intention of the ESA to protect species and the ecosystems upon which they depend by allowing Federal agencies to carry out, permit, or fund an action without proper environmental review and expert third-party consultation from Federal wildlife experts. Under this new rule, Federal agencies can unilaterally circumvent the formal review process, eliminating longstanding and scientifically grounded safeguards that serve to protect the biodiversity of our Nation's ecosystems and avert harm to thousands of endangered and threatened species.

(b) STATEMENT OF POLICY.—It is the policy of the United States Government to work in conjunction with States, territories, tribal governments, international organizations, and foreign governments in order to act as a steward of the environment for the benefit of public health, to maintain air quality and water quality, to sus-

tain 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 Fed. Reg. 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 Fed. Reg. 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 Fed. Reg. 13608) withdrawing a July 13, 2000, rule revising the Total Maximum Daily Load program of the Federal Water Pollution Control Act (65 Fed. Reg. 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 Fed. Reg. 21468), replacing the 2005 final rule (70 Fed. Reg. 1022, Jan. 5, 2005), as amended March 3, 2006 (71 Fed. Reg. 10837) and the 2000 final rule adopted on November 9, 2000 (65 Fed. Reg. 67514) as amended on September 29, 2004 (69 Fed. Reg. 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 Fed. Reg. 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. 1008. GAO REPORT ON HEALTH EFFECTS OF DEEPWATER HORIZON OIL RIG EXPLOSION IN THE GULF COAST.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the type and scope of health care services administered through the Department of Health and Human Services addressing the provision of health care to racial and ethnic minorities (whether residents, cleanup workers, or volunteers) affected by the explosion of the mobile offshore drilling unit Deepwater Horizon that occurred on April 20, 2010.

(b) SPECIFIC COMPONENTS; REPORTING.—In carrying out subsection (a), the Comptroller General shall—

(1) assess the type, size, and scope of programs administered by the Department of Health and Human Services that focus on provision of health care to communities in the Gulf Coast;

(2) identify the merits and disadvantages associated with each the programs;

(3) perform an analysis of the costs and benefits of the programs;

(4) determine whether there is any duplication of programs; and

(5) not later than 180 days after the date of the enactment of this Act, report findings and recommendations for improving access to health care for racial and ethnic minorities to the Congress.

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