

117TH CONGRESS
2D SESSION

S. _____

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

IN THE SENATE OF THE UNITED STATES

Mr. BOOKER (for himself and Mr. WARNOCK) introduced the following bill;
which was read twice and referred to the Committee on

A BILL

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

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Health Equity and
5 Accountability Act of 2022”.

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

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

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

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- Sec. 1001. Strengthening data collection, improving data analysis, and expanding data reporting.
- Sec. 1002. Elimination of prerequisite of direct appropriations for data collection and analysis.
- Sec. 1003. Collection of data for the Medicare program.
- Sec. 1004. Revision of HIPAA claims standards.
- Sec. 1005. National Center for Health Statistics.
- Sec. 1006. Disparities data collected by the Federal Government.
- Sec. 1007. Data collection and analysis grants to minority-serving institutions.
- Sec. 1008. Safety and effectiveness of drugs with respect to racial and ethnic background.
- Sec. 1009. Improving health data regarding Native Hawaiians and Pacific Islanders.
- Sec. 1010. Clarification of simplified administrative reporting requirement.
- Sec. 1011. Data collection regarding pandemic preparedness, testing, infections, and deaths.
- Sec. 1012. Commission on Ensuring Data for Health Equity.
- Sec. 1013. Task Force on Preventing Bias in AI and Algorithms.

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- Sec. 2001. Definitions; findings.
- Sec. 2002. Improving access to services for individuals with limited English proficiency.
- Sec. 2003. Ensuring standards for culturally and linguistically appropriate services in health care.
- Sec. 2004. Culturally and linguistically appropriate health care in the Public Health Service Act.
- Sec. 2005. Pilot program for improvement and development of State medical interpreting services.
- Sec. 2006. Training tomorrow's doctors for culturally and linguistically appropriate care: graduate medical education.
- Sec. 2007. Federal reimbursement for culturally and linguistically appropriate services under the Medicare, Medicaid, and State Children's Health Insurance Programs.
- Sec. 2008. Increasing understanding of and improving health literacy.
- Sec. 2009. Requirements for health programs or activities receiving Federal funds.
- Sec. 2010. Report on Federal efforts to provide culturally and linguistically appropriate health care services.
- Sec. 2011. English instruction for individuals with limited English proficiency.
- Sec. 2012. Implementation.
- Sec. 2013. Language access services.
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- Sec. 3003. Loan repayment program of Centers for Disease Control and Prevention.

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- Sec. 3004. Allied health workforce diversity.
- Sec. 3005. Cooperative agreements for online degree programs at schools of public health and schools of allied health.
- Sec. 3006. National Health Care Workforce Commission.
- Sec. 3007. Scholarship and fellowship programs.
- Sec. 3008. McNair Postbaccalaureate Achievement Program.
- Sec. 3009. Rules for determination of full-time equivalent residents for cost-reporting periods.
- Sec. 3010. Developing and implementing strategies for local health equity.
- Sec. 3011. Health Professions Workforce Fund.
- Sec. 3012. Future advancement of academic nursing.
- Sec. 3013. Findings; sense of Congress relating to graduate medical education.
- Sec. 3014. Career support for skilled, internationally educated health professionals.
- Sec. 3015. Study and report on strategies for increasing diversity.
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- Sec. 3017. National Hispanic Nurses Day.
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- Sec. 4003. Availability of basic assistance to lawfully present noncitizens.
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- Sec. 9002. Treatment of Medicare payments under title VI of the Civil Rights Act of 1964.
- Sec. 9003. Accountability and transparency within the Department of Health and Human Services.
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- Sec. 10008. Establish an interagency counsel and grant programs on social determinants of health.
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1 **SEC. 3. FINDINGS.**

2 The Congress finds as follows:

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

9 (2) Health disparities are a function of not only
 10 access to health care, but also the social deter-
 11 minants of health—including the environment, the

1 physical structure of communities, nutrition and
2 food options, educational attainment, employment,
3 race, ethnicity, sex, geography, language preference,
4 immigrant or citizenship status, sexual orientation,
5 gender identity, socioeconomic status, or disability
6 status—that directly and indirectly affect the health,
7 health care, and wellness of individuals and commu-
8 nities.

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

12 (4) All efforts to reduce health disparities and
13 barriers to high-quality health services require better
14 and more consistent data, and better and more con-
15 sistent collection of and access to data.

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

19 (6) Racial and ethnic minorities and under-
20 served populations must be included early and equi-
21 tably in health reform innovations.

22 (7) Efforts to improve minority health have
23 been limited by inadequate resources in funding,
24 staffing, stewardship, and accountability. Targeted
25 investments that are focused on disparities elimi-

1 nation must be made in providing care and services
2 that are community-based, including prevention and
3 policies addressing social determinants of health.

4 (8) In 2011, the Department of Health and
5 Human Services developed the HHS Action Plan to
6 Reduce Racial and Ethnic Health Disparities and
7 the National Stakeholder Strategy for Achieving
8 Health Equity, which are 2 strategic plans that rep-
9 resent the first coordinated roadmap in the United
10 States to reducing health disparities. These com-
11 prehensive plans, along with the National Prevention
12 Strategy issued by the National Prevention Council
13 of the Department of Health and Human Services,
14 Healthy People 2030, and the National Quality
15 Strategy of the Agency for Healthcare Research and
16 Quality, as well as critical resources such as the
17 2012 National Healthcare Quality and Disparities
18 Reports, will work to increase the number of people
19 in the United States who are healthy at every stage
20 of life.

21 (9) The Secretary of Health and Human Serv-
22 ices has also reviewed and advanced updated clinical
23 guidelines and developed other strategic planning
24 documents to combat health disparities with a high
25 impact on minority populations and to provide high-

1 quality family planning services. Such guidelines and
2 documents include the National HIV/AIDS Strategy,
3 the Action Plan for the Prevention, Care, and Treat-
4 ment of Viral Hepatitis, and recommendations of the
5 Centers for Disease Control and Prevention and the
6 Office of Population Affairs.

7 (10) The Patient Protection and Affordable
8 Care Act (Public Law 111–148), as amended by the
9 Health Care and Education Reconciliation Act of
10 2010 (Public Law 111–152), represents the biggest
11 advancement for minority health in the 40 years im-
12 mediately preceding the enactment of this Act.

13 (11) The Health Information Technology for
14 Economic and Clinical Health Act, part of the
15 American Recovery and Reinvestment Act of 2009
16 (Public Law 111–5), provides that the nationwide
17 health information exchange infrastructure be devel-
18 oped and used to reduce health disparities, among
19 other purposes.

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

3 **SEC. 1001. STRENGTHENING DATA COLLECTION, IMPROV-**
4 **ING DATA ANALYSIS, AND EXPANDING DATA**
5 **REPORTING.**

6 (a) AMENDMENTS TO THE PUBLIC HEALTH SERVICE
7 ACT.—

8 (1) PURPOSE.—The purpose of the amend-
9 ments made by this subsection is to promote cul-
10 turally and linguistically appropriate data collection,
11 analysis, and reporting by race, ethnicity, sex, pri-
12 mary language, sexual orientation, disability status,
13 gender identity, age, and socioeconomic status in
14 federally supported health programs.

15 (2) AHRQ GENERAL AUTHORITIES.—Section
16 902(a) of the Public Health Service Act (42 U.S.C.
17 299a(a)) is amended—

18 (A) in paragraph (8), by striking “and” at
19 the end;

20 (B) in paragraph (9), by striking the pe-
21 riod at the end and inserting “; and”; and

22 (C) by adding at the end the following:

23 “(10) cultural and linguistic competence of
24 health care services and of data collection activities
25 described under section 3101.”.

1 (3) OFFICE OF MINORITY HEALTH.—Section
2 1707(g)(1) of the Public Health Service Act (42
3 U.S.C. 300u–6(g)(1)) is amended by inserting “Mid-
4 dle Easterners and North Africans;” after
5 “Blacks;”.

6 (4) OFFICE OF THE NATIONAL COORDINATOR
7 FOR HEALTH INFORMATION TECHNOLOGY.—Section
8 3001 of the Public Health Service Act (42 U.S.C.
9 300jj–11) is amended—

10 (A) in subsection (b)—

11 (i) in paragraph (10), by striking
12 “and” at the end;

13 (ii) in paragraph (11), by striking the
14 period at the end and inserting “; and”;
15 and

16 (iii) by adding at the end the fol-
17 lowing:

18 “(12) ensures the interoperability of health in-
19 formation systems among federally conducted or
20 supported health care or public health programs,
21 State health agencies, and social service agencies.”;
22 and

23 (B) by amending clause (vii) in subsection
24 (c)(3)(A) to read as follows:

1 “(vii) Strategies to enhance the use of
2 health information technology in improving
3 the quality of health care; reducing medical
4 errors; reducing health disparities and en-
5 suring the provision of equitable health
6 services; improving public health; increas-
7 ing prevention and coordination with com-
8 munity resources; ensuring interoperability
9 among federally conducted or supported
10 health care or public health programs,
11 State health agencies, and social service
12 agencies; and improving the continuity of
13 care among health care settings.”.

14 (5) DATA COLLECTION, ANALYSIS, AND QUAL-
15 ITY.—Section 3101 of the Public Health Service Act
16 (42 U.S.C. 300kk) is amended—

17 (A) in subsections (a)(1)(A), (a)(1)(C),
18 (a)(2)(B), and (a)(2)(E), by striking “and dis-
19 ability status” and inserting “sexual orienta-
20 tion, gender identity, age, disability status, and
21 socioeconomic status”;

22 (B) in subsection (a)(1), by amending sub-
23 paragraph (D) to read as follows:

24 “(D) data for additional population groups
25 if such groups can be aggregated into the data

1 collection standards described under paragraph
2 (2).”;

3 (C) in subsection (a)(2)—

4 (i) in subparagraph (C)—

5 (I) in clause (i), by striking
6 “and” at the end;

7 (II) in clause (ii)—

8 (aa) by striking “is a minor
9 or legally incapacitated” and in-
10 serting “is a minor, requires as-
11 sistance with communication in
12 speech or writing, or is legally in-
13 capacitated”; and

14 (bb) by striking the semi-
15 colon at the end and inserting “;
16 and”; and

17 (III) by adding at the end the
18 following:

19 “(iii) collects data in a manner that is
20 culturally and linguistically appropriate;”;

21 (ii) in subparagraph (D)(iii), by strik-
22 ing “and” at the end;

23 (iii) in subparagraph (E), by striking
24 the period at the end and inserting “;
25 and”; and

1 (iv) by adding at the end the fol-
2 lowing:

3 “(F) use, where practicable, the standards
4 developed by the Health and Medicine Division
5 of the National Academies of Sciences, Engi-
6 neering, and Medicine (formerly known as the
7 ‘Institute of Medicine’) in the 2009 publication
8 titled ‘Race, Ethnicity, and Language Data:
9 Standardization for Health Care Quality Im-
10 provement’.”; and

11 (6) in subsection (a)(3), by amending subpara-
12 graph (B) to read as follows:

13 “(B) develop interoperability and security
14 systems for data management among federally
15 conducted or supported health care or public
16 health programs, State health agencies, and so-
17 cial service agencies.”.

18 (b) COROLLARY PROVISIONS.—

19 (1) RECOMMENDATIONS BY THE DATA COUN-
20 CIL.—The Data Council of the Department of
21 Health and Human Services, in consultation with
22 the Director of the National Center for Health Sta-
23 tistics, the Deputy Assistant Secretary for Minority
24 Health, the Deputy Assistant Secretary for Women’s
25 Health, the Administrator of the Centers for Medi-

1 care & Medicaid, the National Coordinator for
2 Health Information Technology, and other appro-
3 priate public and private entities and officials, shall
4 make recommendations to the Secretary of Health
5 and Human Services concerning how to—

6 (A) implement the amendments made by
7 this section, while minimizing the cost and ad-
8 ministrative burdens of data collection and re-
9 porting on all parties, including patients and
10 providers;

11 (B) expand awareness among Federal
12 agencies, States, territories, Indian Tribes,
13 counties, municipalities, health providers, health
14 plans, and the general public that data collec-
15 tion, analysis, and reporting by race, ethnicity,
16 sex, primary language, sexual orientation, gen-
17 der identity, age, socioeconomic status, and dis-
18 ability status is legal and necessary to ensure
19 equity and nondiscrimination in the quality of
20 health care services;

21 (C) ensure that future patient record sys-
22 tems follow Federal standards promulgated
23 under the HITECH Act (42 U.S.C. 201 note)
24 for the collection and meaningful use of elec-
25 tronic health data on race, ethnicity, sex, pri-

1 mary language, sexual orientation, gender iden-
2 tity, age, socioeconomic status, and disability
3 status;

4 (D) improve health and health care data
5 collection and analysis for more population
6 groups if such groups can be aggregated into
7 minimum race and ethnicity categories, includ-
8 ing exploring the feasibility of enhancing collec-
9 tion efforts in States, counties, and municipali-
10 ties for racial and ethnic groups that comprise
11 a significant proportion of the population of the
12 State, county, or municipality;

13 (E) provide researchers with greater access
14 to racial, ethnic, primary language, sex, sexual
15 orientation, gender identity, age, socioeconomic
16 status, and disability status data, subject to all
17 applicable privacy and confidentiality require-
18 ments, including HIPAA privacy and security
19 law as defined in section 3009(a) of the Public
20 Health Service Act (42 U.S.C. 300jj–19(a));

21 (F) ensure the cultural and linguistic com-
22 petence of entities that receive Federal support
23 to collect and report data pursuant to the
24 amendments made by subsection (a); and

1 (G) safeguard and prevent the misuse of
2 data collected under section 3101 of the Public
3 Health Service Act (42 U.S.C. 300kk), as
4 amended by subsection (a)(5).

5 (2) RULES OF CONSTRUCTION.—Nothing in
6 this section shall be construed to—

7 (A) permit the use of information collected
8 under this section or any provision amended by
9 this section in a manner that would adversely
10 affect any individual providing any such infor-
11 mation; or

12 (B) diminish any requirements on health
13 care providers to collect data, including such re-
14 quirements in effect on or after the date of en-
15 actment of this Act.

16 (3) TECHNICAL ASSISTANCE FOR THE ANALYSIS
17 OF HEALTH DISPARITY DATA.—The Secretary of
18 Health and Human Services, acting through the Di-
19 rector of the Agency for Healthcare Research and
20 Quality, and in coordination with the Assistant Sec-
21 retary for Planning and Evaluation, the Adminis-
22 trator of the Centers for Medicare & Medicaid Serv-
23 ices, the Director of the National Center for Health
24 Statistics, the Director of the National Institutes of
25 Health, and the National Coordinator for Health In-

1 formation Technology, shall provide technical assist-
2 ance to agencies of the Department of Health and
3 Human Services in meeting Federal standards for
4 health disparity data collection and for analysis of
5 racial, ethnic, and other disparities in health and
6 health care in programs conducted or supported by
7 such agencies by—

8 (A) identifying appropriate quality assur-
9 ance mechanisms to monitor for health dispari-
10 ties;

11 (B) specifying the clinical, diagnostic, or
12 therapeutic measures which should be mon-
13 itored;

14 (C) developing new quality measures relat-
15 ing to racial and ethnic disparities and their
16 overlap with other disparity factors in health
17 and health care;

18 (D) identifying the level at which data
19 analysis should be conducted;

20 (E) sharing data with external organiza-
21 tions for research and quality improvement pur-
22 poses; and

23 (F) identifying and addressing issues relat-
24 ing to the interoperability of Federal- and
25 State-level health information systems which

1 undermine the ability of health-related pro-
2 grams collecting data under this section to
3 achieve the purpose described in subsection
4 (a)(1).

5 (4) REFERENCES.—Except as otherwise speci-
6 fied, any reference to the term “racial and ethnic
7 minority group” in any Federal regulation, guid-
8 ance, order, or document for establishment or imple-
9 mentation of any federally conducted or supported
10 health care or public health program, activity, or
11 survey shall be treated as having the definition given
12 to such term in section 1707(g) of the Public Health
13 Service Act (42 U.S.C. 300u–6(g)).

14 (5) AUTHORIZATION OF APPROPRIATIONS.—To
15 carry out this subsection, subsection (a), and the
16 amendments made by subsection (a), there are au-
17 thorized to be appropriated such sums as may be
18 necessary for each of fiscal years 2023 through
19 2027.

20 (c) ADDITIONS TO THE PUBLIC HEALTH SERVICE
21 ACT.—Title XXXIV of the Public Health Service Act, as
22 added by titles II and III of this Act, is further amended
23 by inserting after subtitle B the following:

1 **“Subtitle C—Strengthening Data**
2 **Collection, Improving Data**
3 **Analysis, and Expanding Data**
4 **Reporting**

5 **“SEC. 3431. ESTABLISHING GRANTS FOR DATA COLLECTION**
6 **IMPROVEMENT ACTIVITIES.**

7 “(a) IN GENERAL.—The Secretary, acting through
8 the Director of the Agency for Healthcare Research and
9 Quality and in consultation with the Deputy Assistant
10 Secretary for Minority Health, the Director of the Na-
11 tional Institutes of Health, the Assistant Secretary for
12 Planning and Evaluation, the National Coordinator for
13 Health Information Technology, and the Director of the
14 National Center for Health Statistics, shall establish a
15 technical assistance program under which the Secretary
16 provides grants to eligible entities to assist such entities
17 in complying with section 3101.

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

20 “(1) enhance or upgrade computer technology
21 that will facilitate collection, analysis, and reporting
22 of racial, ethnic, primary language, sexual orienta-
23 tion, sex, gender identity, socioeconomic status, and
24 disability status data;

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

6 “(3) develop mechanisms for submitting col-
7 lected data subject to any applicable privacy and
8 confidentiality regulations;

9 “(4) develop educational programs to inform
10 health plans, health providers, health-related agen-
11 cies, and the general public that data collection and
12 reporting by race, ethnicity, primary language, sex-
13 ual orientation, sex, gender identity, disability sta-
14 tus, and socioeconomic status are legal and essential
15 for eliminating health and health care disparities;
16 and

17 “(5) develop educational programs to train
18 health providers, health care organizations, health
19 plans, health-related agencies, and frontline health
20 care workers on how to collect and report
21 disaggregated data in a culturally and linguistically
22 appropriate manner.

23 “(c) ELIGIBLE ENTITY.—To be eligible for grants
24 under this section, an entity shall be a State, territory,
25 Indian Tribe, municipality, county, health provider, health

1 care organization, or health plan making a demonstrated
2 effort to bring data collections into compliance with sec-
3 tion 3101.

4 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated to carry out this section
6 such sums as may be necessary for each of fiscal years
7 2023 through 2027.

8 **“SEC. 3432. OVERSAMPLING OF UNDERREPRESENTED**
9 **GROUPS IN FEDERAL HEALTH SURVEYS.**

10 “(a) NATIONAL STRATEGY.—

11 “(1) IN GENERAL.—The Secretary, acting
12 through the Director of the National Center for
13 Health Statistics, and other officials within the De-
14 partment of Health and Human Services as the Sec-
15 retary determines appropriate, shall develop and im-
16 plement a sustainable national strategy for oversam-
17 pling underrepresented populations within the cat-
18 egories of race, ethnicity, sex, primary language, sex-
19 ual orientation, disability status, gender identity,
20 and socioeconomic status as determined appropriate
21 by the Secretary in Federal health surveys and pro-
22 gram data collections. Such national strategy shall
23 include a strategy for oversampling of Middle East-
24 erners and North Africans, Asian Americans, Native
25 Hawaiians, and Pacific Islanders.

1 “(2) CONSULTATION.—In developing and imple-
2 menting a national strategy, as described in para-
3 graph (1), not later than 180 days after the date of
4 the enactment of this section, the Secretary shall—

5 “(A) consult with representatives of com-
6 munity groups, nonprofit organizations, non-
7 governmental organizations, and government
8 agencies working with underrepresented popu-
9 lations;

10 “(B) solicit the participation of representa-
11 tives from other Federal departments and agen-
12 cies, including subagencies of the Department
13 of Health and Human Services; and

14 “(C) consult on, and use as models, the
15 2014 National Health Interview Survey over-
16 sample of Native Hawaiian and Pacific Islander
17 populations, the 2016 Behavioral Risk Factor
18 Survey of Health Risk Behaviors Among Arab
19 Adults Within the State of Michigan, and the
20 2017 Behavioral Risk Factor Surveillance Sys-
21 tem oversample of American Indian and Alaska
22 Native communities.

23 “(b) PROGRESS REPORT.—Not later than 2 years
24 after the date of enactment of this section, the Secretary
25 shall submit to the Congress a progress report, which shall

1 include the national strategy required by subsection
2 (a)(1).

3 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
4 carry out this section, there are authorized to be appro-
5 priated such sums as may be necessary for fiscal years
6 2023 through 2027.”.

7 **SEC. 1002. ELIMINATION OF PREREQUISITE OF DIRECT AP-**
8 **PROPRIATIONS FOR DATA COLLECTION AND**
9 **ANALYSIS.**

10 Section 3101 of the Public Health Service Act (42
11 U.S.C. 300kk), as amended by section 1001(a), is further
12 amended—

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

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

16 **SEC. 1003. COLLECTION OF DATA FOR THE MEDICARE PRO-**
17 **GRAM.**

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

21 **“SEC. 1150D. COLLECTION OF DATA FOR THE MEDICARE**
22 **PROGRAM.**

23 “(a) REQUIREMENT.—

24 “(1) IN GENERAL.—The Commissioner of So-
25 cial Security, in consultation with the Administrator

1 of the Centers for Medicare & Medicaid Services,
2 shall collect data on the race, ethnicity, sex, primary
3 language, sexual orientation, gender identity, socio-
4 economic status, and disability status of all appli-
5 cants for social security benefits under title II or
6 Medicare benefits under title XVIII.

7 “(2) DATA COLLECTION STANDARDS.—In col-
8 lecting data under paragraph (1), the Commissioner
9 of Social Security shall at least use the standards
10 for data collection developed under section 3101 of
11 the Public Health Service Act or the standards de-
12 veloped by the Office of Management and Budget,
13 whichever is more disaggregated. In the event there
14 are no standards for the demographic groups listed
15 under paragraph (1), the Commissioner shall consult
16 with stakeholder groups representing the various
17 identities as well as with the Office of Minority
18 Health within the Centers for Medicare & Medicaid
19 Services to develop appropriate standards.

20 “(3) DATA FOR ADDITIONAL POPULATION
21 GROUPS.—Where practicable, the information col-
22 lected by the Commissioner of Social Security under
23 paragraph (1) shall include data for additional popu-
24 lation groups if such groups can be aggregated into

1 the race and ethnicity categories outlined by the
2 data collection standards described in paragraph (2).

3 “(4) COLLECTION OF DATA FOR MINORS AND
4 LEGALLY INCAPACITATED INDIVIDUALS.—With re-
5 spect to the collection of the data described in para-
6 graph (1) of applicants who are under 18 years of
7 age or otherwise legally incapacitated, the Commis-
8 sioner of Social Security shall require that—

9 “(A) such data be collected from the par-
10 ent or legal guardian of such an applicant; and

11 “(B) the primary language of the parent
12 or legal guardian of such an applicant or recipi-
13 ent be used in collecting the data.

14 “(5) QUALITY OF DATA.—The Commissioner of
15 Social Security shall periodically review the quality
16 and completeness of the data collected under para-
17 graph (1) and make adjustments as necessary to im-
18 prove both.

19 “(6) TRANSMISSION OF DATA.—Upon enroll-
20 ment in Medicare benefits under title XVIII, the
21 Commissioner of Social Security shall transmit an
22 individual’s demographic data as collected under
23 paragraph (1) to the Centers for Medicare & Med-
24 icaid Services.

1 “(7) ANALYSIS AND REPORTING OF DATA.—

2 With respect to data transmitted under paragraph
3 (5), the Administrator of the Centers for Medicare
4 & Medicaid Services, in consultation with the Com-
5 missioner of Social Security, shall—

6 “(A) require that such data be uniformly
7 analyzed and that such analysis be reported at
8 least annually to Congress;

9 “(B) incorporate such data in other anal-
10 ysis and reporting on health disparities and the
11 provision of inequitable health care services by
12 a health care provider, as appropriate;

13 “(C) make such data available to research-
14 ers, under the protections outlined in paragraph
15 (7);

16 “(D) provide opportunities to individuals
17 enrolled in Medicare to submit updated data;
18 and

19 “(E) ensure that the provision of assist-
20 ance or benefits to an applicant is not denied
21 or otherwise adversely affected because of the
22 failure of the applicant to provide any of the
23 data collected under paragraph (1).

24 “(8) PROTECTION OF DATA.—The Commis-
25 sioner of Social Security shall ensure (through the

1 promulgation of regulations or otherwise) that all
2 data collected pursuant to subsection (a) is pro-
3 tected—

4 “(A) under the same privacy protections as
5 the Secretary applies to health data under the
6 regulations promulgated under section 264(c) of
7 the Health Insurance Portability and Account-
8 ability Act of 1996 (relating to the privacy of
9 individually identifiable health information and
10 other protections); and

11 “(B) from all inappropriate internal use by
12 any entity that collects, stores, or receives the
13 data, including use of such data in determina-
14 tions of eligibility (or continued eligibility) in
15 health plans, and from other inappropriate
16 uses, as defined by the Secretary.

17 “(b) RULE OF CONSTRUCTION.—Nothing in this sec-
18 tion shall be construed to permit the use of information
19 collected under this section in a manner that would ad-
20 versely affect any individual providing any such informa-
21 tion.

22 “(c) TECHNICAL ASSISTANCE.—The Secretary of
23 Health and Human Services may, either directly or by
24 grant or contract, provide technical assistance to enable

1 any entity to comply with the requirements of this section
2 or with regulations implementing this section.

3 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section
5 \$500 million for 2022 and \$100 million for each fiscal
6 year thereafter.”.

7 **SEC. 1004. REVISION OF HIPAA CLAIMS STANDARDS.**

8 (a) IN GENERAL.—Not later than 1 year after the
9 date of enactment of this Act, the Secretary of Health and
10 Human Services shall revise the regulations promulgated
11 under part C of title XI of the Social Security Act (42
12 U.S.C. 1320d et seq.) (relating to the collection of data
13 on demographics in a health-related transaction) to re-
14 quire—

15 (1) the use, at a minimum, of standards for
16 data collection on race, ethnicity, sex, primary lan-
17 guage, sexual orientation, gender identity, age, dis-
18 ability status, and socioeconomic status developed
19 under section 3101 of the Public Health Service Act
20 (42 U.S.C. 300kk), as amended by section
21 1001(a)(5); and

22 (2) in consultation with the Office of the Na-
23 tional Coordinator for Health Information Tech-
24 nology, the designation of the appropriate racial,

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

3 (b) DISSEMINATION.—The Secretary of Health and
4 Human Services shall disseminate the new standards de-
5 veloped under subsection (a) to all entities that are subject
6 to the regulations described in such subsection and provide
7 technical assistance with respect to the collection of the
8 data involved.

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

14 **SEC. 1005. NATIONAL CENTER FOR HEALTH STATISTICS.**

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

17 (1) in paragraph (1), by striking “2003” and
18 inserting “2024”;

19 (2) in paragraph (2), in the first sentence, by
20 striking “2003” and inserting “2024”; and

21 (3) in paragraph (3), by striking “2002” and
22 inserting “2024”.

1 **SEC. 1006. DISPARITIES DATA COLLECTED BY THE FED-**
2 **ERAL GOVERNMENT.**

3 (a) REPOSITORY OF GOVERNMENT DATA.—The Sec-
4 retary of Health and Human Services, in coordination
5 with the officials referenced in subsection (b), shall estab-
6 lish a centralized electronic repository of Federal Govern-
7 ment data on factors related to the health and well-being
8 of the population of the United States.

9 (b) COLLECTION; SUBMISSION.—Not later than 180
10 days after the date of enactment of this Act, and January
11 31 of each year thereafter, each department, agency, and
12 office of the Federal Government that has collected data
13 on race, ethnicity, sex, primary language, sexual orienta-
14 tion, gender identity, age, disability status, or socio-
15 economic status during the preceding calendar year shall
16 submit such data to the repository of Federal Government
17 data established under subsection (a).

18 (c) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—
19 Not later than April 30, 2021, and April 30 of each year
20 thereafter, the Secretary of Health and Human Services,
21 acting through the Assistant Secretary for Planning and
22 Evaluation, the Assistant Secretary for Health, the Direc-
23 tor of the Agency for Healthcare Research and Quality,
24 the Director of the National Center for Health Statistics,
25 the Administrator of the Centers for Medicare & Medicaid
26 Services, the Director of the National Institute on Minor-

1 ity Health and Health Disparities, and the Deputy Assist-
2 ant Secretary for Minority Health, shall—

3 (1) prepare and make available datasets for
4 public use that relate to disparities in health status,
5 health care access, health care quality, health out-
6 comes, public health, the provision of equitable
7 health services, and other areas of health and well-
8 being by factors that include race, ethnicity, sex, pri-
9 mary language, sexual orientation, gender identity,
10 disability status, and socioeconomic status;

11 (2) ensure that these datasets are publicly iden-
12 tified on the repository established under subsection
13 (a) as “disparities” data; and

14 (3) submit a report to the Congress on the
15 availability and use of such data by public stake-
16 holders.

17 **SEC. 1007. DATA COLLECTION AND ANALYSIS GRANTS TO**
18 **MINORITY-SERVING INSTITUTIONS.**

19 (a) **AUTHORITY.**—The Secretary of Health and
20 Human Services, acting through the Director of the Na-
21 tional Institute on Minority Health and Health Disparities
22 and the Deputy Assistant Secretary for Minority Health,
23 shall award grants to eligible entities to access and analyze
24 racial and ethnic data on disparities in health and health
25 care, and where possible other data on disparities in health

1 and health care, to monitor and report on progress to re-
2 duce and eliminate disparities in health and health care.

3 (b) ELIGIBLE ENTITY.—In this section, the term “el-
4 igible entity” means an entity that has an accredited pub-
5 lic health, health policy, or health services research pro-
6 gram and is any of the following:

7 (1) A part B institution, as defined in section
8 322 of the Higher Education Act of 1965 (20
9 U.S.C. 1061).

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

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

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

17 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
18 out this section, there are authorized to be appropriated
19 such sums as may be necessary for fiscal years 2023
20 through 2027.

21 **SEC. 1008. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
22 **RESPECT TO RACIAL AND ETHNIC BACK-**
23 **GROUND.**

24 (a) IN GENERAL.—Chapter V of the Federal Food,
25 Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amend-

1 ed by inserting after section 505G (21 U.S.C. 355h) the
2 following:

3 **“SEC. 505H. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
4 **RESPECT TO RACIAL AND ETHNIC BACK-**
5 **GROUND.**

6 “(a) PREAPPROVAL STUDIES.—If there is evidence of
7 a racial or ethnic disparity in safety or effectiveness with
8 respect to a drug or biological product, then—

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

13 “(B) in the case of a biological product, the evi-
14 dence required under section 351(a) of the Public
15 Health Service Act for approval of a biologics license
16 application for the biological product shall include
17 adequate and well-controlled investigations of the
18 disparity; and

19 “(2) if the investigations described in subpara-
20 graph (A) or (B) of paragraph (1) confirm that
21 there is such a disparity, the labeling of the drug or
22 biological product shall include appropriate informa-
23 tion about the disparity.

24 “(b) POSTMARKET STUDIES.—

1 “(1) IN GENERAL.—If there is evidence of a ra-
2 cial or ethnic disparity in safety or effectiveness with
3 respect to a drug for which there is an approved ap-
4 plication under section 505 of this Act or of a bio-
5 logical product for which there is an approved li-
6 cense under section 351 of the Public Health Service
7 Act, the Secretary may by order require the holder
8 of the approved application or license to conduct, by
9 a date specified by the Secretary, postmarket studies
10 to investigate the disparity.

11 “(2) LABELING.—If the Secretary determines
12 that the postmarket studies confirm that there is a
13 disparity described in paragraph (1), the labeling of
14 the drug or biological product shall include appro-
15 priate information about the disparity.

16 “(3) STUDY DESIGN.—The Secretary may, in
17 an order under paragraph (1), specify all aspects of
18 the design of the postmarket studies required under
19 such paragraph for a drug or biological product, in-
20 cluding the number of studies and study partici-
21 pants, and the other demographic characteristics of
22 the study participants.

23 “(4) MODIFICATIONS OF STUDY DESIGN.—The
24 Secretary may, by order and as necessary, modify
25 any aspect of the design of a postmarket study re-

1 quired in an order under paragraph (1) after issuing
2 such order.

3 “(5) STUDY RESULTS.—The results from a
4 study required under paragraph (1) shall be sub-
5 mitted to the Secretary as a supplement to the drug
6 application or biologics license application.

7 “(c) APPLICATIONS UNDER SECTION 505(j).—

8 “(1) IN GENERAL.—A drug for which an appli-
9 cation has been submitted or approved under section
10 505(j) shall not be considered ineligible for approval
11 under that section or misbranded under section 502
12 on the basis that the labeling of the drug omits in-
13 formation relating to a disparity on the basis of ra-
14 cial or ethnic background as to the safety or effec-
15 tiveness of the drug, whether derived from investiga-
16 tions or studies required under this section or de-
17 rived from other sources, when the omitted informa-
18 tion is protected by patent or by exclusivity under
19 section 505(j)(5)(F).

20 “(2) LABELING.—Notwithstanding paragraph
21 (1), the Secretary may require that the labeling of
22 a drug approved under section 505(j) that omits in-
23 formation relating to a disparity on the basis of ra-
24 cial or ethnic background as to the safety or effec-
25 tiveness of the drug include a statement of any ap-

1 appropriate contraindications, warnings, or precautions
2 related to the disparity that the Secretary considers
3 necessary.

4 “(d) DEFINITION.—In this section, the term ‘evi-
5 dence of a racial or ethnic disparity in safety or effective-
6 ness’, with respect to a drug or biological product, in-
7 cludes—

8 “(1) evidence that there is a disparity on the
9 basis of racial or ethnic background as to safety or
10 effectiveness of a drug or biological product in the
11 same chemical class as the drug or biological prod-
12 uct;

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

16 “(3) other evidence as the Secretary may deter-
17 mine appropriate.”.

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

21 “(gg) If it is a drug and the holder of the approved
22 application under section 505 or license under section 351
23 of the Public Health Service Act for the drug has failed
24 to complete the investigations or studies required under

1 section 505H, or comply with any other requirement of
2 such section 505H.”.

3 (c) DRUG FEES.—Section 736(a)(1)(A)(ii) of the
4 Federal Food, Drug, and Cosmetic Act (21 U.S.C.
5 379h(a)(1)(A)(ii)) is amended by inserting after “are not
6 required” the following: “, including postmarket studies
7 required under section 505H,”.

8 **SEC. 1009. IMPROVING HEALTH DATA REGARDING NATIVE**
9 **HAWAIIANS AND PACIFIC ISLANDERS.**

10 Part B of title III of the Public Health Service Act
11 (42 U.S.C. 243 et seq.) is amended by inserting after sec-
12 tion 317U the following:

13 **“SEC. 317V. NATIVE HAWAIIAN AND PACIFIC ISLANDER**
14 **HEALTH DATA.**

15 “(a) DEFINITIONS.—In this section:

16 “(1) INSULAR AREA.—The term ‘insular area’
17 means Guam, the Commonwealth of the Northern
18 Mariana Islands, American Samoa, the United
19 States Virgin Islands, the Federated States of Mi-
20 cronesia, the Republic of Palau, or the Republic of
21 the Marshall Islands.

22 “(2) NATIVE HAWAIIANS AND PACIFIC ISLAND-
23 ERS (NHPI).—The term ‘Native Hawaiians and Pa-
24 cific Islanders’ or ‘NHPI’ means people having ori-
25 gins in any of the original peoples of American

1 Samoa, the Commonwealth of the Northern Mariana
2 Islands, the Federated States of Micronesia, Guam,
3 Hawaii, the Republic of the Marshall Islands, the
4 Republic of Palau, or any other Pacific Island.

5 “(3) NHPI STAKEHOLDER GROUPS.—The term
6 ‘NHPI stakeholder group’ includes each of the fol-
7 lowing:

8 “(A) COMMUNITY GROUP.—A group of
9 NHPI who are organized at the community
10 level, and may include a church group, social
11 service group, national advocacy organization,
12 or cultural group.

13 “(B) NONPROFIT, NONGOVERNMENTAL
14 ORGANIZATION.—A group of NHPI with a dem-
15 onstrated history of addressing NHPI issues,
16 including a NHPI coalition.

17 “(C) DESIGNATED ORGANIZATION.—An
18 entity established to represent NHPI popu-
19 lations and which has statutory responsibilities
20 to provide, or has community support for pro-
21 viding, health care.

22 “(D) GOVERNMENT REPRESENTATIVES OF
23 NHPI POPULATIONS.—Representatives from Ha-
24 waii, American Samoa, the Commonwealth of
25 the Northern Mariana Islands, the Federated

1 States of Micronesia, Guam, the Republic of
2 Palau, and the Republic of the Marshall Is-
3 lands.

4 “(b) PRELIMINARY HEALTH SURVEY.—

5 “(1) IN GENERAL.—The Secretary, acting
6 through the Director of the National Center for
7 Health Statistics of the Centers for Disease Control
8 and Prevention (referred to in this section as
9 ‘NCHS’), shall conduct a preliminary health survey
10 in order to identify the major areas and regions in
11 the continental United States, Hawaii, American
12 Samoa, the Commonwealth of the Northern Mariana
13 Islands, the Federated States of Micronesia, Guam,
14 the Republic of Palau, and the Republic of the Mar-
15 shall Islands in which NHPI people reside.

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

19 “(A) useful in determining health status
20 and health care needs of NHPI populations; or

21 “(B) required for developing or imple-
22 menting the national strategy under subsection
23 (c).

24 “(3) METHODOLOGY.—Methodology for the
25 health survey described in paragraph (1), including

1 plans for designing questions, implementation, sam-
2 pling, and analysis, shall be developed in consulta-
3 tion with NHPI stakeholder groups.

4 “(4) TIMEFRAME.—The survey required under
5 this subsection shall be completed not later than 18
6 months after the date of enactment of the Health
7 Equity and Accountability Act of 2022.

8 “(c) NATIONAL STRATEGY.—

9 “(1) IN GENERAL.—The Secretary, acting
10 through the Director of the NCHS and other agen-
11 cies within the Department of Health and Human
12 Services as the Secretary determines appropriate,
13 shall develop and implement a sustainable national
14 strategy for identifying and evaluating the health
15 status and health care needs of NHPI populations
16 living in the continental United States, Hawaii,
17 American Samoa, the Commonwealth of the North-
18 ern Mariana Islands, the Federated States of Micro-
19 nesia, Guam, the Republic of Palau, and the Repub-
20 lic of the Marshall Islands.

21 “(2) CONSULTATION.—In developing and imple-
22 menting a national strategy, as described in para-
23 graph (1), not later than 180 days after the date of
24 enactment of the Health Equity and Accountability
25 Act of 2022, the Secretary—

1 “(A) shall consult with representatives of
2 NHPI stakeholder groups; and

3 “(B) may solicit the participation of rep-
4 resentatives from other Federal agencies.

5 “(d) PROGRESS REPORT.—Not later than 2 years
6 after the date of enactment of the Health Equity and Ac-
7 countability Act of 2022, the Secretary shall submit to
8 Congress a progress report, which shall include the na-
9 tional strategy described in subsection (c)(1).

10 “(e) STUDY AND REPORT BY THE HEALTH AND
11 MEDICINE DIVISION.—

12 “(1) IN GENERAL.—The Secretary shall seek to
13 enter into an agreement with the Health and Medi-
14 cine Division of the National Academies of Sciences,
15 Engineering, and Medicine to conduct a study, with
16 input from stakeholders in insular areas, on each of
17 the following:

18 “(A) The standards and definitions of
19 health care applied to health care systems in in-
20 sular areas and the appropriateness of such
21 standards and definitions.

22 “(B) The status and performance of health
23 care systems in insular areas, evaluated based
24 upon standards and definitions, as the Sec-
25 retary determines appropriate.

1 “(C) The effectiveness of donor aid in ad-
2 dressing health care needs and priorities in in-
3 sular areas.

4 “(D) The progress toward implementation
5 of recommendations of the Committee on
6 Health Care Services in the United States—As-
7 sociated Pacific Basin that are set forth in the
8 1998 report entitled ‘Pacific Partnerships for
9 Health: Charting a New Course’.

10 “(2) REPORT.—An agreement described in
11 paragraph (1) shall require the Health and Medicine
12 Division to submit to the Secretary and to Congress,
13 not later than 2 years after the date of the enact-
14 ment of the Health Equity and Accountability Act of
15 2022, a report containing a description of the results
16 of the study conducted under paragraph (1), includ-
17 ing the conclusions and recommendations of the
18 Health and Medicine Division for each of the items
19 described in subparagraphs (A) through (D) of such
20 paragraph.

21 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
22 carry out this section, there are authorized to be appro-
23 priated such sums as may be necessary for fiscal years
24 2023 through 2027.”.

1 **SEC. 1010. CLARIFICATION OF SIMPLIFIED ADMINISTRA-**
2 **TIVE REPORTING REQUIREMENT.**

3 Section 11(a) of the Food and Nutrition Act of 2008
4 (7 U.S.C. 2020(a)) is amended by adding at the end the
5 following:

6 “(5) SIMPLIFIED ADMINISTRATIVE REPORTING
7 REQUIREMENT.—With respect to any obligation of a
8 State agency to comply with the notification require-
9 ment under paragraph (2) of section 421(e) of the
10 Personal Responsibility and Work Opportunity Rec-
11 onciliation Act of 1996 (8 U.S.C. 1631(e)), notwith-
12 standing the requirement to include in that notifica-
13 tion the names of the sponsor and the sponsored
14 alien involved, the State agency shall be considered
15 to have complied with the notification requirement if
16 the State agency submits to the Attorney General a
17 report that includes the aggregate number of excep-
18 tions granted by the State agency under paragraph
19 (1) of that section.”.

20 **SEC. 1011. DATA COLLECTION REGARDING PANDEMIC PRE-**
21 **PAREDNESS, TESTING, INFECTIONS, AND**
22 **DEATHS.**

23 (a) SKILLED NURSING FACILITIES QUALITY RE-
24 PORTING.—Section 1819 of the Social Security Act (42
25 U.S.C. 1395i–3) is amended by adding at the end the fol-
26 lowing new subsection:

1 “(l) REQUIREMENTS RELATING TO REPORTING DUR-
2 ING PUBLIC HEALTH EMERGENCIES.—During a public
3 health emergency declared by the Secretary pursuant to
4 section 319 of the Public Health Service Act, a skilled
5 nursing facility shall, not later than one year after the first
6 day of such declaration, and monthly thereafter during the
7 application of such declaration, submit to the Secretary
8 the following information, with respect to such facility and
9 the residents of such facility:

10 “(1) Information described in section
11 483.80(g)(1) of title 42, Code of Federal Regula-
12 tions.

13 “(2) The age, race, ethnicity, sex, sexual ori-
14 entation, gender identity, socioeconomic status, dis-
15 ability status, and preferred language of the resi-
16 dents of such skilled nursing facility.”.

17 (b) TRANSPARENCY OF DEMOGRAPHIC INFORMATION
18 IN CERTAIN SETTINGS.—

19 (1) DEMOGRAPHIC INFORMATION.—The Sec-
20 retary of Health and Human Services shall post the
21 following information with respect to skilled nursing
22 facilities (as defined in section 1819(a) of the Social
23 Security Act (42 U.S.C. 1395i–3(a))), congregate
24 care settings (including skilled nursing facilities, as-
25 sisted living facilities, prisons and jails, residential

1 behavioral health care and psychiatric facilities, and
2 facilities providing services for aging adults and peo-
3 ple with disabilities), and nursing facilities (as de-
4 fined in section 1919(a) of such Act (42 U.S.C.
5 1396r(a))) on the Nursing Home Compare website
6 (as described in section 1819(i) of the Social Secu-
7 rity Act (42 U.S.C. 1395i-3(i))), or a successor
8 website, aggregated by State:

9 (A) The age, race, ethnicity, sex, sexual
10 orientation, gender identity, socioeconomic sta-
11 tus, disability status, and preferred language of
12 the residents of such skilled nursing facilities,
13 congregate care settings (including skilled nurs-
14 ing facilities, assisted living facilities, prisons
15 and jails, residential behavioral health care and
16 psychiatric facilities, and facilities providing
17 services for aging adults and people with dis-
18 abilities), and nursing facilities with suspected
19 or confirmed infections, including residents pre-
20 viously treated for COVID-19.

21 (B) The age, race, ethnicity, sex, sexual
22 orientation, gender identity, socioeconomic sta-
23 tus, disability status, and preferred language
24 relating to total deaths and public health emer-
25 gency-related deaths among residents of such

1 skilled nursing facilities, congregate settings
2 (including skilled nursing facilities, assisted liv-
3 ing facilities, prisons and jails, residential be-
4 havioral health care and psychiatric facilities,
5 and facilities providing services for aging adults
6 and people with disabilities), and nursing facili-
7 ties.

8 (2) CONFIDENTIALITY.—Any information re-
9 ported under this subsection that is made available
10 to the public shall be made so available in a manner
11 that protects the identity of residents of skilled nurs-
12 ing facilities, congregate care settings (including
13 skilled nursing facilities, assisted living facilities,
14 prisons and jails, residential behavioral health care
15 and psychiatric facilities, and facilities providing
16 services for aging adults and people with disabil-
17 ities), and nursing facilities.

18 (3) IMPLEMENTATION.—Notwithstanding any
19 other provision of law, the Secretary of Health and
20 Human Services may implement the provisions of
21 this subsection by program instruction or otherwise.

22 (c) EQUITABLE DATA COLLECTION AND DISCLOSURE
23 REGARDING PANDEMICS.—Part A of title XI of the Social
24 Security Act (42 U.S.C. 1301 et seq.) as amended by sec-

1 tion 1003, is further amended by adding at the end the
2 following new section:

3 **“SEC. 1150E. EQUITABLE DATA COLLECTION AND DISCLO-**
4 **SURE REGARDING PANDEMICS.**

5 “(a) IN GENERAL.—Not later than 60 days after the
6 Secretary submits to Congress written notification of the
7 determination that a disease or disorder presents a public
8 health emergency or that a public health emergency other-
9 wise exists, subject to the succeeding subsections, the Sec-
10 retary, acting through the Director of the Centers for Dis-
11 ease Control and Prevention and the Administrator of the
12 Centers for Medicare & Medicaid Services and in consulta-
13 tion with the Director of the Indian Health Service, shall
14 collect and make publicly available on the website of the
15 Centers for Disease Control and Prevention and the Cen-
16 ters for Medicare & Medicaid Services, and update every
17 day during a pandemic, data collected across all surveil-
18 lance systems relating to a public health emergency de-
19 clared under section 319 of the Public Health Service Act
20 that is caused by a disease (as determined by the Sec-
21 retary), disaggregated by race, ethnicity, sex, sexual ori-
22 entation, gender identity, age, preferred language, socio-
23 economic status, disability status, and county, including
24 the following:

1 “(1) Data relating to all testing for the patho-
2 gen or pathogens causing the pandemic, including
3 the number of individuals tested and the number of
4 tests that were positive.

5 “(2) Data relating to treatment for the patho-
6 gen causing the pandemic, including hospitalizations
7 and intensive care unit admissions.

8 “(3) Data relating to pandemic outcomes, in-
9 cluding total fatalities and case fatality rates (ex-
10 pressed as the proportion of individuals who were in-
11 fected with the pathogen causing the pandemic and
12 died from the pathogen).

13 “(4) In the case a vaccine is developed in re-
14 sponse to a pandemic, data relating to such vaccina-
15 tion, including—

16 “(A) the number of vaccines administered;

17 “(B) the number of vaccinations offered,
18 accepted, and refused;

19 “(C) the most common reasons for refusal;
20 and

21 “(D) the percentage of vaccine doses allo-
22 cated and administered to each priority group.

23 “(b) APPLICATION OF CERTAIN STANDARDS WITH
24 RESPECT TO DATA COLLECTION.—To the extent prac-
25 ticable, data collected under subsection (a) shall follow

1 standards developed by the Department of Health and
2 Human Services Office of Minority Health and be col-
3 lected, analyzed, and reported in accordance with the
4 standards promulgated by the Assistant Secretary for
5 Planning and Evaluation under title XXXI of the Public
6 Health Service Act.

7 “(c) PRIVACY.—In publishing data pursuant to sub-
8 section (a), the Secretary shall take all necessary steps to
9 protect the privacy of individuals whose information is in-
10 cluded in such data, including—

11 “(1) complying with privacy protections pro-
12 vided under the regulations promulgated under sec-
13 tion 264(c) of the Health Insurance and Account-
14 ability Act of 1996; and

15 “(2) protections from all inappropriate internal
16 use by an entity that collects, stores, or receives the
17 data, including use of such data in determinations of
18 eligibility (or continued eligibility) in health plans,
19 and from inappropriate uses.”.

20 (d) REPORT REQUIREMENTS FOLLOWING PUBLIC
21 HEALTH EMERGENCIES.—

22 (1) PUBLICLY AVAILABLE SUMMARY.—Not later
23 than 60 days after the date on which the Secretary
24 of Health and Human Services certifies that a public
25 health emergency declared under section 319 of the

1 Public Health Service Act has ended, the Secretary
2 shall make publicly available on the website of the
3 Department of Health and Human Services a sum-
4 mary of the final statistics related to such emer-
5 gency.

6 (2) REPORT TO CONGRESS.—Not later than 60
7 days after the date on which the Secretary of Health
8 and Human Services certifies that a public health
9 emergency declared under section 319 of the Public
10 Health Service Act has ended, the Secretary shall
11 submit to the Committee on Health, Education,
12 Labor, and Pensions and the Committee on Finance
13 of the Senate and the Committee on Energy and
14 Commerce and the Committee on Ways and Means
15 of the House of Representatives a report—

16 (A) describing the testing, hospitalization,
17 mortality rates, vaccination rates, and preferred
18 language of patients associated with the pan-
19 demic by race and ethnicity, rural and urban
20 areas (as defined in section 1886(d)(2)(D) of
21 the Social Security Act (42 U.S.C.
22 1395ww(d)(2)(D)), and congregate care set-
23 tings (including skilled nursing facilities, as-
24 sisted living facilities, prisons and jails, residen-
25 tial behavioral health care and psychiatric facili-

1 ties, and facilities providing services for aging
2 adults and people with disabilities) and noncon-
3 gregate care settings (as such terms are defined
4 by the Secretary); and

5 (B) proposing evidenced-based response
6 strategies to safeguard the health of these com-
7 munities in future pandemics.

8 **SEC. 1012. COMMISSION ON ENSURING DATA FOR HEATH**
9 **EQUITY.**

10 (a) IN GENERAL.—Not later than 30 days after the
11 date of enactment of this Act, the Secretary of Health and
12 Human Services (referred to in this section as the “Sec-
13 retary”) shall establish a commission, to be known as the
14 “Commission on Ensuring Data for Heath Equity” (re-
15 ferred to in this section as the “Commission”) to provide
16 clear and robust guidance to improve the collection, anal-
17 ysis, and use of demographic data in responding to future
18 public health emergencies.

19 (b) MEMBERSHIP AND CHAIRPERSON.—

20 (1) MEMBERSHIP.—The Commission shall be
21 composed of—

22 (A) the Assistant Secretary for Prepared-
23 ness and Response;

24 (B) the Director of the Centers for Disease
25 Control and Prevention;

1 (C) the Director of the National Institutes
2 of Health;

3 (D) the Commissioner of Food and Drugs;

4 (E) the Administrator of the Federal
5 Emergency Management Agency;

6 (F) the Director of the National Institute
7 on Minority Health and Health Disparities;

8 (G) the Director of the Indian Health
9 Service;

10 (H) the Administrator of the Centers for
11 Medicare & Medicaid Services;

12 (I) the Director of the Agency for
13 Healthcare Research and Quality;

14 (J) the Surgeon General;

15 (K) the Administrator of the Health Re-
16 sources and Services Administration;

17 (L) the Director of the Office of Minority
18 Health;

19 (M) the Director of the Office of Women's
20 Health;

21 (N) the Chairperson of the National Coun-
22 cil on Disability;

23 (O) at least 4 State, local, territorial, and
24 Tribal public health officials representing de-
25 partments of public health, or an Urban Indian

1 health representative, who shall represent juris-
2 dictions from different regions of the United
3 States with relatively high concentrations of
4 historically marginalized populations and rural
5 populations, to be appointed by the Secretary;

6 (P) the National Coordinator for Health
7 Information Technology;

8 (Q) at least 3 independent individuals with
9 expertise on racially and ethnically diverse rep-
10 resentation with knowledge or field experience
11 with community-based participatory research on
12 racial and ethnic disparities in public health, to
13 be appointed by the Secretary; and

14 (R) at least 4 individuals with expertise on
15 health equity and demographic data disparities
16 with knowledge of, or field experience in, lan-
17 guage, disability status, sex, sexual orientation,
18 gender identity, or socioeconomic status.

19 (2) CHAIRPERSON.—The Assistant Secretary
20 for Preparedness and Response shall serve as the
21 Chairperson of the Commission.

22 (c) DUTIES.—The Commission shall—

23 (1) examine barriers to collecting, analyzing,
24 and using demographic data in public health;

1 (2) determine how to best use such data to pro-
2 mote health equity across the United States and re-
3 duce racial, Tribal, and other demographic dispari-
4 ties in health outcomes;

5 (3)(A) gather available data related to treat-
6 ment of individuals with disabilities during the
7 COVID–19 pandemic and other public health emer-
8 gencies, including access to vaccinations, denial of
9 treatment for preexisting conditions, removal or de-
10 nial of disability related equipment (including ven-
11 tilators and continuous positive airway pressure
12 (commonly referred to as “CPAP”) machines), and
13 data on completion of do-not-resuscitate orders; and

14 (B) identify barriers to obtaining accurate and
15 timely data related to treatment of such individuals;

16 (4) solicit input from public health officials,
17 community-connected organizations, health care pro-
18 viders, State and local agency officials, Tribal offi-
19 cials, and other experts on barriers to, and best
20 practices for, collecting demographic data; and

21 (5) recommend policy changes that the data in-
22 dicates are necessary to reduce demographic dispari-
23 ties in health outcomes.

24 (d) REPORT.—Not later than 1 year after the date
25 of the enactment of this Act, the Commission shall submit

1 to Congress, and publish on the website of the Department
2 of Health and Human Services, a report containing—

3 (1) the findings of the Commission pursuant to
4 subsection (c);

5 (2) to the extent possible, an analysis of—

6 (A) racial and other demographic dispari-
7 ties in COVID–19 mortality, including an anal-
8 ysis of comorbidities and case fatality rates;

9 (B) sex, sexual orientation, and gender
10 identity disparities in COVID–19 treatment and
11 mortality; and

12 (C) Federal Government policies that dis-
13 parately exacerbate the COVID–19 impact, and
14 recommendations to improve racial and other
15 demographic disparities in health outcomes;

16 (3) an analysis of COVID–19 treatment of indi-
17 viduals with disabilities, including equity of access to
18 treatment and equipment and intersections of dis-
19 ability status with other demographic factors, includ-
20 ing race;

21 (4) an analysis of what demographic data is
22 currently being collected, the accuracy of that data
23 and any gaps, how this data is currently being used
24 to inform efforts to combat COVID–19, and what

1 resources are needed to supplement existing public
2 health data collection; and

3 (5) the Commission's recommendations with re-
4 spect to—

5 (A) how to enhance State, local, territorial,
6 and Tribal capacity to conduct public health re-
7 search on COVID–19 and in future public
8 health emergencies, with a focus on expanded
9 capacity to analyze data on disparities cor-
10 related with race, ethnicity, income, sex, sexual
11 orientation, gender identity, age, disability sta-
12 tus, specific geographic areas, and other rel-
13 evant demographic characteristics;

14 (B) how to collect, process, and disclose to
15 the public the data described in subparagraph
16 (A) in a way that maintains individual privacy
17 while helping direct the State, local, and Tribal
18 response to public health emergencies;

19 (C) how to improve demographic data col-
20 lection related to COVID–19 and other public
21 health emergencies in the short-term and long-
22 term, including how to continue to grow and
23 value the Tribal sovereignty of data and infor-
24 mation concerning urban and rural Tribal com-
25 munities;

1 (D) how to improve transparency and eq-
2 uity of treatment for individuals with disabil-
3 ities during the COVID–19 public health emer-
4 gency and future public health emergencies; and

5 (E) how to support State, local, and Tribal
6 capacity to eliminate barriers to vaccinations,
7 testing, and treatment during the COVID–19
8 public health emergency and future public
9 health emergencies.

10 (e) STAFF OF COMMISSION.—

11 (1) ADDITIONAL STAFF.—The Chairperson of
12 the Commission may appoint and fix the pay of ad-
13 ditional staff to the Commission as the Chairperson
14 considers appropriate.

15 (2) APPLICABILITY OF CERTAIN CIVIL SERVICE
16 LAWS.—The staff of the Commission may be ap-
17 pointed without regard to the provisions of title 5,
18 United States Code, governing appointments in the
19 competitive service, and may be paid without regard
20 to the provisions of chapter 51 and subchapter III
21 of chapter 53 of that title relating to classification
22 and General Schedule pay rates.

23 (3) DETAILEES.—Any Federal Government em-
24 ployee may be detailed to the Commission without
25 reimbursement from the Commission, and the

1 detailee shall retain the rights, status, and privileges
2 of his or her regular employment without interrup-
3 tion.

4 (f) COORDINATION WITH OTHER EFFORTS.—The
5 Secretary shall, in establishing the Commission under this
6 section, take such steps as may be necessary to ensure
7 that the work of the Commission does not overlap with,
8 or otherwise duplicate, other Federal Government efforts
9 with respect to ensuring health equity in data collection
10 in public health emergencies.

11 (g) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated such sums as may be
13 necessary to carry out this section.

14 **SEC. 1013. TASK FORCE ON PREVENTING BIAS IN AI AND**
15 **ALGORITHMS.**

16 (a) IN GENERAL.—Not later than 30 days after the
17 date of enactment of this Act, the Secretary of Health and
18 Human Services (referred to in this section as the “Sec-
19 retary”) shall establish a Task Force to be known as the
20 “Task Force on Preventing AI and Algorithmic Bias in
21 Healthcare” (referred to in this section as the “Task
22 Force”) to provide clear and robust guidance on how to
23 ensure that the development and integration of artificial
24 intelligence and algorithmic technologies within the health

1 care service delivery process does not exacerbate health
2 disparities and expands access to health care services.

3 (b) MEMBERSHIP AND CHAIRPERSON.—

4 (1) MEMBERSHIP.—The Task Force shall be
5 composed of—

6 (A) the Chief Information Officer of the
7 Department of Health and Human Services;

8 (B) the Director of the Centers for Disease
9 Control and Prevention;

10 (C) the Director of the National Institutes
11 of Health;

12 (D) the Commissioner of Food and Drugs;

13 (E) the Administrator of the Federal
14 Emergency Management Agency;

15 (F) the Director of the National Institute
16 on Minority Health and Health Disparities;

17 (G) the Director of the Indian Health
18 Service;

19 (H) the Administrator of the Centers for
20 Medicare & Medicaid Services;

21 (I) the Director of the Agency for
22 Healthcare Research and Quality;

23 (J) the Surgeon General;

24 (K) the Administrator of the Health Re-
25 sources and Services Administration;

1 (L) the Director of the Office of Minority
2 Health;

3 (M) the Director of the Office of Women's
4 Health;

5 (N) the Chairperson of the National Coun-
6 cil on Disability;

7 (O) the National Coordinator for Health
8 Information Technology;

9 (P) at least 4 State, local, territorial, and
10 Tribal public health officials representing de-
11 partments of public health, or an Urban Indian
12 health representative, who shall represent juris-
13 dictions from different regions of the United
14 States with relatively high concentrations of
15 historically marginalized populations, to be ap-
16 pointed by the Secretary;

17 (Q) at least 3 independent individuals with
18 expertise on racially and ethnically diverse rep-
19 resentation with knowledge or field experience
20 with community-based participatory research on
21 racial and ethnic disparities in public health, to
22 be appointed by the Secretary; and

23 (R) at least 4 individuals with expertise on
24 health equity and demographic data disparities
25 with knowledge of, or field experience in, lan-

1 guage, disability status, sex, sexual orientation,
2 gender identity, or socioeconomic status.

3 (2) CHAIRPERSON.—The Chief Information Of-
4 ficer of the Department of Health and Human Serv-
5 ices (or the Chief Information Officer’s designee)
6 shall serve as the Chairperson of the Task Force.

7 (c) DUTIES.—The Task Force shall—

8 (1) examine where to place artificial intelligence
9 and algorithms in the health care service delivery
10 process relative to the use of autonomous human de-
11 cision-makers;

12 (2) identify the risks of health care system utili-
13 zation of artificial intelligence and algorithms in
14 terms of civil rights, civil liberties, and discrimina-
15 tory bias in health care access, quality, and out-
16 comes; and

17 (3) prepare and submit the report under sub-
18 section (d).

19 (d) REPORT.—Not later than 1 year after the date
20 of enactment of this Act, the Task Force shall—

21 (1) submit a written report of the findings of
22 the examination under paragraph (1) and rec-
23 ommendations to Congress with respect to imple-
24 mentation of artificial intelligence and algorithms in

1 health care delivery and mitigation of the risks asso-
2 ciated with that implementation; and

3 (2) publish such report on the website of the
4 Department of Health and Human Services.

5 (e) PUBLIC COMMENT.—Not later than 60 days after
6 the date of the date of the enactment of this Act, the Task
7 Force shall publish in the Federal Register a notice pro-
8 viding for a public comment period on the duties and ac-
9 tivities of the Task Force of not less than 90 days, begin-
10 ning on the date of that publication.

11 (f) STAFF OF COMMISSION.—

12 (1) ADDITIONAL STAFF.—The Chairperson of
13 the Task Force may appoint and fix the pay of addi-
14 tional staff to the Task Force as the Chairperson
15 considers appropriate.

16 (2) APPLICABILITY OF CERTAIN CIVIL SERVICE
17 LAWS.—The staff of the Task Force may be ap-
18 pointed without regard to the provisions of title 5,
19 United States Code, governing appointments in the
20 competitive service, and may be paid without regard
21 to the provisions of chapter 51 and subchapter III
22 of chapter 53 of that title relating to classification
23 and General Schedule pay rates.

24 (3) DETAILEES.—Any Federal Government em-
25 ployee may be detailed to the Task Force without re-

1 imbursement from the Task Force, and the detailee
2 shall retain the rights, status, and privileges of his
3 or her regular employment without interruption.

4 **TITLE II—CULTURALLY AND LIN-**
5 **GUISTICALLY APPROPRIATE**
6 **HEALTH AND HEALTH CARE**

7 **SEC. 2001. DEFINITIONS; FINDINGS.**

8 (a) DEFINITIONS.—In this title, the definitions in
9 section 3400 of the Public Health Service Act, as added
10 by section 2004, shall apply.

11 (b) FINDINGS.—Congress finds the following:

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

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

22 (3) The number of limited English speaking
23 residents in the United States who speak English
24 less than very well and, therefore, cannot effectively

1 communicate with health and social service providers
2 continues to increase significantly.

3 (4) The responsibility to fund language services
4 in the provision of health care and health care-re-
5 lated services to individuals with limited English
6 proficiency and individuals with communication dis-
7 abilities such as cognitive, hearing, vision, or print
8 impairments is a societal one that cannot fairly be
9 placed solely upon the health care, public health, or
10 social services community.

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

22 (6) Both the Americans with Disabilities Act of
23 1990 (42 U.S.C. 12101 et seq.) and the Rehabilita-
24 tion Act of 1973 (29 U.S.C. 701 et seq.) prohibit
25 discrimination on the basis of disability and require

1 the provision of appropriate auxiliary aids and serv-
2 ices necessary to ensure effective communication
3 with individuals with disabilities. The type of auxil-
4 iary aid or service necessary to ensure effective com-
5 munication will vary in accordance with the method
6 of communication used by the individual, the nature,
7 length, and complexity of the communication in-
8 volved, and the context in which the communication
9 is taking place. A public accommodation should con-
10 sult with individuals with disabilities whenever pos-
11 sible to determine what type of auxiliary aid is need-
12 ed to ensure effective communication. The public ac-
13 commodation should use the individual's preferred
14 method of communication whenever possible, unless
15 it would be an undue burden to the public accommo-
16 dation and an alternative would provide an equally
17 effective means of communication. The ultimate de-
18 cision as to what measures to take rests with the
19 public accommodation, provided that the method
20 chosen results in effective communication.

21 (7) Section 1557 of the Patient Protection and
22 Affordable Care Act (42 U.S.C. 18116) builds on
23 title VI of the Civil Rights Act of 1964 (42 U.S.C.
24 2000d et seq.) and section 504 of the Rehabilitation
25 Act of 1973 (29 U.S.C. 794), prohibits discrimina-

1 tion on the basis of race, color, national origin, dis-
2 ability, sex, and age, requires the provision of lan-
3 guage services to ensure effective communication
4 with individuals with limited English proficiency,
5 and requires the provision of appropriate auxiliary
6 aids and services necessary to ensure effective com-
7 munication with individuals with disabilities.

8 (8) Linguistic diversity in the health care and
9 health care-related services workforce is important
10 for providing all patients the environment most con-
11 ducive to positive health outcomes.

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

21 (10) Access to English as a second language,
22 foreign language, and sign language interpreters,
23 translated and alternative format documents, read-
24 ers, and other auxiliary aids and services, are essen-
25 tial to ensure effective communication and eliminate

1 the language barriers that impede access to health
2 care.

3 (11) Culturally competent language services in
4 health care settings should be available as a matter
5 of course.

6 **SEC. 2002. IMPROVING ACCESS TO SERVICES FOR INDIVID-**
7 **UALS WITH LIMITED ENGLISH PROFICIENCY.**

8 (a) PURPOSE.—Consistent with the goals provided in
9 Executive Order 13166 (42 U.S.C. 2000d–1 note; relating
10 to improving access to services for persons with limited
11 English proficiency), it is the purpose of this section—

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

16 (2) to require each Federal agency to examine
17 the services it provides and develop and implement
18 a system by which individuals with limited English
19 proficiency can obtain culturally competent services
20 and meaningful access to those services consistent
21 with, and without substantially burdening, the fun-
22 damental mission of the agency;

23 (3) to require each Federal agency to translate
24 any English language written material prepared for
25 the general public relating to a public health emer-

1 agency, including vaccine distribution and education,
2 into the top 15 non-English languages in the United
3 States (according to the most recent data from the
4 American Community Survey or its replacement) not
5 later than 7 days after any such material is made
6 available in English;

7 (4) to require each Federal agency to ensure
8 that recipients of Federal financial assistance pro-
9 vide culturally competent services and meaningful
10 access to applicants and beneficiaries who are indi-
11 viduals with limited English proficiency;

12 (5) to ensure that recipients of Federal finan-
13 cial assistance take reasonable steps, consistent with
14 the guidelines set forth in the “Guidance to Federal
15 Financial Assistance Recipients Regarding Title VI
16 Prohibition Against National Origin Discrimination
17 Affecting Limited English Proficient Persons” (67
18 Fed. Reg. 41455 (June 18, 2002)), to ensure cul-
19 turally and linguistically appropriate access to their
20 programs and activities by individuals with limited
21 English proficiency; and

22 (6) to ensure compliance with title VI of the
23 Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.)
24 and section 1557 of the Patient Protection and Af-
25 fordable Care Act (42 U.S.C. 18116) (prohibiting

1 health care providers and organizations from dis-
2 criminating in the provision of services).

3 (b) FEDERALLY CONDUCTED PROGRAMS AND AC-
4 TIVITIES.—

5 (1) IN GENERAL.—Not later than 120 days
6 after the date of enactment of this Act, each Federal
7 agency providing financial assistance to, or admin-
8 istering, a health program or activity described in
9 section 2003(a) shall prepare a plan or update a
10 plan to improve culturally and linguistically appro-
11 priate access to such program or activity with re-
12 spect to individuals with limited English proficiency.
13 Not later than 1 year after the date of enactment
14 of this title, each such Federal agency shall ensure
15 that such plan is fully implemented.

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

18 (A) the steps the agency will take to en-
19 sure that individuals with limited English pro-
20 ficiency have access to each health program or
21 activity supported or administered by the agen-
22 cy;

23 (B) the policies and procedures for identi-
24 fying, assessing, and meeting the culturally and
25 linguistically appropriate language needs of its

1 beneficiaries that are individuals with limited
2 English proficiency served by such program or
3 activity;

4 (C) the steps the agency will take for such
5 program or activity to be culturally and linguis-
6 tically appropriate by—

7 (i) providing a range of language as-
8 sistance options;

9 (ii) giving notice to individuals with
10 limited English proficiency of the right to
11 competent language services;

12 (iii) training staff (at least annually);

13 and

14 (iv) monitoring and assessing the
15 quality of the language services (at least
16 annually);

17 (D) the steps the agency will take for such
18 program or activity to provide reasonable ac-
19 commodations necessary for individuals with
20 limited English proficiency, including those in-
21 dividuals with a communication disability, to
22 understand communications from the agency;

23 (E) the steps the agency will take to en-
24 sure that applications, forms, and other signifi-
25 cant documents for such program or activity

1 are competently translated into the primary
2 language of a client that is an individual with
3 limited English proficiency where such mate-
4 rials are needed to improve access of such client
5 to such program or activity;

6 (F) the resources the agency will provide
7 to improve cultural and linguistic appropriate-
8 ness to assist recipients of Federal funds to im-
9 prove access to health care-related programs
10 and activities for individuals with limited
11 English proficiency;

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

17 (H) the resources the agency will provide
18 to ensure that family, particularly minor chil-
19 dren, and friends are not used to provide inter-
20 pretation services, except as permitted under
21 section 1557 of the Patient Protection and Af-
22 fordable Care Act (42 U.S.C. 18116); and

23 (I) the steps the agency will take and re-
24 sources the agency will provide to ensure that

1 individuals know their rights, including the abil-
2 ity to file a complaint.

3 (3) SUBMISSION OF PLAN TO DOJ.—Each agen-
4 cy that is required to prepare a plan under para-
5 graph (1) shall—

6 (A) consult with populations who are di-
7 rectly impacted by policies in the plan and their
8 representatives in the development of the plan;
9 and

10 (B) when the plan is finalized, send a copy
11 of such plan to the Attorney General, to serve
12 as the central repository of all such plans.

13 **SEC. 2003. ENSURING STANDARDS FOR CULTURALLY AND**
14 **LINGUISTICALLY APPROPRIATE SERVICES IN**
15 **HEALTH CARE.**

16 (a) APPLICABILITY.—This section shall apply to any
17 health program or activity—

18 (1) of which any part is receiving Federal fi-
19 nancial assistance, including credits, subsidies, or
20 contracts of insurance; or

21 (2) that is carried out (including indirectly
22 through contracts, subcontracts, or other support)
23 by an executive agency or any entity established
24 under title I of the Patient Protection and Afford-

1 able Care Act (42 U.S.C. 18001 et seq.) (or amend-
2 ments made thereby).

3 (b) STANDARDS.—Each program or activity de-
4 scribed in subsection (a)—

5 (1) shall implement strategies to recruit, retain,
6 and promote individuals at all levels to maintain a
7 diverse staff and leadership that can provide cul-
8 turally and linguistically appropriate health care to
9 patient populations of the service area of the pro-
10 gram or activity;

11 (2) shall educate and train governance, leader-
12 ship, and workforce at all levels and across all dis-
13 ciplines of the program or activity in culturally and
14 linguistically appropriate policies and practices on an
15 ongoing basis at least yearly;

16 (3) shall offer and provide language assistance,
17 including trained and competent bilingual staff and
18 interpreter services, to individuals with limited
19 English proficiency or who have other communica-
20 tion needs, at no cost to the individual at all points
21 of contact, and during all hours of operation, to fa-
22 cilitate timely access to health care services and
23 health care-related services;

24 (4) shall for each language group consisting of
25 individuals with limited English proficiency that con-

1 stitutes 5 percent or 500 individuals, whichever is
2 less, of the population of persons eligible to be
3 served or likely to be affected or encountered in the
4 service area of the program or activity, make avail-
5 able at a fifth grade reading level—

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

9 (B) information or notices about termi-
10 nation of benefits in such language;

11 (C) signage; and

12 (D) any other documents or types of docu-
13 ments designated by the Secretary;

14 (5) shall develop and implement clear goals,
15 policies, operational plans, and management, ac-
16 countability, and oversight mechanisms to provide
17 culturally and linguistically appropriate services and
18 infuse them throughout the planning and operations
19 of the program or activity;

20 (6) shall conduct initial and ongoing, at least
21 annually, organizational assessments of culturally
22 and linguistically appropriate services-related activi-
23 ties and integrate valid linguistic, competence-related
24 National Standards for Culturally and Linguistically
25 Appropriate Services (CLAS) measures into the in-

1 ternal audits, performance improvement programs,
2 patient satisfaction assessments, continuous quality
3 improvement activities, and outcomes-based evalua-
4 tions of the program or activity and develop ways to
5 standardize assessments;

6 (7) shall ensure that, consistent with the pri-
7 vacy protections provided for under the regulations
8 promulgated under section 264(c) of the Health In-
9 surance Portability and Accountability Act of 1996,
10 data on an individual required to be collected pursu-
11 ant to section 3101, including the individual's alter-
12 native format preferences and policy modification
13 needs, are—

14 (A) collected in health records;

15 (B) integrated into the management infor-
16 mation systems of the program or activity;

17 (C) reported in such a way as to be inter-
18 operable with health information systems at the
19 Federal and State levels; and

20 (D) periodically updated;

21 (8) shall maintain a current demographic, cul-
22 tural, and epidemiological profile of the community,
23 conduct regular assessments of community health
24 assets and needs, and use the results of such assess-
25 ments to accurately plan for and implement services

1 that respond to the cultural and linguistic character-
2 istics of the service area of the program or activity;

3 (9) shall develop participatory, collaborative
4 partnerships with community-based organizations
5 and utilize a variety of formal and informal mecha-
6 nisms to facilitate community and patient involve-
7 ment in designing, implementing, and evaluating
8 policies and practices to ensure culturally and lin-
9 guistically appropriate service-related activities;

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

15 (11) shall annually make available to the public
16 information about their progress and successful in-
17 novations in implementing the standards under this
18 section, translated materials of such information
19 that is culturally and linguistically appropriate to
20 the communities served under this section, and pro-
21 vide public notice in such communities about the
22 availability of this information; and

23 (12) shall, if requested, regularly make avail-
24 able to the head of each Federal entity from which
25 Federal funds are provided, information about the

1 progress and successful innovations of the program
2 or activity in implementing the standards under this
3 section as required by the head of such entity.

4 (c) COMMENTS ACCEPTED THROUGH NOTICE AND
5 COMMENT RULEMAKING.—An agency carrying out a pro-
6 gram or activity described in subsection (a)—

7 (1) shall ensure that comments with respect to
8 such program or activity that are accepted through
9 notice and comment rulemaking are accepted in all
10 languages;

11 (2) may not require such comments to be sub-
12 mitted only in English; and

13 (3) shall ensure that any such comments that
14 are not submitted in English are considered, during
15 the agency's review of such comments, equally as
16 such comments that are submitted in English.

17 **SEC. 2004. CULTURALLY AND LINGUISTICALLY APPRO-**
18 **PRIATE HEALTH CARE IN THE PUBLIC**
19 **HEALTH SERVICE ACT.**

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

1 **“TITLE XXXIV—CULTURALLY**
2 **AND LINGUISTICALLY APPRO-**
3 **PRIATE HEALTH CARE**

4 **“SEC. 3400. DEFINITIONS.**

5 “(a) IN GENERAL.—In this title:

6 “(1) BILINGUAL.—The term ‘bilingual’, with
7 respect to an individual, means an individual who
8 has a sufficient degree of proficiency in 2 languages.

9 “(2) CULTURAL.—The term ‘cultural’ means
10 relating to integrated patterns of human behavior
11 that include the language, thoughts, communica-
12 tions, actions, customs, beliefs, values, age, and in-
13 stitutions of racial, ethnic, religious, or social
14 groups, including lesbian, gay, bisexual, transgender,
15 queer, and questioning individuals, and individuals
16 with physical and mental disabilities.

17 “(3) CULTURALLY AND LINGUISTICALLY AP-
18 PROPRIATE.—The term ‘culturally and linguistically
19 appropriate’ means being respectful of and respon-
20 sive to the cultural and linguistic needs of all indi-
21 viduals.

22 “(4) EFFECTIVE COMMUNICATION.—The term
23 ‘effective communication’ means an exchange of in-
24 formation between the provider of health care or
25 health care-related services and the recipient of such

1 services who is limited in English proficiency, or has
2 a communication impairment such as a hearing, vi-
3 sion, speaking, or cognitive disability, that enables
4 access to, understanding of, and benefit from health
5 care or health care-related services, and full partici-
6 pation in the development of their treatment plan.

7 “(5) GRIEVANCE RESOLUTION PROCESS.—The
8 term ‘grievance resolution process’ means all aspects
9 of dispute resolution including filing complaints,
10 grievance and appeal procedures, and court action.

11 “(6) HEALTH CARE GROUP.—The term ‘health
12 care group’ means a group of physicians organized,
13 at least in part, for the purposes of providing physi-
14 cian services under the Medicaid program under title
15 XIX of the Social Security Act, the State Children’s
16 Health Insurance Program under title XXI of such
17 Act, or the Medicare program under title XVIII of
18 such Act, including a provider of services under part
19 B of such title XVIII, and may include a hospital,
20 a hospice provider, a palliative care provider, and
21 any other individual or entity furnishing services
22 covered under any such program that is affiliated
23 with the health care group.

1 “(7) HEALTH CARE.—The term ‘health care’
2 includes all health care needed throughout the life
3 cycle and the end of life.

4 “(8) HEALTH CARE SERVICES.—The term
5 ‘health care services’ means services that address
6 physical and mental health conditions, as well as
7 conditions impacted by social determinants of health,
8 in all care settings throughout the life cycle and the
9 end of life.

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

14 “(10) HEALTH EDUCATOR.—The term ‘health
15 educator’ includes a professional with a bacca-
16 laureate degree who is responsible for designing, im-
17 plementing, and evaluating individual and population
18 health promotion, health education (including edu-
19 cation on end-of-life care options), end-of-life care,
20 or chronic disease prevention programs.

21 “(11) INDIAN; INDIAN TRIBE.—The terms ‘In-
22 dian’ and ‘Indian Tribe’ have the meanings given
23 such terms in section 4 of the Indian Self-Deter-
24 mination and Education Assistance Act.

1 “(12) INDIVIDUAL WITH A DISABILITY.—The
2 term ‘individual with a disability’ means any indi-
3 vidual who has a disability as defined for the pur-
4 pose of section 504 of the Rehabilitation Act of
5 1973.

6 “(13) INDIVIDUAL WITH LIMITED ENGLISH
7 PROFICIENCY.—The term ‘individual with limited
8 English proficiency’ means an individual who self-
9 identifies on the Census as speaking English less
10 than ‘very well’.

11 “(14) INTEGRATED HEALTH CARE DELIVERY
12 SYSTEM.—The term ‘integrated health care delivery
13 system’ means an interdisciplinary system that
14 brings together providers from the primary health,
15 mental health, substance use disorder, hospice and
16 palliative care, and related disciplines to improve the
17 health outcomes of an individual and the community.
18 Such providers may include hospitals, health, mental
19 health, or substance use prevention and treatment
20 clinics and providers, home health agencies, home-
21 and community-based services providers, congregate
22 care settings (including any skilled nursing facilities,
23 assisted living facilities, prisons and jails, residential
24 behavioral health care and psychiatric facilities, and
25 facilities providing services for aging adults and peo-

1 ple with disabilities), ambulatory surgery centers, re-
2 habilitation centers, and employed, independent, or
3 contracted physicians.

4 “(15) INTERPRETING; INTERPRETATION.—The
5 terms ‘interpreting’ and ‘interpretation’ mean the
6 transmission of a spoken, written, or signed message
7 from one language or format into another, faithfully,
8 accurately, and objectively.

9 “(16) LANGUAGE ACCESS.—The term ‘language
10 access’ means the provision of language services to
11 an individual with limited English proficiency or an
12 individual with communication disabilities designed
13 to enhance that individual’s access to, understanding
14 of, or benefit from health care services or health
15 care-related services.

16 “(17) LANGUAGE ASSISTANCE SERVICES.—The
17 term ‘language assistance services’ includes—

18 “(A) oral language assistance, including in-
19 terpretation in non-English languages provided
20 in-person or remotely by a qualified interpreter
21 for an individual with limited English pro-
22 ficiency, and the use of qualified bilingual or
23 multilingual staff to communicate directly with
24 individuals with limited English proficiency;

1 “(B) written translation, performed by a
2 qualified translator, of written content in paper
3 or electronic form into languages other than
4 English; and

5 “(C) taglines.

6 “(18) MINORITY.—

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

10 “(B) POPULATIONS.—The term ‘minority’,
11 with respect to populations, refers to racial and
12 ethnic minority groups, members of sexual and
13 gender minority groups, and individuals with a
14 disability.

15 “(19) MINORITY GROUP.—The term ‘minority
16 group’ means a racial and ethnic minority group as
17 defined in this section.

18 “(20) ONSITE INTERPRETATION.—The term
19 ‘onsite interpretation’ means a method of inter-
20 preting or interpretation for which the interpreter is
21 in the physical presence of the provider of health
22 care services or health care-related services and the
23 recipient of such services who is limited in English
24 proficiency or has a communication impairment such
25 as an impairment in hearing, vision, or learning.

1 “(21) QUALIFIED INDIVIDUAL WITH A DIS-
2 ABILITY.—The term ‘qualified individual with a dis-
3 ability’ means, with respect to a health program or
4 activity, an individual with a disability who, with or
5 without reasonable modifications to policies, prac-
6 tices, or procedures, the removal of architectural,
7 communication, or transportation barriers, or the
8 provision of auxiliary aids and services, meets the es-
9 sential eligibility requirements for the receipt of aids,
10 benefits, or services offered or provided by the health
11 program or activity.

12 “(22) QUALIFIED INTERPRETER FOR AN INDIVIDUAL WITH A DISABILITY.—The term ‘qualified
13 interpreter for an individual with a disability’, with
14 respect to an individual with a disability—

15 “(A) means an interpreter for such indi-
16 vidual who by means of a remote interpreting
17 service or an onsite appearance—

18 “(i) adheres to generally accepted in-
19 terpreter ethics principles, including client
20 confidentiality; and
21 “(ii) is able to interpret effectively, ac-

22 curately, and impartially, both receptively
23 and expressively, using any necessary spe-
24

1 cialized vocabulary, terminology, and phra-
2 seology; and

3 “(B) may include—

4 “(i) sign language interpreters;

5 “(ii) oral transliterators, which are in-
6 dividuals who represent or spell in the
7 characters of another alphabet; and

8 “(iii) cued language transliterators,
9 which are individuals who represent or
10 spell by using a small number of
11 handshapes.

12 “(23) QUALIFIED INTERPRETER FOR AN INDIVIDUAL WITH LIMITED ENGLISH PROFICIENCY.—
13
14 The term ‘qualified interpreter for an individual with
15 limited English proficiency’ means an interpreter
16 who by means of a remote interpreting service or an
17 onsite appearance—

18 “(A) adheres to generally accepted inter-
19 preter ethics principles, including client con-
20 fidentiality;

21 “(B) has demonstrated proficiency in
22 speaking and understanding both spoken
23 English and one or more other spoken lan-
24 guages; and

1 “(C) is able to interpret effectively, accu-
2 rately, and impartially, both receptively and ex-
3 pressly, to and from such languages and
4 English, using any necessary specialized vocab-
5 ulary, terminology, and phraseology.

6 “(24) QUALIFIED TRANSLATOR.—The term
7 ‘qualified translator’ means a translator who—

8 “(A) adheres to generally accepted trans-
9 lator ethics principles, including client confiden-
10 tiality;

11 “(B) has demonstrated proficiency in writ-
12 ing and understanding both written English
13 and one or more other written non-English lan-
14 guages; and

15 “(C) is able to translate effectively, accu-
16 rately, and impartially to and from such lan-
17 guages and English, using any necessary spe-
18 cialized vocabulary, terminology, and phrase-
19 ology.

20 “(25) RACIAL AND ETHNIC MINORITY GROUP.—

21 The term ‘racial and ethnic minority group’ means
22 Indians and Alaska Natives, African Americans (in-
23 cluding Caribbean Blacks, Africans, and other
24 Blacks), Asian Americans, Hispanics (including

1 Latinos), Middle Easterners and North Africans,
2 and Native Hawaiians and other Pacific Islanders.

3 “(26) SECRETARY.—The term ‘Secretary’
4 means the Secretary of Health and Human Services,
5 acting through the Director of the Agency for
6 Healthcare Research and Quality.

7 “(27) SEXUAL AND GENDER MINORITY
8 GROUP.—The term ‘sexual and gender minority
9 group’ encompasses lesbian, gay, bisexual, and
10 transgender populations, as well as those whose sex-
11 ual orientation, gender identity and expression, or
12 reproductive development varies from traditional, so-
13 cietal, cultural, or physiological norms.

14 “(28) SIGHT TRANSLATION.—The term ‘sight
15 translation’ means the transmission of a written
16 message in one language into a spoken or signed
17 message in another language, or an alternative for-
18 mat in English or another language.

19 “(29) STATE.—Notwithstanding section 2, the
20 term ‘State’ means each of the several States, the
21 District of Columbia, the Commonwealth of Puerto
22 Rico, the United States Virgin Islands, Guam,
23 American Samoa, and the Commonwealth of the
24 Northern Mariana Islands.

1 “(30) TELEPHONIC INTERPRETATION.—The
2 term ‘telephonic interpretation’ (also known as ‘over
3 the phone interpretation’ or ‘OPI’) means, with re-
4 spect to interpretation for an individual with limited
5 English proficiency, a method of interpretation in
6 which the interpreter is not in the physical presence
7 of the provider of health care services or health care-
8 related services and such individual receiving such
9 services, but the interpreter is connected via tele-
10 phone.

11 “(31) TRANSLATION.—The term ‘translation’
12 means the transmission of a written message in one
13 language into a written or signed message in an-
14 other language, and includes translation into an-
15 other language or alternative format, such as large
16 print font, Braille, audio recording, or CD.

17 “(32) UNDERSERVED COMMUNITIES.—The
18 term ‘underserved communities’ means populations
19 sharing a particular characteristic, as well as geo-
20 graphic communities, who have been systematically
21 denied a full opportunity to participate in aspects of
22 economic, social, and civic life, such as—

23 “(A) Black, Latino, and Indigenous and
24 Native American persons, Asian Americans and

1 Pacific Islanders, Middle Easterners and North
2 Africans, and other persons of color;

3 “(B) members of religious minorities;

4 “(C) lesbian, gay, bisexual, transgender,
5 and queer persons;

6 “(D) persons with disabilities;

7 “(E) persons who live in rural areas; and

8 “(F) persons otherwise adversely affected
9 by persistent poverty or inequality as defined in
10 Executive Order 13985.

11 “(33) UNDERSERVED POPULATIONS.—The
12 term ‘underserved populations’ means populations
13 sharing a particular characteristic, as well as geo-
14 graphic communities, who have been systematically
15 denied a full opportunity to participate in aspects of
16 economic, social, and civic life, as defined in Execu-
17 tive Order 13985.

18 “(34) VIDEO REMOTE INTERPRETING SERV-
19 ICES.—The term ‘video remote interpreting services’
20 means the provision, in health care services or health
21 care-related services, through a qualified interpreter
22 for an individual with limited English proficiency, of
23 video remote interpreting services that are—

24 “(A) in real-time, full-motion video, and
25 audio over a dedicated high-speed, wide-band-

1 width video connection or wireless connection
2 that delivers high-quality video images that do
3 not produce lags, choppy, blurry, or grainy im-
4 ages, or irregular pauses in communication; and
5 “(B) in a sharply delineated image that is
6 large enough to display.

7 “(35) VITAL DOCUMENT.—The term ‘vital doc-
8 ument’ includes applications for government pro-
9 grams that provide health care services, medical or
10 financial consent forms, financial assistance docu-
11 ments, letters containing important information re-
12 garding patient instructions (such as prescriptions,
13 referrals to other providers, and discharge plans)
14 and participation in a program (such as a Medicaid
15 managed care program), notices pertaining to the
16 reduction, denial, or termination of services or bene-
17 fits, notices of the right to appeal such actions, and
18 notices advising individuals with limited English pro-
19 ficiency with communication disabilities of the avail-
20 ability of free language services, alternative formats,
21 and other outreach materials.

22 “(b) REFERENCE.—In any reference in this title to
23 a regulatory provision applicable to a ‘handicapped indi-
24 vidual’, the term ‘handicapped individual’ in such provi-

1 sion shall have the same meaning as the term ‘individual
2 with a disability’ as defined in subsection (a).

3 **“Subtitle A—Resources and Innova-**
4 **tion for Culturally and Linguis-**
5 **tically Appropriate Health Care**

6 **“SEC. 3401. ROBERT T. MATSUI CENTER FOR CULTURALLY**
7 **AND LINGUISTICALLY APPROPRIATE HEALTH**
8 **CARE.**

9 “(a) ESTABLISHMENT.—The Secretary shall estab-
10 lish and support a center to be known as the ‘Robert T.
11 Matsui Center for Culturally and Linguistically Appro-
12 priate Health Care’ (referred to in this section as the
13 ‘Center’) to carry out each of the following activities:

14 “(1) INTERPRETATION SERVICES.—

15 “(A) IN GENERAL.—The Center shall pro-
16 vide resources via the internet to identify and
17 link health care providers to competent and
18 qualified interpreter and translation services.

19 “(B) TRAINING.—For purposes of pro-
20 viding the services described in subparagraph
21 (A), the Center shall adopt a language access
22 plan that includes training requirements for
23 Center staff to provide such services.

24 “(2) TRANSLATION OF WRITTEN MATERIAL.—

1 “(A) VITAL DOCUMENTS.—The Center
2 shall provide, directly or through contract, to
3 providers of health care services and health
4 care-related services, at no cost to such pro-
5 viders and in a timely and reasonable manner,
6 vital documents—

7 “(i) which may be submitted by cov-
8 ered entities (as defined in section 92.4 of
9 title 45, Code of Federal Regulations, as in
10 effect on May 18, 2016) for translation
11 into non-English languages or alternative
12 formats at a fifth-grade reading level; and

13 “(ii) from competent translation serv-
14 ices, the quality of which shall be mon-
15 itored and reported publicly.

16 “(B) FORMS.—For each form developed or
17 revised by the Secretary that will be used by in-
18 dividuals with limited English proficiency in
19 health care or health care-related settings, the
20 Center shall, not later than 45 calendar days of
21 the Secretary receiving final approval of the
22 form from the Office of Management and
23 Budget—

24 “(i) translate the form, at a min-
25 imum, into the top 15 non-English lan-

1 guages in the United States according to
2 the most recent data from the American
3 Community Survey or its replacement; and
4 “(ii) post all translated forms on the
5 Center’s website.

6 “(3) TOLL-FREE CUSTOMER SERVICE TELE-
7 PHONE NUMBER.—The Center shall provide,
8 through a toll-free number, a customer service line
9 for individuals with limited English proficiency that
10 is linked to the toll-free telephone number 1–800–
11 MEDICARE and a toll-free telephone hotline pro-
12 vided for pursuant to section 1311(d)(4)(B) of the
13 Patient Protection and Affordable Care Act by an
14 Exchange established under title I of such Act—

15 “(A) to obtain information about federally
16 conducted or funded health programs, including
17 the Medicare program under title XVIII of the
18 Social Security Act, the Medicaid program
19 under title XIX of such Act, and the State Chil-
20 dren’s Health Insurance Program under title
21 XXI of such Act, and coverage available
22 through an Exchange established under title I
23 of the Patient Protection and Affordable Care
24 Act, and other sources of free or reduced care
25 including federally qualified health centers, enti-

1 ties receiving assistance under title X, and pub-
2 lic health departments;

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

6 “(C) to learn how to access language serv-
7 ices.

8 “(4) HEALTH INFORMATION CLEARING-
9 HOUSE.—

10 “(A) IN GENERAL.—The Center shall de-
11 velop and maintain, and make available on the
12 internet and in print, an information clearing-
13 house that includes the information described in
14 subparagraphs (B) through (F)—

15 “(i) to facilitate the provision of lan-
16 guage services by providers of health care
17 services and health care-related services to
18 reduce medical errors;

19 “(ii) to improve medical outcomes, im-
20 prove cultural competence, reduce health
21 care costs caused by miscommunication
22 with individuals with limited English pro-
23 ficiency; and

24 “(iii) to reduce or eliminate the dupli-
25 cation of efforts to translate materials.

1 “(B) DOCUMENT TEMPLATES.—The Cen-
2 ter shall collect and evaluate for accuracy, de-
3 velop, and make available templates for stand-
4 ard documents that are necessary for patients
5 and consumers to access and make educated de-
6 cisions about their health care, including tem-
7 plates for each of the following:

8 “(i) Administrative and legal docu-
9 ments, including—

10 “(I) intake forms;

11 “(II) forms related to the Medi-
12 care program under title XVIII of the
13 Social Security Act, the Medicaid pro-
14 gram under title XIX of such Act,
15 and the State Children’s Health In-
16 surance Program under title XXI of
17 such Act, including eligibility informa-
18 tion for such programs;

19 “(III) forms informing patients
20 of the compliance and consent re-
21 quirements pursuant to the regula-
22 tions under section 264(c) of the
23 Health Insurance Portability and Ac-
24 countability Act of 1996 (42 U.S.C.
25 1320–2 note); and

1 “(IV) documents concerning in-
2 formed consent, advanced directives,
3 and waivers of rights.

4 “(ii) Clinical information, such as how
5 to take medications, how to prevent trans-
6 mission of a contagious disease, and other
7 prevention and treatment instructions.

8 “(iii) Public health, patient education,
9 and outreach materials, such as immuniza-
10 tion notices, health warnings, or screening
11 notices.

12 “(iv) Additional health or health care-
13 related materials as determined appro-
14 priate by the Director of the Center.

15 “(C) STRUCTURE OF FORMS.—In oper-
16 ating the clearinghouse, the Center shall—

17 “(i) ensure that the documents posted
18 in English and non-English languages are
19 culturally and linguistically appropriate;

20 “(ii) allow public review of the docu-
21 ments before dissemination in order to en-
22 sure that the documents are understand-
23 able and culturally and linguistically ap-
24 propriate for the target populations;

1 “(iii) allow health care providers to
2 customize the documents for their use;

3 “(iv) facilitate access to such docu-
4 ments;

5 “(v) provide technical assistance with
6 respect to the access and use of such infor-
7 mation; and

8 “(vi) carry out any other activities the
9 Secretary determines to be useful to fulfill
10 the purposes of the clearinghouse.

11 “(D) LANGUAGE ASSISTANCE PRO-
12 GRAMS.—The Center shall provide for the col-
13 lection and dissemination of information on cur-
14 rent examples of language assistance programs
15 and strategies to improve language services for
16 individuals with limited English proficiency, in-
17 cluding case studies using de-identified patient
18 information, program summaries, and program
19 evaluations.

20 “(E) CULTURALLY AND LINGUISTICALLY
21 APPROPRIATE MATERIALS.—The Center shall
22 provide, at no cost, to all health care providers
23 and all providers of health care-related services,
24 information relating to culturally and linguis-
25 tically appropriate health care for minority pop-

1 ulations residing in the United States, includ-
2 ing—

3 “(i) tenets of culturally and linguis-
4 tically appropriate care;

5 “(ii) culturally and linguistically ap-
6 propriate self-assessment tools;

7 “(iii) culturally and linguistically ap-
8 propriate training tools;

9 “(iv) strategic plans to increase cul-
10 tural and linguistic appropriateness in dif-
11 ferent types of providers of health care
12 services and health care-related services,
13 including regional collaborations among
14 health care organizations for health care
15 services and health care-related services;
16 and

17 “(v) culturally and linguistically ap-
18 propriate information for educators, practi-
19 tioners, students, and researchers.

20 “(F) TRANSLATION GLOSSARIES.—The
21 Center shall—

22 “(i) develop and publish on its website
23 translation glossaries that provide stand-
24 ardized translations of commonly used

1 terms and phrases utilized in documents
2 translated by the Center; and

3 “(ii) make such glossaries available—

4 “(I) free of charge;

5 “(II) in each language in which
6 the Center translates forms under
7 paragraph (2)(B);

8 “(III) in alternative formats in
9 accordance with the Americans with
10 Disabilities Act of 1990 (42 U.S.C.
11 12101 et seq.); and

12 “(IV) in paper format upon re-
13 quest.

14 “(G) INFORMATION ABOUT PROGRESS.—

15 The Center shall—

16 “(i) regularly collect and make pub-
17 licly available information about the
18 progress of entities receiving grants under
19 section 3402 regarding successful innova-
20 tions in implementing the requirements of
21 this subsection; and

22 “(ii) provide public notice in the enti-
23 ties’ communities about the availability of
24 such information.

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

5 “(c) AVAILABILITY OF LANGUAGE ACCESS.—The Di-
6 rector of the Center shall collaborate with the Deputy As-
7 sistant Secretary for Minority Health, the Administrator
8 of the Centers for Medicare & Medicaid Services, and the
9 Administrator of the Health Resources and Services Ad-
10 ministration to notify health care providers and health
11 care organizations about the availability of language ac-
12 cess services by the Center.

13 “(d) EDUCATION.—The Secretary, directly or
14 through contract, shall undertake a national education
15 campaign to inform providers, individuals with limited
16 English proficiency, individuals with hearing or vision im-
17 pairments, health professionals, graduate schools, commu-
18 nity health centers, social service providers, and commu-
19 nity-based organizations about—

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

22 “(2) the value of using trained and competent
23 interpreters and the risks associated with using fam-
24 ily members, friends, minors, and untrained bilin-
25 gual staff;

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

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

5 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated to carry out this section
7 \$5,000,000 for each of fiscal years 2023 through 2027.

8 **“SEC. 3402. INNOVATIONS IN CULTURALLY AND LINGUIS-**
9 **TICALLY APPROPRIATE HEALTH CARE**
10 **GRANTS.**

11 “(a) IN GENERAL.—

12 “(1) GRANTS.—The Secretary shall award
13 grants to eligible entities to enable such entities to
14 design, implement, and evaluate innovative, cost-ef-
15 fective programs to improve culturally and linguis-
16 tically appropriate access to health care services for
17 individuals with limited English proficiency and com-
18 munication disabilities.

19 “(2) COORDINATION.—In making grants under
20 this section, and in the design and implementation
21 of the program established under this section, the
22 Secretary shall coordinate with, and ensure the par-
23 ticipation of, other agencies including the Health Re-
24 sources and Services Administration, the National
25 Institute on Minority Health and Health Disparities

1 at the National Institutes of Health, and the Office
2 of Minority Health.

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

5 “(1) a city, county, Indian Tribe, State, or sub-
6 division thereof;

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

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

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

13 “(5) an integrated health care delivery system;

14 “(6) a public hospital;

15 “(7) a health care group, university, or college;

16 or

17 “(8) any other entity designated by the Sec-
18 retary.

19 “(c) APPLICATION.—An eligible entity seeking a
20 grant under this section shall prepare and submit to the
21 Secretary an application, at such time, in such manner,
22 and containing such additional information as the Sec-
23 retary may reasonably require.

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

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

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

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

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

17 “(5) develop participatory, collaborative part-
18 nerships with communities encompassing the patient
19 populations of individuals with limited English pro-
20 ficiency served by the grant to gain input in design-
21 ing and implementing language services;

22 “(6) develop and implement grievance resolu-
23 tion processes that are culturally and linguistically
24 appropriate and capable of identifying, preventing,

1 and resolving complaints by individuals with limited
2 English proficiency;

3 “(7) develop short-term medical and mental
4 health interpretation training courses and incentives
5 for bilingual health care staff who are asked to pro-
6 vide interpretation services in the workplace;

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

13 “(9) provide staff language training instruction,
14 which shall include information on the practical limi-
15 tations of such instruction for nonnative speakers;

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

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

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

24 “(13) ensure that, consistent with the privacy
25 protections provided for under the regulations pro-

1 mulgated under section 264(c) of the Health Insur-
2 ance Portability and Accountability Act of 1996 and
3 any applicable State privacy laws, data on the indi-
4 vidual patient or recipient’s race, ethnicity, and pri-
5 mary language are collected (and periodically up-
6 dated) in health records and integrated into the or-
7 ganization’s information management systems or
8 any similar system used to store and retrieve data;
9 and

10 “(14) ensure that culturally competent care and
11 language assistance are available to individuals with
12 limited English proficiency.

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

18 “(f) EVALUATION.—

19 “(1) BY GRANTEES.—An entity that receives a
20 grant under this section shall submit to the Sec-
21 retary an evaluation that describes, in the manner
22 and to the extent required by the Secretary, the ac-
23 tivities carried out with funds received under the
24 grant, and how such activities improved access to
25 health care services and health care-related services

1 and the quality of health care for individuals with
2 limited English proficiency. Such evaluation shall be
3 collected and disseminated through the Robert T.
4 Matsui Center for Culturally and Linguistically App-
5 appropriate Health Care established under section
6 3401. The Director of the Agency for Healthcare
7 Research and Quality shall notify grantees of the
8 availability of technical assistance for the evaluation
9 and provide such assistance upon request.

10 “(2) BY SECRETARY.—The Director of the
11 Agency for Healthcare Research and Quality shall
12 evaluate or arrange with other individuals or organi-
13 zations to evaluate projects funded under this sec-
14 tion.

15 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
16 is authorized to be appropriated to carry out this section
17 \$5,000,000 for each of fiscal years 2023 through 2027.

18 **“SEC. 3403. RESEARCH ON CULTURAL AND LANGUAGE COM-**
19 **PETENCE.**

20 “(a) IN GENERAL.—The Secretary shall expand re-
21 search concerning language access in the provision of
22 health care services.

23 “(b) ELIGIBILITY.—The Secretary may conduct the
24 research described in subsection (a) or enter into contracts

1 with other individuals or organizations to conduct such re-
2 search.

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

6 “(1) To identify the barriers to mental and be-
7 havioral services that are faced by individuals with
8 limited English proficiency.

9 “(2) To identify health care providers’ and
10 health administrators’ knowledge and awareness of
11 the barriers to quality health care services that are
12 faced by individuals with limited English proficiency
13 and communication disabilities.

14 “(3) To identify optimal approaches for deliv-
15 ering language access.

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

18 “(A) the collection by providers of health
19 care services and health care-related services of
20 data on the race, ethnicity, and primary lan-
21 guage of recipients of such services, taking into
22 account existing research conducted by the Gov-
23 ernment or private sector;

24 “(B) the development and implementation
25 of data collection and reporting systems; and

1 “(C) effective privacy safeguards for col-
2 lected data.

3 “(5) To develop a minimum data collection set
4 for primary language.

5 “(6) To evaluate the most effective ways in
6 which the Secretary can create or coordinate, and
7 subsidize or otherwise fund, telephonic interpretation
8 services for health care providers, taking into consid-
9 eration, among other factors, the flexibility necessary
10 for such a system to accommodate variations in—

11 “(A) provider type;

12 “(B) languages needed and their frequency
13 of use;

14 “(C) type of encounter;

15 “(D) time of encounter, including whether
16 the encounter occurs during regular business
17 hours and after hours; and

18 “(E) location of encounter.

19 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated to carry out this section
21 \$5,000,000 for each of fiscal years 2023 through 2027.”.

1 **SEC. 2005. PILOT PROGRAM FOR IMPROVEMENT AND DE-**
2 **VELOPMENT OF STATE MEDICAL INTER-**
3 **PRETING SERVICES.**

4 (a) GRANTS AUTHORIZED.—The Secretary of Health
5 and Human Services (referred to in this section as the
6 “Secretary”) shall award 1 grant in accordance with this
7 section to each of 3 States (to be selected by the Sec-
8 retary) to assist each such State in designing, imple-
9 menting, and evaluating a statewide program to provide
10 onsite interpreter services under the State Medicaid plan.

11 (b) GRANT PERIOD.—A grant awarded under this
12 section is authorized for the period of 3 fiscal years begin-
13 ning on October 1, 2023, and ending on September 30,
14 2026.

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

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

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

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

24 (4) that has a population of qualified LEP en-
25 rollees that is linguistically diverse, requiring inter-

1 preter services in at least 200 non-English lan-
2 guages.

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

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

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

13 (A) a statewide health care information
14 technology system that is designed to achieve
15 efficiencies and economies of scale with respect
16 to onsite interpreter services provided to health
17 care providers in the State participating in the
18 State Medicaid plan; and

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

21 (i) procuring and scheduling inter-
22 preter services for qualified LEP enrollees;

23 (ii) procuring and scheduling inter-
24 preter services for individuals with limited

1 English proficiency seeking to enroll in the
2 State Medicaid plan;

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

6 (iv) consulting regularly with organi-
7 zations representing LEP consumers, in-
8 terpreters, and health care providers; and

9 (3) develop mechanisms to establish, improve,
10 and strengthen the competency of the medical inter-
11 pretation workforce that serves qualified LEP enroll-
12 ees in the State, including a national certification
13 process that is valid, credible, and vendor-neutral.

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

18 (1) A description of the language access needs
19 of individuals in the State enrolled in the State Med-
20 icaid plan.

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

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

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

3 (C) collect information that accurately
4 tracks the language services requested by con-
5 sumers as compared to the language services
6 provided by health care providers in the State
7 participating in the State Medicaid plan.

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

12 (f) DEFINITIONS.—In this section:

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

15 (A) who is limited English proficient; and

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

18 (2) STATE.—The term “State” has the mean-
19 ing given the term in section 1101(a)(1) of the So-
20 cial Security Act (42 U.S.C. 1301(a)(1)), for pur-
21 poses of title XIX of such Act (42 U.S.C. 1396 et
22 seq.).

23 (3) STATE MEDICAID PLAN.—The term “State
24 Medicaid plan” means a State plan under title XIX

1 of the Social Security Act (42 U.S.C. 1396 et seq.)
2 or a waiver of such a plan.

3 (4) UNITED STATES.—The term “United
4 States” has the meaning given the term in section
5 1101(a)(2) of the Social Security Act (42 U.S.C.
6 1301(a)(2)), for purposes of title XIX of such Act
7 (42 U.S.C. 1396 et seq.).

8 (g) CONTINUATION PAST DEMONSTRATION.—Any
9 State receiving a grant under this section must agree to
10 directly pay for language services in Medicaid for all Med-
11 icaid providers by the end of the grant period.

12 (h) FUNDING.—

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

16 (2) AVAILABILITY OF FUNDS.—Amounts appro-
17 priated pursuant to the authorization in paragraph
18 (1) are authorized to remain available without fiscal
19 year limitation.

20 (3) INCREASED FEDERAL FINANCIAL PARTICI-
21 PATION.—Section 1903(a)(2)(E) of the Social Secu-
22 rity Act (42 U.S.C. 1396b(a)(2)(E)) is amended by
23 inserting “(or, in the case of a State that was
24 awarded a grant under section 2005 of the Health
25 Equity and Accountability Act of 2022, 100 percent

1 for each quarter occurring during the grant period
2 specified in subsection (b) of such section)” after
3 “75 percent”.

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

7 **SEC. 2006. TRAINING TOMORROW’S DOCTORS FOR CUL-**
8 **TURALLY AND LINGUISTICALLY APPRO-**
9 **PRIATE CARE: GRADUATE MEDICAL EDU-**
10 **CATION.**

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

15 “(L) TREATMENT OF CULTURALLY AND
16 LINGUISTICALLY APPROPRIATE TRAINING.—In
17 determining a hospital’s number of full-time
18 equivalent residents for purposes of this sub-
19 section, all the time that is spent by an intern
20 or resident in an approved medical residency
21 training program for education and training in
22 culturally and linguistically appropriate service
23 delivery, which shall include all medically under-
24 served populations (as defined in section
25 330(b)(3) of the Public Health Service Act),

1 shall be counted toward the determination of
2 full-time equivalency.”.

3 (b) INDIRECT MEDICAL EDUCATION.—Section
4 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
5 1395ww(d)(5)(B)) is amended—

6 (1) by moving the left margin of clause (xii) 4
7 ems to the left; and

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

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

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

18 **SEC. 2007. FEDERAL REIMBURSEMENT FOR CULTURALLY**
19 **AND LINGUISTICALLY APPROPRIATE SERV-**
20 **ICES UNDER THE MEDICARE, MEDICAID, AND**
21 **STATE CHILDREN’S HEALTH INSURANCE**
22 **PROGRAMS.**

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

25 (1) ESTABLISHMENT.—

1 (A) IN GENERAL.—Not later than 6
2 months after the date of the enactment of this
3 Act, the Secretary of Health and Human Serv-
4 ices (in this subsection referred to as the “Sec-
5 retary”), acting through the Centers for Medi-
6 care & Medicaid Services and in consultation
7 with the Center for Medicare and Medicaid In-
8 novation (as referred to in section 1115A of the
9 Social Security Act (42 U.S.C. 1315a)), shall
10 establish a demonstration program under which
11 the Secretary shall award grants to eligible
12 Medicare service providers to provide culturally
13 and linguistically appropriate services to Medi-
14 care beneficiaries who are limited English pro-
15 ficient, including beneficiaries who live in di-
16 verse and underserved communities.

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

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

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

4 (2) ELIGIBILITY REQUIREMENTS.—To be eligi-
5 ble for a grant under this subsection, an entity must
6 meet the following requirements:

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

9 (i) a provider of services under part A
10 of title XVIII of the Social Security Act
11 (42 U.S.C. 1395c et seq.);

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

14 (iii) a Medicare Advantage organiza-
15 tion offering a Medicare Advantage plan
16 under part C of such title (42 U.S.C.
17 1395w–21 et seq.); or

18 (iv) a PDP sponsor offering a pre-
19 scription drug plan under part D of such
20 title (42 U.S.C. 1395w–101 et seq.).

21 (B) UNDERSERVED COMMUNITIES.—The
22 entity must serve a community that, with re-
23 spect to necessary language services for improv-
24 ing access and utilization of health care among

1 individuals with limited English proficiency, is
2 disproportionately underserved.

3 (C) APPLICATION.—The entity must pre-
4 pare and submit to the Secretary an applica-
5 tion, at such time, in such manner, and accom-
6 panied by such additional information as the
7 Secretary may require.

8 (D) REPORTING.—In the case of a grantee
9 that received a grant under this subsection in
10 a previous year, such grantee is only eligible for
11 continued payments under a grant under this
12 subsection if the grantee met the reporting re-
13 quirements under paragraph (9) for such year.
14 If a grantee fails to meet the requirements of
15 such paragraph for the first year of a grant, the
16 Secretary may terminate the grant and solicit
17 applications from new grantees to participate in
18 the demonstration program.

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

21 (A) at least 10 grants to providers of serv-
22 ices described in paragraph (2)(A)(i);

23 (B) at least 10 grants to service providers
24 described in paragraph (2)(A)(ii);

1 (C) at least 10 grants to organizations de-
2 scribed in paragraph (2)(A)(iii); and

3 (D) at least 10 grants to sponsors de-
4 scribed in paragraph (2)(A)(iv).

5 (4) CONSIDERATIONS IN AWARDING GRANTS.—

6 (A) VARIATION AMONG GRANTEES.—In
7 awarding grants under this subsection, the Sec-
8 retary shall select grantees to ensure the fol-
9 lowing:

10 (i) The grantees provide many dif-
11 ferent types of language services.

12 (ii) The grantees serve Medicare bene-
13 ficiaries who speak different languages,
14 and who, as a population, have differing
15 needs for language services.

16 (iii) The grantees serve Medicare
17 beneficiaries in both urban and rural set-
18 tings.

19 (iv) The grantees represent each Cen-
20 ters for Medicare & Medicaid Services re-
21 gion, as defined by the Secretary.

22 (v) The grantees serve Medicare bene-
23 ficiaries in at least two large metropolitan
24 statistical areas with racial, ethnic, sexual,

1 gender, disability, and economically diverse
2 populations.

3 (B) PRIORITY FOR PARTNERSHIPS WITH
4 COMMUNITY ORGANIZATIONS AND AGENCIES.—

5 In awarding grants under this subsection, the
6 Secretary shall give priority to eligible entities
7 that have a partnership with—

8 (i) a community organization; or

9 (ii) a consortia of community organi-
10 zations, State agencies, and local agencies;
11 that has experience in providing language serv-
12 ices.

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

15 (A) IN GENERAL.—Subject to subpara-
16 graph (E), a grantee may only use grant funds
17 received under this subsection to pay for the
18 provision of competent language services to
19 Medicare beneficiaries who are individuals with
20 limited English proficiency.

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

24 (i) interpreter and translation services
25 that—

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

3 (aa) if the grantee operates
4 in a State that has statewide
5 health care interpreter standards,
6 meet the State standards cur-
7 rently in effect; or

8 (bb) if the grantee operates
9 in a State that does not have
10 statewide health care interpreter
11 standards, utilize competent in-
12 terpreters who follow the Na-
13 tional Council on Interpreting in
14 Health Care's Code of Ethics and
15 Standards of Practice and com-
16 ply with the requirements of sec-
17 tion 1557 of the Patient Protec-
18 tion and Affordable Care Act (42
19 U.S.C. 18116) as published in
20 the Federal Register on May 18,
21 2016; and

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

24 (aa) onsite interpretation;

1 (bb) telephonic interpreta-
2 tion; or

3 (cc) video interpretation;
4 and

5 (ii) the direct provision of health care
6 or health care-related services by a com-
7 petent bilingual health care provider.

8 (C) EXCEPTIONS.—The requirements of
9 subparagraph (B)(i)(I) do not apply, with re-
10 spect to interpreter and translation services and
11 a grantee—

12 (i) in the case of a Medicare bene-
13 ficiary who is limited English proficient,
14 if—

15 (I) such beneficiary has been in-
16 formed, in the beneficiary's primary
17 language, of the availability of free in-
18 terpreter and translation services and
19 the beneficiary instead requests that a
20 family member, friend, or other per-
21 son provide such services; and

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

1 (ii) in the case of a medical emergency
2 where the delay directly associated with ob-
3 taining a competent interpreter or trans-
4 lation services would jeopardize the health
5 of the patient.

6 Clause (ii) shall not be construed to exempt
7 emergency rooms or similar entities that regu-
8 larly provide health care services in medical
9 emergencies to patients who are individuals
10 with limited English proficiency from any appli-
11 cable legal or regulatory requirements related to
12 providing competent interpreter and translation
13 services without undue delay.

14 (D) MEDICARE ADVANTAGE ORGANIZA-
15 TIONS AND PDP SPONSORS.—A grantee that is
16 a Medicare Advantage organization or a pre-
17 scription drug plan sponsor must provide at
18 least 50 percent of the grant funds that the
19 grantee receives under this subsection directly
20 to the entity's network providers (including all
21 health providers and pharmacists) for the pur-
22 pose of providing support for such providers to
23 provide competent language services to Medi-
24 care beneficiaries who are individuals with lim-
25 ited English proficiency.

1 (E) ADMINISTRATIVE AND REPORTING
2 COSTS.—A grantee may use up to 10 percent of
3 the grant funds to pay for administrative costs
4 associated with the provision of competent lan-
5 guage services and for reporting required under
6 paragraph (9).

7 (6) DETERMINATION OF AMOUNT OF GRANT
8 PAYMENTS.—

9 (A) IN GENERAL.—Payments to grantees
10 under this subsection shall be calculated based
11 on the estimated numbers of Medicare bene-
12 ficiaries who are limited English proficiency in
13 a grantee’s service area utilizing—

14 (i) data on the numbers of English
15 learners who speak English less than “very
16 well” from the most recently available data
17 from the Bureau of the Census or other
18 State-based study the Secretary determines
19 is likely to yield accurate data regarding
20 the number of such individuals in such
21 service area; or

22 (ii) data provided by the grantee, if
23 the grantee routinely collects data on the
24 primary language of the Medicare bene-
25 ficiaries that the grantee serves and the

1 Secretary determines that the data is accu-
2 rate and shows a greater number of indi-
3 viduals with limited English proficiency
4 than would be estimated using the data
5 under clause (i).

6 (B) DISCRETION OF SECRETARY.—Subject
7 to subparagraph (C), the amount of payment
8 made to a grantee under this subsection may be
9 modified annually at the discretion of the Sec-
10 retary, based on changes in the data under sub-
11 paragraph (A) with respect to the service area
12 of a grantee for the year.

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

17 (7) ASSURANCES.—Grantees under this sub-
18 section shall, as a condition of receiving a grant
19 under this subsection—

20 (A) ensure that clinical and support staff
21 receive appropriate ongoing education and
22 training in linguistically appropriate service de-
23 livery;

24 (B) ensure the linguistic competence of bi-
25 lingual providers;

1 (C) offer and provide appropriate language
2 services at no additional charge to each patient
3 who is limited English proficient for all points
4 of contact between the patient and the grantee,
5 in a timely manner during all hours of oper-
6 ation;

7 (D) notify Medicare beneficiaries of their
8 right to receive language services in their pri-
9 mary language at least annually;

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

13 (F) ensure that—

14 (i) primary language data are col-
15 lected for recipients of language services
16 and such data are consistent with stand-
17 ards developed under title XXXIV of the
18 Public Health Service Act, as added by
19 section 2002 of this Act, to the extent such
20 standards are available upon the initiation
21 of the demonstration program; and

22 (ii) consistent with the privacy protec-
23 tions provided under the regulations pro-
24 mulgated pursuant to section 264(c) of the
25 Health Insurance Portability and Account-

1 ability Act of 1996 (42 U.S.C. 1320d-2
2 note), if the recipient of language services
3 is a minor or is incapacitated, primary lan-
4 guage data must also be collected on the
5 parent or legal guardian of such recipient.

6 (8) NO COST SHARING.—Medicare beneficiaries
7 who are limited English proficient shall not have to
8 pay cost sharing or co-payments for competent lan-
9 guage services provided under this demonstration
10 program.

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

16 (A) The number of Medicare beneficiaries
17 to whom competent language services are pro-
18 vided, disaggregated by age and entitlement
19 basis (on the basis of age, disability, or deter-
20 mination of end stage renal disease).

21 (B) The primary languages of those Medi-
22 care beneficiaries.

23 (C) The types of language services pro-
24 vided to such beneficiaries.

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

5 (E) The types of interpretation services
6 provided to such beneficiaries, and the approxi-
7 mate length of time such service is provided to
8 such beneficiaries.

9 (F) The costs of providing competent lan-
10 guage services.

11 (G) An account of the training or accredi-
12 tation of bilingual staff, interpreters, and trans-
13 lators providing services funded by the grant
14 under this subsection.

15 (10) EVALUATION AND REPORT TO CON-
16 GRESS.—Not later than 1 year after the completion
17 of a 3-year grant under this subsection, the Sec-
18 retary shall conduct an evaluation of the demonstra-
19 tion program under this subsection and shall submit
20 to the Congress a report that includes the following:

21 (A) An analysis of the patient outcomes
22 and the costs of furnishing care to the Medicare
23 beneficiaries who are individuals with limited
24 English proficiency participating in the project
25 as compared to such outcomes and costs for

1 such Medicare beneficiaries not participating,
2 based on the data provided under paragraph (9)
3 and any other information available to the Sec-
4 retary.

5 (B) The effect of delivering language serv-
6 ices on—

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

9 (ii) the efficiency and cost effective-
10 ness of health care delivery;

11 (iii) patient satisfaction with respect
12 to both health service delivery and lan-
13 guage assistance;

14 (iv) health outcomes; and

15 (v) the provision of culturally appro-
16 priate services provided to such bene-
17 ficiaries.

18 (C) The extent to which bilingual staff, in-
19 terpreters, and translators providing services
20 under such demonstration were trained or ac-
21 credited and the nature of accreditation or
22 training needed by type of provider, service, or
23 other category as determined by the Secretary
24 to ensure the provision of high-quality interpre-
25 tation, translation, or other language services to

1 Medicare beneficiaries if such services are ex-
2 panded pursuant to section 1115A(c) of the So-
3 cial Security Act (42 U.S.C. 1315a(c)).

4 (D) Recommendations, if any, regarding
5 the extension of such project to the entire Medi-
6 care Program, subject to the provisions of such
7 section 1115A(c).

8 (11) APPROPRIATIONS.—There is appropriated
9 to carry out this subsection, in equal parts from the
10 Federal Hospital Insurance Trust Fund under sec-
11 tion 1817 of the Social Security Act (42 U.S.C.
12 1395i) and the Federal Supplementary Medical In-
13 surance Trust Fund under section 1841 of such Act
14 (42 U.S.C. 1395t), \$16,000,000 for each fiscal year
15 of the demonstration program.

16 (12) LIMITED ENGLISH PROFICIENT DE-
17 FINED.—In this subsection, the term “limited
18 English proficient” refers to individuals who self-
19 identify on the Census as speaking English less than
20 “very well”.

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

23 (1) INCLUSION AS RURAL HEALTH CLINIC
24 SERVICES.—Section 1861 of the Social Security Act
25 (42 U.S.C. 1395x) is amended—

1 (A) in subsection (aa)(1)—

2 (i) in subparagraph (B), by striking

3 “and” at the end;

4 (ii) in subparagraph (C), by adding

5 “and” at the end; and

6 (iii) by inserting after subparagraph

7 (C) the following new subparagraph:

8 “(D) language assistance services as defined in

9 subsection (lll),”; and

10 (B) by adding at the end the following new

11 subsection:

12 “Language Assistance Services and Related Terms

13 “(lll) The term ‘language assistance services’ means

14 ‘language access’ or ‘language assistance services’ (as

15 those terms are defined in section 3400 of the Public

16 Health Service Act) furnished by a ‘qualified interpreter

17 for an individual with limited English proficiency’ or a

18 ‘qualified translator’ (as those terms are defined in such

19 section 3400) to an ‘individual with limited English pro-

20 ficiency’ (as defined in such section 3400).”.

21 (2) COVERAGE.—Section 1832(a)(2) of the So-

22 cial Security Act (42 U.S.C. 1395k(a)(2)) is amend-

23 ed—

24 (A) in subparagraph (I), by striking “and”

25 at the end;

1 (B) in subparagraph (J), by striking the
2 period at the end and inserting “; and”; and

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

5 “(K) language assistance services (as de-
6 fined in section 1861(l)).”.

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

9 (A) in paragraph (9), by striking “and” at
10 the end;

11 (B) in paragraph (10), by striking the pe-
12 riod at the end and inserting “; and”; and

13 (C) by inserting after paragraph (10) the
14 following new paragraph:

15 “(11) in the case of language assistance serv-
16 ices (as defined in section 1861(l)), 100 percent of
17 the reasonable charges for such services, as deter-
18 mined in consultation with the Medicare Payment
19 Advisory Commission.”.

20 (4) WAIVER OF BUDGET NEUTRALITY.—For
21 the 3-year period beginning on the date of enact-
22 ment of this section, the budget neutrality provision
23 of section 1848(c)(2)(B)(ii) of the Social Security
24 Act (42 U.S.C. 1395w-4(c)(2)(B)(ii)) shall not

1 apply with respect to language assistance services
2 (as defined in section 1861(l) of such Act).

3 (c) MEDICARE PARTS C AND D.—

4 (1) IN GENERAL.—Medicare Advantage plans
5 under part C of title XVIII of the Social Security
6 Act (42 U.S.C. 1395w–21 et seq.) and prescription
7 drug plans under part D of such title (42 U.S.C.
8 1395q–101) shall comply with title VI of the Civil
9 Rights Act of 1964 (42 U.S.C. 2000d et seq.) and
10 section 1557 of the Patient Protection and Afford-
11 able Care Act (42 U.S.C. 18116) to provide effective
12 language services to enrollees of such plans.

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

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

1 of the organization (or sponsor) related to recruit-
2 ment and retention efforts directed to workforce di-
3 versity and linguistically and culturally appropriate
4 provision of services in each of the following con-
5 texts:

6 “(A) The collection of data in a manner
7 that meets the requirements of title I of the
8 Health Equity and Accountability Act of 2022,
9 regarding the enrollee population.

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

14 “(C) Evaluation of the language services
15 programs and services offered by the organiza-
16 tion (or sponsor) with respect to the enrollee
17 population, such as through analysis of com-
18 plaints or satisfaction survey results.

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

22 “(E) The periodic provision of educational
23 information to plan enrollees on the language
24 services and programs offered by the organiza-
25 tion (or sponsor).”.

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

3 (1) PAYMENTS TO STATES.—Section
4 1903(a)(2)(E) of the Social Security Act (42 U.S.C.
5 1396b(a)(2)(E)), as amended by section 2005(h)(3),
6 is further amended by—

7 (A) striking “75” and inserting “95”;

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

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

13 (2) STATE PLAN REQUIREMENTS.—Section
14 1902(a)(10)(A) of the Social Security Act (42
15 U.S.C. 1396a(a)(10)(A)) is amended by striking
16 “and (30)” and inserting “(30), and (31)”.

17 (3) DEFINITION OF MEDICAL ASSISTANCE.—

18 (A) IN GENERAL.—Section 1905(a) of the
19 Social Security Act (42 U.S.C. 1396d(a)) is
20 amended—

21 (i) in paragraph (30), by striking
22 “and” at the end;

23 (ii) by redesignating paragraph (31)
24 as paragraph (32); and

1 (iii) by inserting after paragraph (30)
2 the following new paragraph:

3 “(31) language assistance services, as such
4 term is defined in section 1861(lll), provided in a
5 timely manner to individuals with limited English
6 proficiency as defined in section 3400 of the Public
7 Health Service Act; and”.

8 (B) CONFORMING AMENDMENTS.—

9 (i) Section 1902(nm)(3) of the Social
10 Security Act (42 U.S.C. 1396a(nm)(3)) is
11 amended by striking “paragraph (30)” and
12 inserting “the last paragraph”.

13 (ii) Section 1905(a) of the Social Se-
14 curity Act (42 U.S.C. 1396d(a)) is amend-
15 ed, in the 5th sentence, by striking “para-
16 graph (30)” and inserting “the last para-
17 graph”.

18 (4) USE OF DEDUCTIONS AND COST SHAR-
19 ING.—Subsections (a)(2) and (b)(2) of section
20 1916(a)(2) of the Social Security Act (42 U.S.C.
21 1396o(a)(2)) are each amended—

22 (A) in subparagraph (G), by inserting a
23 comma after “plan”;

24 (B) in subparagraph (H), by striking “;
25 or” and inserting a comma;

1 (C) in subparagraph (I), by striking “;
2 and” and inserting “, or”; and

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

5 “(J) language assistance services described
6 in section 1905(a)(31); and”.

7 (5) CHIP COVERAGE REQUIREMENTS.—Section
8 2103 of the Social Security Act (42 U.S.C. 1397cc)
9 is amended—

10 (A) in subsection (a), in the matter before
11 paragraph (1), by striking “(7) and (8)” and
12 inserting “(7), (8), (9), (10), (11), and (12)”;

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

15 “(12) LANGUAGE ASSISTANCE SERVICES.—The
16 child health assistance provided to a targeted low-in-
17 come child shall include coverage of language assist-
18 ance services, as such term is defined in section
19 1861(lll), provided in a timely manner to individuals
20 with limited English proficiency (as defined in sec-
21 tion 3400 of the Public Health Service Act).”; and

22 (C) in subsection (e)(2)—

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

1 (ii) by inserting “language assistance
2 services described in subsection (c)(12),”
3 before “visits described in”.

4 (6) DEFINITION OF CHILD HEALTH ASSIST-
5 ANCE.—Section 2110(a)(27) of the Social Security
6 Act (42 U.S.C. 1397jj(a)(27)) is amended by strik-
7 ing “translation” and inserting “language assistance
8 services as described in section 2103(c)(12)”.

9 (7) STATE DATA COLLECTION.—Pursuant to
10 the reporting requirement described in section
11 2107(b)(1) of the Social Security Act (42 U.S.C.
12 1397gg(b)(1)), the Secretary of Health and Human
13 Services shall require that States collect data on—

14 (A) the primary language of individuals re-
15 ceiving child health assistance under title XXI
16 of the Social Security Act (42 U.S.C. 1397aa et
17 seq.); and

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

21 (8) CHIP PAYMENTS TO STATES.—Section
22 2105 of the Social Security Act (42 U.S.C. 1397ee)
23 is amended—

24 (A) in subsection (a)(1)—

1 (i) in the matter preceding subpara-
2 graph (A), by striking “75” and inserting
3 “95”; and

4 (ii) in subparagraph (D)(iv), by strik-
5 ing “translation or interpretation services”
6 and inserting “language assistance serv-
7 ices”; and

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

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

17 (1) PAYMENT OF COSTS.—

18 (A) IN GENERAL.—Subject to subpara-
19 graph (B), the Secretary of Health and Human
20 Services (referred to in this subsection as the
21 “Secretary”) shall make payments (on a quar-
22 terly basis) directly to eligible entities to sup-
23 port the provision of language assistance serv-
24 ices to individuals with limited English pro-
25 ficiency in an amount equal to an eligible enti-

1 ty's eligible costs for providing such services for
2 the quarter.

3 (B) FUNDING.—Out of any funds in the
4 Treasury not otherwise appropriated, there are
5 appropriated to the Secretary such sums as
6 may be necessary for each of fiscal years 2022
7 through 2026.

8 (C) RELATION TO MEDICAID DSH.—Pay-
9 ments under this subsection shall not offset or
10 reduce payments under section 1923 of the So-
11 cial Security Act (42 U.S.C. 1396r-4), nor
12 shall payments under such section be consid-
13 ered when determining uncompensated costs as-
14 sociated with the provision of language assist-
15 ance services for the purposes of this sub-
16 section.

17 (2) METHODOLOGY FOR PAYMENT OF
18 CLAIMS.—

19 (A) IN GENERAL.—The Secretary shall es-
20 tablish a methodology to determine the average
21 per person cost of language assistance services.

22 (B) DIFFERENT ENTITIES.—In estab-
23 lishing such methodology, the Secretary may es-
24 tablish different methodologies for different
25 types of eligible entities.

1 (C) NO INDIVIDUAL CLAIMS.—The Sec-
2 retary may not require eligible entities to sub-
3 mit individual claims for language assistance
4 services for individual patients as a requirement
5 for payment under this subsection.

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

13 (4) GUIDELINES.—Not later than 6 months
14 after the date of enactment of this Act, the Sec-
15 retary shall establish and distribute guidelines con-
16 cerning the implementation of this subsection.

17 (5) REPORTING REQUIREMENTS.—

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

1 be in a form and manner determined by the
2 Secretary.

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

8 (6) DEFINITIONS.—In this subsection:

9 (A) ELIGIBLE COSTS.—The term “eligible
10 costs” means, with respect to an eligible entity
11 that provides language assistance services to
12 limited English proficient individuals, the prod-
13 uct of—

14 (i) the average per person cost of lan-
15 guage assistance services, determined ac-
16 cording to the methodology devised under
17 paragraph (2); and

18 (ii) the number of individuals with
19 limited English proficiency who are pro-
20 vided language assistance services by the
21 entity and for whom no reimbursement is
22 available for such services under the
23 amendments made by subsection (a), (b),
24 (c), or (d) or by private health insurance.

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

3 (i) is a Medicaid provider that is—

4 (I) a physician;

5 (II) a hospital with a low-income
6 utilization rate (as defined in section
7 1923(b)(3) of the Social Security Act
8 (42 U.S.C. 1396r–4(b)(3))) of greater
9 than 25 percent;

10 (III) a federally qualified health
11 center (as defined in section
12 1905(l)(2)(B) of the Social Security
13 Act (42 U.S.C. 1396d(l)(2)(B)));

14 (IV) a hospice provider; or

15 (V) a palliative care provider;

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

21 (iii) prepares and submits an applica-
22 tion to the Secretary, at such time, in such
23 manner, and accompanied by such infor-
24 mation as the Secretary may require, to

1 ascertain the entity’s eligibility for funding
2 under this subsection.

3 (C) LANGUAGE ASSISTANCE SERVICES.—

4 The term “language assistance services” has
5 the meaning given such term in section
6 1861(III) of the Social Security Act, as added by
7 subsection (b).

8 (f) APPLICATION OF CIVIL RIGHTS ACT OF 1964,
9 SECTION 1557 OF THE AFFORDABLE CARE ACT, AND
10 OTHER LAWS.—Nothing in this section shall be construed
11 to limit otherwise existing obligations of recipients of Fed-
12 eral financial assistance under title VI of the Civil Rights
13 Act of 1964 (42 U.S.C. 2000d et seq.), section 1557 of
14 the Affordable Care Act, or other laws that protect the
15 civil rights of individuals.

16 (g) EFFECTIVE DATE.—

17 (1) IN GENERAL.—Except as otherwise pro-
18 vided and subject to paragraph (2), the amendments
19 made by this section shall take effect on January 1,
20 2023.

21 (2) EXCEPTION IF STATE LEGISLATION RE-
22 QUIRED.—In the case of a State plan for medical as-
23 sistance under title XIX of the Social Security Act
24 (42 U.S.C. 1396 et seq.) or a State plan for child
25 health assistance under title XXI of such Act (42

1 U.S.C. 1397aa et seq.) which the Secretary of
2 Health and Human Services determines requires
3 State legislation (other than legislation appro-
4 priating funds) in order for the plan to meet the ad-
5 ditional requirement imposed by the amendments
6 made by this section, such State plan shall not be
7 regarded as failing to comply with the requirements
8 of such title solely on the basis of its failure to meet
9 this additional requirement before the first day of
10 the first calendar quarter beginning after the close
11 of the first regular session of the State legislature
12 that begins after the date of the enactment of this
13 Act. For purposes of the previous sentence, in the
14 case of a State that has a 2-year legislative session,
15 each year of such session shall be deemed to be a
16 separate regular session of the State legislature.

17 **SEC. 2008. INCREASING UNDERSTANDING OF AND IMPROV-**
18 **ING HEALTH LITERACY.**

19 (a) IN GENERAL.—The Secretary, in consultation
20 with the Director of the National Institute on Minority
21 Health and Health Disparities and the Deputy Assistant
22 Secretary for Minority Health, shall award grants to eligi-
23 ble entities to improve health care for patient populations
24 that have low health literacy.

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

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

6 (2) prepare and submit to the Secretary an ap-
7 plication at such time, in such manner, and con-
8 taining such information as the Secretary may rea-
9 sonably require.

10 (c) USE OF FUNDS.—

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

15 (A) to define and increase the under-
16 standing of health literacy across all areas of
17 health care, including end of life care;

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

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

22 (D) for any other activity determined ap-
23 propriate by the Director.

24 (2) HEALTH RESOURCES AND SERVICES ADMIN-
25 ISTRATION.—A grant under subsection (a) that is

1 awarded through the Administrator of the Health
2 Resources and Services Administration shall be used
3 to conduct demonstration projects for interventions
4 for patients with low health literacy that may in-
5 clude—

6 (A) the development of new disease man-
7 agement and end of life care programs for pa-
8 tients with low health literacy;

9 (B) the tailoring of disease management
10 programs and end of life care addressing men-
11 tal, physical, oral, and behavioral health condi-
12 tions for patients with low health literacy;

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

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

17 (E) the conduct of educational campaigns
18 for patients and providers about low health lit-
19 eracy;

20 (F) the conduct of educational campaigns
21 concerning health directed specifically at pa-
22 tients with mental disabilities, including those
23 with cognitive and intellectual disabilities, de-
24 signed to reduce the incidence of low health lit-
25 eracy among these populations, which shall

1 have instructional materials in the plain lan-
2 guage standards promulgated under the Plain
3 Writing Act of 2010 (5 U.S.C. 301 note) for
4 Federal agencies; and

5 (G) other activities determined appropriate
6 by the Administrator.

7 (d) DEFINITIONS.—In this section:

8 (1) LOW HEALTH LITERACY.—The term “low
9 health literacy” means the inability of an individual
10 to obtain, process, and understand basic health in-
11 formation and services needed to make appropriate
12 health decisions.

13 (2) SECRETARY.—The term “Secretary” means
14 the Secretary of Health and Human Services—

15 (A) acting through the Director of the
16 Agency for Healthcare Research and Quality,
17 with respect to grants under subsection (c)(1);
18 and

19 (B) acting through the Administrator of
20 the Health Resources and Services Administra-
21 tion with respect to grants under subsection
22 (c)(2).

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

1 such sums as may be necessary for each of fiscal years
2 2023 through 2027.

3 **SEC. 2009. REQUIREMENTS FOR HEALTH PROGRAMS OR**
4 **ACTIVITIES RECEIVING FEDERAL FUNDS.**

5 (a) COVERED ENTITY; COVERED PROGRAM OR AC-
6 TIVITY.—In this section—

7 (1) the term “covered entity” has the meaning
8 given such term in section 92.4 of title 45, Code of
9 Federal Regulations, as in effect on May 18, 2016
10 (81 Fed. Reg. 31466); and

11 (2) the term “health program or activity” has
12 the meaning given such term in section 92.4 of title
13 45, Code of Federal Regulations, as in effect on May
14 18, 2016 (81 Fed. Reg. 31466).

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

19 (1) ensure that appropriate clinical and support
20 staff receive ongoing education and training in cul-
21 turally and linguistically appropriate service delivery
22 at least annually;

23 (2) offer and provide appropriate language as-
24 sistance services at no additional charge to each pa-
25 tient that is an individual with limited English pro-

1 ficiency at all points of contact, in a timely manner
2 during all hours of operation;

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

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

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

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

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

16 (B) The covered entity informs the patient
17 in the primary language of the patient that he
18 or she has the option of having the entity pro-
19 vide to the patient an interpreter and trans-
20 lation services without charge.

21 (C) The covered entity informs the patient
22 that the entity may not require an individual
23 with a limited English proficiency to use a fam-
24 ily member or friend as an interpreter.

1 (D) The covered entity evaluates whether
2 the person the patient wishes to use as an in-
3 terpreter is competent. If the covered entity has
4 reason to believe that such person is not com-
5 petent as an interpreter, the entity provides its
6 own interpreter to protect the covered entity
7 from liability if the patient's interpreter is later
8 found not competent.

9 (E) If the covered entity has reason to be-
10 lieve that there is a conflict of interest between
11 the interpreter and patient, the covered entity
12 may not use the patient's interpreter.

13 (F) The covered entity has the patient sign
14 a waiver, witnessed by at least 1 individual not
15 related to the patient, that includes the infor-
16 mation stated in subparagraphs (A) through
17 (E) and is translated into the patient's primary
18 language.

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

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

1 similar entities that regularly provide health care services
2 in medical emergencies are exempt from legal or regu-
3 latory requirements related to competent interpreter serv-
4 ices.

5 **SEC. 2010. REPORT ON FEDERAL EFFORTS TO PROVIDE**
6 **CULTURALLY AND LINGUISTICALLY APPRO-**
7 **PRIATE HEALTH CARE SERVICES.**

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

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

19 (2) a description and analysis of best practices,
20 model programs, guidelines, and other effective
21 strategies for providing access to culturally and lin-
22 guistically appropriate health care services;

23 (3) recommendations on the development and
24 implementation of policies and practices by providers
25 of health care services and health care-related serv-

1 ices for individuals with limited English proficiency,
2 including people with cognitive, hearing, vision, or
3 print impairments;

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

8 (5) a description of the effect of providing lan-
9 guage services on quality of health care and access
10 to care; and

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

13 (b) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated to carry out this section
15 such sums as may be necessary for each of fiscal years
16 2023 through 2027.

17 **SEC. 2011. ENGLISH INSTRUCTION FOR INDIVIDUALS WITH**
18 **LIMITED ENGLISH PROFICIENCY.**

19 (a) GRANTS AUTHORIZED.—The Secretary of Edu-
20 cation is authorized to provide grants to eligible entities
21 for the provision of English as a second language (in this
22 section referred to as “ESL”) instruction to individuals
23 with limited English proficiency, including health care-re-
24 lated English instruction, and shall determine, after con-

1 sultation with appropriate stakeholders, the mechanism
2 for administering and distributing such grants.

3 (b) ELIGIBLE ENTITY.—In this section, the term “el-
4 igible entity” means—

5 (1) a State; or

6 (2) a community-based organization that pre-
7 dominantly employs and serves racial and ethnic mi-
8 nority groups (as defined in section 1707(g) of the
9 Public Health Service Act (42 U.S.C. 300u-6(g)).

10 (c) APPLICATION.—An eligible entity that desires to
11 receive a grant under this section shall apply by submit-
12 ting to the Secretary of Education an application at such
13 time, in such manner, and containing such information as
14 the Secretary may require.

15 (d) USE OF GRANT.—An eligible entity shall use
16 grant funds provided under this section to—

17 (1) develop and implement a plan for assuring
18 the availability of ESL instruction, free of charge, to
19 the community served by the eligible entity, that ef-
20 fectively integrates information about the nature of
21 the United States health care system, how to access
22 care, and any special language skills that may be re-
23 quired for individuals with limited English pro-
24 ficiency to access and regularly negotiate the health
25 care system effectively;

1 (2) develop a plan for making ESL instruction
2 available free to charge to individuals with limited
3 English proficiency in the community served by the
4 eligible entity who are seeking instruction, including,
5 where appropriate, through the use of public-private
6 partnerships; and

7 (3) provide ESL instruction to individuals with
8 limited English proficiency in the community served
9 by the eligible entity.

10 (e) SUPPLEMENT, NOT SUPPLANT.—An eligible enti-
11 ty awarded a grant under this section shall use funds
12 made available under this section to supplement, and not
13 supplant, other Federal, State, and local funds that would
14 otherwise be expended to carry out activities under this
15 section.

16 (f) DUTIES OF THE SECRETARY.—The Secretary of
17 Education shall—

18 (1) collect and make publicly available annual
19 data on how much Federal, State, and local govern-
20 ments spend annually on ESL instruction;

21 (2) collect data from eligible entities awarded a
22 grant under this section to identify the unmet needs
23 of individuals with limited English proficiency for
24 appropriate ESL instruction, including—

1 (A) the preferred written and spoken lan-
2 guage of such individuals;

3 (B) the availability of enrollment in ESL
4 instruction programs in the communities served
5 by each eligible entity awarded a grant under
6 this section, including the extent of waiting lists
7 for ESL instruction, how many programs main-
8 tain waiting lists, and, for programs that do not
9 have waiting lists, the reasons why such a list
10 is unnecessary or otherwise not maintained;

11 (C) the availability of programs to geo-
12 graphically isolated communities;

13 (D) the impact of course enrollment poli-
14 cies, including open enrollment, on the avail-
15 ability of ESL instruction;

16 (E) the number of individuals with limited
17 English proficiency and the number of individ-
18 uals enrolled in ESL instruction programs in
19 the communities served by each eligible entity
20 awarded a grant under this section;

21 (F) the effectiveness of the ESL instruc-
22 tion provided through grants awarded under
23 this section in meeting the needs of individuals
24 receiving such instruction; and

1 (G) an assessment of the need for pro-
2 grams that integrate job training and ESL in-
3 struction, to assist individuals with limited
4 English proficiency in obtaining better jobs;

5 (3) determine the cost and most appropriate
6 methods of making ESL instruction available to all
7 individuals with limited English proficiency in the
8 United States who are seeking instruction; and

9 (4) not later than 1 year after the date of en-
10 actment of this Act, issue a report to Congress
11 that—

12 (A) assesses the information collected in
13 paragraphs (1), (2), and (3) and makes rec-
14 ommendations on steps that should be taken to
15 realize the goal of making ESL instruction
16 available to all individuals with limited English
17 proficiency in the United States who are seek-
18 ing instruction; and

19 (B) evaluates the impact of the grant pro-
20 gram authorized under this section on the ac-
21 cessibility of, and ability to effectively negotiate,
22 the health care system for individuals with lim-
23 ited English proficiency who have received ESL
24 instruction funded by a grant under this sec-
25 tion.

1 (g) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to the Secretary of Edu-
3 cation \$250,000,000 for each of fiscal years 2023 through
4 2027 to carry out this section.

5 **SEC. 2012. IMPLEMENTATION.**

6 (a) GENERAL PROVISIONS.—

7 (1) IMMUNITY.—A person injured by a violation
8 of this title (including an amendment made by this
9 title) by a State may bring a civil action in the ap-
10 propriate Federal court for such injury in accord-
11 ance with this section.

12 (2) REMEDIES.—In a civil action under this
13 section for a violation of this title, such remedies
14 shall be available as would be available in a civil ac-
15 tion for such violation against any party other than
16 a State.

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

22 **SEC. 2013. LANGUAGE ACCESS SERVICES.**

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

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

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

5 (b) EMPLOYER-SPONSORED MINIMUM ESSENTIAL
6 COVERAGE.—

7 (1) IN GENERAL.—Section 36B(e)(2)(C) of the
8 Internal Revenue Code of 1986 is amended by redes-
9 ignating clauses (iii) and (iv) as clauses (iv) and (v),
10 respectively, and by inserting after clause (ii) the fol-
11 lowing new clause:

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

22 (2) CONFORMING AMENDMENTS.—

23 (A) Section 36B(e)(2)(C) of such Code is
24 amended by striking “clause (iii)” each place it

1 appears in clauses (i) and (ii) and inserting
2 “clause (iv)”.

3 (B) Section 36B(c)(2)(C)(iv) of such Code,
4 as redesignated by this subsection, is amended
5 by striking “(i) and (ii)” and inserting “(i), (ii),
6 and (iii)”.

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

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

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

14 (3) by adding at the end the following new sub-
15 paragraph:

16 “(E) reduce health disparities through the
17 provision of language access services, including
18 oral interpretation and written translations.”.

19 (d) REGULATIONS REGARDING INTERNAL CLAIMS
20 AND APPEALS AND EXTERNAL REVIEW PROCESSES FOR
21 HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—
22 The Secretary of the Treasury, the Secretary of Labor,
23 and the Secretary of Health and Human Services shall
24 amend the regulations in section 54.9815–2719(e) of title
25 26, Code of Federal Regulations, section 2590.715–

1 2719(e) of title 29, Code of Federal Regulations, and sec-
2 tion 147.136(e) of title 45, Code of Federal Regulations,
3 (or a successor regulation) respectively, to require group
4 health plans and health insurance issuers offering group
5 or individual health insurance coverage to which such sec-
6 tions apply—

7 (1) to provide oral interpretation services with-
8 out any threshold requirements;

9 (2) to provide in the English versions of all no-
10 tices a statement prominently displayed in not less
11 than 15 non-English languages clearly indicating
12 how to access the language services provided by the
13 plan or issuer; and

14 (3) with respect to the requirements for pro-
15 viding relevant notices in a culturally and linguis-
16 tically appropriate manner in the applicable non-
17 English languages, to apply a threshold that 5 per-
18 cent of the population, or not less than 500 individ-
19 uals, in the county is literate only in the same non-
20 English language in order for the language to be
21 considered an applicable non-English language.

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

24 (1) amend the single streamlined application
25 form developed pursuant to section 1413 of the Pa-

1 tient Protection and Affordable Care Act (42 U.S.C.
2 18083) to collect the preferred spoken and written
3 language for each household member applying for
4 coverage under a qualified health plan through an
5 Exchange under title I of such Act (42 U.S.C.
6 18001 et seq.);

7 (2) require navigators, certified application
8 counselors, and other individuals assisting with en-
9 rollment to collect and report requests for language
10 assistance; and

11 (3) require the toll-free telephone hotlines es-
12 tablished pursuant to section 1311(d)(4)(B) of the
13 Patient Protection and Affordable Care Act (42
14 U.S.C. 18031(d)(4)(B)) to submit an annual report
15 documenting the number of language assistance re-
16 quests, the types of languages requested, the range
17 and average wait time for a consumer to speak with
18 an interpreter, the number of complaints and any
19 steps the hotline, and any entity contracting with
20 the Secretary to provide language services, have
21 taken to actively address some of the consumer com-
22 plaints.

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

1 **SEC. 2014. MEDICALLY UNDERSERVED POPULATIONS.**

2 Section 330(b)(3) of the Public Health Service Act
3 (42 U.S.C. 254b(b)(3)) is amended to read as follows:

4 “(3) **MEDICALLY UNDERSERVED.**—The term
5 ‘medically underserved’, with respect to a popu-
6 lation, refers to—

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

9 “(i) an area with a shortage of per-
10 sonal health services; or

11 “(ii) a population group having a
12 shortage of such services; or

13 “(B) a population of individuals, not con-
14 fined to a particular urban or rural area, who
15 are designated by the Secretary as having a
16 shortage of personal health services due to a
17 specific demographic trait.”.

18 **TITLE III—HEALTH WORKFORCE**
19 **DIVERSITY**

20 **SEC. 3001. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
21 **ACT.**

22 Title XXXIV of the Public Health Service Act, as
23 added by section 2004, is amended by adding at the end
24 the following:

1 **“Subtitle B—Diversifying the**
2 **Health Care Workplace**

3 **“SEC. 3411. NATIONAL WORKING GROUP ON WORKFORCE**
4 **DIVERSITY.**

5 “(a) IN GENERAL.—The Secretary, acting through
6 the Bureau of Health Workforce of the Health Resources
7 and Services Administration, shall award a grant to an
8 entity determined appropriate by the Secretary for the es-
9 tablishment of a national working group on workforce di-
10 versity.

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

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

15 “(A) The Health Resources and Services
16 Administration.

17 “(B) The Department of Health and
18 Human Services Data Council.

19 “(C) The Office of Minority Health of the
20 Department of Health and Human Services.

21 “(D) The Substance Abuse and Mental
22 Health Services Administration.

23 “(E) The Bureau of Labor Statistics of
24 the Department of Labor.

1 “(F) The National Institute on Minority
2 Health and Health Disparities.

3 “(G) The Agency for Healthcare Research
4 and Quality.

5 “(H) The Institute of Medicine Study
6 Committee for the 2004 workforce diversity re-
7 port.

8 “(I) The Indian Health Service.

9 “(J) The Department of Education.

10 “(K) Minority-serving academic institu-
11 tions.

12 “(L) Consumer organizations.

13 “(M) Health professional associations, in-
14 cluding those that represent underrepresented
15 minority populations.

16 “(N) Researchers in the area of health
17 workforce.

18 “(O) Health workforce accreditation enti-
19 ties.

20 “(P) Private (including nonprofit) founda-
21 tions that have sponsored workforce diversity
22 initiatives.

23 “(Q) Local and State health departments.

24 “(R) Representatives of community mem-
25 bers to be included on admissions committees

1 for health profession schools pursuant to sub-
2 section (c)(9).

3 “(S) National community-based organiza-
4 tions that serve as a national intermediary to
5 their urban affiliate members and have dem-
6 onstrated capacity to train health care profes-
7 sionals.

8 “(T) The Veterans Health Administration.

9 “(U) Other entities determined appropriate
10 by the Secretary.

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

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

19 “(1) Review public and private health workforce
20 diversity initiatives.

21 “(2) Identify successful health workforce diver-
22 sity programs and practices.

23 “(3) Examine challenges relating to the devel-
24 opment and implementation of health workforce di-
25 versity initiatives.

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

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

7 “(6) Develop recommended standards for work-
8 force diversity that could be applicable to all health
9 professions programs and programs funded under
10 this Act.

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

13 “(8) Develop a workforce data collection or
14 tracking system to identify where racial and ethnic
15 minority health professionals practice.

16 “(9) Develop a strategy for the inclusion of
17 community members on admissions committees for
18 health profession schools.

19 “(10) Help with monitoring of standards for di-
20 versity, equity, and inclusion.

21 “(11) Other activities determined appropriate
22 by the Secretary.

23 “(d) ANNUAL REPORT.—Not later than 1 year after
24 the establishment of the working group under subsection
25 (a), and annually thereafter, the working group shall pre-

1 pare and make available to the general public for com-
2 ment, an annual report on the activities of the working
3 group. Such report shall include the recommendations of
4 the working group for improving health workforce diver-
5 sity.

6 “(e) COORDINATION WITH OTHER EFFORTS.—In
7 providing for the establishment of the working group
8 under subsection (a), the Secretary shall take such steps
9 as may be necessary to ensure that the work of the work-
10 ing group does not overlap with, or otherwise duplicate,
11 other Federal Government efforts with respect to ensuring
12 health equity in data collection in public health emer-
13 gencies.

14 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated to carry out this section
16 such sums as may be necessary for each of fiscal years
17 2023 through 2027.

18 **“SEC. 3412. TECHNICAL CLEARINGHOUSE FOR HEALTH**
19 **WORKFORCE DIVERSITY.**

20 “(a) IN GENERAL.—The Secretary, acting through
21 the Deputy Assistant Secretary for Minority Health, and
22 in collaboration with the Bureau of Health Workforce
23 within the Health Resources and Services Administration
24 and the National Institute on Minority Health and Health
25 Disparities, shall establish a technical clearinghouse on

1 health workforce diversity within the Office of Minority
2 Health and coordinate current and future clearinghouses
3 related to health workforce diversity.

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

7 “(1) Information on the importance of health
8 workforce diversity.

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

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

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

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

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

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

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

6 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated to carry out this section
8 such sums as may be necessary for each of fiscal years
9 2023 through 2027.

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

13 “(a) IN GENERAL.—The Secretary, acting through
14 the Administrator of the Health Resources and Services
15 Administration and the Director of the Centers for Dis-
16 ease Control and Prevention, shall award grants to eligible
17 entities that demonstrate a commitment to health work-
18 force diversity.

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

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

1 “(A) part B institutions, as defined in sec-
2 tion 322 of the Higher Education Act of 1965;

3 “(B) historically Black professional or
4 graduate institutions eligible for grants under
5 section 326 of the Higher Education Act of
6 1965;

7 “(C) Hispanic-serving health professions
8 schools;

9 “(D) Hispanic-serving institutions, as de-
10 fined in section 502 of such Act;

11 “(E) Tribal Colleges or Universities, as de-
12 fined in section 316 of such Act;

13 “(F) Asian American and Native American
14 Pacific Islander-serving institutions, as defined
15 in section 371(c) of such Act;

16 “(G) institutions that have programs to re-
17 cruit and retain underrepresented minority
18 health professionals, in which a significant
19 number of the enrolled participants are under-
20 represented minorities;

21 “(H) health professional associations,
22 which may include underrepresented minority
23 health professional associations; and

24 “(I) institutions, including national and re-
25 gional community-based organizations with

1 demonstrated commitment to a diversified
2 workforce—

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

6 “(ii) with whom partnerships have
7 been formed for the purpose of increasing
8 workforce diversity; and

9 “(iii) in which at least 20 percent of
10 the enrolled participants are underrep-
11 resented minorities; and

12 “(2) submit to the Secretary an application at
13 such time, in such manner, and containing such in-
14 formation 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—

24 “(1) educational outreach programs relating to
25 opportunities in the health professions;

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

3 “(3) postbaccalaureate programs;

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

7 “(5) supporting workforce diversity in kinder-
8 garten through 12th grade and other health pipeline
9 programs;

10 “(6) mentoring programs;

11 “(7) internship or rotation programs involving
12 hospitals, health systems, health plans, and other
13 health entities;

14 “(8) community partnership development for
15 purposes relating to workforce diversity; or

16 “(9) leadership training.

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

22 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to carry out this section
24 such sums as may be necessary for each of fiscal years
25 2023 through 2027.

1 **“SEC. 3414. CAREER DEVELOPMENT FOR SCIENTISTS AND**
2 **RESEARCHERS.**

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

13 “(b) RESEARCH FUNDING.—The head of each agency
14 listed in subsection (a) shall establish or expand existing
15 programs to provide research funding to scientists and re-
16 searchers in training. Under such programs, the head of
17 each such entity shall give priority in allocating research
18 funding to support health research in traditionally under-
19 served communities, including underrepresented minority
20 communities, and research classified as community or
21 participatory.

22 “(c) DATA COLLECTION.—The head of each agency
23 listed in subsection (a) shall collect data on the number
24 (expressed as an absolute number and a percentage) of
25 underrepresented minority and nonminority applicants
26 who receive and are denied agency funding at every stage

1 of review. Such data shall be reported annually to the Sec-
2 retary and the appropriate committees of Congress.

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

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

19 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated to carry out this section
21 such sums as may be necessary for each of fiscal years
22 2023 through 2027.

1 **“SEC. 3415. CAREER SUPPORT FOR NONRESEARCH HEALTH**
2 **PROFESSIONALS.**

3 “(a) IN GENERAL.—The Secretary, acting through
4 the Director of the Centers for Disease Control and Pre-
5 vention, the Assistant Secretary for Mental Health and
6 Substance Use, the Administrator of the Health Resources
7 and Services Administration, and the Administrator of the
8 Centers for Medicare & Medicaid Services, shall establish
9 a program to award grants to universities and other insti-
10 tutions to enter into agreements with eligible individuals
11 under which—

12 “(1) the university or institution supports the
13 eligible individual’s career in a nonresearch-related
14 health and wellness profession; and

15 “(2) the eligible individual commits to per-
16 forming a period of obligated service in such a ca-
17 reer to serve, or to work on health issues affecting,
18 underserved communities, such as racial and ethnic
19 minority communities.

20 “(b) ELIGIBLE INDIVIDUALS.—To be an eligible indi-
21 vidual for purposes of subsection (a), an individual shall
22 be a student in a health professions school, a graduate
23 of such a school who is working in a health profession,
24 an individual working in a health or wellness profession
25 (including mental and behavioral health), or a faculty
26 member of such a school.

1 “(c) APPLICATION.—To seek a grant under this sec-
2 tion, a university or other institution shall submit to the
3 Secretary an application at such time, in such manner,
4 and containing such information as the Secretary may re-
5 quire.

6 “(d) USE OF FUNDS.—A university or other institu-
7 tion receiving a grant under this section shall use the
8 grant for agreements described in subsection (a). Such
9 agreements may—

10 “(1) support an eligible individual’s health ac-
11 tivities or projects that involve underserved commu-
12 nities, including racial and ethnic minority commu-
13 nities;

14 “(2) support an eligible individual’s health-re-
15 lated career advancement activities;

16 “(3) pay, or reimburse for payment of, student
17 loans or training or credentialing costs for eligible
18 individuals who are health professionals and are fo-
19 cused on health issues affecting underserved commu-
20 nities, including racial and ethnic minority commu-
21 nities; and

22 “(4) establish and promote leadership training
23 programs for eligible individuals to decrease health
24 disparities and to increase cultural competence with

1 the goal of increasing diversity in leadership posi-
2 tions.

3 “(e) DEFINITION.—In this section, the term ‘career
4 in a nonresearch-related health and wellness profession’
5 means employment or intended employment in the field
6 of public health, health policy, health management, health
7 administration, medicine, nursing, pharmacy, psychology,
8 social work, psychiatry, other mental and behavioral
9 health, allied health, community health, social work, or
10 other fields determined appropriate by the Secretary,
11 other than in a position that involves research.

12 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this section
14 such sums as may be necessary for each of fiscal years
15 2023 through 2027.

16 **“SEC. 3416. RESEARCH ON THE EFFECT OF WORKFORCE DI-**
17 **VERSITY ON QUALITY.**

18 “(a) IN GENERAL.—The Director of the Agency for
19 Healthcare Research and Quality (in this section referred
20 to as the ‘Director’), in collaboration with the Deputy As-
21 sistant Secretary for Minority Health and the Director of
22 the National Institute on Minority Health and Health Dis-
23 parities, shall award grants to eligible entities to expand
24 research on the link between health workforce diversity
25 and quality health care.

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

3 “(1) be a clinical, public health, or health serv-
4 ices research entity or other entity determined ap-
5 propriate by the Director; and

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

9 “(c) USE OF FUNDS.—Amounts received under a
10 grant awarded under subsection (a) shall be used to sup-
11 port research that investigates the effect of health work-
12 force diversity on—

13 “(1) language access;

14 “(2) cultural competence;

15 “(3) patient satisfaction;

16 “(4) timeliness of care;

17 “(5) safety of care;

18 “(6) effectiveness of care;

19 “(7) efficiency of care;

20 “(8) patient outcomes;

21 “(9) community engagement;

22 “(10) resource allocation;

23 “(11) organizational structure;

24 “(12) compliance of care; or

1 “(13) other topics determined appropriate by
2 the Director.

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

8 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
9 are authorized to be appropriated to carry out this section
10 such sums as may be necessary for each of fiscal years
11 2023 through 2027.

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

13 “(a) ESTABLISHMENT.—The Secretary, acting
14 through the Office of Minority Health, in collaboration
15 with the National Institute on Minority Health and Health
16 Disparities, the Office for Civil Rights, the Centers for
17 Disease Control and Prevention, the Centers for Medicare
18 & Medicaid Services, the Health Resources and Services
19 Administration, and other appropriate public and private
20 entities, shall establish and coordinate a health and health
21 care disparities education program to support, develop,
22 and implement educational initiatives and outreach strate-
23 gies that inform health care professionals and the public
24 about the existence of and methods to reduce racial and
25 ethnic disparities in health and health care.

1 “(b) ACTIVITIES.—The Secretary, through the edu-
2 cation program established under subsection (a), shall,
3 through the use of public awareness and outreach cam-
4 paigns targeting the general public and the medical com-
5 munity at large—

6 “(1) disseminate scientific evidence for the ex-
7 istence and extent of racial and ethnic disparities in
8 health care, including disparities that are not other-
9 wise attributable to known factors such as access to
10 care, patient preferences, or appropriateness of
11 intervention, as described in the 2002 report of the
12 National Academy of Medicine (formerly the ‘Insti-
13 tute of Medicine’) entitled ‘Unequal Treatment: Con-
14 fronting Racial and Ethnic Disparities in Health
15 Care’, as well as the impact of disparities related to
16 age, disability status, socioeconomic status, sex, gen-
17 der identity, and sexual orientation on racial and
18 ethnic minorities;

19 “(2) disseminate new research findings to
20 health care providers and patients to assist them in
21 understanding, reducing, and eliminating health and
22 health care disparities;

23 “(3) disseminate information about the impact
24 of linguistic and cultural barriers on health care
25 quality and the obligation of health providers who

1 receive Federal financial assistance to ensure that
2 individuals with limited English proficiency have ac-
3 cess to language access services;

4 “(4) disseminate information about the impor-
5 tance and legality of racial, ethnic, disability status,
6 socioeconomic status, sex, gender identity, and sex-
7 ual orientation, and primary language data collec-
8 tion, analysis, and reporting;

9 “(5) design and implement specific educational
10 initiatives to health care providers relating to health
11 and health care disparities;

12 “(6) assess the impact of the programs estab-
13 lished under this section in raising awareness of
14 health and health care disparities and providing in-
15 formation on available resources; and

16 “(7) design and implement specific educational
17 initiatives to educate the health care workforce relat-
18 ing to unconscious bias.

19 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated to carry out this section
21 such sums as may be necessary for each of fiscal years
22 2023 through 2027.”.

1 **SEC. 3002. HISPANIC-SERVING INSTITUTIONS, HISTORI-**
2 **CALLY BLACK COLLEGES AND UNIVERSITIES,**
3 **HISTORICALLY BLACK PROFESSIONAL OR**
4 **GRADUATE INSTITUTIONS, ASIAN AMERICAN**
5 **AND NATIVE AMERICAN PACIFIC ISLANDER-**
6 **SERVING INSTITUTIONS, TRIBAL COLLEGES,**
7 **REGIONAL COMMUNITY-BASED ORGANIZA-**
8 **TIONS, AND NATIONAL MINORITY MEDICAL**
9 **ASSOCIATIONS.**

10 Part B of title VII of the Public Health Service Act
11 (42 U.S.C. 293 et seq.) is amended by adding at the end
12 the following:

13 **“SEC. 742. HISPANIC-SERVING INSTITUTIONS, HISTORI-**
14 **CALLY BLACK COLLEGES AND UNIVERSITIES,**
15 **HISTORICALLY BLACK PROFESSIONAL OR**
16 **GRADUATE INSTITUTIONS, ASIAN AMERICAN**
17 **AND NATIVE AMERICAN PACIFIC ISLANDER-**
18 **SERVING INSTITUTIONS, AND TRIBAL COL-**
19 **LEGES.**

20 “(a) IN GENERAL.—The Secretary, acting through
21 the Administrator of the Health Resources and Services
22 Administration and in consultation with the Secretary of
23 Education, shall award grants to Hispanic-serving institu-
24 tions, historically Black colleges and universities, histori-
25 cally Black professional or graduate institutions eligible
26 for grants under section 326 of the Higher Education Act

1 of 1965, Asian American and Native American Pacific Is-
2 lander-serving institutions, Tribal Colleges or Universities,
3 regional community-based organizations, and national mi-
4 nority medical associations, for counseling, mentoring, and
5 providing information on financial assistance to prepare
6 underrepresented minority individuals to enroll in and
7 graduate from health professional schools and to increase
8 services for underrepresented minority students includ-
9 ing—

10 “(1) mentoring with underrepresented health
11 professionals;

12 “(2) providing financial assistance information
13 for continued education and applications to health
14 professional schools; and

15 “(3) retaining existing enrolled underrep-
16 resented minority students in a health professions
17 school.

18 “(b) DEFINITIONS.—In this section:

19 “(1) ASIAN AMERICAN AND NATIVE AMERICAN
20 PACIFIC ISLANDER-SERVING INSTITUTION.—The
21 term ‘Asian American and Native American Pacific
22 Islander-serving institution’ has the meaning given
23 such term in section 320(b) of the Higher Education
24 Act of 1965.

1 “(2) HISPANIC-SERVING INSTITUTION.—The
2 term ‘Hispanic-serving institution’ means an entity
3 that—

4 “(A) is a school or program for which
5 there is a definition under section 799B;

6 “(B) has an enrollment of full-time equiva-
7 lent students that is made up of at least 9 per-
8 cent Hispanic students;

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

12 “(D) has been effective in recruiting and
13 retaining Hispanic faculty members;

14 “(E) has a significant number of graduates
15 who are providing health services to medically
16 underserved populations or to individuals in
17 health professional shortage areas; and

18 “(F) is a Hispanic Center of Excellence in
19 Health Professions Education designated under
20 section 736(d)(2) of the Public Health Service
21 Act (42 U.S.C. 293(d)(2)).

22 “(3) HISTORICALLY BLACK COLLEGE AND UNI-
23 VERSITY.—The term ‘historically Black college and
24 university’ has the meaning given the term ‘part B

1 institution’ as defined in section 322 of the Higher
2 Education Act of 1965.

3 “(4) TRIBAL COLLEGE OR UNIVERSITY.—The
4 term ‘Tribal College or University’ has the meaning
5 given such term in section 316(b) of the Higher
6 Education Act of 1965.

7 “(c) CERTAIN LOAN REPAYMENT PROGRAMS.—In
8 carrying out the National Health Service Corps Loan Re-
9 payment Program established under subpart III of part
10 D of title III and the loan repayment program under sec-
11 tion 317F, the Secretary shall ensure, notwithstanding
12 such subpart or section, that loan repayments of not less
13 than \$50,000 per year per person are awarded for repay-
14 ment of loans incurred for enrollment or participation of
15 underrepresented minority individuals in health profes-
16 sional schools and other health programs described in this
17 section.

18 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
19 are authorized to be appropriated to carry out this section
20 such sums as may be necessary for each of fiscal years
21 2023 through 2027.”.

22 **SEC. 3003. LOAN REPAYMENT PROGRAM OF CENTERS FOR**
23 **DISEASE CONTROL AND PREVENTION.**

24 Section 317F(c)(1) of the Public Health Service Act
25 (42 U.S.C. 247b–7(c)(1)) is amended by striking

1 “\$500,000 for fiscal year 1994, and such sums as may
2 be necessary for each of the fiscal years 1995 through
3 2002” and inserting “such sums as may be necessary for
4 each of fiscal years 2023 through 2027”.

5 **SEC. 3004. ALLIED HEALTH WORKFORCE DIVERSITY.**

6 (a) INCREASING WORKFORCE DIVERSITY IN THE
7 PROFESSIONS OF PHYSICAL THERAPY, OCCUPATIONAL
8 THERAPY, RESPIRATORY THERAPY, AUDIOLOGY, AND
9 SPEECH-LANGUAGE PATHOLOGY.—Title VII of the Public
10 Health Service Act is amended—

11 (1) by redesignating part G (42 U.S.C. 295j et
12 seq.) as part H; and

13 (2) by inserting after part F (42 U.S.C. 295h)
14 the following new part:

15 **“PART G—INCREASING WORKFORCE DIVERSITY**
16 **IN THE PROFESSIONS OF PHYSICAL THER-**
17 **APY, OCCUPATIONAL THERAPY, RES-**
18 **PIRATORY THERAPY, AUDIOLOGY, AND**
19 **SPEECH-LANGUAGE PATHOLOGY**

20 **“SEC. 783. SCHOLARSHIPS AND STIPENDS.**

21 “(a) IN GENERAL.—The Secretary may award grants
22 and contracts to eligible entities to increase educational
23 opportunities in the professions of physical therapy, occu-
24 pational therapy, respiratory therapy, audiology, and
25 speech-language pathology for eligible individuals by—

1 “(1) providing student scholarships or stipends,
2 including for—

3 “(A) completion of an accelerated degree
4 program;

5 “(B) completion of an associate’s, bach-
6 elor’s, master’s, or doctoral degree program;
7 and

8 “(C) entry by a diploma or associate’s de-
9 gree practitioner into a bridge or degree com-
10 pletion program;

11 “(2) providing assistance for completion of pre-
12 requisite courses or other preparation necessary for
13 acceptance for enrollment in the eligible entity; and

14 “(3) carrying out activities to increase the re-
15 tention of students in one or more programs in the
16 professions of physical therapy, occupational ther-
17 apy, respiratory therapy, audiology, and speech-lan-
18 guage pathology.

19 “(b) CONSIDERATION OF RECOMMENDATIONS.—In
20 carrying out subsection (a), the Secretary shall take into
21 consideration the recommendations of national organiza-
22 tions representing the professions of physical therapy, oc-
23 cupational therapy, respiratory therapy, audiology, and
24 speech-language pathology, including the American Phys-
25 ical Therapy Association, the American Occupational

1 Therapy Association, the American Speech-Language-
2 Hearing Association, the American Association for Res-
3 piratory Care, the American Academy of Audiology, and
4 the Academy of Doctors of Audiology.

5 “(c) REQUIRED INFORMATION AND CONDITIONS FOR
6 AWARD RECIPIENTS.—

7 “(1) IN GENERAL.—The Secretary may require
8 recipients of awards under this section to report to
9 the Secretary concerning the annual admission, re-
10 tention, and graduation rates for eligible individuals
11 in programs of the recipient leading to a degree in
12 any of the professions of physical therapy, occupa-
13 tional therapy, respiratory therapy, audiology, and
14 speech-language pathology.

15 “(2) FALLING RATES.—If any of the rates re-
16 ported by a recipient under paragraph (1) fall below
17 the average for such recipient over the 2 years pre-
18 ceding the year covered by the report, the recipient
19 shall provide the Secretary with plans for imme-
20 diately improving such rates.

21 “(3) INELIGIBILITY.—A recipient described in
22 paragraph (2) shall be ineligible for continued fund-
23 ing under this section if the plan of the recipient
24 fails to improve the rates within the 1-year period
25 beginning on the date such plan is implemented.

1 “(d) DEFINITIONS.—In this section:

2 “(1) ELIGIBLE ENTITIES.—The term ‘eligible
3 entity’ means an accredited education program that
4 is carrying out a program for recruiting and retain-
5 ing students underrepresented in the professions of
6 physical therapy, occupational therapy, respiratory
7 therapy, audiology, and speech-language pathology
8 (including racial or ethnic minorities, or students
9 from disadvantaged backgrounds).

10 “(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible
11 individual’ means an individual who—

12 “(A) is a member of a class of persons who
13 are underrepresented in the professions of phys-
14 ical therapy, occupational therapy, respiratory
15 therapy, audiology, and speech-language pathol-
16 ogy, including individuals who are—

17 “(i) racial or ethnic minorities;

18 “(ii) from disadvantaged backgrounds;

19 or

20 “(iii) individuals with a disability (as
21 defined in section 3(1) of the Americans
22 with Disabilities Act of 1990), or who have
23 an individualized education program (as
24 defined in section 602 of the Individuals
25 with Disabilities Education Act), are cov-

1 ered under section 504 of the Rehabilita-
2 tion Act of 1973, or have other documenta-
3 tion establishing the student’s disability
4 (as such term is defined in section 3(1) of
5 the Americans with Disabilities Act of
6 1990);

7 “(B) has a financial need for a scholarship
8 or stipend; and

9 “(C) is enrolled (or accepted for enroll-
10 ment) at an audiology, speech-language pathol-
11 ogy, respiratory therapy, physical therapy, or
12 occupational therapy program as a full-time
13 student at an eligible entity.

14 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
15 is authorized to be appropriated to carry out this section
16 \$8,000,000 for the first fiscal year commencing after the
17 date of enactment of the Health Equity and Accountability
18 Act of 2022 and each of the 4 succeeding fiscal years.”.

19 (b) ELIGIBILITY CLARIFICATION REGARDING STU-
20 DENTS SUPPORTED THROUGH MENTAL AND BEHAV-
21 IORAL HEALTH EDUCATION AND TRAINING GRANTS.—
22 Section 756(a)(1) of the Public Health Service Act (42
23 U.S.C. 294e–1(a)(1)) is amended by inserting after “occu-
24 pational therapy” the following: “(which may include mas-
25 ter’s and doctoral level programs)”.

1 **SEC. 3005. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
2 **GREE PROGRAMS AT SCHOOLS OF PUBLIC**
3 **HEALTH AND SCHOOLS OF ALLIED HEALTH.**

4 Part D of title VII of the Public Health Service Act
5 (42 U.S.C. 294 et seq.) is amended by inserting after sec-
6 tion 755 of such Act (42 U.S.C. 294e) the following:

7 **“SEC. 755A. COOPERATIVE AGREEMENTS FOR ONLINE DE-**
8 **GREE PROGRAMS.**

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

18 “(b) PRIORITY.—In entering into cooperative agree-
19 ments under this section, the Secretary shall give priority
20 to any school of public health or school of allied health
21 that has an established track record of serving medically
22 underserved communities.

23 “(c) REQUIREMENTS.—As a condition of entering
24 into a cooperative agreement with the Secretary under this
25 section, a school of public health or school of allied health

1 shall agree to design and implement an online degree pro-
2 gram that meets the following restrictions:

3 “(1) Enrollment of individuals who have ob-
4 tained a secondary school diploma or its recognized
5 equivalent.

6 “(2) Maintaining a significant enrollment of
7 underrepresented minority or disadvantaged stu-
8 dents.

9 “(3) Achieving a high completion rate of en-
10 rolled underrepresented minority or disadvantaged
11 students.

12 “(d) PERIOD OF COOPERATIVE AGREEMENTS.—The
13 period during which payments are made through a cooper-
14 ative agreement entered into under this section may not
15 exceed 3 years.

16 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated to carry out this section
18 such sums as may be necessary for each of fiscal years
19 2023 through 2027.”.

20 **SEC. 3006. NATIONAL HEALTH CARE WORKFORCE COMMIS-**
21 **SION.**

22 (a) SENSE OF CONGRESS.—It is the sense of Con-
23 gress that the National Health Care Workforce Commis-
24 sion established by section 5101 of the Patient Protection
25 and Affordable Care Act (42 U.S.C. 294q) should, in car-

1 rying out its assigned duties under that section, give at-
2 tention to the needs of racial and ethnic minorities, indi-
3 viduals with lower socioeconomic status, individuals with
4 mental, developmental, and physical disabilities, lesbian,
5 gay, bisexual, transgender, queer, and questioning popu-
6 lations, and individuals who are members of multiple mi-
7 nority or special population groups.

8 (b) REAUTHORIZATION.—Section 5101(h)(2) of the
9 Patient Protection and Affordable Care Act (42 U.S.C.
10 294q(h)(2)) is amended by striking “such sums as may
11 be necessary” and inserting “\$3,000,000 for each of fiscal
12 years 2023 through 2025”.

13 **SEC. 3007. SCHOLARSHIP AND FELLOWSHIP PROGRAMS.**

14 Subtitle B of title XXXIV of the Public Health Serv-
15 ice Act, as added by section 3001, is further amended by
16 inserting after section 3417 the following:

17 **“SEC. 3418. DAVID SATCHER PUBLIC HEALTH AND HEALTH**
18 **SERVICES CORPS.**

19 “(a) IN GENERAL.—The Director of the Centers for
20 Disease Control and Prevention, in collaboration with the
21 Administrator of the Health Resources and Services Ad-
22 ministration and the Deputy Assistant Secretary for Mi-
23 nority Health, shall award grants to eligible entities to in-
24 crease awareness among secondary and postsecondary stu-
25 dents of career opportunities in the health professions.

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

3 “(1) be a clinical, public health, or health serv-
4 ices organization, community-based or nonprofit en-
5 tity, or other entity determined appropriate by the
6 Director of the Centers for Disease Control and Pre-
7 vention;

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

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

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

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

20 “(1) Medicine.

21 “(2) Nursing.

22 “(3) Public health.

23 “(4) Pharmacy.

24 “(5) Health administration and management.

25 “(6) Health policy.

1 “(7) Psychology.

2 “(8) Dentistry.

3 “(9) International health.

4 “(10) Social work.

5 “(11) Allied health.

6 “(12) Psychiatry.

7 “(13) Hospice care.

8 “(14) Community health, patient navigation,
9 and peer support.

10 “(15) Other professions determined appropriate
11 by the Director of the Centers for Disease Control
12 and Prevention.

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

17 “(1) serve a high proportion of individuals from
18 disadvantaged backgrounds;

19 “(2) have experience in health disparity elimi-
20 nation programs;

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

23 “(4) provide counseling or other services de-
24 signed to assist disadvantaged individuals in success-

1 fully completing their education at the postsecondary
2 level.

3 “(e) STIPENDS.—

4 “(1) IN GENERAL.—Subject to paragraph (2),
5 an entity receiving a grant under this section may
6 use the funds made available through such grant to
7 award stipends for educational and living expenses
8 to students participating in the internship supported
9 by the grant.

10 “(2) LIMITATIONS.—A stipend awarded under
11 paragraph (1) to an individual—

12 “(A) may not be provided for a period that
13 exceeds 6 months; and

14 “(B) may not exceed \$20 per day for an
15 individual (notwithstanding any other provision
16 of law regarding the amount of a stipend).

17 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated to carry out this section
19 such sums as may be necessary for each of fiscal years
20 2023 through 2027.

21 **“SEC. 3419. LOUIS STOKES PUBLIC HEALTH SCHOLARS**
22 **PROGRAM.**

23 “(a) IN GENERAL.—The Director of the Centers for
24 Disease Control and Prevention, in collaboration with the
25 Deputy Assistant Secretary for Minority Health, shall

1 award scholarships to eligible individuals under subsection
2 (b) who seek a career in public health.

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

5 “(1) have interest, knowledge, or skill in public
6 health research or public health practice, or other
7 health professions as determined appropriate by the
8 Director of the Centers for Disease Control and Pre-
9 vention;

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

12 “(3) demonstrate promise for becoming a leader
13 in public health;

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

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

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

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

25 “(1) are from disadvantaged backgrounds;

1 “(2) have secured admissions to a minority-
2 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.

7 “(e) SCHOLARSHIPS.—The Secretary may approve
8 payment of scholarships under this section for such indi-
9 viduals for any period of education in student under-
10 graduate tenure, except that such a scholarship may not
11 be provided to an individual for more than 4 years, and
12 such a scholarship may not exceed \$10,000 per academic
13 year for an individual (notwithstanding any other provi-
14 sion of law regarding the amount of a scholarship).

“(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 2023 through 2027.

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

“(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Deputy Assistant Secretary for Minority Health, the Assistant Secretary for Mental Health and Substance Use, and the Director of the Indian Health Service, shall award

1 research fellowships to eligible individuals under sub-
2 section (b) to conduct research that will examine gender
3 and health disparities and to pursue a career in the health
4 professions.

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

7 “(1) have experience in health research or pub-
8 lic health practice;

9 “(2) reside in a health professional shortage
10 area designated by the Secretary under section 332;

11 “(3) have expressed an interest in the health
12 professions;

13 “(4) demonstrate promise for becoming a leader
14 in the field of women’s sexual and reproductive
15 health, including family planning;

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

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

22 “(c) USE OF FUNDS.—A fellowship awarded under
23 subsection (a) to an eligible individual under subsection
24 (b) shall be used to support an opportunity for the indi-

1 vidual to become a researcher and advance the research
2 base on the intersection between gender and health.

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

7 “(1) are from disadvantaged backgrounds; and

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

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

22 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to carry out this section
24 such sums as may be necessary for each of fiscal years
25 2023 through 2027

1 **“SEC. 3421. PAUL DAVID WELLSTONE INTERNATIONAL**
2 **HEALTH FELLOWSHIP PROGRAM.**

3 “(a) IN GENERAL.—The Director of the Agency for
4 Healthcare Research and Quality, in collaboration with
5 the Deputy Assistant Secretary for Minority Health, shall
6 award research fellowships to eligible individuals under
7 subsection (b) to advance their understanding of inter-
8 national health.

9 “(b) ELIGIBILITY.—To be eligible to receive a fellow-
10 ship under subsection (a), an individual shall—

11 “(1) have educational experience in the field of
12 international health;

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

15 “(3) demonstrate promise for becoming a leader
16 in the field of international health;

17 “(4) be in the fourth year of a 4-year institu-
18 tion of higher education or a recent graduate of a
19 4-year institution of higher education; and

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

23 “(c) USE OF FUNDS.—A fellowship awarded under
24 subsection (a) to an eligible individual under subsection
25 (b) shall be used to support an opportunity for the indi-
26 vidual to become a health professional and to advance the

1 knowledge of the individual about international issues re-
2 lating to health care access and quality.

3 “(d) PRIORITY.—In awarding fellowships under sub-
4 section (a), the Director of the Agency for Healthcare Re-
5 search and Quality shall give priority to eligible individuals
6 under subsection (b) that—

7 “(1) are from a disadvantaged background; and

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

17 “(e) FELLOWSHIPS.—A fellowship awarded under
18 this section may not—

19 “(1) be provided to an eligible individual for
20 more than a period of 6 months;

21 “(2) be awarded to a graduate of a 4-year insti-
22 tution of higher education that has not been enrolled
23 in such institution for more than 1 year; or

“(3) exceed \$4,000 per academic year (notwithstanding any other provision of law regarding the amount of a fellowship).

1 “(2) serve in a health professional shortage
2 area designated by the Secretary under section 332;

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

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

8 “(c) USE OF FUNDS.—Amounts received under a
9 grant awarded under subsection (a) shall be used to sup-
10 port opportunities that expose students to non-research-
11 based health professions, including—

12 “(1) public health policy;

13 “(2) health care and pharmaceutical policy;

14 “(3) health care administration and manage-
15 ment;

16 “(4) health economics; and

17 “(5) other professions determined appropriate
18 by the Director of the Agency for Healthcare Re-
19 search and Quality, the Administrator of the Centers
20 for Medicare & Medicaid Services, or the Adminis-
21 trator of the Health Resources and Services Admin-
22 istration.

23 “(d) PRIORITY.—In awarding grants under sub-
24 section (a), the Director of the Agency for Healthcare Re-
25 search and Quality, the Administrator of the Centers for

1 Medicare & Medicaid Services, and the Administrator of
2 the Health Resources and Services Administration, in col-
3 laboration with the Deputy Assistant Secretary for Minor-
4 ity Health, shall give priority to entities that—

5 “(1) have experience with health disparity elimi-
6 nation programs;

7 “(2) facilitate training in the fields described in
8 subsection (c); and

9 “(3) provide counseling or other services de-
10 signed to assist students in successfully completing
11 their education at the postsecondary level.

12 “(e) STIPENDS.—

13 “(1) IN GENERAL.—Subject to paragraph (2),
14 an entity receiving a grant under this section may
15 use the funds made available through such grant to
16 award stipends for educational and living expenses
17 to students participating in the opportunities sup-
18 ported by the grant.

19 “(2) LIMITATIONS.—A stipend awarded under
20 paragraph (1) to an individual—

21 “(A) may not be provided for a period that
22 exceeds 2 months; and

23 “(B) may not exceed \$100 per day (not-
24 withstanding any other provision of law regard-
25 ing the amount of a stipend).

1 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 such sums as may be necessary for each of fiscal years
4 2023 through 2027.

5 **“SEC. 3423. LEADERSHIP FELLOWSHIP PROGRAMS.**

6 “(a) IN GENERAL.—The Secretary shall award
7 grants to national minority medical or health professional
8 associations to develop leadership fellowship programs for
9 underrepresented health professionals in order to—

10 “(1) assist such professionals in becoming fu-
11 ture leaders in public health and health care delivery
12 institutions; and

13 “(2) increase diversity in decision-making posi-
14 tions that can improve the health of underserved
15 communities.

16 “(b) USE OF FUNDS.—A leadership fellowship pro-
17 gram supported under this section shall—

18 “(1) focus on training mid-career physicians
19 and health care executives who have documented
20 leadership experience and a commitment to public
21 health services in underserved communities; and

22 “(2) support Federal public health policy and
23 budget programs, and priorities that impact health
24 equity, through activities such as didactic lectures
25 and leader site visits.

1 “(c) PERIOD OF GRANTS.—The period during which
2 payments are made under a grant awarded under sub-
3 section (a) may not exceed 3 years.

4 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated to carry out this section
6 such sums as may be necessary for each of fiscal years
7 2023 through 2027.”.

8 **SEC. 3008. MCNAIR POSTBACCALAUREATE ACHIEVEMENT**
9 **PROGRAM.**

10 Section 402E of the Higher Education Act of 1965
11 (20 U.S.C. 1070a–15) is amended by striking subsection
12 (g) and inserting the following:

13 “(g) COLLABORATION IN HEALTH PROFESSION DI-
14 VERSITY TRAINING PROGRAMS.—The Secretary shall co-
15 ordinate with the Secretary of Health and Human Serv-
16 ices to ensure that there is collaboration between the goals
17 of the program under this section and programs of the
18 Health Resources and Services Administration that pro-
19 mote health workforce diversity. The Secretary of Edu-
20 cation shall take such measures as may be necessary to
21 encourage students participating in projects assisted
22 under this section to consider health profession careers.

23 “(h) FUNDING.—From amounts appropriated pursu-
24 ant to the authority of section 402A(g), the Secretary
25 shall, to the extent practicable, allocate funds for projects

1 authorized by this section in an amount that is not less
2 than \$31,000,000 for each of the fiscal years 2023
3 through 2027.”.

4 **SEC. 3009. RULES FOR DETERMINATION OF FULL-TIME**
5 **EQUIVALENT RESIDENTS FOR COST-REPORT-**
6 **ING PERIODS.**

7 (a) DGME DETERMINATIONS.—Section 1886(h)(4)
8 of the Social Security Act (42 U.S.C. 1395ww(h)(4)), as
9 amended by section 2006(a), is amended—

10 (1) in subparagraph (E), by striking “Subject
11 to subparagraphs (J) and (K), such rules” and in-
12 serting “Subject to subparagraphs (J), (K), and
13 (M), such rules”;

14 (2) in subparagraph (J), by striking “Such
15 rules” and inserting “Subject to subparagraph (M),
16 such rules”;

17 (3) in subparagraph (K), by striking “In deter-
18 mining” and inserting “Subject to subparagraph
19 (M), in determining”; and

20 (4) by adding at the end the following new sub-
21 paragraph:

22 “(M) TREATMENT OF CERTAIN RESIDENTS
23 AND INTERNS.—For purposes of cost-reporting
24 periods beginning on or after October 1, 2022,
25 in determining the hospital’s number of full-

1 time equivalent residents for purposes of this
2 paragraph, all time spent by an intern or resi-
3 dent in an approved medical residency training
4 program shall be counted toward the determina-
5 tion of full-time equivalency if the hospital—

6 “(i) is recognized as a subsection (d)
7 hospital;

8 “(ii) is recognized as a subsection (d)
9 Puerto Rico hospital;

10 “(iii) is reimbursed under a reim-
11 bursement system authorized under section
12 1814(b)(3); or

13 “(iv) is a provider-based hospital out-
14 patient department.”.

15 (b) IME DETERMINATIONS.—Section
16 1886(d)(5)(B)(xi) of the Social Security Act (42 U.S.C.
17 1395ww(d)(5)(B)(xi)) is amended—

18 (1) in subclause (II), by striking “In deter-
19 mining” and inserting “Subject to subclause (IV), in
20 determining”;

21 (2) in subclause (III), by striking “In deter-
22 mining” and inserting “Subject to subclause (IV), in
23 determining”; and

24 (3) by inserting after subclause (III) the fol-
25 lowing new subclause:

1 “(IV) For purposes of cost-reporting peri-
2 ods beginning on or after October 1, 2022, the
3 provisions of subparagraph (M) of subsection
4 (h)(4) shall apply under this subparagraph in
5 the same manner as they apply under such sub-
6 section.”.

7 **SEC. 3010. DEVELOPING AND IMPLEMENTING STRATEGIES**
8 **FOR LOCAL HEALTH EQUITY.**

9 (a) GRANTS.—The Secretary of Health and Human
10 Services, acting jointly with the Secretary of Education
11 and the Secretary of Labor, shall make grants to an eligi-
12 ble institution of higher education for the purposes of—

13 (1) in accordance with subsection (b), devel-
14 oping capacity—

15 (A) to build an evidence base for successful
16 strategies for increasing local health equity; and

17 (B) to serve as national models of driving
18 local health equity; and

19 (2) in accordance with subsection (c), devel-
20 oping a strategic partnership with the community in
21 which the institution is located.

22 (b) DEVELOPING CAPACITY FOR INCREASING LOCAL
23 HEALTH EQUITY.—As a condition on receipt of a grant
24 under subsection (a), an institution of higher education
25 shall agree to use such grant to build an evidence base

1 for successful strategies for increasing local health equity,
2 and to serve as a national model of driving local health
3 equity, by supporting—

4 (1) resources to strengthen institutional metrics
5 and capacity to execute institution-wide health work-
6 force goals that can serve as models for increasing
7 health equity in communities across the United
8 States;

9 (2) collaborations among a cohort of institu-
10 tions in implementing systemic change, partnership
11 development, and programmatic efforts supportive of
12 health equity goals across disciplines and popu-
13 lations; and

14 (3) enhanced or newly developed data systems
15 and research infrastructure capable of informing
16 current and future workforce efforts and building a
17 foundation for a broader research agenda targeting
18 urban health disparities.

19 (c) STRATEGIC PARTNERSHIPS.—As a condition on
20 receipt of a grant under subsection (a), an institution of
21 higher education shall agree to use the grant to develop
22 a strategic partnership with the community in which such
23 institution is located for the purposes of—

24 (1) strengthening connections between such in-
25 stitution and the community—

1 (A) to improve evaluation of, and address,
2 the health and health workforce needs of such
3 community; and

4 (B) to engage such community in health
5 workforce development;

6 (2) developing, enhancing, or accelerating inno-
7 vative undergraduate and graduate programs in the
8 biomedical sciences and health professions; and

9 (3) strengthening pipeline programs in the bio-
10 medical sciences and health professions, including by
11 developing partnerships between institutions of high-
12 er education and elementary schools and secondary
13 schools to recruit the next generation of health pro-
14 fessionals earlier in the pipeline to a health care ca-
15 reer.

16 (d) ELIGIBLE INSTITUTION OF HIGHER EDUCATION
17 DEFINED.—For purposes of this section, an “eligible in-
18 stitution of higher education” includes—

19 (1) a program authorized under section 317(a)
20 of the Higher Education Act of 1965 (20 U.S.C.
21 1059d(a)); or

22 (2) a professional or graduate institution de-
23 scribed in section 326 of such Act (20 U.S.C.
24 1063b).

1 (e) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 such sums as may be necessary for each of fiscal years
4 2023 through 2027.

5 **SEC. 3011. HEALTH PROFESSIONS WORKFORCE FUND.**

6 (a) ESTABLISHMENT.—There is established in the
7 Health Resources and Services Administration of the De-
8 partment of Health and Human Services a Health Profes-
9 sions Workforce Fund to provide for expanded and sus-
10 tained national investment in the health professions and
11 nursing workforce development programs under title VII
12 and title VIII of the Public Health Service Act (42 U.S.C.
13 292 et seq.; 42 U.S.C. 296 et seq.).

14 (b) FUNDING.—

15 (1) IN GENERAL.—There is authorized to be
16 appropriated, and there is appropriated, out of any
17 monies in the Treasury not otherwise appropriated,
18 to the Health Professions Workforce Fund—

19 (A) \$392,000,000 for fiscal year 2023;

20 (B) \$412,000,000 for fiscal year 2024;

21 (C) \$432,000,000 for fiscal year 2025;

22 (D) \$454,000,000 for fiscal year 2026;

23 (E) \$476,000,000 for fiscal year 2027;

24 (F) \$500,000,000 for fiscal year 2028;

25 (G) \$525,000,000 for fiscal year 2029; and

1 (H) \$552,000,000 for fiscal year 2030.

2 (2) HEALTH PROFESSIONS EDUCATION PRO-
3 GRAMS.—For the purpose of carrying out health
4 professions education programs authorized under
5 title VII of the Public Health Service Act (42 U.S.C.
6 292 et seq.), in addition to any other amounts au-
7 thorized to be appropriated for such purpose, there
8 is authorized to be appropriated out of any monies
9 in the Health Professions Workforce Fund, the fol-
10 lowing:

11 (A) \$265,000,000 for fiscal year 2023.

12 (B) \$278,000,000 for fiscal year 2024.

13 (C) \$292,000,000 for fiscal year 2025.

14 (D) \$307,000,000 for fiscal year 2026.

15 (E) \$322,000,000 for fiscal year 2027.

16 (F) \$338,000,000 for fiscal year 2028.

17 (G) \$355,000,000 for fiscal year 2029.

18 (H) \$373,000,000 for fiscal year 2030.

19 (3) NURSING WORKFORCE DEVELOPMENT PRO-
20 GRAMS.—For the purpose of carrying out nursing
21 workforce development programs authorized under
22 title VIII of the Public Health Service Act (42
23 U.S.C. 296 et seq.), in addition to any other
24 amounts authorized to be appropriated for such pur-
25 pose, there is authorized to be appropriated out of

1 any monies in the Health Professions Workforce
2 Fund, the following:

3 (A) \$127,000,000 for fiscal year 2023.

4 (B) \$134,000,000 for fiscal year 2024.

5 (C) \$140,000,000 for fiscal year 2025.

6 (D) \$147,000,000 for fiscal year 2026.

7 (E) \$154,000,000 for fiscal year 2027.

8 (F) \$162,000,000 for fiscal year 2028.

9 (G) \$170,000,000 for fiscal year 2029.

10 (H) \$179,000,000 for fiscal year 2030.

11 **SEC. 3012. FUTURE ADVANCEMENT OF ACADEMIC NURS-**
12 **ING.**

13 (a) SUPPORT FOR NURSING EDUCATION AND THE
14 FUTURE NURSING WORKFORCE.—Part D of title VIII of
15 the Public Health Service Act (42 U.S.C. 296p et seq.)
16 is amended by adding at the end the following:

17 **“SEC. 832. NURSING EDUCATION ENHANCEMENT AND MOD-**
18 **ERNIZATION GRANTS IN UNDERSERVED**
19 **AREAS.**

20 “(a) IN GENERAL.—The Secretary, acting through
21 the Administrator of the Health Resources and Services
22 Administration, may award grants to schools of nursing
23 for—

24 “(1) increasing the number of faculty and stu-
25 dents at such schools in order to enhance the pre-

1 paredness of the United States for, and the ability
2 of the United States to address and quickly respond
3 to, public health emergencies declared under section
4 319 and pandemics; or

5 “(2) the enhancement and modernization of
6 nursing education programs.

7 “(b) PRIORITY.—In selecting grant recipients under
8 this section, the Secretary shall give priority to schools of
9 nursing that—

10 “(1) are located in a medically underserved
11 community;

12 “(2) are located in a health professional short-
13 age area as defined under section 332(a); or

14 “(3) are institutions of higher education listed
15 under section 371(a) of the Higher Education Act of
16 1965.

17 “(c) CONSIDERATION.—In awarding grants under
18 this section, the Secretary, to the extent practicable, may
19 ensure equitable distribution of awards among the geo-
20 graphic regions of the United States.

21 “(d) USE OF FUNDS.—A school of nursing that re-
22 ceives a grant under this section may use the funds award-
23 ed through such grant for activities that include—

24 “(1) enhancing enrollment and retention of stu-
25 dents at such school, with a priority for students

1 from disadvantaged backgrounds (including racial or
2 ethnic groups underrepresented in the nursing work-
3 force), individuals from rural and underserved areas,
4 low-income individuals, and first generation college
5 students (as defined in section 402A(h)(3) of the
6 Higher Education Act of 1965);

7 “(2) creating, supporting, or modernizing edu-
8 cational programs and curriculum at such school;

9 “(3) retaining current faculty, and hiring new
10 faculty, with an emphasis on faculty from racial or
11 ethnic groups who are underrepresented in the nurs-
12 ing workforce;

13 “(4) modernizing infrastructure at such school,
14 including audiovisual or other equipment, personal
15 protective equipment, simulation and augmented re-
16 ality resources, telehealth technologies, and virtual
17 and physical laboratories;

18 “(5) partnering with a health care facility,
19 nurse-managed health clinic, community health cen-
20 ter, or other facility that provides health care in
21 order to provide educational opportunities for the
22 purpose of establishing or expanding clinical edu-
23 cation;

24 “(6) enhancing and expanding nursing pro-
25 grams that prepare nurse researchers and scientists;

1 “(7) establishing nurse-led intradisciplinary and
2 interprofessional educational partnerships; and

3 “(8) other activities that the Secretary deter-
4 mines further the development, improvement, and
5 expansion of schools of nursing.

6 “(e) REPORTS FROM ENTITIES.—Each school of
7 nursing awarded a grant under this section shall submit
8 an annual report to the Secretary on the activities con-
9 ducted under such grant, and other information as the
10 Secretary may require.

11 “(f) REPORT TO CONGRESS.—Not later than 5 years
12 after the date of the enactment of this section, the Sec-
13 retary shall submit to the Committee on Health, Edu-
14 cation, Labor, and Pensions of the Senate and the Com-
15 mittee on Energy and Commerce of the House of Rep-
16 resentatives a report that provides a summary of the ac-
17 tivities and outcomes associated with grants made under
18 this section. Such report shall include—

19 “(1) a list of schools of nursing receiving grants
20 under this section, including the primary geographic
21 location of any school of nursing that was improved
22 or expanded through such a grant;

23 “(2) the total number of students who are en-
24 rolled at or who have graduated from any school of

1 nursing that was improved or expanded through a
2 grant under this section, which such statistic shall—

3 “(A) to the extent such information is
4 available, be deidentified and disaggregated by
5 race, ethnicity, age, sex, geographic region, dis-
6 ability status, and other relevant factors; and

7 “(B) include an indication of the number
8 of such students who are from racial or ethnic
9 groups underrepresented in the nursing work-
10 force, such students who are from rural or un-
11 derserved areas, such students who are low-in-
12 come students, and such students who are first
13 generation college students (as defined in sec-
14 tion 402A(h)(3) of the Higher Education Act of
15 1965);

16 “(3) to the extent such information is available,
17 the effects of the grants awarded under this section
18 on retaining and hiring of faculty, including any in-
19 crease in diverse faculty, the number of clinical edu-
20 cation partnerships, the modernization of nursing
21 education infrastructure, and other ways this section
22 helps address and quickly respond to public health
23 emergencies and pandemics;

24 “(4) recommendations for improving the grants
25 awarded under this section; and

1 “(5) any other considerations as the Secretary
2 determines appropriate.

3 “(g) AUTHORIZATION OF APPROPRIATIONS.—To
4 carry out this section, there is authorized to be appro-
5 priated \$1,000,000,000, to remain available until ex-
6 pended.”.

7 (b) STRENGTHENING NURSE EDUCATION.— The
8 heading of part D of title VIII of the Public Health Serv-
9 ice Act (42 U.S.C. 296p et seq.) is amended by striking
10 “**BASIC**”.

11 **SEC. 3013. FINDINGS; SENSE OF CONGRESS RELATING TO**
12 **GRADUATE MEDICAL EDUCATION.**

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

14 (1) Projections by the Association of American
15 Medical Colleges and other expert entities, such as
16 the Health Resources and Services Administration,
17 have indicated a nationwide shortage of up to
18 121,900 physicians, split evenly between primary
19 care and specialists, by 2032.

20 (2) Primarily due to the growing and aging
21 population, over the next decade, physician demand
22 is expected to grow up to 17 percent.

23 (3) The United States Census Bureau estimates
24 that the United States population will grow from
25 321,000,000 in 2015 to 347,000,000 in 2025. Fur-

1 ther, the number of Medicare beneficiaries is esti-
2 mated to increase from 47,800,000 in 2015 to ap-
3 proximately 66,000,000 in 2025.

4 (4) Approximately 36 percent of practicing phy-
5 sicians are over the age of 55 and are likely to retire
6 within the next decade.

7 (5) A nationwide physician shortage will result
8 in many individuals in the United States waiting
9 longer and traveling farther for health care; seeking
10 nonemergent care in emergency departments; and
11 delaying treatment until the health care needs of
12 such individuals become more serious, complex, and
13 costly.

14 (6) Changing demographics (such as an aging
15 population), new health care delivery models (such
16 as medical homes), and other factors (such as dis-
17 aster preparedness) are contributing to a shortage of
18 both generalist and specialist physicians.

19 (7) These shortages will have the most severe
20 impact on vulnerable and underserved populations,
21 including racial and ethnic minorities and the ap-
22 proximately 20 percent of people in the United
23 States who live in rural or inner-city locations des-
24 ignated as health professional shortage areas.

1 (8) The health care utilization equity model of
2 the Association of American Medical Colleges esti-
3 mates that if racial and ethnic minorities and indi-
4 viduals from rural areas utilized health care in a
5 similar way to their Caucasian counterparts living in
6 metropolitan areas, the physician shortage would re-
7 quire an additional 96,000 physicians.

8 (9) To address the physician shortage in rural
9 and medically underserved areas, medical education
10 and training need to be accessible to underrep-
11 resented minorities (including individuals who are
12 African American, Hispanic, Native American, or
13 Native Hawaiian), and need to increase pathway
14 programs for such underrepresented minorities who
15 make up less than 12 percent of individuals enrolled
16 in graduate medical education and for international
17 students who make up 25 percent of individuals en-
18 rolled in graduate medical education. Immigration
19 pathways like student, exchange-visitor, and employ-
20 ment visas, and programs like the National Interest
21 Waiver and Conrad 30 J-1 Visa Waiver, help im-
22 prove health access across the United States.

23 (10) United States medical school enrollment
24 was expected to grow by 30 percent from 2018 to

1 2019 to help reduce the shortage of quality physi-
2 cians in the United States.

3 (11) An increase in United States medical
4 school graduates must be accompanied by an in-
5 crease of 4,000 graduate medical education training
6 positions each year.

7 (12) Graduate medical education programs and
8 teaching hospitals provide venues in which the next
9 generation of physicians learns to work collabo-
10 ratively with other physicians and health profes-
11 sionals, adopt more efficient care delivery models
12 (such as care coordination and medical homes), in-
13 corporate health information technology and elec-
14 tronic health records in every aspect of their work,
15 apply new methods of assuring quality and safety,
16 and participate in groundbreaking clinical and public
17 health research.

18 (13) The Medicare program under title XVIII
19 of the Social Security Act (42 U.S.C. 1395 et seq.)
20 (having more beneficiaries than any other health
21 care program), supports its “fair share” of the costs
22 associated with graduate medical education.

23 (14) In general, the level of support of graduate
24 medical education by the Medicare program has
25 been capped since 1997 and has not been increased

1 to support the expansion of graduate medical edu-
2 cation programs needed to avert the projected physi-
3 cian shortage or to accommodate the increase in
4 United States medical school graduates.

5 (b) SENSE OF CONGRESS.—It is the sense of Con-
6 gress that eliminating the limit of the number of residency
7 positions that receive some level of Medicare support
8 under section 1886(h) of the Social Security Act (42
9 U.S.C. 1395ww(h)), also referred to as the Medical grad-
10 uate medical education cap, is critical to—

11 (1) ensuring an appropriate supply of physi-
12 cians to meet the health care needs in the United
13 States;

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

16 (3) increasing the racial and ethnic diversity of
17 physicians in the United States; and

18 (4) mitigating disparities in health and health
19 care.

20 **SEC. 3014. CAREER SUPPORT FOR SKILLED, INTERNATION-**
21 **ALLY EDUCATED HEALTH PROFESSIONALS.**

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

23 (1) According to a 2018 study, the State and
24 local public health workforce has shrunk by more
25 than 50,000 individuals since the beginning of the

1 2008 Great Recession, and almost one quarter of in-
2 dividuals comprising the governmental public health
3 workforce plan to leave or retire in the coming years.

4 (2) Shortages are projected for other health
5 professions, including within the fields of nursing
6 (500,000 by 2025), dentistry (15,000 by 2025),
7 pharmacy (38,000 by 2030), mental and behavioral
8 health (236,880 by 2025), and primary care (46,000
9 by 2025).

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

16 (4) Vulnerable and underserved populations and
17 health professional shortage areas will be most se-
18 verely impacted by the health workforce shortage.

19 (5) According to the Migration Policy Institute,
20 more than 2,000,000 college-educated immigrants in
21 the United States today are unemployed or under-
22 employed in low- or semi-skilled jobs that fail to
23 draw on their education and expertise.

1 (6) Approximately 2 out of every 5 internation-
2 ally educated immigrants are unemployed or under-
3 employed.

4 (7) According to the Drexel University Center
5 for Labor Markets and Policy, underemployment for
6 internationally educated immigrant women is 28 per-
7 cent higher than for their male counterparts.

8 (8) According to the Drexel University Center
9 for Labor Markets and Policy, the mean annual
10 earnings of underemployed immigrants were
11 \$32,000, or 43 percent less than United States born
12 college graduates employed in the college labor mar-
13 ket.

14 (9) According to Upwardly Global and the Wel-
15 come Back Initiative, with proper guidance and sup-
16 port, underemployed skilled immigrants typically in-
17 crease their income by 215 percent to 900 percent.

18 (10) According to the Brookings Institution and
19 the Partnership for a New American Economy, im-
20 migrants working in the health workforce are, on av-
21 erage, better educated than United States-born
22 workers in the health workforce.

23 (b) GRANTS TO ELIGIBLE ENTITIES.—

24 (1) AUTHORITY TO PROVIDE GRANTS.—The
25 Secretary of Health and Human Services acting

1 through the Bureau of Health Workforce within the
2 Health Resources and Services Administration, the
3 National Institute on Minority Health and Health
4 Disparities, or the Office of Minority Health (in this
5 section referred to as the “Secretary”) may award
6 grants to eligible entities under paragraph (2) to
7 carry out activities described in subsection (c).

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

10 (A) be a clinical, public health, or health
11 services organization, a community-based or
12 nonprofit entity, an academic institution, a
13 faith-based organization, a State, county, or
14 local government, an area health education cen-
15 ter, or another entity determined appropriate by
16 the Secretary; and

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

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

22 (1) to provide services to assist unemployed and
23 underemployed skilled immigrants, residing in the
24 United States, who have legal, permanent work au-
25 thorization and who are internationally educated

1 health professionals, enter into the health workforce
2 of the United States with employment matching
3 their health professional skills and education, and
4 advance in employment to positions that better
5 match their health professional education and exper-
6 tise;

7 (2) to provide training opportunities to reduce
8 barriers to entry and advancement in the health
9 workforce for skilled, internationally educated immi-
10 grants;

11 (3) to educate employers regarding the abilities
12 and capacities of internationally educated health
13 professionals;

14 (4) to assist in the evaluation of foreign creden-
15 tials;

16 (5) to support preceptorships for international
17 medical graduates in hospital primary care training;
18 and

19 (6) to facilitate access to contextualized and ac-
20 celerated courses on English as a second language.

21 **SEC. 3015. STUDY AND REPORT ON STRATEGIES FOR IN-**
22 **CREASING DIVERSITY.**

23 (a) STUDY.—The Comptroller General of the United
24 States shall conduct a study on strategies for increasing
25 the diversity of the health professional workforce. Such

1 study shall include an analysis of strategies for increasing
2 the number of health professionals from rural, lower in-
3 come, and underrepresented minority communities, includ-
4 ing which strategies are most effective for achieving such
5 goal.

6 (b) REPORT.—Not later than 2 years after the date
7 of enactment of this Act, the Comptroller General shall
8 submit to Congress a report on the study conducted under
9 subsection (a), together with recommendations for such
10 legislation and administrative action as the Comptroller
11 General determines appropriate.

12 **SEC. 3016. CONRAD STATE 30 PROGRAM; PHYSICIAN RETEN-**
13 **TION.**

14 (a) CONRAD STATE 30 PROGRAM EXTENSION.—Sec-
15 tion 220(c) of the Immigration and Nationality Technical
16 Corrections Act of 1994 (Public Law 103–416; 8 U.S.C.
17 1182 note) is amended by striking “September 30, 2015”
18 and inserting “September 30, 2022”.

19 (b) RETAINING PHYSICIANS WHO HAVE PRACTICED
20 IN MEDICALLY UNDERSERVED COMMUNITIES.—Section
21 201(b)(1) of the Immigration and Nationality Act (8
22 U.S.C. 1151(b)(1)) is amended by adding at the end the
23 following:

24 “(F)(i) Alien physicians who have com-
25 pleted service requirements for a national inter-

1 est waiver requested under section
2 203(b)(2)(B)(ii), including—

3 “(I) alien physicians who completed
4 such service before the date of the enact-
5 ment of the Health Equity and Account-
6 ability Act of 2022; and

7 “(II) the spouse or children of an
8 alien physician described in subclause (I).

9 “(ii) Nothing in this subparagraph may be
10 construed—

“(I) to prevent the filing of a petition with the Secretary of Homeland Security for classification under section 204(a) or the filing of an application for adjustment of status under section 245 by an alien physician described in clause (i) before the date on which such alien physician completes the service described in section 214(l) or worked full-time as a physician for an aggregate of 5 years at the location identified in the waiver of the 2-year foreign residence requirement under section 214(l) or in an area or areas designated by the Secretary of Health and Human Serv-

1 ices as having a shortage of health care
2 professionals; or

3 “(II) to permit the Secretary of
4 Homeland Security to grant a petition or
5 application described in subclause (I) until
6 the alien has satisfied all of the require-
7 ments of the waiver received under section
8 214(l).”.

9 (c) EMPLOYMENT PROTECTIONS FOR PHYSICIANS.—

(1) EXCEPTIONS TO 2-YEAR FOREIGN RESIDENCY REQUIREMENT.—Section 214(l)(1) of the Immigration and Nationality Act (8 U.S.C. 1184(l)(1)) is amended—

14 (A) in the matter preceding subparagraph
15 (A), by striking “Attorney General shall not”
16 and inserting “Secretary of Homeland Security
17 may not”;

(B) in subparagraph (A), by striking “Director of the United States Information Agency” and inserting “Secretary of State”;

21 (C) in subparagraph (B), by inserting “,
22 except as provided in paragraphs (7) and (8)”
23 before the semicolon at the end;

24 (D) in subparagraph (C), by amending
25 clauses (i) and (ii) to read as follows:

1 “(i) the alien demonstrates a bona
2 fide offer of full-time employment at a
3 health facility or health care organization,
4 which employment has been determined by
5 the Secretary of Homeland Security to be
6 in the public interest; and

7 “(ii) the alien—

8 “(I) has accepted employment
9 with the health facility or health care
10 organization in a geographic area or
11 areas which are designated by the
12 Secretary of Health and Human Serv-
13 ices as having a shortage of health
14 care professionals;

15 “(II) begins employment by the
16 later of the date that is—

17 “(aa) 120 days after receiv-
18 ing such waiver;

19 “(bb) 120 days after com-
20 pleting graduate medical edu-
21 cation or training under a pro-
22 gram approved pursuant to sec-
23 tion 212(j)(1); or

24 “(cc) 120 days after receiv-
25 ing nonimmigrant status or em-

1 employment authorization, if the
2 alien or the alien’s employer peti-
3 tions for such nonimmigrant sta-
4 tus or employment authorization
5 not later than 120 days after the
6 date on which the alien completes
7 his or her graduate medical edu-
8 cation or training under a pro-
9 gram approved pursuant to sec-
10 tion 212(j)(1); and

11 “(III) agrees to continue to work
12 for a total of not less than 3 years in
13 the status authorized for such employ-
14 ment under this subsection, except as
15 provided in paragraph (8); and”; and

16 (E) in subparagraph (D), in the matter
17 preceding clause (i), by inserting “, subject to
18 paragraph (8),” before “in the case”.

19 (2) ALLOWABLE VISA STATUS FOR PHYSICIANS
20 FULFILLING WAIVER REQUIREMENTS IN MEDICALLY
21 UNDERSERVED AREAS.—Section 214(l)(2)(A) of
22 such Act (8 U.S.C. 1184(l)(2)(A)) is amended to
23 read as follows:

24 “(A) Upon the request of an interested
25 Federal agency or an interested State agency

1 for recommendation of a waiver under this sec-
2 tion by a physician who is maintaining valid
3 nonimmigrant status under section
4 101(a)(15)(J) and received a favorable rec-
5 ommendation by the Secretary of State, the
6 Secretary of Homeland Security may change
7 the status of such physician to any status au-
8 thorized for employment under this Act. The
9 numerical limitations set forth in subsection
10 (g)(1)(A) shall not apply to any alien whose
11 status is changed under this subparagraph.”.

12 (3) VIOLATION OF AGREEMENTS.—Section
13 214(l)(3)(A) of such Act (8 U.S.C. 1184(l)(3)(A)) is
14 amended by inserting “substantial requirement of
15 an” before “agreement entered into”.

16 (4) PHYSICIAN EMPLOYMENT IN UNDERSERVED
17 AREAS.—Section 214(l) of such Act (8 U.S.C.
18 1184(l)), as amended by this section, is further
19 amended by adding at the end the following:

20 “(4)(A) If an interested State agency denies the
21 application for a waiver under paragraph (1)(B)
22 from a physician pursuing graduate medical edu-
23 cation or training pursuant to section 101(a)(15)(J)
24 because the State has requested the maximum num-
25 ber of waivers permitted for that fiscal year, the

1 physician's nonimmigrant status shall be extended
2 for up to 6 months if the physician agrees to seek
3 a waiver under this subsection (except for paragraph
4 (1)(D)(ii)) to work for an employer described in
5 paragraph (1)(C) in a State that has not yet re-
6 quested the maximum number of waivers.

7 “(B) A physician described in subparagraph (A)
8 may only work for the employer referred to in sub-
9 paragraph (A) during the period beginning on the
10 date on which a new waiver application is filed with
11 such State and ending on the earlier of—

12 “(i) the date on which the Secretary of
13 Homeland Security denies such waiver; or

14 “(ii) the date on which the Secretary ap-
15 proves an application for change of status
16 under paragraph (2)(A) pursuant to the ap-
17 proval of such waiver.”.

18 (5) CONTRACT REQUIREMENTS.—Section 214(l)
19 of such Act, as amended by this section, is further
20 amended by adding at the end the following:

21 “(5) An alien granted a waiver under para-
22 graph (1)(C) shall enter into an employment agree-
23 ment with the contracting health facility or health
24 care organization that—

1 “(A) specifies the maximum number of on-
2 call hours per week (which may be a monthly
3 average) that the alien will be expected to be
4 available and the compensation the alien will re-
5 ceive for on-call time;

6 “(B) specifies—

7 “(i) whether the contracting facility or
8 organization will pay the alien’s mal-
9 practice insurance premiums;

10 “(ii) whether the employer will provide
11 malpractice insurance; and

12 “(iii) the amount of such insurance
13 that will be provided;

14 “(C) describes all of the work locations
15 that the alien will work including a statement
16 that the contracting facility or organization will
17 not add additional work locations without the
18 approval of the Federal agency or State agency
19 that requested the waiver; and

20 “(D) does not include a non-compete provi-
21 sion.

22 “(6) An alien granted a waiver under this sub-
23 section whose employment relationship with a health
24 facility or health care organization terminates under
25 paragraph (1)(C)(ii) during the 3-year service period

1 required under paragraph (1) shall be considered to
2 be maintaining lawful status in an authorized period
3 of stay during the 120-day period referred to in
4 items (aa) and (bb) of subclause (III) of paragraph
5 (1)(C)(ii) or the 45-day period referred to in sub-
6 clause (III)(cc) of such paragraph.”.

7 (6) RECAPTURING WAIVER SLOTS LOST TO
8 OTHER STATES.—Section 214(l) of such Act, as
9 amended by this section, is further amended by add-
10 ing at the end the following:

11 “(7) If a recipient of a waiver under this sub-
12 section terminates the recipient’s employment with a
13 health facility or health care organization pursuant
14 to paragraph (1)(C)(ii), including termination of em-
15 ployment because of circumstances described in
16 paragraph (1)(C)(ii)(III), and accepts new employ-
17 ment with such a facility or organization in a dif-
18 ferent State, the State from which the alien is de-
19 parting may be accorded an additional waiver by the
20 Secretary of State for use in the fiscal year in which
21 the alien’s employment was terminated.”.

22 (7) EXCEPTION TO 3-YEAR WORK REQUIRE-
23 MENT.—Section 214(l) of such Act, as amended by
24 this section, is further amended by adding at the
25 end the following:

1 “(8) The 3-year work requirement set forth in
2 subparagraphs (C) and (D) of paragraph (1) shall
3 not apply if—

4 “(A)(i) the Secretary of Homeland Secu-
5 rity determines that extenuating circumstances,
6 including violations by the employer of the em-
7 ployment agreement with the alien or of labor
8 and employment laws, exist that justify a lesser
9 period of employment at such facility or organi-
10 zation; and

11 “(ii) not later than 120 days after the em-
12 ployment termination date (unless the Secretary
13 determines that extenuating circumstances
14 would justify an extension), the alien dem-
15 onstrates another bona fide offer of employment
16 at a health facility or health care organization
17 in a geographic area or areas which are des-
18 ignated by the Secretary of Health and Human
19 Services as having a shortage of health care
20 professionals, for the remainder of such 3-year
21 period;

22 “(B)(i) the interested State agency that re-
23 quested the waiver attests that extenuating cir-
24 cumstances, including violations by the em-
25 ployer of the employment agreement with the

1 alien or of labor and employment laws, exist
2 that justify a lesser period of employment at
3 such facility or organization; and

4 “(ii) the alien demonstrates, not later than
5 120 days after the employment termination
6 date (unless the Secretary determines that ex-
7 tenuating circumstances would justify an exten-
8 sion), another bona fide offer of employment at
9 a health facility or health care organization in
10 a geographic area or areas which are designated
11 by the Secretary of Health and Human Services
12 as having a shortage of health care profes-
13 sionals, for the remainder of such 3-year period;
14 or

15 “(C) the alien—

16 “(i) elects not to pursue a determina-
17 tion of extenuating circumstances pursuant
18 to subclause (A) or (B);

19 “(ii) terminates the alien’s employ-
20 ment relationship with the health facility
21 or health care organization at which the
22 alien was employed;

23 “(iii) not later than 45 days after the
24 employment termination date, dem-
25 onstrates another bona fide offer of em-

1 ployment at a health facility or health care
2 organization in a geographic area or areas,
3 in the State that requested the alien’s
4 waiver, which are designated by the Sec-
5 retary of Health and Human Services as
6 having a shortage of health care profes-
7 sionals; and

8 “(iv) agrees to be employed for the re-
9 mainder of such 3-year period, and 1 addi-
10 tional year for each termination under
11 clause (ii).”.

12 (d) ALLOTMENT OF CONRAD 30 WAIVERS.—

13 (1) IN GENERAL.—Section 214(l) of the Immi-
14 gration and Nationality Act (8 U.S.C. 1184(l)), as
15 amended by subsection (c), is further amended by
16 adding at the end the following:

17 “(9)(A)(i) All States shall be allotted 35 waivers
18 under paragraph (1)(B) for each fiscal year if 90 percent
19 of the waivers available to the States receiving at least
20 5 waivers were used in the previous fiscal year.

21 “(ii) When an allotment occurs under clause (i), all
22 States shall be allotted an additional 5 waivers under
23 paragraph (1)(B) for each subsequent fiscal year if 90
24 percent of the waivers available to the States receiving at
25 least 5 waivers were used in the previous fiscal year. If

1 the States are allotted 45 or more waivers for a fiscal year,
2 the States will only receive an additional increase of 5
3 waivers the following fiscal year if 95 percent of the waiv-
4 ers available to the States receiving at least 1 waiver were
5 used in the previous fiscal year.

6 “(B) Any increase in allotments under subparagraph
7 (A) shall be maintained indefinitely, unless in a fiscal year
8 the total number of such waivers granted is 5 percent
9 lower than in the last year in which there was an increase
10 in the number of waivers allotted pursuant to this para-
11 graph. In such case—

12 “(i) the number of waivers allotted beginning in
13 the next fiscal year shall be decreased by 5 for all
14 States; and

15 “(ii) each additional 5 percent decrease in such
16 waivers granted from the last year in which there
17 was an increase in the allotment, shall result in an
18 additional decrease of 5 waivers allotted for all
19 States, provided that the number of waivers allotted
20 for all States shall not drop below 30.”.

21 (2) ACADEMIC MEDICAL CENTERS.—Section
22 214(l)(1)(D) of such Act, as amended by subsection
23 (c)(1)(E), is further amended—

24 (A) in clause (ii), by striking “and” at the
25 end;

1 (B) in clause (iii), by striking the period at
2 the end and inserting “; and”; and

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

4 “(iv) in the case of a request by an inter-
5 ested State agency—

6 “(I) the head of such agency deter-
7 mines that the alien is to practice medicine
8 in, or be on the faculty of a residency pro-
9 gram at, an academic medical center (as
10 defined in section 411.355(e)(2) of title 42,
11 Code of Federal Regulations), without re-
12 gard to whether such facility is located
13 within an area designated by the Secretary
14 of Health and Human Services as having
15 a shortage of health care professionals; and

16 “(II) the head of such agency deter-
17 mines that—

18 “(aa) the alien physician’s work
19 is in the public interest; and

20 “(bb) subject to paragraph (6),
21 the grant of such waiver would not
22 cause the number of the waivers
23 granted on behalf of aliens for such
24 State for a fiscal year to exceed 3,

1 within the limitation under subpara-
2 graph (B).”.

3 (e) AMENDMENTS TO THE PROCEDURES, DEFINI-
4 TIONS, AND OTHER PROVISIONS RELATED TO PHYSICIAN
5 IMMIGRATION.—

6 (1) DUAL INTENT FOR PHYSICIANS SEEKING
7 GRADUATE MEDICAL TRAINING.—Section 214(b) of
8 the Immigration and Nationality Act (8 U.S.C.
9 1184(b)) is amended by striking “and other than a
10 nonimmigrant described in any provision of section
11 101(a)(15)(H)(i) except subclause (b1) of such sec-
12 tion)” and inserting “a nonimmigrant described in
13 any provision of section 101(a)(15)(H)(i) (except
14 subclause (b1) of such section), and an alien coming
15 to the United States to receive graduate medical
16 education or training as described in section 212(j)
17 or to take examinations required to receive graduate
18 medical education or training as described in section
19 212(j))”.

20 (2) PHYSICIAN NATIONAL INTEREST WAIVER
21 CLARIFICATIONS.—

22 (A) PRACTICE AND GEOGRAPHIC AREA.—
23 Section 203(b)(2)(B)(ii)(I) of the Immigration
24 and Nationality Act (8 U.S.C.

1 1153(b)(2)(B)(ii)(I)) is amended by striking
2 items (aa) and (bb) and inserting the following:

3 “(aa) the alien physician agrees to
4 work on a full-time basis practicing pri-
5 mary care, specialty medicine, or a com-
6 bination thereof, in an area or areas des-
7 ignated by the Secretary of Health and
8 Human Services as having a shortage of
9 health care professionals, or at a health
10 care facility under the jurisdiction of the
11 Secretary of Veterans Affairs; or

12 “(bb) the alien physician is pursuing
13 such waiver based upon service at a facility
14 or facilities that serve patients who reside
15 in a geographic area or areas designated
16 by the Secretary of Health and Human
17 Services as having a shortage of health
18 care professionals (without regard to
19 whether such facility or facilities are lo-
20 cated within such an area) and a Federal
21 agency, or a local, county, regional, or
22 State department of public health deter-
23 mines the alien physician’s work was or
24 will be in the public interest.”.

1 (B) FIVE-YEAR SERVICE REQUIREMENT.—

2 Section 203(b)(2)(B)(ii) of such Act is amend-
3 ed—

4 (i) by moving subclauses (II), (III),
5 and (IV) 4 ems to the left; and

6 (ii) in subclause (II)—

7 (I) by inserting “(aa)” after
8 “(II)”; and

9 (II) by adding at the end the fol-
10 lowing:

11 “(bb) The 5-year service requirement
12 described in item (aa) shall begin on the
13 date on which the alien physician begins
14 work in the shortage area in any legal sta-
15 tus and not on the date on which an immi-
16 grant visa petition is filed or approved.
17 Such service shall be aggregated without
18 regard to when such service began and
19 without regard to whether such service
20 began during or in conjunction with a
21 course of graduate medical education.

22 “(cc) An alien physician shall not be
23 required to submit an employment contract
24 with a term exceeding the balance of the 5-
25 year commitment yet to be served or an

1 employment contract dated within a min-
2 imum time period before filing a visa peti-
3 tion under this subsection.

4 “(dd) An alien physician shall not be
5 required to file additional immigrant visa
6 petitions upon a change of work location
7 from the location approved in the original
8 national interest immigrant petition.”.

9 (3) TECHNICAL CLARIFICATION REGARDING AD-
10 VANCED DEGREE FOR PHYSICIANS.—Section
11 203(b)(2)(A) of such Act is amended by adding at
12 the end the following: “An alien physician holding a
13 foreign medical degree that has been deemed suffi-
14 cient for acceptance by an accredited United States
15 medical residency or fellowship program shall be
16 considered a member of the professions holding an
17 advanced degree or its equivalent for purposes of
18 this paragraph.”.

19 (4) SHORT-TERM WORK AUTHORIZATION FOR
20 PHYSICIANS COMPLETING THEIR RESIDENCIES.—

21 (A) IN GENERAL.—A physician completing
22 graduate medical education or training de-
23 scribed in section 212(j) of the Immigration
24 and Nationality Act (8 U.S.C. 1182(j)) as a
25 nonimmigrant described in section

1 101(a)(15)(H)(i) of such Act (8 U.S.C.
2 1101(a)(15)(H)(i))—

3 (i) shall have such nonimmigrant sta-
4 tus automatically extended until October 1
5 of the fiscal year for which a petition for
6 a continuation of such nonimmigrant sta-
7 tus has been submitted in a timely manner
8 and the employment start date for the ben-
9 eficiary of such petition is October 1 of
10 that fiscal year; and

11 (ii) shall be authorized to be employed
12 incident to status during the period be-
13 tween the filing of such petition and Octo-
14 ber 1 of such fiscal year.

15 (B) TERMINATION.—The status and em-
16 ployment authorization of a physician described
17 in subparagraph (A) shall terminate on the date
18 that is 30 days after the date on which a peti-
19 tion described in clause (i)(I) is rejected, denied
20 or revoked.

21 (C) AUTOMATIC EXTENSION.—The status
22 and employment authorization of a physician
23 described in subparagraph (A) will automati-
24 cally extend to October 1 of the next fiscal year
25 if all of the visas described in section

1 101(a)(15)(H)(i) of the Immigration and Na-
2 tionality Act (8 U.S.C. 1101(a)(15)(H)(i)) that
3 were authorized to be issued for the fiscal year
4 have been issued.

5 (5) APPLICABILITY OF SECTION 212(e) TO
6 SPOUSES AND CHILDREN OF J-1 EXCHANGE VISI-
7 TORS.—A spouse or child of an exchange visitor de-
8 scribed in section 101(a)(15)(J) of the Immigration
9 and Nationality Act (8 U.S.C. 1101(a)(15)(J)) shall
10 not be subject to the requirements under section
11 212(e) of such Act (8 U.S.C. 1182(e)).

12 **SEC. 3017. NATIONAL HISPANIC NURSES DAY.**

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

14 (1) A special group of nurses in the Nation are
15 the Hispanic nurses.

16 (2) Hispanic nurses provide culturally and eth-
17 nically competent care and are educated to be sen-
18 sitive to regional and community customs of persons
19 needing care.

20 (3) Hispanic nurses are well-positioned to pro-
21 vide leadership to eliminate health care disparities
22 that exist in the Nation.

23 (4) Since 1975, the National Association of
24 Hispanic Nurses (NAHN) has represented Hispanic
25 nurses (RNs/LPNs) in the United States and is the

1 only nursing organization for Hispanic nurses whose
2 mission is to advance the health in Hispanic commu-
3 nities and to lead, promote, and advocate for edu-
4 cational, professional, and leadership opportunities
5 for Hispanic nurses.

6 (5) Since September is the month that has been
7 set aside to honor the contributions of Hispanics, it
8 is only fitting that Hispanic nurses be recognized
9 and honored during this time for their outstanding
10 contributions to their community and country.

11 (6) The designation of an observation day will
12 help to raise awareness of the accomplishments of
13 Hispanic nurses and pave the way for the important
14 work that they must continue to carry out.

15 (7) Each February, the National Association of
16 Hispanic Nurses convenes nearly 100 nursing lead-
17 ers from academia, research, education, and practice
18 in the District of Columbia for a day on Capitol Hill
19 promoting legislation that improves the health of
20 Hispanic communities.

21 (8) Hispanic nurses are strong allies to Con-
22 gress as they help inform, educate, and work closely
23 with legislators to improve the education, retention,
24 recruitment, and practice of all nurses and, more

1 importantly, the health and safety of the patients for
2 whom they provide care.

3 (9) Hispanic nurses add needed diversity to the
4 nursing profession, and these nurses have engaged
5 in numerous ways to support communities and the
6 needs of an overlooked, under resourced, and under-
7 served population being severely impacted by
8 COVID-19.

9 (b) SENSE OF CONGRESS.—The Congress—

10 (1) supports the goals and ideals, and the des-
11 ignation, of National Hispanic Nurses Day, as pro-
12 posed by the National Association of Hispanic
13 Nurses;

14 (2) recognizes the significant contributions of
15 Hispanic nurses to the health care system of the
16 United States; and

17 (3) encourages the people of the United States
18 to observe National Hispanic Nurses Day with ap-
19 propriate recognition, ceremonies, activities, and pro-
20 grams to demonstrate the importance of Hispanic
21 nurses to the everyday lives of patients and the com-
22 munities they serve.

1 **SEC. 3018. EXPANDING MEDICAL EDUCATION.**

2 Subpart II of part C of title VII of the Public Health
3 Service Act (42 U.S.C. 293m et seq.) is amended by add-
4 ing at the end the following:

5 **“SEC. 749C. GRANTS FOR SCHOOLS OF MEDICINE AND**
6 **SCHOOLS OF OSTEOPATHIC MEDICINE IN UN-**
7 **DESERVED AREAS.**

8 “(a) IN GENERAL.—The Secretary, acting through
9 the Administrator of the Health Resources and Services
10 Administration, may award grants to institutions of high-
11 er education (including consortiums of such institutions)
12 for the establishment, improvement, or expansion of a
13 school of medicine or osteopathic medicine, or a branch
14 campus of a school of medicine or osteopathic medicine.

15 “(b) PRIORITY.—In selecting grant recipients under
16 this section, the Secretary shall give priority to any insti-
17 tution of higher education (or consortium of such institu-
18 tions) that—

19 “(1) proposes to use the grant for the establish-
20 ment of a school of medicine or osteopathic medi-
21 cine, or a branch campus of a school of medicine or
22 osteopathic medicine, in an area—

23 “(A) in which no other such school is
24 based; and

1 “(B) that is a medically underserved com-
2 munity or a health professional shortage area;
3 or

4 “(2) is an institution described in section
5 371(a) of the Higher Education Act of 1965.

6 “(c) CONSIDERATIONS.—In awarding grants under
7 this section, the Secretary, to the extent practicable, may
8 ensure equitable distribution of awards among the geo-
9 graphical regions of the United States.

10 “(d) USE OF FUNDS.—An institution of higher edu-
11 cation (or a consortium of such institutions)—

12 “(1) shall use grant amounts received under
13 this section to—

14 “(A) recruit, enroll, and retain students,
15 including individuals who are from disadvan-
16 taged backgrounds (including racial and ethnic
17 groups underrepresented among medical stu-
18 dents and health professions), individuals from
19 rural and underserved areas, low-income indi-
20 viduals, and first generation college students, at
21 a school of medicine or osteopathic medicine or
22 branch campus of a school of medicine or osteo-
23 pathic medicine; and

24 “(B) develop, implement, and expand cur-
25 riculum that emphasizes care for rural and un-

1 derserved populations, including accessible and
2 culturally and linguistically appropriate care
3 and services, at such school or branch campus;
4 and

5 “(2) may use grant amounts received under this
6 section to—

7 “(A) plan and construct—

8 “(i) a school of medicine or osteo-
9 pathic medicine in an area in which no
10 other such school is based; or

11 “(ii) a branch campus of a school of
12 medicine or osteopathic medicine in an
13 area in which no other such school is
14 based;

15 “(B) plan, develop, and meet criteria for
16 accreditation for a school of medicine or osteo-
17 pathic medicine or branch campus of a school
18 of medicine or osteopathic medicine;

19 “(C) hire faculty, including faculty from
20 racial and ethnic groups who are underrep-
21 resented among the medical and other health
22 professions, and other staff to serve at such a
23 school or branch campus;

24 “(D) support educational programs at such
25 a school or branch campus;

1 “(E) modernize and expand infrastructure
2 at such a school or branch campus; and

3 “(F) support other activities that the Sec-
4 retary determines further the establishment,
5 improvement, or expansion of a school of medi-
6 cine or osteopathic medicine or branch campus
7 of a school of medicine or osteopathic medicine.

8 “(e) APPLICATION.—To be eligible to receive a grant
9 under subsection (a), an institution of higher education
10 (or a consortium of such institutions), shall submit an ap-
11 plication to the Secretary at such time, in such manner,
12 and containing such information as the Secretary may re-
13 quire, including a description of the institution’s or con-
14 sortium’s planned activities described in subsection (d).

15 “(f) REPORTING.—

16 “(1) REPORTS FROM ENTITIES.—Each institu-
17 tion of higher education, or consortium of such insti-
18 tutions, awarded a grant under this section shall
19 submit an annual report to the Secretary on the ac-
20 tivities conducted under such grant, and other infor-
21 mation as the Secretary may require.

22 “(2) REPORT TO CONGRESS.—Not later than 5
23 years after the date of enactment of this section and
24 every 5 years thereafter, the Secretary shall submit
25 to the Committee on Health, Education, Labor, and

1 Pensions of the Senate and the Committee on En-
2 ergy and Commerce of the House of Representatives
3 a report that provides a summary of the activities
4 and outcomes associated with grants made under
5 this section. Such reports shall include—

6 “(A) a list of awardees, including their pri-
7 mary geographic location, and location of any
8 school of medicine or osteopathic medicine, or a
9 branch campus of a school of medicine or osteo-
10 pathic medicine that was established, improved,
11 or expanded under a grant awarded under this
12 section;

13 “(B) the total number of students (includ-
14 ing the number of students from racial and eth-
15 nic groups underrepresented among medical
16 students and health professions, low-income
17 students, and first generation college students)
18 who—

19 “(i) are enrolled at or who have grad-
20 uated from any school of medicine or os-
21 teopathic medicine, or a branch campus of
22 z school of medicine or osteopathic medi-
23 cine, that was established, improved, or ex-
24 panded under a grant awarded under this
25 section, deidentified and disaggregated by

1 race, ethnicity, age, sex, geographic region,
2 disability status, and other relevant fac-
3 tors, to the extent such information is
4 available; and

5 “(ii) subsequently participate in an
6 accredited internship or medical residency
7 program upon graduation from any school
8 of medicine or osteopathic medicine, or a
9 branch campus of a school of medicine or
10 osteopathic medicine, that was established,
11 improved, or expanded under a grant
12 awarded under this section, deidentified
13 and disaggregated by race, ethnicity, age,
14 sex, geographic region, disability status,
15 medical specialty pursued, and other rel-
16 evant factors, to the extent such informa-
17 tion is available;

18 “(C) the effects of the grants awarded
19 under this section on the health care provider
20 workforce, including any impact on demo-
21 graphic representation disaggregated by race,
22 ethnicity, and sex, and the fields or specialties
23 pursued by students who have graduated from
24 any school of medicine or osteopathic medicine,
25 or a branch campus of a school of medicine or

1 osteopathic medicine, that was established, im-
2 proved, or expanded under a grant awarded
3 under this section;

4 “(D) the effects of the grants awarded
5 under this section on health care access in un-
6 derserved areas, including medically under-
7 served communities and health professional
8 shortage areas; and

9 “(E) recommendations for improving the
10 grants awarded under this section, and any
11 other considerations as the Secretary deter-
12 mines appropriate.

13 “(3) PUBLIC AVAILABILITY.—The Secretary
14 shall make reports submitted under paragraph (2)
15 publicly available on the internet website of the De-
16 partment of Health and Human Services.

17 “(g) DEFINITIONS.—In this section:

18 “(1) BRANCH CAMPUS.—

19 “(A) IN GENERAL.—The term ‘branch
20 campus’, with respect to a school of medicine or
21 osteopathic medicine, means an additional loca-
22 tion of such school that is geographically apart
23 and independent of the main campus, at which
24 the school offers at least 50 percent of the pro-
25 gram leading to a degree of doctor of medicine

1 or doctor of osteopathy that is offered at the
2 main campus.

3 “(B) INDEPENDENCE FROM MAIN CAM-
4 PUS.—For purposes of subparagraph (A), the
5 location of a school described in such subpara-
6 graph shall be considered to be independent of
7 the main campus described in such subpara-
8 graph if the location—

9 “(i) is permanent in nature;

10 “(ii) offers courses in educational pro-
11 grams leading to a degree, certificate, or
12 other recognized educational credential;

13 “(iii) has its own faculty and adminis-
14 trative or supervisory organization; and

15 “(iv) has its own budgetary and hiring
16 authority.

17 “(2) FIRST GENERATION COLLEGE STUDENT.—
18 The term ‘first generation college student’ has the
19 meaning given such term in section 402A(h)(3) of
20 the Higher Education Act of 1965.

21 “(3) HEALTH PROFESSIONAL SHORTAGE
22 AREA.—The term ‘health professional shortage area’
23 has the meaning given such term in section 332(a).

24 “(4) INSTITUTION OF HIGHER EDUCATION.—
25 The term ‘institution of higher education’ has the

1 meaning given such term in section 101 of the High-
2 er Education Act of 1965.

3 “(h) AUTHORIZATION OF APPROPRIATIONS.—To
4 carry out this section, there is authorized to be appro-
5 priated \$1,000,000,000, to remain available until ex-
6 pended.”.

7 **TITLE IV—IMPROVING HEALTH**
8 **CARE ACCESS AND QUALITY**

9 **SEC. 4000. DEFINITION.**

10 In this title and the amendments made by this title,
11 the term “health care” includes all health care needed
12 throughout the life cycle and the end of life.

13 **Subtitle A—Reducing Barriers to**
14 **Accessing Care**

15 **SEC. 4001. PROTECTING PROTECTED AREAS.**

16 Section 287 of the Immigration and Nationality Act
17 (8 U.S.C. 1357) is amended—

18 (1) by striking “Service” each place such term
19 appears and inserting “Department of Homeland
20 Security”;

21 (2) by striking “Attorney General” each place
22 such term appears and inserting “Secretary of
23 Homeland Security”;

1 (3) in subsection (f)(1), by striking “Commis-
2 sioner” and inserting “Director of U.S. Citizenship
3 and Immigration Services”;

4 (4) in subsection (h)—

5 (A) by striking “of the Immigration and
6 Nationality Act”; and

7 (B) by striking “of such Act”; and

8 (5) by adding at the end the following:

9 “(i)(1) In this subsection:

10 “(A) The term ‘appropriate congressional com-
11 mittees’ means—

12 “(i) the Committee on Homeland Security
13 and Governmental Affairs of the Senate;

14 “(ii) the Committee on the Judiciary of the
15 Senate;

16 “(iii) the Committee on Homeland Security
17 of the House of Representatives; and

18 “(iv) the Committee on the Judiciary of
19 the House of Representatives.

20 “(B) The term ‘enforcement action’—

21 “(i) means an apprehension, arrest, inspec-
22 tion interview, request for identification, search,
23 seizure, service of charging documents or sub-
24 poenas, or surveillance for the purposes of im-
25 migration enforcement; and

1 “(ii) includes an enforcement action at, or
2 focused on, a protected area that is part of a
3 joint case led by another law enforcement agen-
4 cy.

5 “(C) The term ‘exigent circumstances’ means a
6 situation involving—

7 “(i) the imminent risk of death, violence,
8 or physical harm to any person or property, in-
9 cluding a situation implicating terrorism or the
10 national security of the United States;

11 “(ii) the immediate arrest or pursuit of a
12 dangerous felon, terrorist suspect, or other indi-
13 vidual presenting an imminent danger; or

14 “(iii) the imminent risk of destruction of
15 evidence that is material to an ongoing criminal
16 case.

17 “(D) The term ‘protected area’ includes all of
18 the physical space located within 1,000 feet of—

19 “(i) any medical treatment or mental
20 health care facility, including any hospital, doc-
21 tor’s office, health clinic, alcohol or drug pre-
22 vention, counseling, or treatment facilities, sy-
23 ringe exchange services, vaccination, treatment,
24 or testing sites, emergent or urgent care facil-

1 ity, sites that serve pregnant individuals, or
2 community health centers;

3 “(ii) any public or private school, including
4 any known and licensed day care facility, pre-
5 school, sites of early childhood programs, pri-
6 mary school, secondary school, postsecondary
7 school (including colleges and universities), or
8 other institution of learning (including voca-
9 tional or trade schools);

10 “(iii) any scholastic or education-related
11 activity or event or before or after school pro-
12 gram, including field trips and interscholastic
13 events;

14 “(iv) any school bus or school bus stop;

15 “(v) places where children gather such as
16 a playground, recreation center, library, foster
17 care facility, or group home for children;

18 “(vi) any physical structure of an organiza-
19 tion or subdivision of government that—

20 “(I) assists children, pregnant women,
21 victims of crime or abuse, or individuals
22 with significant mental or physical disabil-
23 ities;

24 “(II) provides social services and as-
25 sistance, including homeless shelters, com-

1 munity-based organizations, facilities that
2 serve disabled persons, drug or alcohol
3 counseling and treatment facilities, food
4 banks or food pantries, and other places
5 providing emergency and disaster services
6 or assistance with food and nutrition,
7 housing affordability and income or other
8 services funded by State or local govern-
9 ment, charitable giving, the Special Sup-
10 plemental Nutrition Program for Women,
11 Infants, and Children (WIC), Supple-
12 mental Nutrition Assistance Program
13 (SNAP), Temporary Assistance for Needy
14 Families (TANF), Social Security, or the
15 United States Housing Act; or

16 “(III) provides hospice, palliative, or
17 other available end-of-life care services to
18 terminally ill persons;

19 “(vii) any church, synagogue, mosque, or
20 other place of worship or religious study, in-
21 cluding buildings rented for the purpose of reli-
22 gious services, retreats, counseling, workshops,
23 instruction, and education;

24 “(viii) any Federal, State, or local court-
25 house, including the office of an individual’s

1 legal counsel or representative, and a probation,
2 parole, or supervised release office;

3 “(ix) the site of a funeral, grave-side cere-
4 mony, rosary, wedding, or other religious cere-
5 mony or observance;

6 “(x) any public demonstration, such as a
7 march, rally, or parade;

8 “(xi) any domestic violence shelter, rape
9 crisis center, child advocacy center, supervised
10 visitation center, family justice center, or victim
11 services provider;

12 “(xii) congressional district offices;

13 “(xiii) indoor and outdoor premises of de-
14 partments of motor vehicles;

15 “(xiv) a place where disaster or emergency
16 response and relief is provided, including evacu-
17 ation routes, places where shelter or emergency
18 supplies, food, or water are distributed, or
19 places where registration for disaster-relief as-
20 sistance or family reunification is underway; or

21 “(xv) any other location specified by the
22 Secretary of Homeland Security for purposes of
23 this subsection.

24 “(E) The term ‘prior approval’ means—

1 “(i) in the case of officers and agents of
2 U.S. Immigration and Customs Enforcement,
3 prior written approval to carry out an enforce-
4 ment action involving a specific individual or in-
5 dividuals authorized by—

6 “(I) the Assistant Director of Oper-
7 ations, Homeland Security Investigations;

8 “(II) the Executive Associate Direc-
9 tor, Homeland Security Investigations;

10 “(III) the Assistant Director for Field
11 Operations, Enforcement and Removal Op-
12 erations; or

13 “(IV) the Executive Associate Direc-
14 tor for Field Operations, Enforcement and
15 Removal Operations;

16 “(ii) in the case of officers and agents of
17 U.S. Customs and Border Protection, prior
18 written approval to carry out an enforcement
19 action involving a specific individual or individ-
20 uals authorized by—

21 “(I) a Chief Patrol Agent;

22 “(II) the Director of Field Operations;

23 “(III) the Director of Air and Marine
24 Operations; or

1 “(IV) the Internal Affairs Special
2 Agent in Charge; and

3 “(iii) in the case of other Federal, State,
4 or local law enforcement officers, to carry out
5 an enforcement action involving a specific indi-
6 vidual or individuals authorized by—

7 “(I) the head of the Federal agency
8 carrying out the enforcement action; or

9 “(II) the head of the State or local
10 law enforcement agency carrying out the
11 enforcement action.

12 “(2)(A) An enforcement action may not take place
13 at, or be focused on, a protected area unless—

14 “(i) the action involves exigent circumstances;
15 and

16 “(ii) prior approval for the enforcement action
17 was obtained.

18 “(B) If an enforcement action is initiated pursuant
19 to subparagraph (A) and the exigent circumstances per-
20 mitting the enforcement action cease, the enforcement ac-
21 tion shall be discontinued until such exigent circumstances
22 reemerge.

23 “(C) If an enforcement action is carried out in viola-
24 tion of this subsection—

1 “(i) no information resulting from the enforce-
2 ment action may be entered into the record or re-
3 ceived into evidence in a removal proceeding result-
4 ing from the enforcement action; and

5 “(ii) the noncitizen who is the subject of such
6 removal proceeding may file a motion for the imme-
7 diate termination of the removal proceeding.

8 “(3)(A) This subsection shall apply to any enforce-
9 ment action by officers or agents of the Department of
10 Homeland Security, including—

11 “(i) officers or agents of U.S. Immigration and
12 Customs Enforcement;

13 “(ii) officers or agents of U.S. Customs and
14 Border Protection; and

15 “(iii) any individual designated to perform im-
16 migration enforcement functions pursuant to sub-
17 section (g).

18 “(B) While carrying out an enforcement action at a
19 protected area, officers and agents referred to in subpara-
20 graph (A) shall make every effort—

21 “(i) to limit the time spent at the protected
22 area;

23 “(ii) to limit the enforcement action at the pro-
24 tected area to the person or persons for whom prior
25 approval was obtained; and

1 “(iii) to conduct themselves discreetly.

2 “(C) If, while carrying out an enforcement action
3 that is not initiated at or focused on a protected area,
4 officers or agents are led to a protected area, and no exi-
5 gent circumstance and prior approval with respect to the
6 protected area, such officers or agents shall—

7 “(i) cease before taking any further enforce-
8 ment action;

9 “(ii) conduct themselves in a discreet manner;

10 “(iii) maintain surveillance on an individual;
11 and

12 “(iv) immediately consult their supervisor in
13 order to determine whether such enforcement action
14 should be discontinued.

15 “(D) The limitations under this paragraph shall not
16 apply to the transportation of an individual apprehended
17 at or near a land or sea border to a hospital or health
18 care provider for the purpose of providing medical care
19 to such individual.

20 “(4)(A) Each official specified in subparagraph (B)
21 shall ensure that the employees under his or her super-
22 vision receive annual training on compliance with—

23 “(i) the requirements under this subsection with
24 respect to enforcement actions at or focused on pro-

1 tected areas and enforcement actions that lead offi-
2 cers or agents to a protected area; and

3 “(ii) the requirements under section 239 of this
4 Act and section 384 of the Illegal Immigration Re-
5 form and Immigrant Responsibility Act of 1996 (8
6 U.S.C. 1367).

7 “(B) The officials specified in this subparagraph
8 are—

9 “(i) the Chief Counsel of each Field Office of
10 U.S. Immigration and Customs Enforcement;

11 “(ii) each Field Office Director of U.S. Immi-
12 gration and Customs Enforcement;

13 “(iii) each Special Agent in Charge of U.S. Im-
14 migration and Customs Enforcement;

15 “(iv) each Chief Patrol Agent of U.S. Customs
16 and Border Protection;

17 “(v) the Director of Field Operations of U.S.
18 Customs and Border Protection;

19 “(vi) the Director of Air and Marine Operations
20 of U.S. Customs and Border Protection;

21 “(vii) the Internal Affairs Special Agent in
22 Charge of U.S. Customs and Border Protection; and

23 “(viii) the chief law enforcement officer of each
24 State or local law enforcement agency that enters

1 into a written agreement with the Department of
2 Homeland Security pursuant to subsection (g).

3 “(5) Not later than 180 days after the date of the
4 enactment of the Health Equity and Accountability Act
5 of 2022, the Secretary of Homeland Security shall modify
6 the Notice to Appear form (I-862)—

7 “(A) to provide the subject of an enforcement
8 action with information, written in plain language,
9 summarizing the restrictions against enforcement
10 actions at protected areas set forth in this sub-
11 section and the remedies available to the individual
12 if such action violates such restrictions;

13 “(B) to ensure that the information described
14 in subparagraph (A) is accessible to an individual
15 with limited English proficiency; and

16 “(C) to ensure that a subject of an enforcement
17 action is not permitted to verify that the officers or
18 agents that carried out such action complied with
19 the restrictions set forth in this subsection.

20 “(6)(A) The Director of U.S. Immigration and Cus-
21 toms Enforcement and the Commissioner of U.S. Customs
22 and Border Protection shall each submit an annual report
23 to the appropriate congressional committees that includes
24 the information set forth in subparagraph (B) with respect
25 to the respective agency.

1 “(B) Each report submitted under subparagraph (A)
2 shall include, with respect to the submitting agency during
3 the reporting period—

4 “(i) the number of enforcement actions that
5 were carried out at, or focused on, a protected area;

6 “(ii) the number of enforcement actions in
7 which officers or agents were subsequently led to a
8 protected area; and

9 “(iii) for each enforcement action described in
10 clause (i) or (ii)—

11 “(I) the date on which it occurred;

12 “(II) the specific site, city, county, and
13 State in which it occurred;

14 “(III) whether the site was a protected
15 area and, if so—

16 “(aa) identification of the protected
17 area;

18 “(bb) each reason why the enforce-
19 ment action was taken there;

20 “(cc) where the enforcement action
21 was taken without prior approval, certifi-
22 cation that notification to headquarters of
23 a submitting agency was provided after the
24 enforcement action took place; and

1 “(dd) a report of what occurred dur-
2 ing and immediately after the enforcement
3 action;

4 “(IV) the components of the agency in-
5 volved in the enforcement action;

6 “(V) a description of the enforcement ac-
7 tion, including the nature of the criminal activ-
8 ity of its intended target;

9 “(VI) the number of individuals, if any, ar-
10 rested or taken into custody;

11 “(VII) the number of collateral arrests, if
12 any, and the reasons for each such arrest;

13 “(VIII) a certification whether the location
14 administrator of a protected area was contacted
15 before, during, or after the enforcement action;
16 and

17 “(IX) the percentage of all of the staff
18 members and supervisors reporting to the offi-
19 cials listed in paragraph (4)(B) who completed
20 the training required under paragraph (4)(A).

21 “(7) Nothing in the subsection may be construed—

22 “(A) to affect the authority of Federal, State,
23 or local law enforcement agencies—

1 “(i) to enforce generally applicable Federal
2 or State criminal laws unrelated to immigra-
3 tion; or

4 “(ii) to protect residents from imminent
5 threats to public safety; or

6 “(B) to limit or override the protections pro-
7 vided in—

8 “(i) section 239; or

9 “(ii) section 384 of the Illegal Immigration
10 Reform and Immigrant Responsibility Act of
11 1996 (8 U.S.C. 1367).”.

12 **SEC. 4002. REPEAL OF REQUIREMENT FOR DOCUMENTA-**
13 **TION EVIDENCING CITIZENSHIP OR NATION-**
14 **ALITY UNDER THE MEDICAID PROGRAM.**

15 (a) REPEAL.—Subsections (i)(22) and (x) of section
16 1903 of the Social Security Act (42 U.S.C. 1396b) are
17 each repealed.

18 (b) CONFORMING AMENDMENTS.—

19 (1) STATE PAYMENTS FOR MEDICAL ASSIST-
20 ANCE.—Section 1902 of the Social Security Act (42
21 U.S.C. 1396a) is amended—

22 (A) by amending paragraph (46) of sub-
23 section (a) to read as follows:

24 “(46) provide that information is requested and
25 exchanged for purposes of income and eligibility

1 verification in accordance with a State system which
2 meets the requirements of section 1137 of this
3 Act;”;

4 (B) in subsection (e)(13)(A)(i)—

5 (i) in the matter preceding subclause
6 (I), by striking “sections 1902(a)(46)(B)
7 and 1137(d)” and inserting “section
8 1137(d)”; and

9 (ii) in subclause (IV), by striking
10 “1902(a)(46)(B) or”; and

11 (C) by striking subsection (ee).

12 (2) REPEAL.—Subsection (c) of section 6036 of
13 the Deficit Reduction Act of 2005 (42 U.S.C. 1396b
14 note) is repealed.

15 (c) EFFECTIVE DATE.—The amendments made by
16 this section shall take effect on the date of enactment of
17 this Act.

18 **SEC. 4003. AVAILABILITY OF BASIC ASSISTANCE TO LAW-**

19 **FULLY PRESENT NONCITIZENS.**

20 (a) ELIMINATION OF ARBITRARY ELIGIBILITY RE-
21 STRICTIONS.—

22 (1) IN GENERAL.—Sections 402, 403, 411, 412,
23 421, and 422 of the Personal Responsibility and
24 Work Opportunity Reconciliation Act of 1996 (8

1 U.S.C. 1612, 1613, 1621, 1622, 1631, and 1632)
2 are repealed.

3 (2) CONFORMING AMENDMENTS.—Title IV of
4 the Personal Responsibility and Work Opportunity
5 Reconciliation Act of 1996 (8 U.S.C. 1601 et seq.)
6 is amended—

7 (A) in section 401(b)(5) of (8 U.S.C.
8 1611(b)(5)), by striking “the program defined
9 in section 402(a)(3)(A) (relating to the supple-
10 mental security income program)” and inserting
11 “the Supplemental Security Income Program
12 under title XVI of the Social Security Act (42
13 U.S.C. 1381 et seq.)”;

14 (B) in section 404(a) (8 U.S.C. 1614(a)),
15 by striking “, 402, or 403”;

16 (C) in section 413 (8 U.S.C. 1625)—

17 (i) by striking “A State” and insert-
18 ing the following:

19 “(a) STATE OR LOCAL PUBLIC BENEFIT DE-
20 FINED.—In this section, except as provided in paragraphs
21 (2) and (3), the term ‘State or local public benefit’—

22 “(1) means—

23 “(A) any grant, contract, loan, professional
24 license, or commercial license provided by an
25 agency of a State or local government or by ap-

1 appropriated funds of a State or local govern-
2 ment; and

3 “(B) any retirement, welfare, health, dis-
4 ability, public or assisted housing, postsec-
5 ondary education, food assistance, unemploy-
6 ment benefit, or any other similar benefit for
7 which payments or assistance are provided to
8 an individual, household, or family eligibility
9 unit by an agency of a State or local govern-
10 ment or by appropriated funds of a State or
11 local government;

12 “(2) shall not apply—

13 “(A) to any contract, professional license,
14 or commercial license for a nonimmigrant
15 whose visa for entry is related to such employ-
16 ment in the United States, or to a citizen of a
17 freely associated state, if section 141 of the ap-
18 plicable compact of free association approved in
19 Public Law 99–239 or 99–658 (or a successor
20 provision) is in effect;

21 “(B) with respect to benefits for an alien
22 who as a work authorized nonimmigrant or as
23 an alien lawfully admitted for permanent resi-
24 dence under the Immigration and Nationality
25 Act qualified for such benefits and for whom

the United States under reciprocal treaty agree-
ments is required to pay benefits, as determined
by the Secretary of State, after consultation
with the Attorney General; or

5 “(C) to the issuance of a professional li-
6 cense to, or the renewal of a professional license
7 by, a foreign national not physically present in
8 the United States; and

9 “(3) does not include any Federal public ben-
10 efit.

11 “(b) PROOF OF ELIGIBILITY REQUIREMENT.—A
12 State”; and

(ii) in subsection (b), as so designated, by striking “(as defined in section 411(c))”;

(D) in section 432(d) (8 U.S.C. 1642(d)),
by striking “(as defined in section 411(c))” and
inserting “(as defined in section 413(a))”;

19 (E) in section 435 (8 U.S.C. 1645), by
20 striking “(as provided under section 403)”; and

21 (F) in section 436 (8 U.S.C. 1646)—

(i) by striking “the food stamp pro-
gram (as defined in section 402(a)(3)(B))”
and inserting “the supplemental nutrition
assistance program established under the

1 Food and Nutrition Act of 2008 (7 U.S.C.
2 2011 et seq.)”; and

3 (ii) by striking “the supplemental se-
4 curity income program (as defined in sec-
5 tion 402(a)(3)(A))” and inserting “the
6 Supplemental Security Income Program
7 under title XVI of the Social Security Act
8 (42 U.S.C. 1381 et seq.)”.

9 (b) QUALIFIED NONCITIZENS.—Title IV of the Per-
10 sonal Responsibility and Work Opportunity Reconciliation
11 Act of 1996 (8 U.S.C. 1601 et seq.) is amended—

12 (1) in the title heading, by striking
13 “**ALIENS**” and inserting “**NONCITIZENS**”;

14 (2) in section 401, in the section heading—

15 (A) by striking “**QUALIFIED ALIENS**”
16 and inserting “**QUALIFIED NONCITIZENS**”;
17 and

18 (B) by striking “**ALIENS**” and inserting
19 “**NONCITIZENS**”;

20 (3) by striking “qualified alien” each place it
21 appears and inserting “qualified noncitizen”;

22 (4) by striking “qualified aliens” each place it
23 appears and inserting “qualified noncitizens”;

24 (5) by striking “qualified alien’s” each place it
25 appears and inserting “qualified noncitizen’s”;

1 (6) by striking “an alien” each place that it ap-
2 pears and inserting “a noncitizen”;

3 (7) by striking “alien” each place it appears
4 and inserting “noncitizen”;

5 (8) by striking “aliens” each place it appears
6 and inserting “noncitizens”; and

7 (9) by striking “alien’s” each place it appears
8 and inserting “noncitizen’s”.

9 (c) ACCESS TO BASIC SERVICES FOR LAWFULLY RE-
10 SIDING NONCITIZENS.—Section 431 of the Personal Re-
11 sponsibility and Work Opportunity Reconciliation Act of
12 1996 (8 U.S.C. 1641) is amended—

13 (1) in subsection (b)—

14 (A) in the subsection heading, by striking
15 “QUALIFIED ALIEN” and inserting “QUALIFIED
16 NONCITIZEN”; and

17 (B) in the matter preceding paragraph (1),
18 by striking “benefit” and all that follows
19 through the period at the end of the subsection
20 and inserting “benefit, is lawfully present in the
21 United States.”;

22 (2) in subsection (c)—

23 (A) in the subsection heading, by striking
24 “ALIENS AS QUALIFIED ALIENS” and inserting
25 “NONCITIZENS AS QUALIFIED NONCITIZENS”;

1 (B) in paragraph (3)(B), by striking “; or”
2 and inserting a semicolon’

3 (C) in paragraph (4), by striking the pe-
4 riod at the end and inserting “; or”; and

5 (D) by inserting after paragraph (4) the
6 following:

7 “(5) a noncitizen—

8 “(A) in a category that was treated as law-
9 fully present for purposes of section 1101 of the
10 Patient Protection and Affordable Care Act of
11 2010 (42 U.S.C. 18001);

12 “(B) who met the requirements of section
13 402(a)(2)(D) of the Personal Responsibility and
14 Work Opportunity Reconciliation Act of 1996
15 (8 U.S.C. 1612(a)(2)(D)) on or before January
16 1, 2023;

17 “(C) who is granted special immigrant ju-
18 venile status as described by section
19 101(a)(27)(J) of the Immigration and Nation-
20 ality Act (8 U.S.C. 1101(a)(27)(J));

21 “(D) who has a pending, bona fide applica-
22 tion for nonimmigrant status under section
23 101(a)(15)(U) of the Immigration and Nation-
24 ality Act (8 U.S.C. 1101(a)(15)(U));

1 “(E) who was granted relief under the De-
2 ferred Action for Childhood Arrivals program;
3 or

4 “(F) any other person who is not a citizen
5 of the United States but who resides in a State
6 or territory of the United States and is feder-
7 ally authorized to be present in the United
8 States.”; and

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

10 “(d) NONCITIZEN.—In this title, the term ‘noncit-
11 izen’ means any individual who is not a citizen of the
12 United States.”.

13 (d) CHILD NUTRITION PROGRAMS.—Section 742 of
14 the Personal Responsibility and Work Opportunity Rec-
15 onciliation Act of 1996 (8 U.S.C. 1615) is amended—

16 (1) in subsection (a)—

17 (A) in the subsection heading, by striking
18 “SCHOOL LUNCH AND BREAKFAST PROGRAMS”
19 and inserting “CHILD NUTRITION PROGRAMS”;

20 (B) by striking “the school lunch pro-
21 gram” and inserting “any program”; and

22 (C) by striking “the school breakfast pro-
23 gram under section 4 of the” and inserting
24 “any program under the”; and

25 (2) in subsection (b)(1)—

1 (A) by striking “Nothing in this Act shall
2 prohibit or require a State to provide to an in-
3 dividual who is not a citizen or a qualified alien,
4 as defined in section 431(b),” and inserting “A
5 State shall not deny”; and

6 (B) by striking “paragraph (2)” and in-
7 serting “paragraph (2) on the basis of an indi-
8 vidual’s citizenship or citizenship, alienage, or
9 immigration status”.

10 (e) EXCLUSION OF MEDICAL ASSISTANCE EXPENDI-
11 TURES FOR CITIZENS OF FREELY ASSOCIATED STATES.—
12 Section 1108(h) of the Social Security Act (42 U.S.C.
13 1308(h)) is amended—

14 (1) by striking “Expenditures” and inserting:

15 “(1) IN GENERAL.—Expenditures”; and

16 (2) by adding at the end the following:

17 “(2) MEDICAID PROGRAMS.—With respect to
18 eligibility for benefits for a State plan approved
19 under title XIX, other than medical assistance de-
20 scribed in section 401(b)(1)(A), paragraph (1) shall
21 not apply to any individual who lawfully resides in
22 1 of the 50 States or the District of Columbia in ac-
23 cordance with the Compacts of Free Association be-
24 tween the Government of the United States and the
25 Governments of the Federated States of Micronesia,

1 the Republic of the Marshall Islands, and the Re-
2 public of Palau and shall not apply, at the option of
3 the Governor of Puerto Rico, the Virgin Islands,
4 Guam, the Northern Mariana Islands, or American
5 Samoa as communicated to the Secretary of Health
6 and Human Services in writing, to any individual
7 who lawfully resides in the respective territory in ac-
8 cordance with such Compacts.”.

9 (f) CHILD HEALTH INSURANCE PROGRAM.—Section
10 2107(e)(1) of the Social Security Act (42 U.S.C.
11 1397gg(e)(1)) is amended by striking subparagraph (O).

12 (g) CONFORMING AMENDMENTS.—

13 (1) SUPPLEMENTAL FOOD ASSISTANCE PRO-
14 GRAM.—The Food and Nutrition Act of 2008 (7
15 U.S.C. 2011 et seq.) is amended—

16 (A) in section 5 (7 U.S.C. 2014) —

17 (i) in subsection (d)—

18 (I) in paragraph (1), by striking
19 “law)” and all that follows through
20 the semicolon at the end and inserting
21 “law);”; and

22 (II) in paragraph (10), by strik-
23 ing “subsection (k)” and inserting
24 “subsection (j)”;
25

(ii) by striking subsection (i);

1 (iii) in subsection (j), by striking
2 “subsections (a) through (i)” and inserting
3 “subsections (a) through (h)”; and

4 (iv) by redesignating subsections (j)
5 through (n) as subsection (i) through (m),
6 respectively;

7 (B) in section 6 (7 U.S.C. 2015)—

8 (i) in subsection (f)(2)(B), by striking
9 “an alien lawfully admitted for permanent”
10 and all that follows through the end of the
11 subsection and inserting “a noncitizen law-
12 fully present in the United States.”; and

13 (ii) in subsection (s)(2), by striking
14 “(i), (k), (l), (m), and (n)” and inserting
15 “(j), (k), (l), and (m)”; and

16 (C) in section 11(e)(2)(B)(v)(II) (7 U.S.C.
17 2020(e)(2)(B)(v)(II)), by striking “aliens” and
18 inserting “noncitizens”.

19 (2) MEDICAID.—Section 1903(v) of the Social
20 Security Act (42 U.S.C. 1396b(v)) is amended—

21 (A) in paragraph (1)—

22 (i) in by striking “paragraphs (2) and
23 (4)” and inserting “paragraph (2)”; and

24 (ii) by striking “admitted for” and all
25 that follows through the end of the para-

1 graph and inserting “present in the United
2 States.”; and

3 (B) by striking paragraph (4).

4 (3) HOUSING ASSISTANCE.—Section 214(a) of
5 the Housing and Community Development Act of
6 1980 (42 U.S.C. 1436a(a)) is amended—

7 (A) in paragraph (6), by striking “; or”
8 and inserting a semicolon;

9 (B) in paragraph (7), by striking the pe-
10 riod at the end and inserting “; or”; and

11 (C) by adding at the end the following:

12 “(8) a qualified noncitizen (as defined in sec-
13 tion 431 of the Personal Responsibility and Work
14 Opportunity Reconciliation Act of 1996 (8 U.S.C.
15 1641));”.

16 (4) ASSISTANCE NOT TREATED AS DEBT AB-
17 SENT FRAUD.—Section 213A of the Immigration
18 and Nationality Act (8 U.S.C. 1183a) is amended—

19 (A) in subsection (a)(3)—

20 (i) in subparagraph (A), by striking
21 “(as provided under section 403 of the
22 Personal Responsibility and Work Oppor-
23 tunity Reconciliation Act of 1996)”; and

24 (ii) in subparagraph (B), in the un-
25 designated matter following clause (ii), by

1 striking “(as provided under section 403 of
2 the Personal Responsibility and Work Op-
3 portunity Reconciliation Act of 1996)”;

4 and

5 (B) in subsection (b)(1)(A), by striking
6 “benefit,” and inserting “benefit by fraud,”;

7 and

8 (C) in subsection (d)(2)(B), by striking “,
9 403(c)(2), or 411(b)”.

10 (5) REPORT.—Section 565 of the Illegal Immi-
11 gration Reform and Immigrant Responsibility Act of
12 1996 (8 U.S.C. 1371) is amended—

13 (A) by striking paragraph (2); and

14 (B) by redesignating paragraph (3) as
15 paragraph (2).

16 (h) PRESERVING ACCESS TO HEALTH CARE.—Sec-
17 tion 36B(c)(1)(B) of the Internal Revenue Code of 1986
18 is amended to read as follows:

19 “(B) SPECIAL RULE FOR CERTAIN INDIV-
20 IDUALS LAWFULLY PRESENT IN THE UNITED
21 STATES.—If—

22 “(i) a taxpayer has a household in-
23 come which is not greater than 100 per-
24 cent of an amount equal to the poverty line
25 for a family of the size involved,

1 “(ii) the taxpayer is a non-citizen law-
2 fully present in the United States,

3 “(iii) the taxpayer is ineligible for
4 minimum essential coverage under section
5 5000A(f)(1)(A)(ii), and

6 “(iv) under the Medicaid eligibility
7 criteria for non-citizens in effect on De-
8 cember 26, 2020, the taxpayer would be
9 ineligible for such minimum essential cov-
10 erage by reason of the taxpayer’s immigra-
11 tion status,

12 the taxpayer shall, for purposes of the credit
13 under this section, be treated as an applicable
14 taxpayer with a household income which is
15 equal to 100 percent of the poverty line for a
16 family of the size involved.”.

17 (i) FEDERAL AGENCY GUIDANCE.—Not later than
18 180 days after the date of the enactment of this Act, each
19 Federal agency, as applicable, shall issue guidance with
20 respect to implementing the amendments made by this
21 section.

22 (j) EFFECTIVE DATE.—The amendments made by
23 this section shall take effect on the date of enactment of
24 this Act.

1 **SEC. 4004. IMPROVE AFFORDABILITY AND REDUCE PRE-**
 2 **MIUM COSTS OF HEALTH INSURANCE FOR**
 3 **CONSUMERS.**

4 (a) IN GENERAL.—Section 36B(b)(3)(A) of the In-
 5 ternal Revenue Code of 1986 is amended to read as fol-
 6 lows:

7 “(A) APPLICABLE PERCENTAGE.—The ap-
 8 plicable percentage for any taxable year shall be
 9 the percentage such that the applicable percent-
 10 age for any taxpayer whose household income is
 11 within an income tier specified in the following
 12 table shall increase, on a sliding scale in a lin-
 13 ear manner, from the initial premium percent-
 14 age to the final premium percentage specified in
 15 such table for such income tier:

| “In the case of household income (expressed as a percent of poverty line) within the following in- come tier: | The initial premium percentage is- | The final premium percentage is- |
|---------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-------------------------------------------|
| Up to 150 percent | 0.0 | 0.0 |
| 150 percent up to 200 percent | 0.0 | 3.0 |
| 200 percent up to 250 percent | 3.0 | 4.0 |
| 250 percent up to 300 percent | 4.0 | 6.0 |
| 300 percent up to 400 percent | 6.0 | 8.5 |
| 400 percent and higher | 8.5 | 8.5”. |

16 (b) CONFORMING AMENDMENT.—Section
 17 36B(c)(1)(A) of the Internal Revenue Code of 1986 is
 18 amended by striking “but does not exceed 400 percent”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 2021.

4 **SEC. 4005. REMOVING CITIZENSHIP AND IMMIGRATION**
5 **BARRIERS TO ACCESS TO AFFORDABLE**
6 **HEALTH CARE UNDER THE ACA.**

7 (a) IN GENERAL.—

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

10 (A) in subsection (c)(1)(B), as amended by
11 section 4003(h)—

12 (i) by amending the heading to read
13 as follows: “SPECIAL RULE FOR CERTAIN
14 INDIVIDUALS INELIGIBLE FOR MEDICAID
15 DUE TO STATUS”; and

16 (ii) by amending clause (ii) to read as
17 follows:

18 “(ii) the taxpayer is a noncitizen who
19 is not eligible for the Medicaid program
20 under title XIX of the Social Security Act
21 by reason of the individual’s immigration
22 status,”; and

23 (B) by striking subsection (e).

1 (2) COST-SHARING REDUCTIONS.—Section 1402
2 of the Patient Protection and Affordable Care Act
3 (42 U.S.C. 18071) is amended—

4 (A) by striking subsection (e); and

5 (B) by redesignating subsections (f) and
6 (g) as subsections (e) and (f), respectively.

7 (3) BASIC HEALTH PROGRAM ELIGIBILITY.—
8 Section 1331(e)(1)(B) of the Patient Protection and
9 Affordable Care Act (42 U.S.C. 18051(e)(1)(B)) is
10 amended by striking “lawfully present in the United
11 States,”.

12 (4) RESTRICTIONS ON FEDERAL PAYMENTS.—
13 Section 1412 of the Patient Protection and Afford-
14 able Care Act (42 U.S.C. 18082) is amended—

15 (A) by striking subsection (d); and

16 (B) by redesignating subsection (e) as sub-
17 section (d).

18 (5) REQUIREMENT TO MAINTAIN MINIMUM ES-
19 SENTIAL COVERAGE.—Section 5000A(d) of the In-
20 ternal Revenue Code of 1986 is amended—

21 (A) by striking paragraph (3); and

22 (B) by redesignating paragraph (4) as
23 paragraph (3).

24 (b) CONFORMING AMENDMENTS.—

1 (1) ESTABLISHMENT OF PROGRAM.—Section
2 1411(a) of the Patient Protection and Affordable
3 Care Act (42 U.S.C. 18081(a)) is amended—

4 (A) by striking paragraph (1); and

5 (B) by redesignating paragraphs (2), (3),
6 and (4) as paragraphs (1), (2), and (3), respec-
7 tively.

8 (2) QUALIFIED INDIVIDUALS.—Section 1312(f)
9 of the Patient Protection and Affordable Care Act
10 (42 U.S.C. 18032(f)) is amended—

11 (A) in the heading, by striking “; ACCESS
12 LIMITED TO CITIZENS AND LAWFUL RESI-
13 DENTS”; and

14 (B) by striking paragraph (3).

15 (c) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to years, plan years, and taxable
17 years, as applicable, beginning after December 31, 2022.

18 **SEC. 4006. REMOVING BARRIERS TO ACCESS TO AFFORD-**
19 **ABLE HEALTH CARE FOR LAWFULLY RESID-**
20 **ING IMMIGRANTS UNDER MEDICAID AND**
21 **CHIP.**

22 (a) MEDICAID.—Section 1903(v) of the Social Secu-
23 rity Act (42 U.S.C. 1396b(v)(4)), as amended by section
24 4003(g)(2), is amended by adding at the end the following:

1 “(4) COVERAGE OF LAWFULLY RESIDING IMMI-
2 GRANTS.—

3 “(A) IN GENERAL.—Notwithstanding title
4 IV of the Personal Responsibility and Work Op-
5 portunity Reconciliation Act of 1996, a State
6 shall provide medical assistance under this title
7 to individuals who are lawfully residing in the
8 United States (including individuals described
9 in paragraph (1), battered individuals described
10 in section 431(c) of such Act, and individuals
11 with an approved or pending application for de-
12 ferred action or other federally authorized pres-
13 ence), if they otherwise meet the eligibility re-
14 quirements for medical assistance under the
15 State plan approved under this title (other than
16 the requirement of the receipt of aid or assist-
17 ance under title IV, supplemental security in-
18 come benefits under title XVI, or a State sup-
19 plementary payment).

20 “(B) TREATMENT OF MEDICAL ASSIST-
21 ANCE PROVIDED TO LAWFULLY RESIDING IMMI-
22 GRANTS.—No debt shall accrue under an affi-
23 davit of support against any sponsor of an indi-
24 vidual provided medical assistance under sub-
25 paragraph (A) on the basis of provision of as-

1 sistance to such individual and the cost of such
2 assistance shall not be considered as an unreim-
3 bursed cost.

4 “(C) VERIFICATION REQUIREMENT.—As
5 part of the State’s ongoing eligibility redeter-
6 mination requirements and procedures for an
7 individual provided medical assistance as a re-
8 sult of the application of subparagraph (A), a
9 State shall verify that the individual continues
10 to lawfully reside or be lawfully present in the
11 United States using the documentation pre-
12 sented to the State by the individual on initial
13 enrollment. If the State cannot successfully
14 verify that the individual is lawfully residing or
15 present in the United States in this manner, it
16 shall require that the individual provide the
17 State with further documentation or other evi-
18 dence to verify that the individual is lawfully re-
19 siding or present in the United States.”.

20 (b) CHIP.—Section 2107(e)(1) of the Social Security
21 Act (42 U.S.C. 1397gg(e)(1)), as amended by section
22 4003(f), is amended by inserting after subparagraph (N)
23 the following new subparagraph:

24 “(O) Paragraph (4) of section 1903(v) (re-
25 lating to lawfully residing individuals).”.

1 (c) EFFECTIVE DATE.—

2 (1) IN GENERAL.—Except as provided in para-
3 graph (2), the amendments made by this section
4 shall take effect on the date of enactment of this Act
5 and shall apply to services furnished on or after the
6 date that is 90 days after such date of enactment.

7 (2) EXCEPTION IF STATE LEGISLATION RE-
8 QUIRED.—In the case of a State plan for medical as-
9 sistance under title XIX, or a State child health plan
10 under title XXI, of the Social Security Act which the
11 Secretary of Health and Human Services determines
12 requires State legislation (other than legislation ap-
13 propriating funds) in order for the plan to meet the
14 additional requirements imposed by the amendments
15 made by this section, the respective State plan shall
16 not be regarded as failing to comply with the re-
17 quirements of such title solely on the basis of its
18 failure to meet these additional requirements before
19 the first day of the first calendar quarter beginning
20 after the close of the first regular session of the
21 State legislature that begins after the date of enact-
22 ment of this Act. For purposes of the previous sen-
23 tence, in the case of a State that has a 2-year legis-
24 lative session, each year of such session shall be

1 deemed to be a separate regular session of the State
2 legislature.

3 (d) PRESERVING COVERAGE.—

4 (1) IN GENERAL.—Nothing in this section, in-
5 cluding the amendments made by this section, shall
6 prevent lawfully present noncitizens who are ineli-
7 gible for full benefits under the Medicaid program
8 under title XIX of the Social Security Act from se-
9 curing a credit for which such lawfully present non-
10 citizens would be eligible under section 36B(c)(1)(B)
11 of the Internal Revenue Code of 1986 and under the
12 Medicaid provisions for lawfully present noncitizens,
13 as in effect on the date prior to the date of enact-
14 ment of this Act.

15 (2) DEFINITION.—For purposes of paragraph
16 (1), the term “full benefits” means, with respect to
17 an individual and State, medical assistance for all
18 services covered under the State plan under title
19 XIX of the Social Security Act that is not less in
20 amount, duration, or scope, or is determined by the
21 Secretary of Health and Human Services to be sub-
22 stantially equivalent to the medical assistance avail-
23 able for an individual described in section
24 1902(a)(10)(A)(i) of the Social Security Act (42
25 U.S.C. 1396a(a)(10)(A)(i)).

1 **SEC. 4007. CONSISTENCY IN HEALTH INSURANCE COV-**
2 **ERAGE FOR INDIVIDUALS WITH FEDERALLY**
3 **AUTHORIZED PRESENCE, INCLUDING DE-**
4 **FERRED ACTION.**

5 (a) IN GENERAL.—For purposes of eligibility under
6 any of the provisions described in subsection (b), all indi-
7 viduals granted lawful presence in the United States shall
8 be considered to be lawfully present in the United States.

9 (b) PROVISIONS DESCRIBED.—The provisions de-
10 scribed in this subsection are the following:

11 (1) EXCHANGE ELIGIBILITY.—Section 1311 of
12 the Patient Protection and Affordable Care Act (42
13 U.S.C. 18031).

14 (2) REDUCED COST-SHARING ELIGIBILITY.—
15 Section 1402 of the Patient Protection and Afford-
16 able Care Act (42 U.S.C. 18071).

17 (3) PREMIUM SUBSIDY ELIGIBILITY.—Section
18 36B of the Internal Revenue Code of 1986.

19 (4) MEDICAID AND CHIP ELIGIBILITY.—Titles
20 XIX and XXI of the Social Security Act (42 U.S.C.
21 1396 et seq.; 1397aa et seq.), including under sec-
22 tion 1903(v) of such Act (42 U.S.C. 1396b(v)).

23 (c) EFFECTIVE DATE.—

24 (1) IN GENERAL.—Subsection (a) shall take ef-
25 fect on the date of enactment of this Act.

1 (2) TRANSITION THROUGH SPECIAL ENROLL-
2 MENT PERIOD.—In the case of an individual de-
3 scribed in subsection (a) who, before the first day of
4 the first annual open enrollment period under sub-
5 paragraph (B) of section 1311(c)(6) of the Patient
6 Protection and Affordable Care Act (42 U.S.C.
7 18031(c)(6)) beginning after the date of enactment
8 of this Act, is granted lawful presence in the United
9 States and who, as a result of such subsection,
10 qualifies for a subsidy under a provision described in
11 paragraph (2) or (3) of subsection (b), the Secretary
12 of Health and Human Services shall establish a spe-
13 cial enrollment period under subparagraph (C) of
14 such section 1311(c)(6) during which such individual
15 may enroll in qualified health plans through Ex-
16 changes under title I of the Patient Protection and
17 Affordable Care Act (42 U.S.C. 18001 note et seq.)
18 and qualify for such a subsidy. For such an indi-
19 vidual who has been granted federally authorized
20 presence in the United States as of the date of en-
21 actment of this Act, such special enrollment period
22 shall begin not later than 90 days after such date
23 of enactment. Nothing in this paragraph shall be
24 construed as affecting the authority of the Secretary

1 to establish additional special enrollment periods
2 under such subparagraph (C).

3 **SEC. 4008. STUDY ON THE UNINSURED.**

4 (a) IN GENERAL.—The Secretary of Health and
5 Human Services (in this section referred to as the “Sec-
6 retary”) shall—

7 (1) conduct a study, in accordance with the
8 standards under section 3101 of the Public Health
9 Service Act (42 U.S.C. 300kk), on the demographic
10 characteristics of the population of individuals who
11 do not have health insurance coverage or oral health
12 coverage; and

13 (2) predict, based on such study, the demo-
14 graphic characteristics of the population of individ-
15 uals who would remain without health insurance cov-
16 erage after the end of any annual open enrollment
17 or any special enrollment period or upon enactment
18 and implementation of any legislative changes to the
19 Patient Protection and Affordable Care Act (Public
20 Law 111–148) that affect the number of persons eli-
21 gible for coverage.

22 (b) REPORTING REQUIREMENTS.—

23 (1) IN GENERAL.—Not later than 12 months
24 after the date of the enactment of this Act, the Sec-
25 retary shall submit to the Congress the results of

1 the study under subsection (a)(1) and the prediction
2 made under subsection (a)(2).

3 (2) REPORTING OF DEMOGRAPHIC CHARACTER-
4 ISTICS.—The Secretary shall—

5 (A) report the demographic characteristics
6 under paragraphs (1) and (2) of subsection (a)
7 on the basis of racial and ethnic group (as de-
8 fined in section 1707(g)(1) of the Public Health
9 Service Act), and stratify the reporting on each
10 racial and ethnic group by other demographic
11 characteristics that can impact access to health
12 insurance coverage, such as sexual orientation,
13 gender identity, primary language, disability
14 status, sex, socioeconomic status, age group,
15 citizenship, and immigration status, in a man-
16 ner consistent with title I of this Act, including
17 the amendments made by such title; and

18 (B) not use such report, or any informa-
19 tion gathered in preparing such report—

20 (i) to engage in or anticipate any de-
21 portation or immigration related enforce-
22 ment action by any entity, including the
23 Department of Homeland Security; or

1 (ii) for the exploitation of, or discrimi-
2 nation against, communities of color or the
3 LGBTQ+ population.

4 **SEC. 4009. MEDICAID FALLBACK COVERAGE PROGRAM FOR**
5 **LOW-INCOME ADULTS IN NON-EXPANSION**
6 **STATES.**

7 (a) IN GENERAL.—As soon as possible after the date
8 of enactment of this Act the Secretary of Health and
9 Human Services (in this section referred to as the “Sec-
10 retary”) shall—

11 (1) directly or by contract, establish a program
12 that offers eligible individuals the opportunity to en-
13 roll in health benefits coverage that meets the re-
14 quirements described in subsection (c) and any re-
15 quirements applicable to such coverage pursuant to
16 subsection (d); and

17 (2) ensure that such program is administered
18 consistent with the requirements of section
19 431.10(c)(2) of title 42, Code of Federal Regula-
20 tions.

21 (b) DEFINITION OF ELIGIBLE INDIVIDUAL.—In this
22 section, the term “eligible individual” means an individual
23 who—

1 (1) is described in section
2 1902(a)(10)(A)(i)(VIII) of the Social Security Act
3 (42 U.S.C. 1396a(a)(10)(A)(i)(VIII));

4 (2) resides in a State that—

5 (A) does not expend amounts for medical
6 assistance under title XIX of the Social Secu-
7 rity Act (42 U.S.C. 1396 et seq.) for all individ-
8 uals described in such section; and

9 (B) did not expend amounts for medical
10 assistance under such title for all such individ-
11 uals as of the date of enactment of this Act;
12 and

13 (3) would not be eligible for medical assistance
14 under such State's plan for medical assistance under
15 title XIX of the Social Security Act (42 U.S.C. 1396
16 et seq.), or a waiver of such plan, as such plan or
17 waiver was in effect on such date.

18 (c) HEALTH BENEFITS COVERAGE REQUIRE-
19 MENTS.—The requirements described in this subsection
20 with respect to health benefits coverage are the following:

21 (1) ESSENTIAL HEALTH BENEFITS.—At a min-
22 imum, the coverage meets the minimum standards
23 required under paragraph (5) of section 1937(b) of
24 the Social Security Act (42 U.S.C. 1396u–7(b)) for
25 benchmark coverage described in paragraph (1) of

1 such section or benchmark equivalent coverage de-
2 scribed in paragraph (2) of such section.

3 (2) PREMIUMS AND COST-SHARING.—No pre-
4 miums are imposed for the coverage, and deduct-
5 ibles, cost sharing, or similar charges may only be
6 imposed in accordance with the requirements im-
7 posed on State Medicaid plans under section 1916 of
8 the Social Security Act (42 U.S.C. 1396o).

9 (d) APPLICATION OF REQUIREMENTS AND PROVI-
10 SIONS OF TITLE XIX OF THE SOCIAL SECURITY ACT.—
11 The Secretary shall specify that—

12 (1) any requirement applicable to the furnishing
13 of medical assistance under title XIX of the Social
14 Security Act (42 U.S.C. 1396 et seq.) by States that
15 have elected to make medical assistance available to
16 individuals described in section
17 1902(a)(10)(A)(i)(VIII) of such title (42 U.S.C.
18 1396a(a)(10)(A)(i)(VIII)) that does not conflict with
19 the requirements specified in subsection (c) applies
20 to the program established under this section; and

21 (2) other provisions of such title apply to such
22 program.

23 (e) NO STATE MANDATE.—Nothing in this section
24 shall be construed as requiring a State to make expendi-

1 tures related to the program established under this section
2 and the Secretary shall not impose any such requirement.

3 (f) FUNDING.—There are appropriated to the Sec-
4 retary for each fiscal year beginning with fiscal year 2022
5 from any funds in the Treasury not otherwise appro-
6 priated, such sums as are necessary to carry out this sec-
7 tion.

8 **SEC. 4010. INCREASE AND EXTENSION OF TEMPORARY EN-**
9 **HANCED FMAP FOR STATES WHICH BEGIN TO**
10 **EXPEND AMOUNTS FOR CERTAIN MANDA-**
11 **TORY INDIVIDUALS.**

12 (a) IN GENERAL.—Section 1905(ii)(1) of the Social
13 Security Act (42 U.S.C. 1396d(ii)(1)) is amended—

14 (1) by striking “8-quarter period” and inserting
15 “40-quarter period”; and

16 (2) by striking “5 percentage points” and in-
17 serting “10 percentage points”.

18 (b) EFFECTIVE DATE.—The amendments made by
19 this section shall take effect as if included in the enact-
20 ment of section 9814 of the American Rescue Plan Act
21 of 2021 (Public Law 117–2).

1 **Subtitle B—Improvement of**
2 **Coverage**

3 **SEC. 4101. MEDICAID IN THE TERRITORIES.**

4 (a) ELIMINATION OF GENERAL MEDICAID FUNDING
5 LIMITATIONS (“CAP”) FOR TERRITORIES.—

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

8 (A) in subsection (f), in the matter pre-
9 ceding paragraph (1), by striking “subsections
10 (g) and (h)” and inserting “subsections (g),
11 (h), and (i)”;

12 (B) in subsection (g)(2), in the matter pre-
13 ceding subparagraph (A), by inserting “sub-
14 section (i) and” after “subject to”; and

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

17 “(i) SUNSET OF MEDICAID FUNDING LIMITATIONS
18 FOR PUERTO RICO, THE VIRGIN ISLANDS, GUAM, THE
19 NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA.—
20 Subsections (f) and (g) shall not apply to Puerto Rico,
21 the Virgin Islands, Guam, the Northern Mariana Islands,
22 and American Samoa beginning with fiscal year 2024.”.

23 (2) CONFORMING AMENDMENTS.—

1 (A) Section 1902(j) of the Social Security
2 Act (42 U.S.C. 1396a(j)) is amended by strik-
3 ing “, the limitation in section 1108(f),”.

4 (B) Section 1903(u) of the Social Security
5 Act (42 U.S.C. 1396b(u)) is amended by strik-
6 ing paragraph (4).

7 (3) EFFECTIVE DATE.—The amendments made
8 by this section shall apply beginning with fiscal year
9 2024.

10 (b) ELIMINATION OF SPECIFIC FEDERAL MEDICAL
11 ASSISTANCE PERCENTAGE (FMAP) LIMITATION FOR
12 TERRITORIES.—Section 1905(b) of the Social Security
13 Act (42 U.S.C. 1396d(b)) is amended, in clause (2), by
14 inserting “for fiscal years before fiscal year 2024” after
15 “American Samoa”.

16 (c) PERMITTING MEDICAID DSH ALLOTMENTS FOR
17 TERRITORIES.—Section 1923(f) of the Social Security Act
18 (42 U.S.C. 1396r–4(f)) is amended—

19 (1) in paragraph (6), by adding at the end the
20 following new subparagraph:

21 “(C) TERRITORIES.—

22 “(i) FISCAL YEAR 2023.—For fiscal
23 year 2023, the DSH allotment for Puerto
24 Rico, the Virgin Islands, Guam, the North-
25 ern Mariana Islands, and American Samoa

1 shall bear the same ratio to \$300,000,000
2 as the ratio of the number of individuals
3 who are low-income or uninsured and re-
4 siding in such respective territory (as esti-
5 mated from time to time by the Secretary)
6 bears to the sums of the number of such
7 individuals residing in all of the territories.

8 “(ii) SUBSEQUENT FISCAL YEAR.—
9 For each subsequent fiscal year, the DSH
10 allotment for each such territory is subject
11 to an increase in accordance with para-
12 graph (3).”; and

13 (2) in paragraph (9), by inserting before the pe-
14 riod at the end the following: “, and includes, begin-
15 ning with fiscal year 2023, Puerto Rico, the Virgin
16 Islands, Guam, the Northern Mariana Islands, and
17 American Samoa”.

18 **SEC. 4102. EXTENSION OF THE SUPPLEMENTAL SECURITY**
19 **INCOME PROGRAM TO PUERTO RICO, THE**
20 **UNITED STATES VIRGIN ISLANDS, GUAM, AND**
21 **AMERICAN SAMOA.**

22 (a) IN GENERAL.—Section 303 of the Social Security
23 Amendments of 1972 (86 Stat. 1484) is amended by strik-
24 ing subsection (b).

25 (b) CONFORMING AMENDMENTS.—

1 (1) DEFINITION OF STATE.—Section
2 1101(a)(1) of the Social Security Act (42 U.S.C.
3 1301(a)(1)) is amended by striking the 5th sentence
4 and inserting the following: “Such term when used
5 in title XVI includes Puerto Rico, the United States
6 Virgin Islands, Guam, and American Samoa.”.

7 (2) ELIMINATION OF LIMIT ON TOTAL PAY-
8 MENTS TO THE TERRITORIES.—Section 1108 of
9 such Act (42 U.S.C. 1308) is amended—

10 (A) in the section heading, by striking “;
11 **LIMITATION ON TOTAL PAYMENTS**”;

12 (B) by striking subsection (a); and

13 (C) in subsection (c), by striking para-
14 graphs (2) and (4) and redesignating para-
15 graphs (3) and (5) as paragraphs (2) and (4),
16 respectively.

17 (3) UNITED STATES NATIONALS TREATED THE
18 SAME AS CITIZENS.—Section 1614(a)(1)(B) of such
19 Act (42 U.S.C. 1382c(a)(1)(B)) is amended—

20 (A) in clause (i)(I), by inserting “or na-
21 tional,” after “citizen”;

22 (B) in clause (i)(II), by adding “; or” at
23 the end; and

24 (C) in clause (ii), by inserting “or na-
25 tional” after “citizen”.

1 (4) TERRITORIES INCLUDED IN GEOGRAPHIC
2 MEANING OF UNITED STATES.—Section 1614(e) of
3 such Act (42 U.S.C. 1382c(e)) is amended by strik-
4 ing “and the District of Columbia” and inserting “,
5 the District of Columbia, Puerto Rico, the United
6 States Virgin Islands, Guam, and American
7 Samoa”.

8 (c) WAIVER AUTHORITY.—The Commissioner of So-
9 cial Security may waive or modify any statutory require-
10 ment relating to the provision of benefits under the Sup-
11 plemental Security Income Program under title XVI of the
12 Social Security Act in Puerto Rico, the United States Vir-
13 gin Islands, Guam, or American Samoa, to the extent that
14 the Commissioner deems it necessary in order to adapt
15 the program to the needs of the territory involved.

16 (d) EFFECTIVE DATE.—This section and the amend-
17 ments made by this section shall take effect on the 1st
18 day of the 1st Federal fiscal year that begins 1 year or
19 more after the date of the enactment of this Act.

20 **SEC. 4103. EXTENSION OF MEDICARE SECONDARY PAYER.**

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

1 (1) in the last sentence, by inserting “, and be-
2 fore January 1, 2023” after “prior to such date”;
3 and

4 (2) by adding at the end the following new sen-
5 tence: “Effective for items and services furnished on
6 or after January 1, 2023 (with respect to periods
7 beginning on or after the date that is 42 months
8 prior to such date), clauses (i) and (ii) shall be ap-
9 plied by substituting ‘42-month’ for ‘12-month’ each
10 place it appears.”.

11 (b) EFFECTIVE DATE.—The amendments made by
12 this section shall take effect on the date of enactment of
13 this Act. For purposes of determining an individual’s sta-
14 tus under section 1862(b)(1)(C) of the Social Security Act
15 (42 U.S.C. 1395y(b)(1)(C)), as amended by subsection
16 (a), an individual who is within the coordinating period
17 as of the date of enactment of this Act shall have that
18 period extended to the full 42 months described in the last
19 sentence of such section, as added by the amendment
20 made by subsection (a)(2).

21 **SEC. 4104. INDIAN DEFINED IN TITLE I OF THE PATIENT**
22 **PROTECTION AND AFFORDABLE CARE ACT.**

23 (a) DEFINITION OF INDIAN.—Section 1304 of the
24 Patient Protection and Affordable Care Act (42 U.S.C.
25 18024) is amended by adding at the end the following:

1 “(f) INDIAN.—In this title:

2 “(1) IN GENERAL.—The term ‘Indian’ means—

3 “(A) an Indian, a California Indian, or an
4 Urban Indian (as those terms are defined in
5 section 4 of the Indian Health Care Improve-
6 ment Act (25 U.S.C. 1603)); or

7 “(B) an individual who is of Indian de-
8 scent and a member of an Indian community
9 served by a local facility or program of the In-
10 dian Health Service.

11 “(2) INCLUSIONS.—The term ‘Indian’ includes
12 the following individuals:

13 “(A) A member of a federally recognized
14 Indian Tribe.

15 “(B) A resident of an urban center who
16 meets 1 or more of the following criteria:

17 “(i) A member of a Tribe, band, or
18 other organized group of Indians, including
19 those Tribes, bands, or groups terminated
20 since 1940 and those recognized as of the
21 date of enactment of the Health Equity
22 and Accountability Act of 2022 or later by
23 the State in which they reside, or being a
24 descendant, in the first or second degree,
25 of any such member.

1 “(ii) An Eskimo or Aleut or other
2 Alaska Native.

3 “(iii) An individual who is determined
4 to be an Indian under regulations promul-
5 gated by the Secretary.

6 “(C) An individual who is considered by
7 the Secretary of the Interior to be an Indian for
8 any purpose.

9 “(D) An individual who is considered by
10 the Secretary to be an Indian for purposes of
11 eligibility for services provided by the Indian
12 Health Service, including as a California In-
13 dian, Eskimo, Aleut, or other Alaska Native.”.

14 (b) CONFORMING AMENDMENTS.—

15 (1) AFFORDABLE CHOICES OF HEALTH BEN-
16 EFIT PLANS.—Section 1311(c)(6)(D) of the Patient
17 Protection and Affordable Care Act (42 U.S.C.
18 18031(c)(6)(D)) is amended by striking “(as defined
19 in section 4 of the Indian Health Care Improvement
20 Act)”.

21 (2) REDUCED COST-SHARING FOR INDIVIDUALS
22 ENROLLING IN QUALIFIED HEALTH PLANS.—Section
23 1402(d) of the Patient Protection and Affordable
24 Care Act (42 U.S.C. 18071(d)) is amended—

1 (A) in paragraph (1), in the matter pre-
2 ceding subparagraph (A), by striking “(as de-
3 fined in section 4(d) of the Indian Self-Deter-
4 mination and Education Assistance Act (25
5 U.S.C. 450b(d)))”; and

6 (B) in paragraph (2), in the matter pre-
7 ceding subparagraph (A), by striking “(as so
8 defined)”.

9 (3) EXEMPTION FROM PENALTY FOR NOT
10 MAINTAINING MINIMUM ESSENTIAL COVERAGE.—
11 Section 5000A(e) of the Internal Revenue Code of
12 1986 is amended by striking paragraph (3) and in-
13 serting the following:

14 “(3) INDIANS.—Any applicable individual who
15 is an Indian (as defined in section 1304(f) of the
16 Patient Protection and Affordable Care Act).”.

17 (c) EFFECTIVE DATE OF IRC AMENDMENT.—The
18 amendment made by subsection (b)(3) shall apply to tax-
19 able years beginning after the date of the enactment of
20 this Act.

21 **SEC. 4105. REMOVING MEDICARE BARRIER TO HEALTH**
22 **CARE.**

23 (a) PART A.—Section 1818(a)(3)(B) of the Social
24 Security Act (42 U.S.C. 1395i–2(a)(3)(B)) is amended by
25 striking “an alien” and all that follows through “under

1 this section” and inserting “an individual who is lawfully
2 present in the United States”.

3 (b) PART B.—Section 1836(a)(2)(B) of the Social
4 Security Act (42 U.S.C. 1395o(a)(2)(B)) is amended by
5 striking “an alien” and all that follows through “under
6 this part” and inserting “an individual who is lawfully
7 present in the United States”.

8 **SEC. 4106. LOWERING MEDICARE PREMIUMS AND PRE-**
9 **SCRIPTION DRUG COSTS.**

10 (a) MEDICARE COST ASSISTANCE PROGRAM.—

11 (1) IN GENERAL.—Title XVIII of the Social Se-
12 curity Act (42 U.S.C. 1395 et seq.) is amended by
13 adding at the end the following new section:

14 **“SEC. 1899C. MEDICARE COST ASSISTANCE PROGRAM.**

15 “(a) IN GENERAL.—Effective beginning January 1,
16 2023, in the case of a Medicare Cost Assistance Program
17 eligible individual (as defined in subsection (b)(1)), the
18 Secretary shall provide Medicare cost assistance for the
19 following costs incurred with respect to the individual:

20 “(1) Premiums under section 1818.

21 “(2) Premiums under section 1839.

22 “(3) Coinsurance under this title (including co-
23 insurance described in section 1813).

1 “(4) Deductibles established under this title (in-
2 cluding those described in section 1813 and section
3 1833(b)).

4 “(5) The difference between the amount that is
5 paid under section 1833(a) and the amount that
6 would be paid under such section if any reference to
7 a percent less than 100 percent therein were deemed
8 a reference to ‘100 percent’.

9 “(b) DETERMINATION OF ELIGIBILITY.—

10 “(1) MEDICARE COST ASSISTANCE PROGRAM
11 ELIGIBLE INDIVIDUAL DEFINED.—The term ‘Medi-
12 care Cost Assistance Program eligible individual’
13 means an individual who—

14 “(A) is eligible for, and is receiving, med-
15 ical assistance for the payment of medicare
16 cost-sharing under a State Medicaid program
17 pursuant to clause (i), (iii), or (iv) of section
18 1902(a)(10)(E) as of December 31, 2022; or

19 “(B)(i) is entitled to hospital insurance
20 benefits under part A (including an individual
21 entitled to such benefits pursuant to an enroll-
22 ment under section 1818); and

23 “(ii) has income at or below 200 percent of
24 the poverty line applicable to a family of the
25 size involved.

1 “(2) JOINT DETERMINATION BY COMMISSIONER
2 OF SOCIAL SECURITY FOR LIS AND MEDICARE COST
3 ASSISTANCE.—

4 “(A) IN GENERAL.—The determination of
5 whether an individual is a Medicare Cost As-
6 sistance Program eligible individual shall be de-
7 termined by the Commissioner of Social Secu-
8 rity jointly with the determination of whether
9 an individual is a subsidy eligible individual de-
10 scribed in section 1860D–14(a)(3). Such deter-
11 mination shall be made with respect to eligi-
12 bility for Medicare cost assistance under this
13 section and premium and cost-sharing subsidies
14 under section 1860D–14 upon application of an
15 individual for a determination with respect to
16 eligibility for either such assistance or such sub-
17 sidies. There are authorized to be appropriated
18 to the Social Security Administration such
19 sums as may be necessary for the determination
20 of eligibility under this paragraph.

21 “(B) EFFECTIVE PERIOD.—Determina-
22 tions under this paragraph with respect to eligi-
23 bility for each of such assistance or such sub-
24 sidies shall be effective beginning with the
25 month in which the individual applies for a de-

1 termination described in subparagraph (A) and
2 shall remain in effect until such time as the
3 Secretary determines the individual is no longer
4 eligible as determined under subparagraph
5 (C)(ii).

6 “(C) REDETERMINATIONS.—With respect
7 to eligibility determinations under this para-
8 graph—

9 “(i) redeterminations shall be made at
10 the same time with respect to eligibility for
11 Medicare cost assistance under this section
12 and cost-sharing subsidies under section
13 1860D–14, but not more frequently than
14 once every 12 months;

15 “(ii) a redetermination shall automati-
16 cally determine that an individual remains
17 eligible for such assistance or subsidies un-
18 less—

19 “(I) the Commissioner has infor-
20 mation indicating that the individual’s
21 circumstances have changed such that
22 the individual is no longer eligible for
23 such assistance or subsidies;

24 “(II) the Commissioner sends no-
25 tice to the individual regarding such

1 information that requests a response
2 either confirming or correcting such
3 information; and

4 “(III) the individual either con-
5 firms such information or fails to pro-
6 vide documentation indicating that
7 such circumstances have not changed
8 within 60 days of receiving the notice
9 described in subclause (II);

10 “(iii) the Commissioner shall establish
11 procedures for appeals of such determina-
12 tions that are similar to the procedures de-
13 scribed in the third sentence of section
14 1631(c)(1)(A); and

15 “(iv) judicial review of the final deci-
16 sion of the Commissioner made after a
17 hearing shall be available to the same ex-
18 tent, and with the same limitations, as pro-
19 vided in subsections (g) and (h) of section
20 205.

21 “(D) TREATMENT OF MEDICAID BENE-
22 FICIARIES.—The Secretary shall provide that
23 individuals who are full-benefit dual eligible in-
24 dividuals (as defined in section 1935(c)(6)) or
25 who are recipients of supplemental security in-

1 come benefits under title XVI shall be treated
2 as a Medicare Cost Assistance Program eligible
3 individual and, in the case of such individual
4 who is a part D eligible individual, a subsidy el-
5 igible individual described in section 1860D-
6 14(a)(3).

7 “(E) SIMPLIFIED APPLICATION FORM.—

8 “(i) IN GENERAL.—The Secretary
9 shall develop and distribute a simplified
10 application form for use by individuals in
11 applying for Medicare cost assistance
12 under this section and premium and cost-
13 sharing subsidies under section 1860D-14.
14 Such form shall be easily readable based
15 on culturally fluid language for all demo-
16 graphics beyond just the various languages
17 offered. An audio version, digital version,
18 and photo-voice option should also be pro-
19 vided for all learners. The Secretary shall
20 provide for the translation of such applica-
21 tion form into at least the 10 languages
22 (other than English) that are most often
23 used by individuals applying for hospital
24 insurance benefits under section 226 or
25 226A and shall make the translated forms

1 available to the Commissioner of Social Se-
2 curity.

3 “(ii) CONSULTATION.—In developing
4 the form under clause (i), the Secretary
5 shall consult with beneficiary groups.

6 “(3) INCOME DETERMINATIONS.—For purposes
7 of applying this section—

8 “(A) in the case of an individual who is
9 not treated as a Medicare Cost Assistance Pro-
10 gram eligible individual or a subsidy eligible in-
11 dividual under paragraph (2)(D), income shall
12 be determined in the manner described under
13 section 1612 for purposes of the supplemental
14 security income program, except that support
15 and maintenance furnished in kind shall not be
16 counted as income; and

17 “(B) the term ‘poverty line’ has the mean-
18 ing given such term in section 673(2) of the
19 Community Services Block Grant Act (42
20 U.S.C. 9902(2)), including any revision re-
21 quired by such section.

22 “(c) BENEFICIARY PROTECTIONS.—

23 “(1) IN GENERAL.—In the case in which the
24 payment for Medicare cost assistance for a Medicare
25 Cost Assistance Program eligible individual with re-

1 spect to an item or service is reduced or eliminated,
2 the individual shall not have any legal liability to
3 make payment to a provider of services (as defined
4 in section 1861(u)) or supplier (as defined in section
5 1861(d)) or to an organization described in section
6 1903(m)(1)(A) for the service, and any lawful sanc-
7 tion that may be imposed upon a provider of services
8 or supplier or such an organization for excess
9 charges under this title or title XIX shall apply to
10 the imposition of any charge imposed upon the indi-
11 vidual in such case.

12 “(2) CLARIFICATION.—This paragraph shall
13 not be construed as preventing payment of any
14 medicare cost assistance by a medicare supplemental
15 policy or an employer retiree health plan on behalf
16 of an individual.

17 “(d) ADMINISTRATION.—

18 “(1) IN GENERAL.—The Secretary shall estab-
19 lish procedures for the administration of the pro-
20 gram under this section.

21 “(2) FUNDING.—For purposes of carrying out
22 this section, the Secretary shall make payments from
23 the Federal Hospital Insurance Trust Fund under
24 section 1817 and the Federal Supplementary Med-
25 ical Insurance Trust Fund under section 1841, in

1 such proportion as the Secretary determines appro-
2 priate, of such amounts as the Secretary determines
3 necessary to provide Medicare cost assistance under
4 this section.

5 “(e) REFERENCES TO MEDICARE COST-SHARING.—
6 Effective beginning January 1, 2023, any reference to
7 medicare cost-sharing described in section 1905(p) shall
8 be deemed a reference to Medicare cost assistance under
9 this section.

10 “(f) OUTREACH EFFORTS.—For provisions relating
11 to outreach efforts to increase awareness of the availability
12 of Medicare cost assistance, see section 1144.”.

13 (2) SPECIAL ENROLLMENT PERIOD.—

14 (A) NO PREMIUM PENALTY.—Section
15 1839(b) of the Social Security Act (42 U.S.C.
16 1395r(b)) is amended, in the last sentence, by
17 inserting the following before the period: “or,
18 effective beginning January 1, 2023, for indi-
19 viduals who are Medicare Cost Assistance Pro-
20 gram eligible individuals (as defined in section
21 1899B(b)(1)).”.

22 (B) SPECIAL ENROLLMENT PERIOD.—Sec-
23 tion 1837 of the Social Security Act (42 U.S.C.
24 1395p) is amended by adding at the end the
25 following new subsection:

1 “(p) SPECIAL ENROLLMENT PERIOD FOR MEDICARE
2 COST ASSISTANCE PROGRAM ELIGIBLE INDIVIDUAL.—

3 “(1) IN GENERAL.—Effective beginning Janu-
4 ary 1, 2023, the Secretary shall establish special en-
5 rollment periods for Medicare Cost Assistance Pro-
6 gram eligible individuals (as defined in section
7 1899C(b)(1)).

8 “(2) COVERAGE PERIOD.—In the case of an in-
9 dividual who enrolls during the special enrollment
10 period provided under paragraph (1), the coverage
11 period under this part shall—

12 “(A) begin on the first day of the first
13 month in which the individual applies for a de-
14 termination under section 1899C(b)(2)(A); and

15 “(B) remain in effect until such time as
16 the Secretary determines the individual is no
17 longer eligible as determined under section
18 1899C(b)(2)(C)(ii).”.

19 (C) CONFORMING SUNSET OF STATE
20 AGREEMENTS RELATING TO ENROLLMENT OF
21 QUALIFIED MEDICARE BENEFICIARIES.—

22 (i) PART A.—Section 1818(g) of the
23 Social Security Act (42 U.S.C. 1395i–2(g))
24 is amended by adding at the end the fol-
25 lowing new paragraph:

1 “(3) SUNSET.—This subsection shall not apply on or
2 after January 1, 2023.”.

3 (ii) PART B.—Section 1843(h) of the
4 Social Security Act (42 U.S.C. 1395v(h))
5 is amended by adding at the end the fol-
6 lowing new paragraph:

7 “(3) SUNSET WITH RESPECT TO QUALIFIED MEDI-
8 CARE BENEFICIARIES.—This subsection shall not apply
9 with respect to qualified medicare beneficiaries on or after
10 January 1, 2023.”.

11 (3) PUBLIC AWARENESS CAMPAIGN.—Section
12 1144 of the Social Security Act (42 U.S.C. 1320b–
13 14) is amended by adding at the end the following
14 new subsection:

15 “(d) PUBLIC AWARENESS CAMPAIGN.—

16 “(1) IN GENERAL.—The Commissioner shall
17 conduct a public awareness campaign to educate
18 Medicare beneficiaries on the availability of Medicare
19 cost assistance for low-income individuals under sec-
20 tion 1899B.

21 “(2) COORDINATION.—In carrying out the pub-
22 lic awareness campaign under paragraph (1), the
23 Commissioner shall coordinate with State health in-
24 surance assistance programs described in subsection
25 (a)(1)(A) of section 119 of the Medicare Improve-

1 ments for Patients and Providers Act of 2008 (42
2 U.S.C. 1395b–3 note), the Administrator of the Ad-
3 ministration for Community Living, and the Admin-
4 istrator of the Centers for Medicare & Medicaid
5 Services.

6 “(3) FUNDING.—There is appropriated to the
7 Commissioner, out of any funds in the Treasury not
8 otherwise appropriated, \$10,000,000 for each of fis-
9 cal years 2023 through 2025, to provide grants to
10 State health insurance assistance programs to carry
11 out outreach and education activities under the pub-
12 lic awareness campaign pursuant to this sub-
13 section.”.

14 (b) MOVING MEDICARE COST-SHARING BENEFITS
15 FROM MEDICAID TO MEDICARE.—

16 (1) ENDING MOST MEDICARE COST-SHARING
17 BENEFITS UNDER MEDICAID.—Section 1902(a)(10)
18 of the Social Security Act (42 U.S.C. 1396a(a)(10))
19 is amended—

20 (A) by inserting “for calendar quarters be-
21 ginning before January 1, 2023,” before “for
22 making” each place it appears in clauses (i),
23 (iii), and (iv) of subparagraph (E); and

24 (B) in the matter following subparagraph
25 (G)—

1 (i) by inserting “furnished during cal-
2 endar quarters beginning before January
3 1, 2023” after “(described in section
4 1905(p)(3))”;

5 (ii) by striking “(XV)” and inserting
6 “, (XV)”;

7 (iii) by striking “and (XVIII)” and in-
8 serting “, (XVIII)”;

9 (iv) by striking “and (XIX)” and in-
10 serting “(XIX)”;

11 (v) by inserting “, and (XX) no med-
12 ical assistance for medicare cost-sharing,
13 other than medical assistance for medicare
14 cost-sharing for qualified disabled and
15 working individuals described in section
16 1905(s), shall be made available after Jan-
17 uary 1, 2023” before the semicolon at the
18 end.

19 (2) CONFORMING AMENDMENTS.—

20 (A) TITLE XIX.—

21 (i) Section 1903(i) of such Act (42
22 U.S.C. 1396b(i)), as amended by section
23 4002, is amended—

24 (I) in paragraph (26), by striking
25 “or” at the end;

1 (II) in paragraph (27), by strik-
2 ing the period at the end and insert-
3 ing “; or”; and

4 (III) by inserting after paragraph
5 (27) the following new paragraph:

6 “(28) with respect to any amount expended for
7 medical assistance for medicare cost-sharing (other
8 than medical assistance for medicare cost-sharing
9 for qualified disabled and working individuals de-
10 scribed in section 1905(s)) furnished during cal-
11 endar quarters beginning on or after January 1,
12 2023.”.

13 (ii) Section 1905(a) of such Act (42
14 U.S.C. 1396d(a)) is amended, in the first
15 sentence, by inserting “furnished during
16 calendar quarters beginning before Janu-
17 ary 1, 2023” after “medicare cost-shar-
18 ing”.

19 (iii) Section 1933(g) of such Act (42
20 U.S.C. 1396u-3(g)) is amended—

21 (I) in paragraph (2)(Q), by strik-
22 ing “paragraph (4), for each subse-
23 quent year” and inserting “para-
24 graphs (4) and (5), for each subse-
25 quent year before 2023”; and

1 (II) by adding at the end the fol-
2 lowing:

3 “(5) SUNSET.—No individual shall be selected
4 to be a qualifying individual for any calendar year
5 or period under this section beginning on or after
6 January 1, 2023, and no State allocation shall be
7 made for any fiscal year or period under this section
8 beginning on or after January 1, 2023.”.

9 (iv) Section 1935(a) of such Act (42
10 U.S.C. 1396u–5(a)) is amended—

11 (I) in paragraph (2)(A), by strik-
12 ing “make determinations” and in-
13 serting “prior to January 1, 2023,
14 make determinations”; and

15 (II) in paragraph (3), by insert-
16 ing “prior to January 1, 2023,” be-
17 fore “the State shall”.

18 (c) ENHANCING PRESCRIPTION DRUG AFFORD-
19 ABILITY BY EXPANDING ACCESS TO ASSISTANCE WITH
20 OUT-OF-POCKET COSTS UNDER MEDICARE PART D FOR
21 LOW-INCOME SENIORS AND INDIVIDUALS WITH DISABIL-
22 ITIES.—

23 (1) EXPANDING ACCESS.—Section 1860D–14 of
24 the Social Security Act (42 U.S.C. 1395w–114) is
25 amended—

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1 (A) in subsection (a)—

2 (i) in the subsection heading, by strik-
3 ing “150 PERCENT” and inserting “200
4 PERCENT”;

5 (ii) in paragraph (1)—

6 (I) in the paragraph heading, by
7 striking “135 PERCENT” and inserting
8 “200 PERCENT”; and

9 (II) in the matter preceding sub-
10 paragraph (A)—

11 (aa) by striking “135 per-
12 cent” and inserting “200 per-
13 cent”; and

14 (bb) by striking “and who
15 meets the resources requirement
16 described in paragraph (3)(D) or
17 who is covered under this para-
18 graph under paragraph
19 (3)(B)(i)” and inserting “or who
20 is covered under this paragraph
21 under paragraph (3)(B)(v)”;

22 (iii) by striking paragraph (2);

23 (iv) in paragraph (3)—

24 (I) in subparagraph (A)—

1 (aa) in clause (i), by adding
2 “and” at the end;

3 (bb) in clause (ii)—
4 (AA) by striking “150
5 percent” and inserting “200
6 percent”; and

7 (BB) by striking “;
8 and” at the end and insert-
9 ing a period; and
10 (cc) by striking clause (iii);

11 (II) by striking subparagraphs
12 (B) and (C) and inserting the fol-
13 lowing:

14 “(B) DETERMINATIONS.—For provisions
15 relating to joint determinations with respect to
16 eligibility for Medicare cost assistance under
17 section 1899C and premium and cost-sharing
18 subsidies under this section, see section
19 1899C(b)(2).

20 “(C) INCOME DETERMINATIONS.—For pur-
21 poses of applying this section—

22 “(i) in the case of an individual who
23 is not treated as a Medicare cost-sharing
24 assistance eligible individual and a subsidy
25 eligible individual under section

1 1899C(b)(2)(D), income shall be deter-
2 mined in the manner described under sec-
3 tion 1612 for purposes of the supplemental
4 security income program, except that sup-
5 port and maintenance furnished in kind
6 shall not be counted as income; and

7 “(ii) the term ‘poverty line’ has the
8 meaning given such term in section 673(2)
9 of the Community Services Block Grant
10 Act (42 U.S.C. 9902(2)), including any re-
11 vision required by such section.”; and

12 (III) by striking subparagraphs
13 (D), (E), and (G); and

14 (v) in paragraph (4), by striking sub-
15 paragraph (B); and

16 (B) in subsection (c)(1), in the second sen-
17 tence, by striking “subsections (a)(1)(D) and
18 (a)(2)(E)” and inserting “subsection
19 (a)(1)(D)”.

20 (2) TREATMENT OF REDUCTION OF COST-SHAR-
21 ING FOR INDIVIDUALS RECEIVING HOME AND COM-
22 MUNITY BASED SERVICES.—Section 1860D-
23 14(a)(1)(D)(i) of the Social Security Act (42 U.S.C.
24 1395w-114(a)(1)(D)(i)) is amended—

1 (A) by striking “who would be such an in-
2 stitutionalized individual or couple, if the full-
3 benefit dual eligible individual were not”; and

4 (B) by striking “or subsection (c) or (d) of
5 section 1915 or under a State plan amendment
6 under subsection (i) of such section” and in-
7 serting “, section 1115A, section 1915, or
8 under a State plan amendment”.

9 (3) EFFECTIVE DATE.—The amendments made
10 by this subsection shall apply to plan year 2023 and
11 subsequent plan years.

12 **SEC. 4107. REDUCING COST-SHARING, ALIGNING INCOME**
13 **AND RESOURCE ELIGIBILITY TESTS, SIMPLI-**
14 **FYING ENROLLMENT, AND OTHER PROGRAM**
15 **IMPROVEMENTS FOR LOW-INCOME BENE-**
16 **FICIARIES.**

17 (a) INCREASE IN INCOME ELIGIBILITY TO 135 PER-
18 CENT OF FPL FOR QUALIFIED MEDICARE BENE-
19 FICIARIES.—

20 (1) IN GENERAL.—Section 1905(p)(2)(A) of the
21 Social Security Act (42 U.S.C. 1396d(p)(2)(A)) is
22 amended by striking “shall be at least the percent
23 provided under subparagraph (B) (but not more
24 than 100 percent) of the official poverty line” and

1 all that follows through the period at the end and
2 inserting the following: “shall be—

3 “(i) before January 1, 2023, at least
4 the percent provided under subparagraph
5 (B) (but not more than 100 percent) of
6 the official poverty line (as defined by the
7 Office of Management and Budget, and re-
8 vised annually in accordance with section
9 673(2) of the Omnibus Budget Reconcili-
10 ation Act of 1981) applicable to a family
11 of the size involved; and

12 “(ii) on or after January 1, 2023,
13 equal to 135 percent of the official poverty
14 line (as so defined and revised) applicable
15 to a family of the size involved.”.

16 (2) NOT COUNTING IN-KIND SUPPORT AND
17 MAINTENANCE AS INCOME.—Section 1905(p)(2)(D)
18 of the Social Security Act (42 U.S.C.
19 1396d(p)(2)(D)) is amended by adding at the end
20 the following new clause:

21 “(iii) In determining income under this sub-
22 section, support and maintenance furnished in kind
23 shall not be counted as income.”.

1 (b) INCREASE IN INCOME ELIGIBILITY TO 200 PER-
2 CENT OF FPL FOR SPECIFIED LOW-INCOME MEDICARE
3 BENEFICIARIES.—

4 (1) ELIGIBILITY OF INDIVIDUALS WITH IN-
5 COMES BELOW 150 PERCENT OF FPL.—Section
6 1902(a)(10)(E) of the Social Security Act (42
7 U.S.C. 1396a(a)(10)(E)) is amended—

8 (A) by adding “and” at the end of clause
9 (ii);

10 (B) in clause (iii)—

11 (i) by striking “and 120 percent in
12 1995 and years thereafter” and inserting
13 “120 percent in 1995 and years thereafter
14 before 2023, and 200 percent in 2023 and
15 years thereafter”; and

16 (ii) by striking “and” at the end; and

17 (C) by striking clause (iv).

18 (2) REFERENCES.—Section 1905(p)(1) of the
19 Social Security Act (42 U.S.C. 1396d(p)(1)) is
20 amended by adding at and below subparagraph (C)
21 the following flush sentence:

22 “The term ‘specified low-income medicare beneficiary’
23 means an individual described in section
24 1902(a)(10)(E)(iii).”.

25 (3) CONFORMING AMENDMENTS.—

1 (A) The first sentence of section 1905(b)
2 of such Act (42 U.S.C. 1396d(b)) is amended
3 by striking “and section 1933(d)”.

4 (B) Section 1933 of such Act (42 U.S.C.
5 1396u-3) is repealed.

6 (c) 100 PERCENT FMAP.—Section 1905 of the So-
7 cial Security Act (42 U.S.C. 1396d) is amended by adding
8 at the end the following new subsection:

9 “(jj) INCREASED FMAP FOR EXPANDED MEDICARE
10 COST-SHARING POPULATIONS.—

11 “(1) IN GENERAL.—Notwithstanding subsection
12 (b), with respect to expenditures described in para-
13 graph (2) the Federal medical assistance percentage
14 shall be equal to 100 percent.

15 “(2) EXPENDITURES DESCRIBED.—The expend-
16 itures described in this paragraph are expenditures
17 made on or after January 1, 2023, for medical as-
18 sistance for medicare cost-sharing provided to any
19 individual under clause (i), (ii), or (iii) of section
20 1902(a)(10)(E) who would not have been eligible for
21 medicare cost-sharing under any such clause under
22 the income or resource eligibility standards in effect
23 on October 1, 2018.”.

24 (d) CONSOLIDATION OF LOW-INCOME SUBSIDY RE-
25 SOURCE ELIGIBILITY TESTS.—

1 (1) IN GENERAL.—Section 1860D–14(a)(3) of
2 the Social Security Act (42 U.S.C. 1395w–
3 114(a)(3)) is amended—

4 (A) by striking subparagraph (D);

5 (B) by redesignating subparagraphs (E)
6 through (G) as subparagraphs (D) through (F),
7 respectively; and

8 (C) in the heading of subparagraph (D), as
9 so redesignated, by striking “ALTERNATIVE”.

10 (2) CLARIFICATION OF CERTAIN RULES RELAT-
11 ING TO INCOME AND RESOURCE DETERMINA-
12 TIONS.—Section 1860D–14(a)(3) of the Social Secu-
13 rity Act (42 U.S.C. 1395w–114(a)(3)), as amended
14 by paragraph (1), is amended by striking subpara-
15 graph (F) and inserting the following new subpara-
16 graphs:

17 “(F) RESOURCE EXCLUSIONS.—In deter-
18 mining the resources of an individual (and the
19 eligible spouse of the individual, if any) under
20 section 1613 for purposes of subparagraph
21 (D)—

22 “(i) no part of the value of any life in-
23 surance policy shall be taken into account;

24 “(ii) no part of the value of any vehi-
25 cle shall be taken into account;

“(iii) there shall be excluded an amount equal to \$1,500 each with respect to any individual or eligible spouse of an individual who attests that some of the resources of such individual or spouse will be used to meet the burial and related expenses of such individual or spouse; and

8 “(iv) no balance in, or benefits re-
9 ceived under, an employee pension benefit
10 plan (as defined in section 3 of the Em-
11 ployee Retirement Income Security Act of
12 1974) shall be taken into account.

“(G) FAMILY SIZE.—In determining the size of the family of an individual for purposes of determining the income eligibility of such individual under this section, an individual’s family shall consist of—

18 “(i) the individual;

19 “(ii) the individual’s spouse who lives
20 in the same household as the individual (if
21 any); and

22 “(iii) any other individuals who—

23 “(I) are related to the individual
24 whose income eligibility is in question

1 or such individual's spouse who lives
2 in the same household;

3 “(II) are living in the same
4 household as such individual; and

5 “(III) are dependent on such in-
6 dividual or such individual's spouse
7 who is living in the same household
8 for at least one-half of their financial
9 support.”.

10 (3) CONFORMING AMENDMENTS.—Section
11 1860D–14(a) of the Social Security Act (42 U.S.C.
12 1395w–114(a)) is amended—

13 (A) in paragraph (1), in the matter pre-
14 ceding subparagraph (A), by inserting “(as de-
15 termined under paragraph (3)(G))” after “fam-
16 ily of the size involved”; and

17 (B) in paragraph (3), as amended by para-
18 graphs (1) and (2)—

19 (i) in subparagraph (A), in the matter
20 preceding clause (i), by striking “subpara-
21 graph (F)” and inserting “subparagraph
22 (E)”;

23 (ii) in subparagraph (A)(ii), by insert-
24 ing “(as determined under subparagraph
25 (G))” after “family of the size involved”;

1 (iii) in subparagraph (A)(iii), by strik-
2 ing “or (E)”;

3 (iv) in subparagraph (B)(v), in the
4 matter preceding subclause (I), by striking
5 “subparagraph (F)” and inserting “sub-
6 paragraph (E)”;

7 (v) in subparagraph (D)(i), in the
8 matter preceding subclause (I), by striking
9 “subject to the life insurance policy exclu-
10 sion provided under subparagraph (G)”
11 and inserting “subject to the resource ex-
12 clusions provided under subparagraph
13 (F)”.

14 (e) ALIGNMENT OF LOW-INCOME SUBSIDY AND
15 MEDICARE SAVINGS PROGRAM INCOME AND RESOURCE
16 ELIGIBILITY TESTS.—

17 (1) APPLICATION OF MEDICAID SPOUSAL IM-
18 POVERISHMENT RESOURCE ALLOWANCE TO MSP AND
19 LIS RESOURCE ELIGIBILITY.—Section 1905(p)(1)(C)
20 of the Social Security Act (42 U.S.C.
21 1396d(p)(1)(C)) is amended to read as follows:

22 “(C) whose resources (as determined under sec-
23 tion 1613 for purposes of the supplemental security
24 income program subject to the resource exclusions

1 under subparagraph (G) of section 1860D–14(a)(3))
2 do not exceed—

3 “(i) in the case of an individual with a
4 spouse, an amount equal to the sum of the first
5 amount specified in subsection (f)(2)(A)(i) of
6 section 1924 (as adjusted under subsection (g)
7 of such section) and the amount specified in
8 subsection (f)(2)(A)(ii)(II) of such section (as
9 so adjusted); or

10 “(ii) in the case of an individual who does
11 not have a spouse, an amount equal to $\frac{1}{2}$ of
12 the amount described in clause (i).”.

13 (2) APPLICATION TO QDWIS.—Section
14 1905(s)(3) of the Social Security Act (42 U.S.C.
15 1396d(s)(3)) is amended to read as follows:

16 “(3) whose resources (as determined under sec-
17 tion 1613 for purposes of the supplemental security
18 income program subject to the resource exclusions
19 under subparagraph (G) of section 1860D–14(a)(3))
20 do not exceed—

21 “(A) in the case of an individual with a
22 spouse, the amount in effect for the year under
23 clause (i) of subsection (p)(1)(C); and

24 “(B) in the case of an individual who does
25 not have a spouse, the amount in effect for the

1 year under clause (ii) of subsection (p)(1)(C);
2 and”.

3 (3) APPLICATION TO LIS.—Clause (i) of section
4 1860D–14(a)(3)(D) of the Social Security Act (42
5 U.S.C. 1395w–114(a)(3)(D)), as redesignated and
6 amended by subsection (d)(1), is amended to read as
7 follows:

8 “(i) IN GENERAL.—The resources re-
9 quirement of this subparagraph is that an
10 individual’s resources (as determined under
11 section 1613 for purposes of the supple-
12 mental security income program subject to
13 the resource exclusions provided under
14 subparagraph (G)) do not exceed the
15 amount in effect for the year under section
16 1905(p)(1)(C)(ii).”.

17 (f) ENROLLMENT SIMPLIFICATIONS.—

18 (1) APPLICATION OF 3-MONTH RETROACTIVE
19 ELIGIBILITY TO QMBS.—

20 (A) IN GENERAL.—Section 1902(e)(8) of
21 the Social Security Act (42 U.S.C. 1396a(e)(8))
22 is amended by striking “after the end of the
23 month in which the determination first occurs”
24 and inserting “in or after the third month be-

1 fore the month in which the individual makes
2 application for assistance”.

3 (B) PROCESS FOR SUBMITTING CLAIMS
4 DURING RETROACTIVE ELIGIBILITY PERIOD.—
5 Section 1902(e)(8) of the Social Security Act
6 (42 U.S.C. 1396a(e)(8)) is further amended by
7 adding at the end the following: “The Secretary
8 shall provide for a process under which claims
9 for medical assistance under the State plan may
10 be submitted for services furnished to such an
11 individual during such 3-month period before
12 the month in which the individual made appli-
13 cation for assistance.”.

14 (C) CONFORMING AMENDMENT.—Section
15 1905(a) of the Social Security Act (42 U.S.C.
16 1396d(a)) is amended, in the matter preceding
17 paragraph (1), by striking “or, in the case of
18 medicare cost-sharing with respect to a quali-
19 fied medicare beneficiary described in sub-
20 section (p)(1), if provided after the month in
21 which the individual becomes such a bene-
22 ficiary”.

23 (2) STATE OPTION FOR 12-MONTH CONTINUOUS
24 ELIGIBILITY FOR SLMBS AND QWDIS.—Section

1 1902(e)(12) of the Social Security Act (42 U.S.C.
2 1396a(e)(12)) is amended—

3 (A) by redesignating subparagraphs (A)
4 and (B) as clauses (i) and (ii), respectively;

5 (B) by inserting “(A)” after “(12)”; and

6 (C) by adding at the end the following:

7 “(B) At the option of the State, the plan may provide
8 that an individual who is determined to be eligible for ben-
9 efits under a State plan approved under this title under
10 any of the following eligibility categories, or who is rede-
11 termined to be eligible for such benefits under any of such
12 categories, shall be considered to meet the eligibility re-
13 quirements met on the date of application and shall re-
14 main eligible for those benefits until the end of the 12-
15 month period following the date of the determination or
16 redetermination of eligibility, except that a State may pro-
17 vide for such determinations more frequently, but not
18 more frequently than once every 6 months for an indi-
19 vidual:

20 “(i) A specified low-income medicare beneficiary
21 described in subsection (a)(10)(E)(iii) of this section
22 who is determined eligible for medicare cost sharing
23 described in section 1905(p)(3)(A)(ii).

24 “(ii) A qualified disabled and working indi-
25 vidual described in section 1905(s) who is deter-

1 mined eligible for medicare cost-sharing described in
2 section 1905(p)(3)(A)(i).”.

3 (3) STATE OPTION TO USE EXPRESS LANE ELI-
4 GIBILITY FOR THE MEDICARE SAVINGS PROGRAM.—
5 Section 1902(e)(13)(A) of the Social Security Act
6 (42 U.S.C. 1396a(e)(13)(A)) is amended by adding
7 at the end the following new clause:

8 “(iii) STATE OPTION TO EXTEND EXPRESS
9 LANE ELIGIBILITY TO OTHER POPULATIONS.—

10 “(I) IN GENERAL.—At the option of
11 the State, the State may apply the provi-
12 sions of this paragraph with respect to de-
13 termining eligibility under this title for an
14 eligible individual (as defined in subclause
15 (II)). In applying this paragraph in the
16 case of a State making such an option, any
17 reference in this paragraph to a child with
18 respect to this title (other than a reference
19 to child health assistance) shall be deemed
20 to be a reference to an eligible individual.

21 “(II) ELIGIBLE INDIVIDUAL DE-
22 FINED.—In this clause, the term ‘eligible
23 individual’ means any of the following:

24 “(aa) A qualified medicare bene-
25 ficiary described in section 1905(p)(1)

1 for purposes of determining eligibility
2 for medicare cost-sharing (as defined
3 in section 1905(p)(3)).

4 “(bb) A specified low-income
5 medicare beneficiary described in sub-
6 section (a)(10)(E)(iii) of this section
7 for purposes of determining eligibility
8 for medicare cost-sharing described in
9 section 1905(p)(3)(A)(ii).

10 “(cc) A qualified disabled and
11 working individual described in sec-
12 tion 1905(s) for purposes of deter-
13 mining eligibility for medicare cost-
14 sharing described in section
15 1905(p)(3)(A)(i).”.

16 (g) MEDICAID TREATMENT OF CERTAIN MEDICARE
17 PROVIDERS.—Section 1902(n) of the Social Security Act
18 (42 U.S.C. 1396a(n)) is amended by adding at the end
19 the following new paragraph:

20 “(4) A State plan shall not deny a claim from a pro-
21 vider or supplier with respect to medicare cost-sharing de-
22 scribed in subparagraph (B), (C), or (D) of section
23 1905(p)(3) for an item or service which is eligible for pay-
24 ment under title XVIII on the basis that the provider or
25 supplier does not have a provider agreement in effect

1 under this title or does not otherwise serve all individuals
2 entitled to medical assistance under this title. The State
3 shall create a mechanism through which provider or sup-
4 pliers that do not otherwise have provider agreements with
5 the State can bill the State for medicare cost-sharing for
6 qualified medicare beneficiaries.”.

7 (h) ELIGIBILITY FOR OTHER PROGRAMS.—Section
8 1905(p) of the Social Security Act (42 U.S.C. 1396d(p))
9 is amended by adding at the end the following new para-
10 graph:

11 “(7) Notwithstanding any other provision of law, any
12 medical assistance for some or all medicare cost-sharing
13 under this title shall not be considered income or resources
14 in determining eligibility for, or the amount of assistance
15 or benefits provided under, any other public benefit pro-
16 vided under Federal law or the law of any State or polit-
17 ical subdivision thereof.”.

18 (i) TREATMENT OF QUALIFIED MEDICARE BENE-
19 FICIARIES, SPECIFIED LOW-INCOME MEDICARE BENE-
20 FICIARIES, AND OTHER DUAL ELIGIBLES AS MEDICARE
21 BENEFICIARIES.—Section 1862 of the Social Security Act
22 (42 U.S.C. 1395y) is amended by adding at the end the
23 following new subsection:

24 “(p) TREATMENT OF QUALIFIED MEDICARE BENE-
25 FICIARIES (QMBs), SPECIFIED LOW-INCOME MEDICARE

1 BENEFICIARIES (SLMBS), AND OTHER DUAL ELIGI-
2 BLES.—Nothing in this title shall be construed as author-
3 izing a provider of services or supplier to discriminate
4 (through a private contractual arrangement or otherwise)
5 against an individual who is otherwise entitled to services
6 under this title on the basis that the individual is a quali-
7 fied medicare beneficiary (as defined in section
8 1905(p)(1)), a specified low-income medicare beneficiary,
9 or is otherwise eligible for medical assistance for medicare
10 cost-sharing or other benefits under title XIX.”.

11 (j) ADDITIONAL FUNDING FOR STATE HEALTH IN-
12 SURANCE ASSISTANCE PROGRAMS.—

13 (1) GRANTS.—

14 (A) IN GENERAL.—The Secretary of
15 Health and Human Services (in this subsection
16 referred to as the “Secretary”) shall use
17 amounts made available under subparagraph
18 (B) to make grants to States for State health
19 insurance assistance programs receiving assist-
20 ance under section 4360 of the Omnibus Budg-
21 et Reconciliation Act of 1990.

22 (B) FUNDING.—For purposes of making
23 grants under this subsection, the Secretary
24 shall provide for the transfer, from the Federal
25 Hospital Insurance Trust Fund under section

1 1817 of the Social Security Act (42 U.S.C.
2 1395i) and the Federal Supplementary Medical
3 Insurance Trust Fund under section 1841 of
4 such Act (42 U.S.C. 1395t), in the same pro-
5 portion as the Secretary determines under sec-
6 tion 1853(f) of such Act (42 U.S.C. 1395w-
7 23(f)), of \$50,000,000 to the Centers for Medi-
8 care & Medicaid Services Program Management
9 Account for each of the fiscal years 2024
10 through 2028, to remain available until ex-
11 pended.

12 (2) AMOUNT OF GRANTS.—The amount of a
13 grant to a State under this subsection from the total
14 amount made available under paragraph (1) shall be
15 equal to the sum of the amount allocated to the
16 State under paragraph (3)(A) and the amount allo-
17 cated to the State under subparagraph (3)(B).

18 (3) ALLOCATION TO STATES.—

19 (A) ALLOCATION BASED ON PERCENTAGE
20 OF LOW-INCOME BENEFICIARIES.—The amount
21 allocated to a State under this subparagraph
22 from $\frac{2}{3}$ of the total amount made available
23 under paragraph (1) shall be based on the num-
24 ber of individuals who meet the requirement
25 under subsection (a)(3)(A)(ii) of section

1 1860D–14 of the Social Security Act (42
2 U.S.C. 1395w–114) but who have not enrolled
3 to receive a subsidy under such section 1860D–
4 14 relative to the total number of individuals
5 who meet the requirement under such sub-
6 section (a)(3)(A)(ii) in each State, as estimated
7 by the Secretary.

8 (B) ALLOCATION BASED ON PERCENTAGE
9 OF RURAL BENEFICIARIES.—The amount allo-
10 cated to a State under this subparagraph from
11 $\frac{1}{3}$ of the total amount made available under
12 paragraph (1) shall be based on the number of
13 part D eligible individuals (as defined in section
14 1860D–1(a)(3)(A) of such Act (42 U.S.C.
15 1395w–101(a)(3)(A))) residing in a rural area
16 relative to the total number of such individuals
17 in each State, as estimated by the Secretary.

18 (4) PORTION OF GRANT BASED ON PERCENT-
19 AGE OF LOW-INCOME BENEFICIARIES TO BE USED
20 TO PROVIDE OUTREACH TO INDIVIDUALS WHO MAY
21 BE SUBSIDY ELIGIBLE INDIVIDUALS OR ELIGIBLE
22 FOR THE MEDICARE SAVINGS PROGRAM.—Each
23 grant awarded under this subsection with respect to
24 amounts allocated under paragraph (3)(A) shall be
25 used to provide outreach to individuals who may be

1 subsidy eligible individuals (as defined in section
2 1860D–14(a)(3)(A) of the Social Security Act (42
3 U.S.C. 1395w–114(a)(3)(A))) or eligible for the pro-
4 gram of medical assistance for payment of the cost
5 of medicare cost-sharing under the Medicaid pro-
6 gram pursuant to sections 1902(a)(10)(E) and 1933
7 of such Act (42 U.S.C. 1396a(a)(10)(E), 1396u–3).
8 (k) EFFECTIVE DATE.—

9 (1) IN GENERAL.—Except as provided in para-
10 graph (2), the amendments and repeal made by this
11 section take effect on January 1, 2023, and, with re-
12 spect to title XIX of the Social Security Act, apply
13 to calendar quarters beginning on or after January
14 1, 2023.

15 (2) EXCEPTION FOR STATE LEGISLATION.—In
16 the case of a State plan for medical assistance under
17 title XIX of the Social Security Act which the Sec-
18 retary of Health and Human Services determines re-
19 quires State legislation (other than legislation appro-
20 priating funds) in order for the plan to meet the ad-
21 ditional requirements imposed by the amendments
22 and repeal made by this section, the State plan shall
23 not be regarded as failing to comply with the re-
24 quirements of such title solely on the basis of its
25 failure to meet these additional requirements before

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

9 **SEC. 4108. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**

10 **PROVIDED BY URBAN INDIAN ORGANIZA-**
11 **TIONS.**

12 (a) IN GENERAL.—The third sentence of section
13 1905(b) of the Social Security Act (42 U.S.C. 1396d(b))
14 is amended by striking “for the 8 fiscal year quarters be-
15 ginning with the first fiscal year quarter beginning after
16 the date of the enactment of the American Rescue Plan
17 Act of 2021,” and inserting “and”.

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

1 **SEC. 4109. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE**
2 **PROVIDED TO A NATIVE HAWAIIAN THROUGH**
3 **A FEDERALLY QUALIFIED HEALTH CENTER**
4 **OR A NATIVE HAWAIIAN HEALTH CARE SYS-**
5 **TEM UNDER THE MEDICAID PROGRAM.**

6 (a) IN GENERAL.—The third sentence of section
7 1905(b) of the Social Security Act (42 U.S.C. 1396d(b))
8 is amended by striking “, for such 8 fiscal year quarters”.

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

12 **SEC. 4110. REPEAL OF REQUIREMENT FOR ESTATE RECOV-**
13 **ERY UNDER THE MEDICAID PROGRAM.**

14 Section 1917 of the Social Security Act (42 U.S.C.
15 1396p) is amended—

16 (1) in subsection (a)—

17 (A) by amending paragraph (1) to read as
18 follows:

19 “(1) No lien may be imposed against the prop-
20 erty of any individual prior to his death on account
21 of medical assistance paid or to be paid on his behalf
22 under the State plan, except pursuant to the judg-
23 ment of a court on account of benefits incorrectly
24 paid on behalf of such individual.”;

25 (B) by striking paragraph (2);

1 (C) in paragraph (3), by striking “(1)(B)”
2 and inserting “(1)”; and

3 (D) by redesignating paragraph (3) as
4 paragraph (2); and

5 (2) by amending subsection (b) to read as fol-
6 lows:

7 “(b) ADJUSTMENT OR RECOVERY OF MEDICAL AS-
8 SISTANCE CORRECTLY PAID UNDER A STATE PLAN.—No
9 adjustment or recovery of any medical assistance correctly
10 paid on behalf of an individual under the State plan may
11 be made.”.

12 **SEC. 4111. ALLOW FOR SUSPENSION OF MEDICARE BENE-**
13 **FITS AND PREMIUM LIABILITY FOR INDIVID-**
14 **UALS WHO ARE INCARCERATED AND PRO-**
15 **VIDE A SPECIAL ENROLLMENT PERIOD**
16 **AROUND THE DATE OF RELEASE.**

17 (a) SPECIAL ENROLLMENT PERIOD FOR INDIVID-
18 UALS INCARCERATED AT TIME OF MEDICARE ELIGI-
19 BILITY.—Section 1837(i) of the Social Security Act (42
20 U.S.C. 1395p(i)) is amended by adding at the end the fol-
21 lowing new paragraph:

22 “(5)(A) In the case of an individual who—

23 “(i) at the time the individual first satis-
24 fies paragraph (1) or (2) of section 1836(a), is
25 incarcerated; or

1 “(ii) has elected not to enroll (or to be
2 deemed enrolled) under this section during the
3 individual’s initial enrollment period;
4 there shall be a special enrollment period de-
5 scribed in subparagraph (B).

6 “(B) The special enrollment period re-
7 ferred to in subparagraph (A) is the 6-month
8 period beginning on the first day after which
9 the individual is no longer incarcerated.”.

10 (b) PREMIUM AMOUNT.—Section 1839(a) of the So-
11 cial Security Act (42 U.S.C. 1395r(a)) is amended—

12 (1) in paragraph (1), in the second sentence, by
13 striking “or (7)” and inserting “(7) or (8)”; and

14 (2) by adding at the end the following new
15 paragraph:

16 “(8) In the case of an individual whose coverage pe-
17 riod includes months in which by reason of custody under
18 penal authority coverage is excluded pursuant to section
19 1862(a)(3), the premium amount for such months such
20 individual is in custody under penal authority shall be
21 zero.”.

22 (c) CONFORMING AMENDMENT.—Section 1818(d)(5)
23 of the Social Security Act (42 U.S.C. 1395i–2(d)(5)) is
24 amended by adding at the end the following:

1 “(D) In the case of an individual who is a
2 person who is excluded from coverage pursuant
3 to section 1862(a)(3) by reason of custody
4 under penal authority, the amount of the
5 monthly premium for such individual shall be
6 zero for any month in which such individual is
7 in custody under penal authority.”.

8 **SEC. 4112. FEDERAL EMPLOYEE HEALTH BENEFIT PLANS.**

9 (a) COVERAGE OF PREGNANCY.—The Director of the
10 Office of Personnel Management shall issue such regula-
11 tions as are necessary to ensure that pregnancy is consid-
12 ered a change in family status and a qualifying life event
13 for an individual who is eligible to enroll, but is not en-
14 rolled, in a health benefits plan under chapter 89 of title
15 5, United States Code.

16 (b) EFFECTIVE DATE.—The requirement in para-
17 graph (1) shall apply with respect to any contract entered
18 into under section 8902 of such title beginning 12 months
19 after the date of enactment of this Act.

20 **SEC. 4113. CONTINUATION OF MEDICAID INCOME ELIGI-**
21 **BILITY STANDARD FOR PREGNANT INDIVID-**
22 **UALS AND INFANTS.**

23 Section 1902(l)(2)(A) of the Social Security Act (42
24 U.S.C. 1396a(l)(2)(A)) is amended—

1 (1) in clause (i), by striking “and not more
2 than 185 percent”;

3 (2) in clause (ii)—

4 (A) in subclause (I), by striking “and”
5 after the comma;

6 (B) in subclause (II), by striking the pe-
7 riod at the end and inserting “, and”; and

8 (C) by adding at the end the following:

9 “(III) January 1, 2023, is the
10 percentage provided under clause
11 (v).”; and

12 (3) by adding at the end the following new
13 clause:

14 “(v) The percentage provided under
15 clause (ii) for medical assistance provided
16 on or after January 1, 2023, with respect
17 to individuals described in subparagraph
18 (A) or (B) of paragraph (1) shall not be
19 less than—

20 “(I) the percentage specified for
21 such individuals by the State in an
22 amendment to its State plan (whether
23 approved or not) as of January 1,
24 2014; or

1 “(II) if no such percentage is
2 specified as of January 1, 2014, the
3 percentage established for such indi-
4 viduals under the State’s authorizing
5 legislation or provided for under the
6 State’s appropriations as of that
7 date.”.

8 **Subtitle C—Expansion of Access**

9 **PART 1—GENERAL PROVISIONS**

10 **SEC. 4201. AMENDMENT TO THE PUBLIC HEALTH SERVICE** 11 **ACT.**

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

15 **“Subtitle D—Reconstruction and** 16 **Improvement Grants for Public** 17 **Health Care Facilities Serving** 18 **Pacific Islanders and the Insu-** 19 **lar Areas**

20 **“SEC. 3441. GRANT SUPPORT FOR QUALITY IMPROVEMENT** 21 **INITIATIVES.**

22 “(a) IN GENERAL.—The Secretary, in collaboration
23 with the Administrator of the Health Resources and Serv-
24 ices Administration, the Director of the Agency for
25 Healthcare Research and Quality, and the Administrator

1 of the Centers for Medicare & Medicaid Services, shall
2 award grants to eligible entities for the conduct of dem-
3 onstration projects to improve the quality of and access
4 to health care.

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

7 “(1) be a health center, hospital, health plan,
8 health system, community clinic, hospice or palliative
9 care provider, or other health entity determined ap-
10 propriate by the Secretary—

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

14 “(B) that provides care or treatment for a
15 substantial number of patients who are unin-
16 sured, are receiving assistance under a State
17 plan under title XIX of the Social Security Act
18 (or under a waiver of such plan), or are mem-
19 bers of vulnerable populations, as determined
20 by the Secretary; and

21 “(C)(i) with respect to which, not less than
22 50 percent of the entity’s patient population is
23 made up of racial and ethnic minority groups
24 (as defined in section 1707(g)(1)); or

25 “(ii) that—

1 “(I) serves a disproportionate percent-
2 age of local patients who are from a racial
3 and ethnic minority group, or has a patient
4 population at least 50 percent of which is
5 composed of individuals with limited
6 English proficiency; and

7 “(II) provides an assurance that
8 amounts received under the grant will be
9 used only to support quality improvement
10 activities in the racial and ethnic minority
11 population served; and

12 “(2) prepare and submit to the Secretary an
13 application at such time, in such manner, and con-
14 taining such information as the Secretary may re-
15 quire.

16 “(c) PRIORITY.—In awarding grants under sub-
17 section (a), the Secretary shall give priority to eligible enti-
18 ties that—

19 “(1) demonstrate an intent to operate as part
20 of a health care partnership, network, collaborative,
21 coalition, or alliance where each member entity con-
22 tributes to the design, implementation, and evalua-
23 tion of the proposed intervention; or

1 “(2) intend to use funds to carry out system-
2 wide changes with respect to health care quality im-
3 provement, including—

4 “(A) improved systems for data collection
5 and reporting;

6 “(B) innovative collaborative or similar
7 processes;

8 “(C) group programs with behavioral or
9 self-management interventions;

10 “(D) case management services;

11 “(E) physician or patient reminder sys-
12 tems;

13 “(F) educational interventions;

14 “(G) comprehensive and patient-centric
15 health care;

16 “(H) creation and distribution of education
17 materials on available health care options; or

18 “(I) other activities determined appropriate
19 by the Secretary.

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

1 “(1) with respect to health care systems, activi-
2 ties relating to improving—

3 “(A) patient safety;

4 “(B) timeliness of care;

5 “(C) effectiveness of care;

6 “(D) efficiency of care;

7 “(E) patient centeredness;

8 “(F) health information technology;

9 “(G) accessibility and availability of infor-
10 mation on health care;

11 “(H) comprehensiveness of health care;

12 and

13 “(I) patient involvement and choice in
14 health care; and

15 “(2) with respect to patients, activities relating
16 to—

17 “(A) staying healthy;

18 “(B) getting well, mentally and physically;

19 “(C) living effectively with illness or dis-
20 ability;

21 “(D) preparing for end of life and ensuring
22 that end-of-life care is accessible and available,
23 as well as coping with end-of-life issues; and

24 “(E) shared decisionmaking.

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

5 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated to carry out this section
7 such sums as may be necessary for each of fiscal years
8 2023 through 2030.

9 **“SEC. 3442. CENTERS OF EXCELLENCE.**

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

15 “(1) meet the requirements of section
16 3441(b)(1);

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

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

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

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

1 cially, ethnically, and linguistically diverse popu-
2 lations;

3 “(2) provide training and technical assistance
4 to other hospitals and health systems relating to the
5 provision of high-quality health care to minority pop-
6 ulations; and

7 “(3) develop activities for graduate or con-
8 tinuing medical education that institutionalize a
9 focus on cultural competence training for health care
10 providers.

11 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated to carry out this section,
13 such sums as may be necessary for each of fiscal years
14 2023 through 2030.

15 **“SEC. 3443. RECONSTRUCTION AND IMPROVEMENT GRANTS**
16 **FOR PUBLIC HEALTH CARE FACILITIES SERV-**
17 **ING PACIFIC ISLANDERS AND THE INSULAR**
18 **AREAS.**

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

1 health care facilities and services in a culturally competent
2 and sustainable manner.

3 “(b) ELIGIBILITY.—To be eligible to receive direct fi-
4 nancial assistance under subsection (a), an entity shall be
5 a public health facility or community health center located
6 in American Samoa, Guam, the Commonwealth of the
7 Northern Mariana Islands, the United States Virgin Is-
8 lands, Puerto Rico, or Hawaii that—

9 “(1) is owned or operated by—

10 “(A) the Government of American Samoa,
11 Guam, the Commonwealth of the Northern
12 Mariana Islands, the United States Virgin Is-
13 lands, Puerto Rico, or Hawaii or a unit of local
14 government; or

15 “(B) a nonprofit organization; and

16 “(2)(A) provides care or treatment for a sub-
17 stantial number of patients who are uninsured, are
18 receiving assistance under title XVIII of the Social
19 Security Act or under a State plan under title XIX
20 of such Act (or under a waiver of such plan), or are
21 members of a vulnerable population, as determined
22 by the Secretary; or

23 “(B) serves a disproportionate percentage of
24 local patients that are from a racial and ethnic mi-
25 nority group.

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

9 “(1) consult with and obtain information on all
10 health care facilities needs from the entities receiv-
11 ing direct financial assistance under subsection (a);

12 “(2) include all amounts of Federal assistance
13 received by each such entity in the preceding fiscal
14 year;

15 “(3) review the total unmet needs of health care
16 facilities serving American Samoa, Guam, the Com-
17 monwealth of the Northern Mariana Islands, the
18 United States Virgin Islands, Puerto Rico, and Ha-
19 waii, including needs for renovation and expansion
20 of existing facilities;

21 “(4) include a strategic plan for addressing the
22 needs of each such population identified in the re-
23 port; and

1 “(5) evaluate the effectiveness of the care pro-
2 vided by measuring patient outcomes and cost meas-
3 ures.

4 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated such sums as necessary
6 to carry out this section.”.

7 **SEC. 4202. BORDER HEALTH GRANTS.**

8 (a) DEFINITIONS.—In this section:

9 (1) BORDER AREA.—The term “border area”
10 means the United States-Mexico Border Area, as de-
11 fined in section 8 of the United States-Mexico Bor-
12 der Health Commission Act (22 U.S.C. 290n–6).

13 (2) ELIGIBLE ENTITY.—The term “eligible enti-
14 ty” means an entity that is located in the border
15 area and is any of the following:

16 (A) A State, local government, or Tribal
17 government.

18 (B) A public institution of higher edu-
19 cation.

20 (C) A nonprofit health organization.

21 (D) A community health center.

22 (E) A community clinic that is a health
23 center receiving assistance under section 330 of
24 the Public Health Service Act (42 U.S.C.
25 254b).

1 (F) A nonprofit organization serving immi-
2 grants.

3 (b) AUTHORIZATION.—From funds appropriated pur-
4 suant to subsection (f), the Secretary of Health and
5 Human Services (in this section referred to as the “Sec-
6 retary”), acting through the United States members of the
7 United States-Mexico Border Health Commission, shall
8 award grants to eligible entities to address priorities and
9 recommendations to improve the health of border area
10 residents that are established by—

11 (1) the United States members of the United
12 States-Mexico Border Health Commission;

13 (2) the State border health offices; and

14 (3) the Secretary.

15 (c) APPLICATION.—An eligible entity that desires a
16 grant under subsection (b) shall submit an application to
17 the Secretary at such time, in such manner, and con-
18 taining such information as the Secretary may require and
19 demonstrating the entity’s capacity to provide culturally
20 and linguistically appropriate services to border area resi-
21 dents.

22 (d) USE OF FUNDS.—An eligible entity that receives
23 a grant under subsection (b) shall use the grant funds
24 for—

25 (1) programs relating to—

- 1 (A) maternal and child health;
- 2 (B) primary care and preventative health;
- 3 (C) public health and public health infra-
- 4 structure;
- 5 (D) musculoskeletal health and obesity;
- 6 (E) health education and promotion;
- 7 (F) oral health;
- 8 (G) mental and behavioral health;
- 9 (H) substance use disorders;
- 10 (I) health conditions that have a high prev-
- 11 alence in the border area;
- 12 (J) medical and health services research;
- 13 (K) workforce training and development;
- 14 (L) community health workers, patient
- 15 navigators, and promotores;
- 16 (M) health care infrastructure problems in
- 17 the border area (including planning and con-
- 18 struction grants);
- 19 (N) health disparities in the border area;
- 20 (O) environmental health;
- 21 (P) outreach and enrollment services with
- 22 respect to Federal programs (including pro-
- 23 grams authorized under titles XIX and XXI of
- 24 the Social Security Act (42 U.S.C. 1396 et seq.;
- 25 42 U.S.C. 1397aa et seq.));

1 (Q) end-of-life care; and

2 (R) addressing social determinants of
3 health; and

4 (2) other programs determined appropriate by
5 the Secretary.

6 (e) SUPPLEMENT, NOT SUPPLANT.—Amounts pro-
7 vided to an eligible entity awarded a grant under sub-
8 section (b) shall be used to supplement and not supplant
9 other funds available to the eligible entity to carry out the
10 activities described in subsection (d).

11 (f) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated to carry out this section,
13 \$200,000,000 for fiscal year 2024, and such sums as may
14 be necessary for each succeeding fiscal year.

15 **SEC. 4203. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.**

16 (a) ELIMINATION OF ISOLATION TEST FOR COST-
17 BASED AMBULANCE REIMBURSEMENT.—

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

21 (A) in subparagraph (B)—

22 (i) by striking “owned and”; and

23 (ii) by inserting “(including when
24 such services are provided by the entity

1 under an arrangement with the hospital)”
2 after “hospital”; and

3 (B) by striking the comma at the end of
4 subparagraph (B) and all that follows and in-
5 serting a period.

6 (2) EFFECTIVE DATE.—The amendments made
7 by this subsection shall apply to services furnished
8 on or after January 1, 2023.

9 (b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE
10 TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT
11 REQUIREMENT.—

12 (1) IN GENERAL.—Section 1820(c)(2) of the
13 Social Security Act (42 U.S.C. 1395i–4(c)(2)) is
14 amended—

15 (A) in subparagraph (B)(iii), by striking
16 “provides not more than” and inserting “sub-
17 ject to subparagraph (F), provides not more
18 than”; and

19 (B) by adding at the end the following new
20 subparagraph:

21 “(F) ALTERNATIVE TO 25 INPATIENT BED
22 LIMIT REQUIREMENT.—

23 “(i) IN GENERAL.—A State may elect
24 to treat a facility, with respect to the des-
25 ignation of the facility for a cost reporting

1 period, as satisfying the requirement of
2 subparagraph (B)(iii) relating to a max-
3 imum number of acute care inpatient beds
4 if the facility elects, in accordance with a
5 method specified by the Secretary and be-
6 fore the beginning of the cost reporting pe-
7 riod, to meet the requirement under clause
8 (ii).

9 “(ii) ALTERNATE REQUIREMENT.—
10 The requirement under this clause, with
11 respect to a facility and a cost reporting
12 period, is that the total number of inpa-
13 tient bed days described in subparagraph
14 (B)(iii) during such period will not exceed
15 7,300. For purposes of this subparagraph,
16 an individual who is an inpatient in a bed
17 in the facility for a single day shall be
18 counted as one inpatient bed day.

19 “(iii) WITHDRAWAL OF ELECTION.—
20 The option described in clause (i) shall not
21 apply to a facility for a cost reporting pe-
22 riod if the facility (for any two consecutive
23 cost reporting periods during the previous
24 5 cost-reporting periods) was treated under
25 such option and had a total number of in-

1 patient bed days for each of such two cost
2 reporting periods that exceeded the num-
3 ber specified in such clause.”.

4 (2) EFFECTIVE DATE.—The amendments made
5 by paragraph (1) shall apply to cost reporting peri-
6 ods beginning on or after the date of the enactment
7 of this Act.

8 **SEC. 4204. MEDICARE REMOTE MONITORING PILOT**
9 **PROJECTS.**

10 (a) PILOT PROJECTS.—

11 (1) IN GENERAL.—Not later than 9 months
12 after the date of enactment of this Act, the Sec-
13 retary of Health and Human Services (in this sec-
14 tion referred to as the “Secretary”) shall conduct
15 pilot projects under title XVIII of the Social Secu-
16 rity Act (42 U.S.C. 1395 et seq.) for the purpose of
17 providing incentives to home health agencies to uti-
18 lize home monitoring and communications tech-
19 nologies that—

20 (A) enhance health and health care out-
21 comes for Medicare beneficiaries; and

22 (B) reduce expenditures under such title.

23 (2) SITE REQUIREMENTS.—

1 (A) URBAN AND RURAL.—The Secretary
2 shall conduct the pilot projects under this sec-
3 tion in both urban and rural areas.

4 (B) SITE IN A SMALL STATE.—The Sec-
5 retary shall conduct at least 3 of the pilot
6 projects in a State with a population of less
7 than 1,000,000.

8 (3) DEFINITION OF HOME HEALTH AGENCY.—
9 In this section, the term “home health agency” has
10 the meaning given that term in section 1861(o) of
11 the Social Security Act (42 U.S.C. 1395x(o)).

12 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE
13 OF PROJECTS.—The Secretary shall specify the criteria
14 for identifying those Medicare beneficiaries who shall be
15 considered within the scope of the pilot projects under this
16 section for purposes of the application of subsection (c)
17 and for the assessment of the effectiveness of the home
18 health agency in achieving the objectives of this section.
19 Such criteria may provide for the inclusion in the projects
20 of Medicare beneficiaries who begin receiving home health
21 services under title XVIII of the Social Security Act (42
22 U.S.C. 1395 et seq.) after the date of the implementation
23 of the projects.

24 (c) INCENTIVES.—

1 (1) PERFORMANCE TARGETS.—The Secretary
2 shall establish for each home health agency partici-
3 pating in a pilot project under this section a per-
4 formance target using one of the following meth-
5 odologies, as determined appropriate by the Sec-
6 retary:

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

10 (i) a base expenditure amount equal
11 to the average total payments made to the
12 agency under parts A and B of title XVIII
13 of the Social Security Act (42 U.S.C. 1395
14 et seq.) for Medicare beneficiaries deter-
15 mined to be within the scope of the pilot
16 project in a base period determined by the
17 Secretary; and

18 (ii) an annual per capita expenditure
19 target for such beneficiaries, reflecting the
20 base expenditure amount adjusted for risk
21 and adjusted growth rates.

22 (B) COMPARATIVE PERFORMANCE TAR-
23 GET.—The Secretary shall establish for the
24 agency a comparative performance target equal
25 to the average total payments under such parts

1 A and B during the pilot project for comparable
2 individuals in the same geographic area that
3 are not determined to be within the scope of the
4 pilot project.

5 (2) INCENTIVE.—Subject to paragraph (3), the
6 Secretary shall pay to each participating home care
7 agency an incentive payment for each year under the
8 pilot project equal to a portion of the Medicare sav-
9 ings realized for such year relative to the perform-
10 ance target under paragraph (1).

11 (3) LIMITATION ON EXPENDITURES.—The Sec-
12 retary shall limit incentive payments under this sec-
13 tion in order to ensure that the aggregate expendi-
14 tures under title XVIII of the Social Security Act
15 (42 U.S.C. 1395 et seq.) (including incentive pay-
16 ments under this subsection) do not exceed the
17 amount that the Secretary estimates would have
18 been expended if the pilot projects under this section
19 had not been implemented.

20 (d) WAIVER AUTHORITY.—The Secretary may waive
21 such provisions of titles XI and XVIII of the Social Secu-
22 rity Act (42 U.S.C. 1301 et seq.; 42 U.S.C. 1395 et seq.)
23 as the Secretary determines to be appropriate for the con-
24 duct of the pilot projects under this section.

1 (e) REPORT TO CONGRESS.—Not later than 5 years
2 after the date that the first pilot project under this section
3 is implemented, the Secretary shall submit to Congress a
4 report on the pilot projects. Such report shall contain a
5 detailed description of issues related to the expansion of
6 the projects under subsection (f) and recommendations for
7 such legislation and administrative actions as the Sec-
8 retary considers appropriate.

9 (f) EXPANSION.—If the Secretary determines that
10 any of the pilot projects under this section enhance health
11 outcomes for Medicare beneficiaries and reduce expendi-
12 tures under title XVIII of the Social Security Act (42
13 U.S.C. 1395 et seq.), the Secretary may initiate com-
14 parable projects in additional areas.

15 (g) INCENTIVE PAYMENTS HAVE NO EFFECT ON
16 OTHER MEDICARE PAYMENTS TO AGENCIES.—An incen-
17 tive payment under this section—

18 (1) shall be in addition to the payments that a
19 home health agency would otherwise receive under
20 title XVIII of the Social Security Act for the provi-
21 sion of home health services; and

22 (2) shall have no effect on the amount of such
23 payments.

1 **SEC. 4205. COMMUNITY HEALTH CENTER COLLABORATIVE**
2 **ACCESS EXPANSION.**

3 Section 330(r)(4) of the Public Health Service Act
4 (42 U.S.C. 254b(r)(4)) is amended—

5 (1) in subparagraph (A), by striking “primary
6 health care services” each place it appears and in-
7 serting “primary health care and other mental, den-
8 tal, and physical health services”; and

9 (2) in subparagraph (B)—

10 (A) in clause (i), by striking “and” at the
11 end;

12 (B) in clause (ii), by striking the period at
13 the end and inserting “; and”; and

14 (C) by adding at the end the following:

15 “(iii) in the case of a rural health
16 clinic described in such subparagraph—

17 “(I) that such clinic provides, to
18 the extent possible, enabling services,
19 such as transportation and language
20 assistance (including translation and
21 interpretation); and

22 “(II) that the primary health
23 care and other services described in
24 such subparagraph are subject to full
25 reimbursement according to the pro-
26 spective payment system for Federally

1 qualified health center services under
2 section 1834(o) of the Social Security
3 Act.”.

4 **SEC. 4206. FACILITATING THE PROVISION OF TELEHEALTH**
5 **SERVICES ACROSS STATE LINES.**

6 (a) IN GENERAL.—For purposes of expediting the
7 provision of telehealth services, for which payment is made
8 under the Medicare Program, across State lines, the Sec-
9 retary of Health and Human Services shall, in consulta-
10 tion with representatives of States, physicians, health care
11 practitioners, and patient advocates, encourage and facili-
12 tate the adoption of provisions allowing for multistate
13 practitioner practice across State lines.

14 (b) DEFINITIONS.—In subsection (a):

15 (1) TELEHEALTH SERVICE.—The term “tele-
16 health service” has the meaning given that term in
17 subparagraph (F) of section 1834(m)(4) of the So-
18 cial Security Act (42 U.S.C. 1395m(m)(4)).

19 (2) PHYSICIAN, PRACTITIONER.—The terms
20 “physician” and “practitioner” have the meaning
21 given those terms in subparagraphs (D) and (E), re-
22 spectively, of section 1834(m)(4) of the Social Secu-
23 rity Act (42 U.S.C. 1395m(m)(4)).

24 (3) MEDICARE PROGRAM.—The term “Medicare
25 Program” means the program of health insurance

1 administered by the Secretary of Health and Human
2 Services under title XVIII of the Social Security Act
3 (42 U.S.C. 1395 et seq.).

4 **SEC. 4207. SCORING OF PREVENTIVE HEALTH SAVINGS.**

5 Section 202 of the Congressional Budget and Im-
6 poundment Control Act of 1974 (2 U.S.C. 602) is amend-
7 ed by adding at the end the following:

8 “(h) SCORING OF PREVENTIVE HEALTH SAVINGS.—

9 “(1) DETERMINATION BY THE DIRECTOR.—

10 Upon a request by the chairman or ranking minority
11 member of the Committee on the Budget of the Sen-
12 ate, or by the chairman or ranking minority member
13 of the Committee on the Budget of the House of
14 Representatives, the Director shall determine if a
15 proposed measure would result in reductions in
16 budget outlays in budgetary outyears through the
17 use of preventive health and preventive health serv-
18 ices.

19 “(2) PROJECTIONS.—If the Director determines
20 that a measure would result in substantial reduc-
21 tions in budget outlays as described in paragraph
22 (1), the Director—

23 “(A) shall include, in any projection pre-
24 pared by the Director, a description and esti-
25 mate of the reductions in budget outlays in the

1 budgetary outyears and a description of the
2 basis for such conclusions; and

3 “(B) may prepare a budget projection that
4 includes some or all of the budgetary outyears,
5 notwithstanding the time periods for projections
6 described in subsection (e) and sections 308,
7 402, and 424.

8 “(3) DEFINITIONS.—As used in this sub-
9 section—

10 “(A) the term ‘budgetary outyears’ means
11 the 2 consecutive 10-fiscal-year periods begin-
12 ning with the first fiscal year that is 10 years
13 after the budget year provided for in the most
14 recently agreed to concurrent resolution on the
15 budget; and

16 “(B) the term ‘preventive health’ means an
17 action that focuses on the health of the public,
18 individuals, and defined populations in order to
19 protect, promote, and maintain health, wellness,
20 and functional ability, and prevent disease, dis-
21 ability, and premature death that is dem-
22 onstrated by credible and publicly available epi-
23 demiological projection models, incorporating
24 clinical trials or observational studies in hu-
25 mans, to avoid future health care costs.”.

1 **SEC. 4208. SENSE OF CONGRESS ON MAINTENANCE OF EF-**
2 **FORT PROVISIONS REGARDING CHILDREN'S**
3 **HEALTH.**

4 It is the sense of the Congress that—

5 (1) the maintenance of effort provisions added
6 to sections 1902 and 2105(d) of the Social Security
7 Act (42 U.S.C. 1396a; 42 U.S.C. 1397ee(d)) by sec-
8 tions 2001(b) and 2101(b) of the Patient Protection
9 and Affordable Care Act were intended to maintain
10 the eligibility standards for the Medicaid program
11 under title XIX of the Social Security Act (42
12 U.S.C. 1396 et seq.) and Children's Health Insur-
13 ance Program under title XXI of such Act (42
14 U.S.C. 1397aa et seq.) to protect vulnerable and dis-
15 abled adults, children, and senior citizens, many of
16 whom are also members of communities of color;

17 (2) the maintenance of effort provisions for
18 children's coverage have been extended by the Con-
19 gress through September 30, 2027;

20 (3) the maintenance of effort provisions ensure
21 the continued success of the Medicaid program and
22 Children's Health Insurance Program and were in-
23 tended to specifically protect vulnerable and disabled
24 children, many of whom are also members of com-
25 munities of color; and

1 (4) the maintenance of effort provisions must
2 be strictly enforced and proposals to weaken or
3 waive the maintenance of effort provisions must not
4 be considered.

5 **SEC. 4209. PROTECTION OF THE HHS OFFICES OF MINOR-**
6 **ITY HEALTH.**

7 (a) IN GENERAL.—Pursuant to section 1707A of the
8 Public Health Service Act (42 U.S.C. 300u–6a), the Of-
9 fices of Minority Health established within the Centers for
10 Disease Control and Prevention, the Health Resources
11 and Services Administration, the Substance Abuse and
12 Mental Health Services Administration, the Agency for
13 Healthcare Research and Quality, the Food and Drug Ad-
14 ministration, and the Centers for Medicare & Medicaid
15 Services, are offices that, regardless of change in the
16 structure of the Department of Health and Human Serv-
17 ices, shall report to the Secretary of Health and Human
18 Services.

19 (b) SENSE OF CONGRESS.—It is the sense of the
20 Congress that the Offices of Minority Health referred to
21 in subsection (a) play a critical role in addressing health
22 disparities and should be adequately funded and given a
23 prominent role in evaluating and establishing health poli-
24 cies and programs.

1 **SEC. 4210. OFFICE OF MINORITY HEALTH IN VETERANS**
2 **HEALTH ADMINISTRATION OF DEPARTMENT**
3 **OF VETERANS AFFAIRS.**

4 (a) ESTABLISHMENT AND FUNCTIONS.—Subchapter
5 I of chapter 73 of title 38, United States Code, is amended
6 by inserting after section 7308 the following new section:

7 **“§ 7308A. Office of Minority Health**

8 “(a) ESTABLISHMENT.—There is established in the
9 Department within the Office of the Under Secretary for
10 Health an office to be known as the ‘Office of Minority
11 Health’ (in this section referred to as the ‘Office’).

12 “(b) HEAD.—The Director of the Office of Minority
13 Health shall be the head of the Office. The Director of
14 the Office of Minority Health shall be appointed by the
15 Under Secretary for Health from among individuals quali-
16 fied to perform the duties of the position.

17 “(c) FUNCTIONS.—The functions of the Office are as
18 follows:

19 “(1) To establish short-range and long-range
20 goals and objectives and coordinate all other activi-
21 ties within the Veterans Health Administration that
22 relate to disease prevention, health promotion, health
23 care services delivery, health and health care edu-
24 cation, health care quality, and health care research
25 concerning veterans who are members of a racial or
26 ethnic minority group.

1 “(2) To support research, demonstrations, and
2 evaluations to test new and innovative models for
3 the discharge of activities described in paragraph
4 (1).

5 “(3) To increase knowledge and understanding
6 of health risk factors for veterans who are members
7 of a racial or ethnic minority group.

8 “(4) To develop mechanisms that support bet-
9 ter health care information dissemination, education,
10 prevention, and services delivery to veterans from
11 disadvantaged backgrounds, including veterans who
12 are members of a racial or ethnic minority group.

13 “(5) To enter into contracts or agreements with
14 appropriate public and nonprofit private entities to
15 develop and carry out programs to provide bilingual
16 or interpretive services to assist veterans who are
17 members of a racial or ethnic minority group and
18 who lack proficiency in speaking the English lan-
19 guage in accessing and receiving health care services
20 through the Veterans Health Administration.

21 “(6) To carry out programs to improve access
22 to health care services through the Veterans Health
23 Administration for veterans with limited proficiency
24 in speaking the English language, including the de-

1 velopment and evaluation of demonstration and pilot
2 projects for that purpose.

3 “(7) To advise the Under Secretary for Health
4 on matters relating to the development, implementa-
5 tion, and evaluation of health professions education
6 in decreasing disparities in health care outcomes be-
7 tween veterans who are members of a racial or eth-
8 nic minority group and other veterans, including cul-
9 tural competency as a method of eliminating such
10 health disparities.

11 “(8) To perform such other functions and du-
12 ties as the Secretary or the Under Secretary for
13 Health considers appropriate.

14 “(d) DEFINITIONS.—In this section:

15 “(1) The term ‘racial or ethnic minority group’
16 means any of the following:

17 “(A) American Indians (including Alaska
18 Natives, Eskimos, and Aleuts).

19 “(B) Asian Americans.

20 “(C) Native Hawaiians and Pacific Island-
21 ers.

22 “(D) Blacks.

23 “(E) Hispanics.

24 “(2) The term ‘Hispanic’ means individuals
25 whose origin is from Mexico, Puerto Rico, Cuba,

1 Central or South America, or any other Spanish-
2 speaking country.”.

3 (b) CLERICAL AMENDMENT.—The table of sections
4 at the beginning of such subchapter is amended by insert-
5 ing after the item relating to section 7308 the following
6 new item:

“7308A. Office of Minority Health.”.

7 **SEC. 4211. STUDY OF DSH PAYMENTS TO ENSURE HOSPITAL**
8 **ACCESS FOR LOW-INCOME PATIENTS.**

9 (a) IN GENERAL.—Not later than January 1, 2023,
10 the Comptroller General of the United States shall con-
11 duct a study on how amendments made by the Patient
12 Protection and Affordable Care Act (Public Law 111–
13 148) and the Health Care and Education Reconciliation
14 Act of 2010 (Public Law 111–152) to titles XVIII and
15 XIX of the Social Security Act (42 U.S.C. 1395 et seq.;
16 42 U.S.C. 1396 et seq.) relating to disproportionate share
17 hospital adjustment payments under Medicare and Med-
18 icaid (and subsequent amendments made with respect to
19 such payments) affect the timely access to health care
20 services for low-income patients. Such study shall—

21 (1) evaluate and examine whether States elect-
22 ing to make medical assistance available under sec-
23 tion 1902(a)(10)(A)(i)(VIII) of the Social Security
24 Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) (including
25 States making such an election through a waiver of

1 the State plan) to individuals described in such sec-
2 tion mitigate the need for payments to dispropor-
3 tionate share hospitals under section 1886(d)(5)(F)
4 of the Social Security Act (42 U.S.C.
5 1395ww(d)(5)(F)) and section 1923 of such Act (42
6 U.S.C. 1396r-4), including the impact of such
7 States electing to make medical assistance available
8 to such individuals on—

9 (A) the number of individuals in the
10 United States who are without health insurance
11 and the distribution of such individuals in rela-
12 tion to areas primarily served by dispropor-
13 tionate share hospitals; and

14 (B) the low-income utilization rate of such
15 hospitals and the resulting fiscal sustainability
16 of such hospitals;

17 (2) evaluate the appropriate level and distribu-
18 tion of such payments among such disproportionate
19 share hospitals for purposes of—

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

23 (B) providing timely access to health care
24 services for individuals in medically underserved
25 areas; and

1 (3) assess, with respect to such disproportionate
2 share hospitals—

3 (A) the role played by such hospitals in
4 providing critical access to emergency, inpa-
5 tient, and outpatient health services, including
6 end-of-life services, as well as the location of
7 such hospitals in relation to medically under-
8 served areas; and

9 (B) the extent to which such hospitals sat-
10 isfy the requirements established for charitable
11 hospital organizations under section 501(r) of
12 the Internal Revenue Code of 1986 with respect
13 to community health needs assessments, finan-
14 cial assistance policy requirements, limitations
15 on charges, and billing and collection require-
16 ments.

17 (b) REPORTS.—

18 (1) REPORT TO CONGRESS.—Not later than
19 180 days after the date on which the study under
20 subsection (a) is completed, the Comptroller General
21 of the United States shall submit to the Committee
22 on Energy and Commerce of the House of Rep-
23 resentatives and the Committee on Finance of the
24 Senate a report that contains—

25 (A) the results of the study;

1 (B) recommendations to Congress for any
2 legislative changes to the payments to dis-
3 proportionate share hospitals under section
4 1886(d)(5)(F) of the Social Security Act (42
5 U.S.C. 1395ww(d)(5)(F)) and section 1923 of
6 such Act (42 U.S.C. 1396r-4) that are needed
7 to ensure access to health services for low-in-
8 come patients that—

9 (i) are based on the number of indi-
10 viduals without health insurance, the
11 amount of uncompensated care provided by
12 such hospitals, and the impact of reduced
13 payment levels on low-income communities;
14 and

15 (ii) takes into account any reports
16 submitted by the Secretary of the Treas-
17 ury, in consultation with the Secretary of
18 Health and Human Services, to congres-
19 sional committees regarding the costs in-
20 curred by charitable hospital organizations
21 for charity care, bad debt, nonreimbursed
22 expenses for services provided to individ-
23 uals under the Medicare program under
24 title XVIII of the Social Security Act and
25 the Medicaid program under title XIX of

1 such Act, and any community benefit ac-
2 tivities provided by such organizations.

3 (2) REPORT TO THE SECRETARY OF HEALTH
4 AND HUMAN SERVICES.—Not later than 180 days
5 after the date on which the study under subsection
6 (a) is completed, the Comptroller General of the
7 United States shall submit to the Secretary of
8 Health and Human Services a report that con-
9 tains—

10 (A) the results of the study; and

11 (B) any recommendations for purposes of
12 assisting in the development of the methodology
13 for the adjustment of payments to dispropor-
14 tionate share hospitals, as required under sec-
15 tion 1886(r) of the Social Security Act (42
16 U.S.C. 1395ww(r)) and the reduction of such
17 payments under section 1923(f)(7) of such Act
18 (42 U.S.C. 1396r–4(f)(7)), taking into account
19 the reports referred to in paragraph (1)(B)(ii).

20 **SEC. 4212. REAUTHORIZATION OF PROGRAMS UNDER THE**
21 **NATIVE HAWAIIAN HEALTH CARE IMPROVE-**
22 **MENT ACT.**

23 (a) NATIVE HAWAIIAN HEALTH CARE SYSTEMS.—
24 Section 6(h)(1) of the Native Hawaiian Health Care Im-
25 provement Act (42 U.S.C. 11705(h)(1)) is amended by

1 striking “may be necessary for fiscal years 1993 through
2 2019” and inserting “are necessary”.

3 (b) ADMINISTRATIVE GRANT FOR PAPA OLA
4 LOKAHI.—Section 7(b) of the Native Hawaiian Health
5 Care Improvement Act (42 U.S.C. 11706(b)) is amended
6 by striking “may be necessary for fiscal years 1993
7 through 2019” and inserting “are necessary”.

8 (c) NATIVE HAWAIIAN HEALTH SCHOLARSHIPS.—
9 Section 10(c) of the Native Hawaiian Health Care Im-
10 provement Act (42 U.S.C. 11709(c)) is amended by strik-
11 ing “may be necessary for fiscal years 1993 through
12 2019” and inserting “are necessary”.

13 **PART 2—RURAL**

14 **SEC. 4221. ESTABLISHMENT OF RURAL COMMUNITY HOS-**
15 **PITAL (RCH) PROGRAM.**

16 (a) IN GENERAL.—Section 1861 of the Social Secu-
17 rity Act (42 U.S.C. 1395x), as amended by section
18 2007(b)(1), is amended by adding at the end of the fol-
19 lowing new subsection:

20 “Rural Community Hospital; Rural Community Hospital
21 Services

22 “(mmm)(1) The term ‘rural community hospital’
23 means a hospital (as defined in subsection (e)) that—

1 “(A) is located in a rural area (as defined in
2 section 1886(d)(2)(D)) or treated as being so lo-
3 cated pursuant to section 1886(d)(8)(E);

4 “(B) subject to paragraph (2), has less than 51
5 acute care inpatient beds, as reported in its most re-
6 cent cost report;

7 “(C) makes available 24-hour emergency care
8 services;

9 “(D) subject to paragraph (3), has a provider
10 agreement in effect with the Secretary and is open
11 to the public as of January 1, 2010; and

12 “(E) applies to the Secretary for such designa-
13 tion.

14 “(2) For purposes of paragraph (1)(B), beds in a
15 psychiatric or rehabilitation unit of the hospital which is
16 a distinct part of the hospital shall not be counted.

17 “(3) Paragraph (1)(D) shall not be construed to pro-
18 hibit any of the following from qualifying as a rural com-
19 munity hospital:

20 “(A) A replacement facility (as defined by the
21 Secretary in regulations in effect on January 1,
22 2012) with the same service area (as defined by the
23 Secretary in regulations in effect on such date).

24 “(B) A facility obtaining a new provider num-
25 ber pursuant to a change of ownership.

1 “(C) A facility which has a binding written
2 agreement with an outside, unrelated party for the
3 construction, reconstruction, lease, rental, or financ-
4 ing of a building as of January 1, 2012.

5 “(4) Nothing in this subsection shall be construed as
6 prohibiting a critical access hospital from qualifying as a
7 rural community hospital if the critical access hospital
8 meets the conditions otherwise applicable to hospitals
9 under subsection (e) and section 1866.

10 “(5) Nothing in this subsection shall be construed as
11 prohibiting a rural community hospital participating in
12 the demonstration program under section 410A of the
13 Medicare Prescription Drug, Improvement, and Mod-
14 ernization Act of 2003 (Public Law 108–173; 117 Stat.
15 2313) from qualifying as a rural community hospital if
16 the rural community hospital meets the conditions other-
17 wise applicable to hospitals under subsection (e) and sec-
18 tion 1866.”.

19 (b) PAYMENT.—

20 (1) INPATIENT HOSPITAL SERVICES.—Section
21 1814 of the Social Security Act (42 U.S.C. 1395f)
22 is amended by adding at the end the following new
23 subsection:

1 “Payment for Inpatient Services Furnished in Rural
2 Community Hospitals

3 “(m) The amount of payment under this part for in-
4 patient hospital services furnished in a rural community
5 hospital, other than such services furnished in a psy-
6 chiatric or rehabilitation unit of the hospital which is a
7 distinct part, is, at the election of the hospital in the appli-
8 cation referred to in section 1861(mmm)(1)(E)—

9 “(1) 101 percent of the reasonable costs of pro-
10 viding such services, without regard to the amount
11 of the customary or other charge, or

12 “(2) the amount of payment provided for under
13 the prospective payment system for inpatient hos-
14 pital services under section 1886(d).”.

15 (2) OUTPATIENT SERVICES.—Section 1834 of
16 the Social Security Act (42 U.S.C. 1395m) is
17 amended by adding at the end the following new
18 subsection:

19 “(z) PAYMENT FOR OUTPATIENT SERVICES FUR-
20 NISHED IN RURAL COMMUNITY HOSPITALS.—The
21 amount of payment under this part for outpatient services
22 furnished in a rural community hospital is, at the election
23 of the hospital in the application referred to in section
24 1861(mmm)(1)(E)—

1 “(1) 101 percent of the reasonable costs of pro-
2 viding such services, without regard to the amount
3 of the customary or other charge and any limitation
4 under section 1861(v)(1)(U), or

5 “(2) the amount of payment provided for under
6 the prospective payment system for covered OPD
7 services under section 1833(t).”.

8 (3) EXEMPTION FROM 30-PERCENT REDUCTION
9 IN REIMBURSEMENT FOR BAD DEBT.—Section
10 1861(v)(1)(T) of the Social Security Act (42 U.S.C.
11 1395x(v)(1)(T)) is amended by inserting “(other
12 than for a rural community hospital)” after “In de-
13 termining such reasonable costs for hospitals”.

14 (c) BENEFICIARY COST-SHARING FOR OUTPATIENT
15 SERVICES.—Section 1834(z) of the Social Security Act (as
16 added by subsection (b)(2)) is amended—

17 (1) by redesignating paragraphs (1) and (2) as
18 subparagraphs (A) and (B), respectively;

19 (2) by inserting “(1)” after “(z)”; and

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

21 “(2) The amounts of beneficiary cost-sharing for out-
22 patient services furnished in a rural community hospital
23 under this part shall be as follows:

24 “(A) For items and services that would have
25 been paid under section 1833(t) if furnished by a

1 hospital, the amount of cost-sharing determined
2 under paragraph (8) of such section.

3 “(B) For items and services that would have
4 been paid under section 1833(h) if furnished by a
5 provider of services or supplier, no cost-sharing shall
6 apply.

7 “(C) For all other items and services, the
8 amount of cost-sharing that would apply to the item
9 or service under the methodology that would be used
10 to determine payment for such item or service if pro-
11 vided by a physician, provider of services, or sup-
12 plier, as the case may be.”.

13 (d) CONFORMING AMENDMENTS.—

14 (1) PART A PAYMENT.—Section 1814(b) of the
15 Social Security Act (42 U.S.C. 1395f(b)) is amended
16 in the matter preceding paragraph (1) by inserting
17 “other than inpatient hospital services furnished by
18 a rural community hospital,” after “critical access
19 hospital services,”.

20 (2) PART B PAYMENT.—Section 1833(a) of the
21 Social Security Act (42 U.S.C. 1395l(a)), as amend-
22 ed by section 207(b)(3), is amended—

23 (A) by striking “and” at the end of para-
24 graph (9);

1 (B) by striking the period at the end of
2 paragraph (10) and inserting “; and”; and

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

4 “(11) in the case of outpatient services fur-
5 nished by a rural community hospital, the amounts
6 described in section 1834(z).”.

7 (3) TECHNICAL AMENDMENTS.—

8 (A) CONSULTATION WITH STATE AGEN-
9 CIES.—Section 1863 of the Social Security Act
10 (42 U.S.C. 1395z) is amended by striking “and
11 (dd)(2)” and inserting “(dd)(2), and
12 (mmm)(1)”.

13 (B) PROVIDER AGREEMENTS.—Section
14 1866(a)(2)(A) of the Social Security Act (42
15 U.S.C. 1395cc(a)(2)(A)) is amended by insert-
16 ing “section 1834(z)(2),” after “section
17 1833(b),”.

18 (e) EFFECTIVE DATE.—The amendments made by
19 this section shall apply to items and services furnished on
20 or after October 1, 2022.

21 **SEC. 4222. RURAL HEALTH QUALITY ADVISORY COMMIS-**
22 **SION AND DEMONSTRATION PROJECTS.**

23 (a) RURAL HEALTH QUALITY ADVISORY COMMIS-
24 SION.—

1 (1) ESTABLISHMENT.—Not later than 6
2 months after the date of the enactment of this sec-
3 tion, the Secretary of Health and Human Services
4 (in this section referred to as the “Secretary”) shall
5 establish a commission to be known as the Rural
6 Health Quality Advisory Commission (in this section
7 referred to as the “Commission”).

8 (2) DUTIES OF COMMISSION.—

9 (A) NATIONAL PLAN.—The Commission
10 shall develop, coordinate, and facilitate imple-
11 mentation of a national plan for rural health
12 quality improvement. The national plan shall—

13 (i) identify objectives for rural health
14 quality improvement;

15 (ii) identify strategies to eliminate
16 known gaps in rural health system capacity
17 and improve rural health quality; and

18 (iii) provide recommendations for
19 Federal programs to identify opportunities
20 for strengthening and aligning policies and
21 programs to improve rural health quality.

22 (B) DEMONSTRATION PROJECTS.—The
23 Commission shall design demonstration projects
24 to recommend to the Secretary to test alter-
25 native models for rural health quality improve-

1 ment, including with respect to both personal
2 and population health.

3 (C) MONITORING.—The Commission shall
4 monitor progress toward the objectives identi-
5 fied pursuant to subparagraph (A)(i).

6 (3) MEMBERSHIP.—

7 (A) NUMBER.—The Commission shall be
8 composed of 11 members appointed by the Sec-
9 retary.

10 (B) SELECTION.—The Secretary shall se-
11 lect the members of the Commission from
12 among individuals with significant rural health
13 care and health care quality expertise, including
14 expertise in clinical health care, health care
15 quality research, end-of-life care, population or
16 public health, or purchaser organizations.

17 (4) CONTRACTING AUTHORITY.—Subject to the
18 availability of funds, the Commission may enter into
19 contracts and make other arrangements, as may be
20 necessary to carry out the duties described in para-
21 graph (2).

22 (5) STAFF.—Upon the request of the Commis-
23 sion, the Secretary may detail, on a reimbursable
24 basis, any of the personnel of the Office of Rural
25 Health Policy of the Health Resources and Services

1 Administration, the Agency for Healthcare Research
2 and Quality, or the Centers for Medicare & Medicaid
3 Services to the Commission to assist in carrying out
4 this subsection.

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

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

13 (B) An assessment of achievement of the
14 objectives identified in the national plan devel-
15 oped under paragraph (2) and recommenda-
16 tions for realizing such objectives.

17 (C) Recommendations on Federal legisla-
18 tion, regulations, or administrative policies to
19 enhance rural health quality and outcomes.

20 (b) RURAL HEALTH QUALITY DEMONSTRATION
21 PROJECTS.—

22 (1) IN GENERAL.—Not later than 270 days
23 after the date of the enactment of this section, the
24 Secretary, in consultation with the Rural Health
25 Quality Advisory Commission, the Office of Rural

1 Health Policy of the Health Resources and Services
2 Administration, the Agency for Healthcare Research
3 and Quality, and the Centers for Medicare & Med-
4 icaid Services, shall make grants to eligible entities
5 for a total of 5 demonstration projects to implement
6 and evaluate methods for improving the quality of
7 health care in rural communities. Each such dem-
8 onstration project shall include—

9 (A) alternative community models that—

10 (i) will achieve greater integration of
11 personal and population health services;
12 and

13 (ii) address safety, effectiveness,
14 patient- or community-centeredness, timeli-
15 ness, efficiency, and equity (the 6 aims
16 identified by the National Academy of
17 Medicine (formerly known as the “Institute
18 of Medicine”) in its report entitled “Cross-
19 ing the Quality Chasm: A New Health Sys-
20 tem for the 21st Century” released on
21 March 1, 2001);

22 (B) innovative approaches to the financing
23 and delivery of health care services to achieve
24 rural health quality and accessibility goals for
25 patients; and

1 (C) development of quality improvement
2 support structures to assist rural health sys-
3 tems and professionals in the provision of
4 health care (such as workforce support struc-
5 tures, quality monitoring and reporting, clinical
6 care protocols, and information technology ap-
7 plications).

8 (2) ELIGIBLE ENTITIES.—In this subsection,
9 the term “eligible entity” means a consortium
10 that—

11 (A) shall include—

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

15 (ii) at least one organization rep-
16 resenting multiple community stakeholders;
17 and

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

20 (3) CONSULTATION.—In developing the pro-
21 gram for awarding grants under this subsection, the
22 Secretary shall consult with the Administrator of the
23 Agency for Healthcare Research and Quality, rural
24 health care providers, rural health care researchers,

1 and private and nonprofit groups (including national
2 associations) which are undertaking similar efforts.

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

5 (A) is authorized under title XVIII or XIX
6 of the Social Security Act (42 U.S.C. 1395 et
7 seq.; 42 U.S.C. 1396 et seq.); and

8 (B) is necessary to carry out a demonstra-
9 tion project under this subsection.

10 (5) DEMONSTRATION PROJECT SITES.—The
11 Secretary shall ensure that the 5 demonstration
12 projects funded under this subsection are conducted
13 at a variety of sites representing the diversity of
14 rural communities in the United States.

15 (6) DURATION.—Each demonstration project
16 under this subsection shall be for a period of 4
17 years.

18 (7) INDEPENDENT EVALUATION.—The Sec-
19 retary shall enter into an arrangement with an enti-
20 ty that has experience working directly with rural
21 health systems for the conduct of an independent
22 evaluation of the program carried out under this
23 subsection.

24 (8) REPORT.—Not later than 1 year after the
25 conclusion of all of the demonstration projects fund-

1 ed under this subsection, the Secretary shall submit
2 a report to the Congress on the results of such
3 projects. The report shall include—

4 (A) an evaluation of patient access to care,
5 patient outcomes, and an analysis of the cost
6 effectiveness of each such project; and

7 (B) recommendations on Federal legisla-
8 tion, regulations, or administrative policies to
9 enhance rural health quality and outcomes.

10 (c) APPROPRIATION.—

11 (1) IN GENERAL.—Out of funds in the Treas-
12 ury not otherwise appropriated, there are appro-
13 priated to the Secretary to carry out this section
14 \$30,000,000 for the period of fiscal years 2023
15 through 2027.

16 (2) AVAILABILITY.—

17 (A) IN GENERAL.—Funds appropriated
18 under paragraph (1) shall remain available for
19 expenditure through fiscal year 2027.

20 (B) REPORT.—For purposes of carrying
21 out subsection (b)(8), funds appropriated under
22 paragraph (1) shall remain available for ex-
23 penditure through fiscal year 2028.

1 (3) RESERVATION.—Of the amount appro-
2 priated under paragraph (1), the Secretary shall re-
3 serve—

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

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

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

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

13 **SEC. 4223. RURAL HEALTH CARE SERVICES.**

14 Section 330A of the Public Health Service Act (42
15 U.S.C. 254c) is amended to read as follows:

16 **“SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH,**
17 **RURAL HEALTH NETWORK DEVELOPMENT,**
18 **DELTA RURAL DISPARITIES AND HEALTH**
19 **SYSTEMS DEVELOPMENT, AND SMALL RURAL**
20 **HEALTH CARE PROVIDER QUALITY IMPROVE-**
21 **MENT GRANT PROGRAMS.**

22 “(a) PURPOSE.—The purpose of this section is to
23 provide for grants—

24 “(1) under subsection (b), to promote rural
25 health care services outreach;

1 “(2) under subsection (c), to provide for the
2 planning and implementation of integrated health
3 care networks in rural areas;

4 “(3) under subsection (d), to assist rural com-
5 munities in the Delta Region to reduce health dis-
6 parities and to promote and enhance health system
7 development; and

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

11 “(b) RURAL HEALTH CARE SERVICES OUTREACH
12 GRANTS.—

13 “(1) GRANTS.—The Director of the Office of
14 Rural Health Policy of the Health Resources and
15 Services Administration (referred to in this section
16 as the ‘Director’) may award grants to eligible enti-
17 ties to promote rural health care services outreach
18 by expanding the delivery of health care services to
19 include new and enhanced services in rural areas.
20 The Director may award the grants for periods of
21 not more than 3 years.

22 “(2) ELIGIBILITY.—To be eligible to receive a
23 grant under this subsection for a project, an enti-
24 ty—

1 “(A) shall be a rural public or rural non-
2 profit private entity, a facility that qualifies as
3 a rural health clinic under title XVIII of the
4 Social Security Act, a public or nonprofit entity
5 existing exclusively to provide services to mi-
6 grant and seasonal farm workers in rural areas,
7 or a Tribal government whose grant-funded ac-
8 tivities will be conducted within federally recog-
9 nized Tribal areas;

10 “(B) shall represent a consortium com-
11 posed of members—

12 “(i) that include 3 or more independ-
13 ently owned health care entities; and

14 “(ii) that may be nonprofit or for-
15 profit entities; and

16 “(C) shall not previously have received a
17 grant under this subsection for the same or a
18 similar project, unless the entity is proposing to
19 expand the scope of the project or the area that
20 will be served through the project.

21 “(3) APPLICATIONS.—To be eligible to receive a
22 grant under this subsection, an eligible entity shall
23 prepare and submit to the Director an application at
24 such time, in such manner, and containing such in-
25 formation as the Director may require, including—

1 “(A) a description of the project that the
2 eligible entity will carry out using the funds
3 provided under the grant;

4 “(B) a description of the manner in which
5 the project funded under the grant will meet
6 the health care needs of rural populations in
7 the local community or region to be served;

8 “(C) a plan for quantifying how health
9 care needs will be met through identification of
10 the target population and benchmarks of service
11 delivery or health status, such as—

12 “(i) quantifiable measurements of
13 health and health care status improvement
14 for projects focusing on health promotion;
15 or

16 “(ii) benchmarks of increased access
17 to primary and end-of-life care, including
18 tracking factors such as the number and
19 type of primary and end-of-life care visits,
20 identification of a medical home, or other
21 general measures of such access;

22 “(D) a description of how the local com-
23 munity or region to be served will be involved
24 in the development and ongoing operations of
25 the project;

1 “(E) a plan for sustaining the project after
2 Federal support for the project has ended;

3 “(F) a description of how the project will
4 be evaluated;

5 “(G) the administrative capacity to submit
6 annual performance data electronically as speci-
7 fied by the Director; and

8 “(H) other such information as the Direc-
9 tor determines to be appropriate.

10 “(c) RURAL HEALTH NETWORK DEVELOPMENT
11 GRANTS.—

12 “(1) GRANTS.—

13 “(A) IN GENERAL.—The Director may
14 award rural health network development grants
15 to eligible entities to promote, through planning
16 and implementation, the development of inte-
17 grated health care networks that have combined
18 the functions of the entities participating in the
19 networks in order to—

20 “(i) achieve efficiencies and economies
21 of scale;

22 “(ii) expand access to, coordinate, and
23 improve the quality of the health care de-
24 livery system through development of orga-
25 nizational efficiencies;

1 “(iii) implement health information
2 technology to achieve efficiencies, reduce
3 medical errors, and improve quality;

4 “(iv) coordinate care and manage
5 chronic and terminal illness; and

6 “(v) strengthen the rural health care
7 system as a whole and across all facets of
8 the health care delivery system, including
9 end-of-life care, in such a manner as to
10 show a quantifiable return on investment
11 to the participants in the network.

12 “(B) GRANT PERIODS.—The Director may
13 award such a rural health network development
14 grant—

15 “(i) for a period of 3 years for imple-
16 mentation activities; or

17 “(ii) for a period of 1 year for plan-
18 ning activities to assist in the initial devel-
19 opment of an integrated health care net-
20 work, if the proposed participants in the
21 network do not have a history of collabo-
22 rative efforts and a 3-year grant would be
23 inappropriate.

24 “(2) ELIGIBILITY.—To be eligible to receive a
25 grant under this subsection, an entity—

1 “(A) shall be a rural public or rural non-
2 profit private entity, a facility that qualifies as
3 a rural health clinic under title XVIII of the
4 Social Security Act, a public or nonprofit entity
5 existing exclusively to provide services to mi-
6 grant and seasonal farm workers in rural areas,
7 or a Tribal government whose grant-funded ac-
8 tivities will be conducted within federally recog-
9 nized Tribal areas;

10 “(B) shall represent a network composed
11 of participants—

12 “(i) that include 3 or more independ-
13 ently owned health care entities; and

14 “(ii) that may be nonprofit or for-
15 profit entities; and

16 “(C) shall not previously have received a
17 grant under this subsection (other than a 1-
18 year grant for planning activities) for the same
19 or a similar project.

20 “(3) APPLICATIONS.—To be eligible to receive a
21 grant under this subsection, an eligible entity, in
22 consultation with the appropriate State office of
23 rural health or another appropriate State entity,
24 shall prepare and submit to the Director an applica-
25 tion at such time, in such manner, and containing

1 such information as the Director may require, in-
2 cluding—

3 “(A) a description of the project that the
4 eligible entity will carry out using the funds
5 provided under the grant;

6 “(B) an explanation of the reasons why
7 Federal assistance is required to carry out the
8 project;

9 “(C) a description of—

10 “(i) the history of collaborative activi-
11 ties carried out by the participants in the
12 network;

13 “(ii) the degree to which the partici-
14 pants are ready to integrate their func-
15 tions; and

16 “(iii) how the local community or re-
17 gion to be served will benefit from and be
18 involved in the activities carried out by the
19 network;

20 “(D) a description of how the local com-
21 munity or region to be served will experience in-
22 creased access to quality health care services
23 across the continuum of care as a result of the
24 integration activities carried out by the net-
25 work, including a description of—

1 “(i) return on investment for the com-
2 munity and the network members; and

3 “(ii) other quantifiable performance
4 measures that show the benefit of the net-
5 work activities;

6 “(E) a plan for sustaining the project after
7 Federal support for the project has ended;

8 “(F) a description of how the project will
9 be evaluated;

10 “(G) the administrative capacity to submit
11 annual performance data electronically as speci-
12 fied by the Director; and

13 “(H) other such information as the Direc-
14 tor determines to be appropriate.

15 “(d) DELTA RURAL DISPARITIES AND HEALTH SYS-
16 TEMS DEVELOPMENT GRANTS.—

17 “(1) GRANTS.—The Director may award grants
18 to eligible entities to support reduction of health dis-
19 parities, improve access to health care, and enhance
20 rural health system development in the Delta Re-
21 gion.

22 “(2) ELIGIBILITY.—To be eligible to receive a
23 grant under this subsection, an entity shall be a
24 rural public or rural nonprofit private entity, a facil-
25 ity that qualifies as a rural health clinic under title

1 XVIII of the Social Security Act, a public or non-
2 profit entity existing exclusively to provide services
3 to migrant and seasonal farm workers in rural
4 areas, or a Tribal government whose grant-funded
5 activities will be conducted within federally recog-
6 nized Tribal areas.

7 “(3) APPLICATIONS.—To be eligible to receive a
8 grant under this subsection, an eligible entity shall
9 prepare and submit to the Director an application at
10 such time, in such manner, and containing such in-
11 formation as the Director may require, including—

12 “(A) a description of the project that the
13 eligible entity will carry out using the funds
14 provided under the grant;

15 “(B) an explanation of the reasons why
16 Federal assistance is required to carry out the
17 project;

18 “(C) a description of the manner in which
19 the project funded under the grant will meet
20 the health care needs of the Delta Region;

21 “(D) a description of how the local com-
22 munity or region to be served will experience in-
23 creased access to quality health care services as
24 a result of the activities carried out by the enti-
25 ty;

1 “(E) a description of how health dispari-
2 ties will be reduced or the health system will be
3 improved;

4 “(F) a plan for sustaining the project after
5 Federal support for the project has ended;

6 “(G) a description of how the project will
7 be evaluated including process and outcome
8 measures related to the quality of care provided
9 or how the health care system improves its per-
10 formance;

11 “(H) a description of how the grantee will
12 develop an advisory group made up of rep-
13 resentatives of the communities to be served to
14 provide guidance to the grantee to best meet
15 community need; and

16 “(I) other such information as the Director
17 determines to be appropriate.

18 “(e) SMALL RURAL HEALTH CARE PROVIDER QUAL-
19 ITY IMPROVEMENT GRANTS.—

20 “(1) GRANTS.—The Director may award grants
21 to provide for the planning and implementation of
22 small rural health care provider quality improvement
23 activities. The Director may award the grants for
24 periods of 1 to 3 years.

1 “(2) ELIGIBILITY.—To be eligible for a grant
2 under this subsection, an entity—

3 “(A) shall be—

4 “(i) a rural public or rural nonprofit
5 private health care provider or provider of
6 health care services, such as a rural health
7 clinic; or

8 “(ii) another rural provider or net-
9 work of small rural providers identified by
10 the Director as a key source of local care;
11 and

12 “(B) shall not previously have received a
13 grant under this subsection for the same or a
14 similar project.

15 “(3) PREFERENCE.—In awarding grants under
16 this subsection, the Director shall give preference to
17 facilities that qualify as rural health clinics under
18 title XVIII of the Social Security Act.

19 “(4) APPLICATIONS.—To be eligible to receive a
20 grant under this subsection, an eligible entity shall
21 prepare and submit to the Director an application at
22 such time, in such manner, and containing such in-
23 formation as the Director may require, including—

1 “(A) a description of the project that the
2 eligible entity will carry out using the funds
3 provided under the grant;

4 “(B) an explanation of the reasons why
5 Federal assistance is required to carry out the
6 project;

7 “(C) a description of the manner in which
8 the project funded under the grant will assure
9 continuous quality improvement in the provision
10 of services by the entity;

11 “(D) a description of how the local com-
12 munity or region to be served will experience in-
13 creased access to quality health care services as
14 a result of the activities carried out by the enti-
15 ty;

16 “(E) a plan for sustaining the project after
17 Federal support for the project has ended;

18 “(F) a description of how the project will
19 be evaluated including process and outcome
20 measures related to the quality of care pro-
21 vided; and

22 “(G) other such information as the Direc-
23 tor determines to be appropriate.

24 “(f) GENERAL REQUIREMENTS.—

1 “(1) PROHIBITED USES OF FUNDS.—An entity
2 that receives a grant under this section may not use
3 funds provided through the grant—

4 “(A) to build or acquire real property; or
5 “(B) for construction.

6 “(2) COORDINATION WITH OTHER AGENCIES.—
7 The Director shall coordinate activities carried out
8 under grant programs described in this section, to
9 the extent practicable, with Federal and State agen-
10 cies and nonprofit organizations that are operating
11 similar grant programs, to maximize the effect of
12 public dollars in funding meritorious proposals.

13 “(g) REPORT.—Not later than September 30, 2024,
14 the Secretary shall prepare and submit to the appropriate
15 committees of Congress a report on the progress and ac-
16 complishments of the grant programs described in sub-
17 sections (b), (c), (d), and (e).

18 “(h) DEFINITION OF DELTA REGION.—In this sec-
19 tion, the term ‘Delta Region’ has the meaning given to
20 the term ‘region’ in section 382A of the Consolidated
21 Farm and Rural Development Act (7 U.S.C. 2009aa).

22 “(i) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to carry out this section
24 such sums as may be necessary for each of fiscal years
25 2024 through 2027.”.

1 **PART 3—INDIAN COMMUNITIES**

2 **SEC. 4231. ASSISTANT SECRETARY OF THE INDIAN HEALTH**
3 **SERVICE.**

4 (a) REFERENCES.—Any reference in a law, regula-
5 tion, document, paper, or other record of the United
6 States to the Director of the Indian Health Service shall
7 be deemed to be a reference to the Assistant Secretary
8 of the Indian Health Service.

9 (b) EXECUTIVE SCHEDULE.—Section 5315 of title 5,
10 United States Code, is amended, in the matter relating
11 to the Assistant Secretaries of Health and Human Serv-
12 ices, by striking “(6)” and inserting “(7), 1 of whom shall
13 be the Assistant Secretary of the Indian Health Service”.

14 (c) CONFORMING AMENDMENT.—Section 5316 of
15 title 5, United States Code, is amended by striking “Direc-
16 tor, Indian Health Service, Department of Health and
17 Human Services.”.

18 **SEC. 4232. EXTENSION OF FULL FEDERAL MEDICAL ASSIST-**
19 **ANCE PERCENTAGE TO INDIAN HEALTH**
20 **CARE PROVIDERS.**

21 Section 1905 of the Social Security Act (42 U.S.C.
22 1396d) is amended—

23 (1) in subsection (a), by amending paragraph
24 (9) to read as follows:

25 “(9) clinic services furnished by or under the
26 direction of a physician, without regard to whether

1 the clinic itself is administered by a physician, in-
2 cluding—

3 “(A) such services furnished outside the
4 clinic by clinic personnel to an eligible indi-
5 vidual who does not reside in a permanent
6 dwelling or does not have a fixed home or mail-
7 ing address; and

8 “(B) such services furnished outside the
9 clinic by any Indian Health Service facility, a
10 health program or facility operated by a tribe or
11 tribal organization under the Indian Self-Deter-
12 mination Act (Public Law 93–638), or an
13 urban Indian organization receiving funds
14 under title V of the Indian Health Care Im-
15 provement Act;” and

16 (2) in subsection (b), by inserting after “Papa
17 Ola Lokahi under section 8 of such Act” the fol-
18 lowing: “; the Federal medical assistance percentage
19 shall also be 100 per centum with respect to
20 amounts expended as medical assistance for services
21 which are received by an Indian Health Service facil-
22 ity, a health program or facility operated by a tribe
23 or tribal organization under the Indian Self-Deter-
24 mination Act (Public Law 93–638), or an urban In-

1 dian organization receiving funds under title V of
2 the Indian Health Care Improvement Act”.

3 **SEC. 4233. CONFERRING WITH URBAN INDIAN ORGANIZA-**
4 **TIONS.**

5 Section 514 of the Indian Health Care Improvement
6 Act (25 U.S.C. 1660d) is amended by striking subsection
7 (b) and inserting the following:

8 “(b) REQUIREMENT.—The Secretary shall ensure
9 that the Service and other agencies and offices of the De-
10 partment and the Department of Veterans Affairs confer,
11 to the maximum extent practicable, with urban Indian or-
12 ganizations in carrying out—

13 “(1) this Act; and

14 “(2) other provisions of law relating to Indian
15 health care.”.

16 **PART 4—PROVIDERS**

17 **SEC. 4241. AVAILABILITY OF NON-ENGLISH LANGUAGE**
18 **SPEAKING PROVIDERS.**

19 (a) IN GENERAL.—Section 1311(c)(1)(B) of the Pa-
20 tient Protection and Affordable Care Act (42 U.S.C.
21 18031(c)(1)(B)) is amended by inserting before the semi-
22 colon the following: “and the ability of such provider to
23 provide care in a language other than English either
24 through the provider speaking such language or by the
25 provider having a qualified interpreter for an individual

1 with limited English proficiency (as defined in section
2 3400 of such Act) who speaks such language available
3 during office hours”.

4 (b) EFFECTIVE DATE.—The amendment made by
5 subsection (a) shall not apply to any plan beginning on
6 or prior to the date that is 1 year after the date of the
7 enactment of this Act.

8 **SEC. 4242. ACCESS TO ESSENTIAL COMMUNITY PROVIDERS.**

9 (a) ESSENTIAL COMMUNITY PROVIDERS.—Section
10 1311(c)(1)(C) of the Patient Protection and Affordable
11 Care Act (42 U.S.C. 18031(c)(1)(C)) is amended—

12 (1) by inserting “(i)” after “(C)”; and

13 (2) by adding at the end the following new
14 clauses:

15 “(ii) not later than January 1, 2023, in-
16 crease the percentage of essential community
17 providers as described in clause (i) included in
18 its network by 10 percent annually (based on
19 the level in the plan for 2016) until 90 percent
20 of all federally qualified health centers and 75
21 percent of all other such essential community
22 providers in the contract service area are in-net-
23 work; and

24 “(iii) include at least one essential commu-
25 nity provider in each of the essential community

1 provider categories described in section
2 156.235(a)(2)(ii)(B) of title 45, Code of Fed-
3 eral Regulations (as in effect on the date of en-
4 actment of the Health Equity and Account-
5 ability Act of 2022), in each county in the serv-
6 ice area, where available;”.

7 (b) REPORTING REQUIREMENTS.—Section
8 1311(e)(3) of the Patient Protection and Affordable Care
9 Act (42 U.S.C. 18031(e)(3)) is amended by adding at the
10 end the following new subparagraph:

11 “(E) DATA ON ESSENTIAL COMMUNITY
12 PROVIDERS.—The Secretary shall require quali-
13 fied health plans to submit annually to the Sec-
14 retary data on the percentage of essential com-
15 munity providers as described in clause (ii) of
16 subsection (c)(1)(C), by county, that contract
17 with each qualified health plan offered in that
18 county and the percentage of such essential
19 community providers, by category as described
20 in clause (iii) of such subsection, that contract
21 with each qualified health plan offered in that
22 county. Such data shall be made available to
23 the general public.”.

24 (c) ESSENTIAL COMMUNITY PROVIDER PROVISIONS
25 APPLIED UNDER MEDICARE AND MEDICAID.—

1 (1) MEDICARE.—Section 1852(d)(1) of the So-
2 cial Security Act (42 U.S.C. 1395w–22(d)(1)) is
3 amended—

4 (A) by striking “and” at the end of sub-
5 paragraph (D);

6 (B) by striking the period at the end of
7 subparagraph (E) and inserting “; and”; and

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

10 “(F) the plan meets the requirements of
11 clauses (ii) and (iii) of section 1311(c)(1)(C) of
12 the Patient Protection and Affordable Care Act
13 (relating to inclusion in networks of essential
14 community providers).”.

15 (2) MEDICAID.—Section 1932(b)(5) of the So-
16 cial Security Act (42 U.S.C. 1396u–2(b)(5)) is
17 amended—

18 (A) by striking “and” at the end of sub-
19 paragraph (A);

20 (B) by striking the period at the end of
21 subparagraph (B) and inserting “; and”; and

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

24 “(C) meets the requirements of clauses (ii)
25 and (iii) of section 1311(c)(1)(C) of the Patient

1 Protection and Affordable Care Act (relating to
2 inclusion in networks of essential community
3 providers) with respect to services offered in the
4 service area involved.”.

5 **SEC. 4243. PROVIDER NETWORK ADEQUACY IN COMMU-**
6 **NITIES OF COLOR.**

7 (a) IN GENERAL.—Section 1311(c)(1)(B) of the Pa-
8 tient Protection and Affordable Care Act (42 U.S.C.
9 18031(c)(1)(B)), as amended by section 4241(a), is fur-
10 ther amended—

11 (1) by inserting “(i)” after “(B)”; and

12 (2) by adding at the end the following new
13 clauses:

14 “(ii) meet such network adequacy stand-
15 ards as the Secretary may establish with regard
16 to—

17 “(I) appointment wait time;

18 “(II) travel time and distance to
19 health care provider facilities and providers
20 by public and private transit;

21 “(III) hours of operation to accommo-
22 date individuals who cannot come to pro-
23 vider appointments during standard busi-
24 ness hours;

1 “(IV) availability of health care op-
2 tions for patients; and

3 “(V) other network adequacy stand-
4 ards to ensure that care through these
5 plans is accessible to diverse communities,
6 including individuals with limited English
7 proficiency as defined in section 3400 of
8 such Act; and

9 “(iii) provide coverage for services for en-
10 rollees through out-of-network providers at no
11 additional cost to the enrollees in cases where
12 in-network providers are unable to comply with
13 the standards established under subclause (III)
14 or (IV) of clause (ii) for such services and the
15 out-of-network providers can deliver such serv-
16 ices in compliance with such standards;”.

17 (b) EFFECTIVE DATE.—The amendments made by
18 subsection (a) shall not apply to plans beginning on or
19 prior to the date that is 1 year after the date of the enact-
20 ment of the Health Equity and Accountability Act of
21 2022.

22 **PART 5—DENTAL**

23 **SEC. 4251. IMPROVING ACCESS TO DENTAL CARE.**

24 (a) REPORTS TO CONGRESS.—

1 (1) GAO REPORTS.—Not later than 1 year
2 after the date of the enactment of this Act, the
3 Comptroller General of the United States shall sub-
4 mit to Congress—

5 (A) a report on the Alaska Dental Health
6 Aide Therapists program and the Dental Ther-
7 apist and Advanced Dental Therapist programs
8 in Minnesota, to assess the effectiveness of den-
9 tal therapists in—

10 (i) improving access to timely dental
11 care among communities of color;

12 (ii) providing high-quality care;

13 (iii) providing culturally competent
14 care; and

15 (iv) providing accessible care to people
16 with disabilities;

17 (B) a report on State variations in the use
18 of dental hygienists and the effectiveness of ex-
19 panding the scope of practice for dental hygien-
20 ists in—

21 (i) improving access to timely dental
22 care among communities of color;

23 (ii) providing high-quality care;

24 (iii) providing culturally competent
25 care; and

1 (iv) providing accessible care to people
2 with disabilities; and

3 (C) a report on the use of telehealth serv-
4 ices to enhance services provided by dental hy-
5 gienists and therapists, including recommenda-
6 tions for any modifications to the Medicare pro-
7 gram under title XVIII of the Social Security
8 Act (42 U.S.C. 1395 et seq.) and the Medicaid
9 program under title XIX of such Act (42
10 U.S.C. 1396 et seq.) to better provide for tele-
11 health consultations in conjunction with thera-
12 pists' and hygienists' care.

13 (2) HRSA REPORT ON DENTAL SHORTAGE
14 AREAS.—Not later than 1 year after the date of the
15 enactment of this Act, the Secretary of Health and
16 Human Services, acting through the Administrator
17 of the Health Resources and Services Administra-
18 tion, shall submit to Congress a report which details
19 geographic dental access shortages and the pre-
20 paredness of dental providers to offer culturally and
21 linguistically appropriate, affordable, accessible, and
22 timely services.

23 (b) EXPANSION OF DENTAL HEALTH AID THERA-
24 PISTS IN TRIBAL AND URBAN INDIAN COMMUNITIES.—

1 Section 119 of the Indian Health Care Improvement Act
2 (25 U.S.C. 1616l) is amended—

3 (1) in subsection (d)—

4 (A) by striking paragraph (2) and insert-
5 ing the following:

6 “(2) REQUIREMENT; EXCLUSION.—Subject to
7 paragraphs (3) and (4), in establishing a national
8 program under paragraph (1), the Secretary—

9 “(A) shall not reduce the amounts pro-
10 vided for the Community Health Aide Program
11 described in subsections (a) and (b);

12 “(B) shall exclude dental health aide thera-
13 pist services from services covered under such
14 Program; and

15 “(C) shall include urban Indian organiza-
16 tions.”; and

17 (B) in paragraph (3), by striking “or tribal
18 organization” each place it appears and insert-
19 ing “, tribal organization, or urban Indian orga-
20 nization”; and

21 (2) in subsection (e), by striking “or a tribal or-
22 ganization” and inserting “a tribal organization, or
23 an urban Indian organization”.

24 (c) COVERAGE OF DENTAL SERVICES UNDER THE
25 MEDICARE PROGRAM.—

1 (1) COVERAGE.—Section 1861(s)(2) of the So-
2 cial Security Act (42 U.S.C. 1395x(s)(2)) is amend-
3 ed—

4 (A) in subparagraph (GG), by striking
5 “and” at the end;

6 (B) in subparagraph (HH), by striking the
7 period at the end and inserting “; and”; and

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

10 “(II) dental and oral health services (as defined
11 in subsection (nnn));”.

12 (2) DENTAL AND ORAL HEALTH SERVICES DE-
13 FINED.—Section 1861 of the Social Security Act (42
14 U.S.C. 1395x),as amended by sections 2007(b) and
15 4221(a), is amended by adding at the end the fol-
16 lowing new subsection:

17 “Dental and Oral Health Services

18 “(nnn)(1) The term ‘ dental and oral health services’
19 means services (as defined by the Secretary) that are nec-
20 essary to prevent disease and promote oral health, restore
21 oral structures to health and function, and treat emer-
22 gency conditions, including—

23 “(A) routine diagnostic and preventive care
24 such as dental cleanings, exams, and x-rays;

1 “(B) basic dental services such as fillings and
2 extractions;

3 “(C) major dental services such as root canals,
4 crowns, and dentures;

5 “(D) emergency dental care; and

6 “(E) other necessary services related to dental
7 and oral health (as defined by the Secretary).

8 “(2) For purposes of paragraph (1), such term shall
9 include mobile and portable oral health services (as de-
10 fined by the Secretary) that—

11 “(A) are provided for the purpose of over-
12 coming mobility, transportation, and access barriers
13 for individuals; and

14 “(B) satisfy the standards and certification re-
15 quirements established under section 1902(a)(82)(B)
16 for the State in which the services are provided.”.

17 (3) PAYMENT AND COINSURANCE.—Section
18 1833(a)(1) of the Social Security Act (42 U.S.C.
19 1395l(a)(1)) is amended—

20 (A) by striking “and” before “(DD)”;

21 (B) by inserting before the semicolon at
22 the end the following: “and (EE) with respect
23 to dental and oral health services (as defined in
24 section 1861(nnn)), the amount paid shall be
25 (i) in the case of such services that are preven-

1 tive, 100 percent of the lesser of the actual
2 charge for the services or the amount deter-
3 mined under the payment basis determined
4 under section 1848, and (ii) in the case of all
5 other such services, 80 percent of the lesser of
6 the actual charge for the services or the amount
7 determined under the payment basis determined
8 under section 1848”.

9 (4) PAYMENT UNDER PHYSICIAN FEE SCHED-
10 ULE.—Section 1848(j)(3) of the Social Security Act
11 (42 U.S.C. 1395w-4(j)(3)) is amended by inserting
12 “, (2)(II),” after “(including administration of the
13 health risk assessment)”.

14 (5) DENTURES.—Section 1861(s)(8) of the So-
15 cial Security Act (42 U.S.C. 1395x(s)(8)) is amend-
16 ed—

17 (A) by striking “(other than dental)” and
18 inserting “(including dentures)”; and

19 (B) by striking “internal body”.

20 (6) REPEAL OF GROUND FOR EXCLUSION.—
21 Section 1862(a) of the Social Security Act (42
22 U.S.C. 1395y) is amended by striking paragraph
23 (12).

1 (7) EFFECTIVE DATE.—The amendments made
2 by this section shall apply to services furnished on
3 or after January 1, 2023.

4 (d) REQUIRING COVERAGE OF DENTAL SERVICES
5 FOR UNDER THE MEDICAID PROGRAM.—

6 (1) MANDATORY COVERAGE.—

7 (A) IN GENERAL.—

8 (i) REQUIREMENT.—Section
9 1902(a)(10)(A) of the Social Security Act
10 (42 U.S.C. 1396a(a)(10)(A)) is amended
11 by inserting “, (10)” after “(5)”.

12 (ii) EFFECTIVE DATE.—The amend-
13 ment made by clause (i) shall apply with
14 respect to medical assistance furnished in
15 calendar quarters beginning on or after the
16 date that is 1 year after the date of the en-
17 actment of this Act.

18 (B) BENCHMARK COVERAGE.—Section
19 1937(b)(5) of the Social Security Act (42
20 U.S.C. 1396u–7(b)(5)) is amended by striking
21 the period and inserting , and, beginning with
22 the first quarter beginning on or after the date
23 of the enactment of the Health Equity and Ac-
24 countability Act of 2022, coverage of dental and

1 oral health services (as defined in section
2 1905(kk)).

3 (2) DEFINITION OF SERVICES.—Section 1905
4 of the Social Security Act (42 U.S.C. 1396d), as
5 amended by section 4107, is further amended—

6 (A) in subsection (a)(10), by striking “den-
7 tal services” and inserting “dental and oral
8 health services (as defined in subsection
9 (kk)(1))”; and

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

12 “(kk) DENTAL AND ORAL HEALTH SERVICES.—(1)
13 For purposes of this title, the term ‘dental and oral health
14 services’ means services necessary to prevent disease and
15 promote oral health, restore oral structures to health and
16 function, reduce oral pain, and treat emergency oral condi-
17 tions. Such term includes the services specified in para-
18 graph (2).

19 “(2) For purposes of paragraph (1), the services
20 specified in this paragraph are the following:

21 “(A) Routine diagnostic and preventive care
22 (such as dental cleanings, exams, and x-rays).

23 “(B) Basic dental services (such as fillings and
24 extractions) and major dental services (such as root
25 canals, crowns, and dentures).

1 “(C) Emergency dental care.

2 “(D) Temporomandibular (TMD) and orofacial
3 pain disorder treatment.

4 “(E) Other necessary services related to dental
5 and oral health (as specified by the Secretary).”.

6 “(3) For purposes of paragraph (1), such term shall
7 not include dental care or services provided to individuals
8 under the age of 21 under subsection (r)(3).”.

9 (3) CONFORMING AMENDMENTS.—

10 (A) STATE PLAN REQUIREMENTS.—Section
11 1902(a) of the Social Security Act (42 U.S.C.
12 1396a(a)) is amended—

13 (i) in paragraph (10)(A), in the mat-
14 ter preceding clause (i), by inserting
15 “(10),” after “(5),”;

16 (ii) in paragraph (86), by striking
17 “and” at the end;

18 (iii) in paragraph (87), by striking the
19 period at the end and inserting “; and”;
20 and

21 (iv) by inserting after paragraph (87)
22 the following:

23 “(88) provide for—

24 “(A) informing, in writing, all individuals
25 who have been determined to be eligible for

1 medical assistance of the availability of dental
2 and oral health services (as defined in section
3 1905(kk));

4 “(B) conducting targeted outreach to preg-
5 nant women who have been determined to be el-
6 igible for medical assistance about the avail-
7 ability of medical assistance for such dental
8 services and the importance of receiving dental
9 care while pregnant; and

10 “(C) establishing and maintaining stand-
11 ards for and certification of mobile and portable
12 oral health services (as described in section
13 1905(r)(3)(C)).”.

14 (B) DEFINITION OF MEDICAL ASSIST-
15 ANCE.—Section 1905(a)(12) of the Social Secu-
16 rity Act (42 U.S.C. 1396d(a)(12)) is amended
17 by striking “, dentures,”.

18 (4) MOBILE AND PORTABLE ORAL HEALTH
19 SERVICES UNDER EPSDT.—Section 1905(r)(3) of the
20 Social Security Act (42 U.S.C. 1396d(r)(3)) is
21 amended—

22 (A) in subparagraph (A)(ii), by striking “;
23 and” and inserting a semicolon;

24 (B) in subparagraph (B), by striking the
25 period at the end and inserting “; and”; and

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

3 “(C) which shall include mobile and port-
4 able oral health services (as defined by the Sec-
5 retary) that—

6 “(i) are provided for the purpose of
7 overcoming mobility, transportation, or ac-
8 cess barriers for children; and

9 “(ii) satisfy the standards and certifi-
10 cation requirements established under sec-
11 tion 1902(a)(88)(C) for the State in which
12 the services are provided.”.

13 (5) ENHANCED FMAP; MAINTENANCE OF EF-
14 FORT.—

15 (A) MEDICAID.—Section 1905 of the So-
16 cial Security Act (42 U.S.C. 1396d), as amend-
17 ed by paragraph (2), is further amended—

18 (i) in subsection (b), by striking “and

19 (ii)” and inserting “(ii), and (ll)”; and

20 (ii) by adding at the end of the fol-
21 lowing new subsection:

22 “(ll) INCREASED FMAP FOR EXPENDITURES FOR
23 DENTAL AND ORAL HEALTH SERVICES.—

24 “(1) IN GENERAL.—The Federal medical assist-
25 ance percentage with respect to amounts expended

1 by such State for medical assistance consisting of
2 dental and oral health services (as defined in sub-
3 section (kk)) furnished during the first calendar
4 quarter beginning on or after the date that is 1 year
5 after the date of the enactment of this subsection or
6 during any subsequent quarter) to individuals 21
7 years of age or older shall be equal to, in the case
8 of such services furnished—

9 “(A) during the 3-year period beginning on
10 the first day of such first calendar year, 100
11 percent;

12 “(B) during the 1-year period immediately
13 following the period described in subparagraph
14 (A), 95 percent;

15 “(C) during each subsequent 1-year period
16 (through the third such subsequent period), the
17 percentage specified under this paragraph for
18 the preceding 1-year period, reduced by 5 per-
19 centage points; and

20 “(D) during any quarter beginning after
21 the 7-year period beginning on the first day de-
22 scribed in subparagraph (A), 80 percent.

23 “(2) NO REDUCTION IN FMAP.—Paragraph (1)
24 shall not apply with respect to amounts expended by
25 a State if the Federal medical assistance percentage

1 otherwise applicable to such amounts without appli-
2 cation of such paragraph would be higher than such
3 percentage available to such amounts with applica-
4 tion of such paragraph.”.

5 (6) EXCLUSION OF AMOUNTS ATTRIBUTABLE
6 TO INCREASED FMAP FROM TERRITORIAL CAPS.—
7 Section 1108 of the Social Security Act (42 U.S.C.
8 1308), as amended by section 4101(a), is amend-
9 ed—

10 (A) in subsection (f), in the matter pre-
11 ceding paragraph (1), by striking “subsections
12 (g), (h), and (i)”; and

13 (B) by adding at the end the following:

14 “(j) EXCLUSION FROM CAPS OF AMOUNTS ATTRIB-
15 UTABLE TO INCREASED FMAP FOR COVERAGE OF DEN-
16 TAL AND ORAL SERVICES.—Any payment made to a terri-
17 tory for expenditures for medical assistance that are sub-
18 ject to an increase the Federal medical assistance percent-
19 age applicable to such expenditures under section 1905(l)
20 shall not be taken into account for purposes of applying
21 payment limits under subsections (f) and (g) to the extent
22 that such payment exceeds the amount of the payment
23 that would have been made to the territory for such ex-
24 penditures without regard to such section.”.

1 (e) ORAL HEALTH SERVICES AS AN ESSENTIAL
2 HEALTH BENEFIT.—Section 1302(b) of the Patient Pro-
3 tection and Affordable Care Act (42 U.S.C. 18022(b)), as
4 amended by section 2013(a), is further amended—

5 (1) in paragraph (1)—

6 (A) in subparagraph (J), by striking “oral
7 and”; and

8 (B) by adding at the end the following:

9 “(L) Oral health services for children and
10 adults.”; and

11 (2) by adding at the end the following:

12 “(6) ORAL HEALTH SERVICES.—For purposes
13 of paragraph (1)(K), the term ‘oral health services’
14 means services (as defined by the Secretary) that
15 are necessary to prevent any oral disease and pro-
16 mote oral health, restore oral structures to health
17 and function, and treat emergency oral conditions.”.

18 (f) DEMONSTRATION PROGRAM ON TRAINING AND
19 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
20 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
21 VETERANS IN RURAL AND OTHER UNDERSERVED COM-
22 MUNITIES.—

23 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

24 The Secretary of Veterans Affairs may carry out a
25 demonstration program to establish programs to

1 train and employ alternative dental health care pro-
2 viders in order to increase access to dental health
3 care services for veterans who are entitled to such
4 services from the Department of Veterans Affairs
5 and reside in rural and other underserved commu-
6 nities.

7 (2) TELEHEALTH.—For purposes of alternative
8 dental health care providers and other dental care
9 providers who are licensed to provide clinical care,
10 dental services provided under the demonstration
11 program under this subsection may be administered
12 by such providers through telehealth-enabled collabo-
13 ration and supervision when appropriate and fea-
14 sible.

15 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
16 VIDERS DEFINED.—In this subsection, the term “al-
17 ternative dental health care providers” has the
18 meaning given that term in section 340G–1(a)(2) of
19 the Public Health Service Act (42 U.S.C. 256g–
20 1(a)(2)).

21 (4) AUTHORIZATION OF APPROPRIATIONS.—
22 There are authorized to be appropriated such sums
23 as are necessary to carry out the demonstration pro-
24 gram under this subsection.

1 (g) DEMONSTRATION PROGRAM ON TRAINING AND
2 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
3 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
4 MEMBERS OF THE ARMED FORCES AND DEPENDENTS
5 LACKING READY ACCESS TO SUCH SERVICES.—

6 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

7 The Secretary of Defense may carry out a dem-
8 onstration program to establish programs to train
9 and employ alternative dental health care providers
10 in order to increase access to dental health care
11 services for members of the Armed Forces and their
12 dependents who lack ready access to such services,
13 including the following:

14 (A) Members and dependents who reside in
15 rural areas or areas otherwise underserved by
16 dental health care providers.

17 (B) Members of a reserve component of
18 the Armed Forces in active status who are po-
19 tentially deployable.

20 (2) TELEHEALTH.—For purposes of alternative
21 dental health care providers and other dental care
22 providers who are licensed to provide clinical care,
23 dental services provided under the demonstration
24 program under this subsection may be administered
25 by such providers through telehealth-enabled collabo-

1 ration and supervision when appropriate and fea-
2 sible.

3 (3) DEFINITIONS.—In this subsection:

4 (A) ACTIVE STATUS.—The term “active
5 status” has the meaning given that term in sec-
6 tion 101(d) of title 10, United States Code.

7 (B) ALTERNATIVE DENTAL HEALTH CARE
8 PROVIDERS.—The term “alternative dental
9 health care providers” has the meaning given
10 that term in section 340G–1(a)(2) of the Public
11 Health Service Act (42 U.S.C. 256g–1(a)(2)).

12 (4) AUTHORIZATION OF APPROPRIATIONS.—
13 There are authorized to be appropriated such sums
14 as are necessary to carry out the demonstration pro-
15 gram under this subsection.

16 (h) DEMONSTRATION PROGRAM ON TRAINING AND
17 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
18 PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR
19 PRISONERS WITHIN THE CUSTODY OF THE BUREAU OF
20 PRISONS.—

21 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

22 The Attorney General, acting through the Director
23 of the Bureau of Prisons, may carry out a dem-
24 onstration program to establish programs to train
25 and employ alternative dental health care providers

1 in order to increase access to dental health services
2 for prisoners within the custody of the Bureau of
3 Prisons.

4 (2) TELEHEALTH.—For purposes of alternative
5 dental health care providers and other dental care
6 providers who are licensed to provide clinical care,
7 dental services provided under the demonstration
8 program under this subsection may be administered
9 by such providers through telehealth-enabled collabo-
10 ration and supervision when appropriate and fea-
11 sible.

12 (3) ALTERNATIVE DENTAL HEALTH CARE PRO-
13 VIDERS DEFINED.—In this subsection, the term “al-
14 ternative dental health care providers” has the
15 meaning given that term in section 340G–1(a)(2) of
16 the Public Health Service Act (42 U.S.C. 256g–
17 1(a)(2)).

18 (4) AUTHORIZATION OF APPROPRIATIONS.—
19 There are authorized to be appropriated such sums
20 as are necessary to carry out the demonstration pro-
21 gram under this subsection.

22 (i) DEMONSTRATION PROGRAM ON TRAINING AND
23 EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE
24 PROVIDERS FOR DENTAL HEALTH CARE SERVICES
25 UNDER THE INDIAN HEALTH SERVICE.—

1 (1) DEMONSTRATION PROGRAM AUTHORIZED.—

2 The Secretary of Health and Human Services, act-
3 ing through the Indian Health Service, may carry
4 out a demonstration program to establish programs
5 to train and employ alternative dental health care
6 providers in order to help eliminate oral health dis-
7 parities and increase access to dental services
8 through health programs operated by the Indian
9 Health Service, Indian tribes, tribal organizations,
10 and Urban Indian organizations.

11 (2) TELEHEALTH.—For purposes of alternative
12 dental health care providers and other dental care
13 providers who are licensed to provide clinical care,
14 dental services provided under the demonstration
15 program under this subsection may be administered
16 by such providers through telehealth-enabled collabo-
17 ration and supervision when appropriate and fea-
18 sible.

19 (3) DEFINITIONS.—In this subsection:

20 (A) ALTERNATIVE DENTAL HEALTH CARE
21 PROVIDERS DEFINED.—The term “alternative
22 dental health care providers” has the meaning
23 given that term in section 340G–1(a)(2) of the
24 Public Health Service Act (42 U.S.C. 256g–
25 1(a)(2)).

1 (B) INDIAN HEALTH CARE IMPROVEMENT
2 ACT.—The terms “Indian tribe”, “tribal organi-
3 zation”, and “Urban Indian organization” have
4 the meaning given the terms in section 4 of the
5 Indian Health Care Improvement Act (25
6 U.S.C. 1603).

7 (4) AUTHORIZATION OF APPROPRIATIONS.—
8 There are authorized to be appropriated such sums
9 as are necessary to carry out the demonstration pro-
10 gram under this subsection.

11 **SEC. 4252. ORAL HEALTH LITERACY AND AWARENESS CAM-**
12 **PAIGN.**

13 The Public Health Service Act is amended by insert-
14 ing after section 340G–1 of such Act (42 U.S.C. 256g–
15 1) the following:

16 **“SEC. 340G–2. ORAL HEALTH LITERACY AND AWARENESS.**

17 “(a) CAMPAIGN.—The Secretary, acting through the
18 Administrator of the Health Resources and Services Ad-
19 ministration, shall establish a public education campaign
20 (referred to in this subsection as the ‘campaign’) across
21 all relevant programs of the Health Resources and Serv-
22 ices Administration (including the health center program,
23 oral health workforce programs, maternal and child health
24 programs, the Ryan White HIV/AIDS Program, and rural

1 health programs) to increase oral health literacy and
2 awareness.

3 “(b) STRATEGIES.—In carrying out the campaign,
4 the Secretary shall identify oral health literacy and aware-
5 ness strategies that are evidence-based and focused on oral
6 health care education, including education on prevention
7 of oral disease such as early childhood and other caries,
8 periodontal disease, and oral cancer.

9 “(c) FOCUS.—The Secretary shall design the cam-
10 paign to communicate directly with specific populations,
11 including children, pregnant women, parents, the elderly,
12 individuals with disabilities, and ethnic and racial minority
13 populations, including Indians, Alaska Natives, and Na-
14 tive Hawaiians, in a culturally and linguistically appro-
15 priate manner.

16 “(d) OUTCOMES.—In carrying out the campaign, the
17 Secretary shall include a process for measuring outcomes
18 and effectiveness.

19 “(e) REPORT TO CONGRESS.—Not later than 3 years
20 after the date of enactment of this section, the Secretary
21 shall submit to the Committee on Energy and Commerce
22 of the House of Representatives and the Committee on
23 Health, Education, Labor, and Pensions of the Senate a
24 report on the outcomes and effectiveness of the campaign.

1 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
2 carry out this section, there is authorized to be appro-
3 priated \$750,000 for each of fiscal years 2023 through
4 2027.”.

5 **Subtitle D—Advancing Health Eq-**
6 **uity Through Payment and De-**
7 **livery Reform**

8 **SEC. 4301. SENSE OF CONGRESS.**

9 It is the sense of Congress that—

10 (1) the sustainability of the health care system
11 in the United States hinges on restructuring how
12 health care is paid for, shifting away from paying
13 for the volume of services provided to the value the
14 services provide;

15 (2) high value care is care that provides higher
16 quality care more efficiently, achieving greater
17 health improvement and better health outcomes at
18 lower cost (per patient and overall);

19 (3) a high value health care system must deliver
20 timely, accessible, well-coordinated, high-quality, cul-
21 turally centered, and language-appropriate care to
22 everyone;

23 (4) eliminating health and health care dispari-
24 ties and achieving health equity must be central to

1 and required in efforts to achieve a high value health
2 care system;

3 (5) eliminating such disparities and achieving
4 such equity will require tailored interventions and
5 targeted investments to address inequities in health
6 and health care to make sure that health care deliv-
7 ery and payment efforts are responsive to and inclu-
8 sive of the needs of communities of color and other
9 communities experiencing disparities; and

10 (6) new models of value-based payment and
11 care delivery should prioritize primary care and con-
12 sider the holistic needs of and other factors with re-
13 spect to the patient population, including with re-
14 spect to behavioral health, oral health, end-of-life
15 care, history of adverse childhood experiences and
16 adverse community environments, social deter-
17 minants of health, social risk factors, unmet social
18 needs, and the burden of intergenerational racial
19 and other inequities.

20 **SEC. 4302. CENTERS FOR MEDICARE & MEDICAID SERVICES**

21 **REPORTING AND VALUE BASED PROGRAMS.**

22 (a) ADVANCING HEALTH EQUITY IN REPORTING AND
23 VALUE BASED PAYMENT PROGRAMS.—

24 (1) IN GENERAL.—The Administrator of the
25 Centers for Medicare & Medicaid Services (in this

1 section referred to as the “Administrator”) shall re-
2 quire that a clinician or other professional partici-
3 pating in any pay-for-reporting or value based pay-
4 ment program stratify clinical quality measures by
5 disparity variables, including race, ethnicity, sex, pri-
6 mary language, disability status, sexual orientation,
7 gender identity, and socioeconomic status. A clini-
8 cian or other professional may use existing demo-
9 graphic data collection fields in certified electronic
10 health record technology (as defined in section
11 1848(o)(4) of the Social Security Act (42 U.S.C.
12 1395w-4(o)(4))) to carry out such data stratifica-
13 tion under the preceding sentence. Such stratified
14 data will assist clinicians and other professionals in
15 the identification of disparities obscured in aggre-
16 gated data and assist with the provision of interven-
17 tions that target reducing those disparities.

18 (2) CLINICIAN.—In assessing performance in
19 any value-based payment program, the Adminis-
20 trator shall incorporate a clinician or other profes-
21 sional’s performance in reducing disparities across
22 race, ethnicity, sex, primary language, disability sta-
23 tus, sexual orientation, gender identity, and socio-
24 economic status. Linking performance payments to
25 the reduction of health care disparities across such

1 variables will assist in holding clinicians and other
2 professionals accountable for providing quality care
3 that can lead to decreased health inequities.

4 (3) REQUIREMENT OF ADOPTION OF CERT.—All
5 entities, clinicians, or other professionals partici-
6 pating in the Quality Payment Program of the Cen-
7 ters for Medicare & Medicaid Services shall be re-
8 quired to adopt 2015 certified electronic health
9 record technology (as so defined) as a condition of
10 participating in such program.

11 (b) QUALITY IMPROVEMENT ACTIVITIES.—The Ad-
12 ministrator, upon yearly review of the Quality Payment
13 Program, shall add quality improvement activities that im-
14 plement the Culturally and Linguistically Accessible
15 Standards (CLAS) as Improvement Activities under the
16 Quality Payment Program.

17 **SEC. 4303. DEVELOPMENT AND TESTING OF DISPARITY RE-**
18 **DUCING DELIVERY AND PAYMENT MODELS.**

19 (a) IN GENERAL.—The Center for Medicare and
20 Medicaid Innovation established under section 1115A of
21 the Social Security Act (42 U.S.C. 1315a) (in this section
22 referred to as the “CMI”) shall establish a dedicated fund
23 to identify, test, evaluate, and scale delivery and payment
24 models under the applicable titles (as defined in subsection
25 (a)(4)(B) of such section) that target health disparities

1 among racial and ethnic minorities, including models that
2 support high-value nonmedical services that address so-
3 cially determined barriers to health in all stages of the
4 life cycle through end-of-life, including English proficiency
5 status, low health and health care literacy, lack of access
6 to health care planning, including end-of-life care plan-
7 ning, case management, transportation, enrollment assist-
8 ance needs, stable and affordable housing, utility assist-
9 ance, employment and career development, and nutrition
10 and food security which will help to reduce disparities and
11 impact the overall cost of care.

12 (b) AMENDMENT TO SOCIAL SECURITY ACT.—The
13 second sentence of section 1115A(a)(1) of the Social Secu-
14 rity Act (42 U.S.C. 1315a(a)(1)) is amended by inserting
15 “and improve health equity” after “expenditures”.

16 (c) PILOT PROGRAMS.—The CMI shall prioritize the
17 testing of models under such section 1115A that include
18 partnerships with entities, including community based or-
19 ganizations or other nonprofit entities, to help address so-
20 cially determined barriers to health and health care.

21 (d) ALTERNATIVES.—Any model tested by the CMI
22 under such 1115A shall include measures to assess and
23 track the impact of the model on health disparities, using
24 existing measures such as the Healthcare Disparities and
25 Cultural Competency Measures endorsed by the entity

1 with a contract under section 1890(a) of the Social Secu-
2 rity Act (42 U.S.C. 1395aaa(a)), and stratified by race,
3 ethnicity, English proficiency, gender identity, sexual ori-
4 entation, and disability status.

5 **SEC. 4304. DIVERSITY IN CENTERS FOR MEDICARE AND**
6 **MEDICAID CONSULTATION.**

7 (a) IN GENERAL.—In carrying out the duties under
8 this section, the CMI shall consult representatives of rel-
9 evant Federal agencies, and clinical and analytical experts
10 with expertise in medicine and health care management,
11 specifically such experts with expertise in—

12 (1) the health care needs of minority, rural, and
13 underserved populations; and

14 (2) the financial needs of safety net, community
15 based, rural, and critical access providers, including
16 federally qualified health centers.

17 (b) OPEN DOOR FORUMS.—The CMI shall use open
18 door forums or other mechanisms to seek external feed-
19 back from interested parties and incorporate that feedback
20 into the development of models.

21 **SEC. 4305. SUPPORTING SAFETY NET AND COMMUNITY-**
22 **BASED PROVIDERS TO COMPETE IN VALUE-**
23 **BASED PAYMENT SYSTEMS.**

24 (a) IN GENERAL.—Any pay-for-performance or alter-
25 native payment model that is developed and tested by the

1 Center for Medicare and Medicaid Innovation established
2 under section 1115A of the Social Security Act (42 U.S.C.
3 1315a), or any other agency of the Department of Health
4 and Human Services with respect to the programs under
5 titles XVIII, XIX, or XXI of such Act, shall be assessed
6 for potential impact on safety net, community based, and
7 critical access providers, including Federally qualified
8 health centers.

9 (b) NEW MODELS.—The rollout of any such models
10 shall include training and additional up front resources for
11 community based and safety net providers to enable those
12 providers to participate in the model.

13 **Subtitle E—Health Empowerment** 14 **Zones**

15 **SEC. 4401. DESIGNATION OF HEALTH EMPOWERMENT** 16 **ZONES.**

17 (a) IN GENERAL.—The Secretary may, at the request
18 of an eligible community partnership described in sub-
19 section (b)(1), designate an eligible area described in sub-
20 section (b)(2) as a health empowerment zone for the pur-
21 pose of eligibility for a grant under section 4402.

22 (b) ELIGIBILITY CRITERIA.—

23 (1) ELIGIBLE COMMUNITY PARTNERSHIP.—A
24 community partnership is eligible to submit a re-
25 quest under this section if the partnership—

1 (A) demonstrates widespread public sup-
2 port from key individuals and entities in the eli-
3 gible area, including members of the target
4 community, State and local governments, non-
5 profit organizations including national and re-
6 gional intermediaries with demonstrated capac-
7 ity to serve low-income urban communities, and
8 community and industry leaders, for designa-
9 tion of the eligible area as a health empower-
10 ment zone; and

11 (B) includes representatives of—

12 (i) a broad cross section of stake-
13 holders and residents from communities in
14 the eligible area experiencing dispropor-
15 tionate disparities in health status and
16 health care; and

17 (ii) organizations, facilities, and insti-
18 tutions that have a history of working
19 within and serving such communities.

20 (2) ELIGIBLE AREA.—An area is eligible to be
21 designated as a health empowerment zone under this
22 section if one or more communities in the area expe-
23 rience disproportionate disparities in health status
24 and health care. In determining whether a commu-
25 nity experiences such disparities, the Secretary shall

1 consider data collected by the Department of Health
2 and Human Services focusing on the following areas:

3 (A) Access to affordable, high-quality
4 health care services.

5 (B) The prevalence of disproportionate
6 rates of certain illnesses or diseases including
7 the following:

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

11 (ii) Cancer.

12 (iii) Chronic kidney disease.

13 (iv) Diabetes.

14 (v) Injury (intentional and uninten-
15 tional).

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

18 (vii) Maternal and paternal illnesses
19 and diseases.

20 (viii) Infant mortality.

21 (ix) Mental illness and other disabil-
22 ities.

23 (x) Substance use disorder treatment
24 and prevention, including underage drink-
25 ing.

1 (xi) Nutrition, obesity, and overweight
2 conditions.

3 (xii) Heart disease.

4 (xiii) Hypertension.

5 (xiv) Cerebrovascular disease or
6 stroke.

7 (xv) Tuberculosis.

8 (xvi) HIV/AIDS and other sexually
9 transmitted infections.

10 (xvii) Viral hepatitis.

11 (xviii) Asthma.

12 (xix) Tooth decay and other oral
13 health issues.

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

19 (i) Poverty.

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

22 (iii) Income.

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

25 (v) Work and work environment.

1 (vi) Environmental conditions in the
2 community, including with respect to clean
3 water, clean air, and the presence or ab-
4 sence of pollutants.

5 (vii) Language and English pro-
6 ficiency.

7 (viii) Access to affordable healthy
8 food.

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

12 (x) Access to culturally and linguis-
13 tically competent health and human serv-
14 ices and health and human service pro-
15 viders.

16 (xi) Health-supporting infrastructure.

17 (xii) Health insurance that is ade-
18 quate and affordable.

19 (xiii) Race, racism, and bigotry (con-
20 scious and unconscious).

21 (xiv) Sexual orientation.

22 (xv) Health and health care literacy.

23 (xvi) Place of residence (such as
24 urban areas, rural areas, and reservations
25 of Indian Tribes).

1 (xvii) Stress.

2 (c) PROCEDURE.—

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

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

8 (B) demonstrate that the partnership sub-
9 mitting the request is an eligible community
10 partnership described in subsection (b)(1);

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

13 (D) include a comprehensive assessment of
14 disparities in health status and health care ex-
15 perience by one or more communities in the
16 area;

17 (E) set forth—

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

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

1 (F) include a strategic plan and an action
2 plan for achieving the goals described in sub-
3 paragraph (E)(ii).

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

9 (d) MINIMUM NUMBER.—The Secretary—

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

12 (2) of such zones designated under paragraph
13 (1), shall designate at least one health empowerment
14 zone in each of the several States, the District of
15 Columbia, and each territory or possession of the
16 United States.

17 **SEC. 4402. ASSISTANCE TO THOSE SEEKING DESIGNATION.**

18 At the request of any organization or entity seeking
19 to submit a request under section 4401(a), the Secretary
20 shall provide technical assistance, and may award a grant,
21 to assist such organization or entity—

22 (1) to form an eligible community partnership
23 described in section 4401(b)(1);

1 (2) to complete a health assessment, including
2 an assessment of health disparities under section
3 4401(c)(1)(D); or

4 (3) to prepare and submit a request, including
5 a strategic plan, in accordance with section 4401.

6 **SEC. 4403. BENEFITS OF DESIGNATION.**

7 (a) **PRIORITY.**—In awarding a grant under sub-
8 section (b), a Federal official shall give priority to any ap-
9 plicant that—

10 (1) meets the eligibility criteria for the grant;

11 (2) proposes to use the grant for activities in a
12 health empowerment zone; and

13 (3) demonstrates that such activities will di-
14 rectly and significantly further the goals of the stra-
15 tegic plan approved for such zone under section
16 4401.

17 (b) **GRANTS FOR INITIAL IMPLEMENTATION OF**
18 **STRATEGIC PLAN.**—

19 (1) **IN GENERAL.**—Upon designating an eligible
20 area as a health empowerment zone at the request
21 of an eligible community partnership, the Secretary
22 shall, subject to the availability of appropriations,
23 make a grant to the community partnership for im-
24 plementation of the strategic plan for such zone.

1 (2) GRANT PERIOD.—A grant under paragraph
2 (1) for a health empowerment zone shall be for a pe-
3 riod of 2 years and may be renewed, except that the
4 total period of grants under paragraph (1) for such
5 zone may not exceed 10 years.

6 (3) LIMITATION.—In awarding grants under
7 this subsection, the Secretary shall not give less pri-
8 ority to an applicant or reduce the amount of a
9 grant because the Secretary rendered technical as-
10 sistance or made a grant to the same applicant
11 under section 4401.

12 (4) REPORTING.—The Secretary shall establish
13 metrics for measuring the progress of grantees
14 under this subsection and, based on such metrics,
15 require each such grantee to report to the Secretary
16 not less than every 6 months on the progress in im-
17 plementing the strategic plan for the health em-
18 powerment zone.

19 **SEC. 4404. DEFINITION OF SECRETARY.**

20 In this subtitle, the term “Secretary” means the Sec-
21 retary of Health and Human Services, acting through the
22 Administrator of the Health Resources and Services Ad-
23 ministration and the Deputy Assistant Secretary for Mi-
24 nority Health, and in cooperation with the Director of the
25 Office of Community Services and the Director of the Na-

1 tional Institute on Minority Health and Health Dispari-
2 ties.

3 **SEC. 4405. AUTHORIZATION OF APPROPRIATIONS.**

4 To carry out this subtitle, there is authorized to be
5 appropriated \$100,000,000 for fiscal year 2023.

6 **Subtitle F—Equitable Health Care**
7 **For All**

8 **SEC. 4501. FINDINGS.**

9 Congress finds the following:

10 (1) In 1966, Dr. Martin Luther King, Jr., said
11 “Of all the forms of inequality, injustice in health
12 care is the most shocking and inhuman because it
13 often results in physical death.”.

14 (2) Inequity in health care remains a persistent
15 and devastating reality for many communities, and,
16 in particular, communities of color.

17 (3) The provision of inequitable health care has
18 complex causes, many stemming from systemic in-
19 equality in access to health care, housing, nutrition,
20 economic opportunity, education, and other factors.

21 (4) Health care outcomes for Black commu-
22 nities in particular lag far behind those of the popu-
23 lation as a whole.

24 (5) Dr. Anthony Fauci, Director of the Na-
25 tional Institute of Allergy and Infectious Diseases,

1 said on April 7, 2020, the coronavirus outbreak is
2 “shining a bright light” on “unacceptable” health
3 disparities in the Black community.

4 (6) A contributing factor in health disparities is
5 explicit and implicit bias in the delivery of health
6 care, resulting in inferior care and poorer outcomes
7 for some patients on the basis of factors that include
8 race, national origin, sex (including sexual orienta-
9 tion or gender identity), disability, age, and religion.

10 (7) The National Academy of Medicine (for-
11 merly known as the “Institute of Medicine”) issued
12 a report in 2002 titled “Unequal Treatment”, find-
13 ing that racial and ethnic minorities receive lower-
14 quality health care than Whites do, even when insur-
15 ance status, income, age, and severity of condition is
16 comparable.

17 (8) Just as Congress has sought to eliminate
18 bias, both explicit and implicit, in employment, hous-
19 ing, and other parts of our society, the elimination
20 of bias and the legacy of structural racism in health
21 care is of paramount importance.

22 **SEC. 4502. DATA COLLECTION AND REPORTING.**

23 (a) REQUIRED REPORTING.—

24 (1) IN GENERAL.—The Secretary of Health and
25 Human Services, in consultation with the Director

1 for Civil Rights and Health Equity, the Director of
2 the National Institutes of Health, the Administrator
3 of the Centers for Medicare & Medicaid Services, the
4 Director of the Agency for Healthcare Research and
5 Quality, the Deputy Assistant Secretary for Minority
6 Health, and the Director of the Centers for Disease
7 Control and Prevention, shall by regulation require
8 all health care providers and facilities that are re-
9 quired under other provisions of law to report data
10 on specific health outcomes to the Department of
11 Health and Human Services in aggregate form, to
12 disaggregate such data by demographic characteris-
13 tics, including by race, national origin, sex (including
14 sexual orientation and gender identity), disability,
15 and age, as well as any other factor that the Sec-
16 retary of Health and Human Services determines
17 would be useful for determining a pattern of provi-
18 sion of inequitable health care.

19 (2) PROPOSED REGULATIONS.—Not later than
20 90 days after the date of enactment of this Act, the
21 Secretary of Health and Human Services shall issue
22 proposed regulations to carry out paragraph (1).

23 (b) REPOSITORY.—The Secretary of Health and
24 Human Services shall—

1 (1) not later than 1 year after the date of en-
2 actment of this Act, establish a repository of the
3 disaggregated data reported pursuant to subsection
4 (a);

5 (2) subject to paragraph (3), make the data in
6 such repository publicly available; and

7 (3) ensure that such repository does not contain
8 any data that is individually identifiable.

9 **SEC. 4503. REQUIRING EQUITABLE HEALTH CARE IN THE**
10 **HOSPITAL VALUE-BASED PURCHASING PRO-**
11 **GRAM.**

12 (a) EQUITABLE HEALTH CARE AS VALUE MEASURE-
13 MENT.—Section 1886(b)(3)(B)(viii) of the Social Security
14 Act (42 U.S.C. 1395ww(b)(3)(B)(viii)) is amended by
15 adding at the end the following new subclause:

16 “(XIII)(aa) Effective for payments beginning with
17 fiscal year 2024, in expanding the number of measures
18 under subclause (III), the Secretary shall adopt measures
19 that relate to equitable health care furnished by hospitals
20 in inpatient settings.

21 “(bb) In carrying out this subclause, the Secretary
22 shall solicit input and recommendations from individuals
23 and groups representing communities of color and other
24 protected classes and ensure measures adopted pursuant
25 to this subclause account for social determinants of health,

1 as defined in section 4506(e)(10) of the Health Equity
2 and Accountability Act of 2022.

3 “(cc) For purposes of this subclause, the term ‘equi-
4 table health care’ refers to the principle that high-quality
5 care should be provided to all individuals and health care
6 treatment and services should not vary on account of the
7 real or perceived race, national origin, sex (including sex-
8 ual orientation and gender identity), disability, or age of
9 an individual, as well as any other factor that the Sec-
10 retary determines would be useful for determining a pat-
11 tern of provision of inequitable health care.”.

12 (b) INCLUSION OF EQUITABLE HEALTH CARE MEAS-
13 URES.—Section 1886(o)(2)(B) of the Social Security Act
14 (42 U.S.C. 1395ww(o)(2)(B)) is amended by adding at the
15 end the following new clause:

16 “(iv) INCLUSION OF EQUITABLE
17 HEALTH CARE MEASURES.—Beginning in
18 fiscal year 2024, measures selected under
19 subparagraph (A) shall include the equi-
20 table health care measures described in
21 subsection (b)(3)(B)(viii)(XIII).”.

1 **SEC. 4504. PROVISION OF INEQUITABLE HEALTH CARE AS A**
2 **BASIS FOR PERMISSIVE EXCLUSION FROM**
3 **MEDICARE AND STATE HEALTH CARE PRO-**
4 **GRAMS.**

5 Section 1128(b) of the Social Security Act (42 U.S.C.
6 1320a–7(b)) is amended by adding at the end the fol-
7 lowing new paragraph:

8 “(18) PROVISION OF INEQUITABLE HEALTH
9 CARE.—

10 “(A) IN GENERAL.—Subject to subpara-
11 graph (B), any health care provider that the
12 Secretary determines has engaged in a pattern
13 of providing inequitable health care (as defined
14 in section 4506(e)(7) of the Health Equity and
15 Accountability Act of 2022) on the basis of
16 race, national origin, sex (including sexual ori-
17 entation and gender identity), disability, or age
18 of an individual.

19 “(B) EXCEPTION.—For purposes of car-
20 rying out subparagraph (A), the Secretary shall
21 not exclude any health care provider from par-
22 ticipation in the Medicare program under title
23 XVIII of the Social Security Act or the Med-
24 icaid program under title XIX of such Act if
25 the exclusion of such health care provider would
26 result in increased difficulty in access to health

1 care services for underserved or low-income
2 communities.”.

3 **SEC. 4505. OFFICE FOR CIVIL RIGHTS AND HEALTH EQUITY**
4 **OF THE DEPARTMENT OF HEALTH AND**
5 **HUMAN SERVICES.**

6 (a) NAME OF OFFICE.—Beginning on the date of en-
7 actment of this Act, the Office for Civil Rights of the De-
8 partment of Health and Human Services shall be known
9 as the “Office for Civil Rights and Health Equity” of the
10 Department of Health and Human Services. Any ref-
11 erence to the Office for Civil Rights of the Department
12 of Health and Human Services in any law, regulation,
13 map, document, record, or other paper of the United
14 States shall be deemed to be a reference to the Office for
15 Civil Rights and Health Equity.

16 (b) HEAD OF OFFICE.—The head of the Office for
17 Civil Rights and Health Equity shall be the Director for
18 Civil Rights and Health Equity, to be appointed by the
19 President. Any reference to the Director of the Office for
20 Civil Rights of the Department of Health and Human
21 Services in any law, regulation, map, document, record,
22 or other paper of the United States shall be deemed to
23 be a reference to the Director for Civil Rights and Health
24 Equity.

1 **SEC. 4506. PROHIBITING DISCRIMINATION IN HEALTH**
2 **CARE.**

3 (a) PROHIBITING DISCRIMINATION.—

4 (1) IN GENERAL.—No health care provider
5 may, on the basis, in whole or in part, of race, sex
6 (including sexual orientation and gender identity),
7 disability, age, or religion, subject an individual to
8 the provision of inequitable health care.

9 (2) NOTICE OF PATIENT RIGHTS.—The Sec-
10 retary shall provide to each patient a notice of a pa-
11 tient's rights under this section.

12 (b) ADMINISTRATIVE COMPLAINT AND CONCILIATION
13 PROCESS.—

14 (1) COMPLAINTS AND ANSWERS.—

15 (A) IN GENERAL.—An aggrieved person
16 may, not later than 1 year after an alleged vio-
17 lation of subsection (a) has occurred or con-
18 cluded, file a complaint with the Director alleg-
19 ing provision of inequitable health care by a
20 provider described in subsection (a).

21 (B) COMPLAINT.—A complaint submitted
22 pursuant to subparagraph (A) shall be in writ-
23 ing and shall contain such information and be
24 in such form as the Director requires.

25 (C) OATH OR AFFIRMATION.—The com-
26 plaint and any answer made under this sub-

1 section shall be made under oath or affirmation,
2 and may be reasonably and fairly modified at
3 any time.

4 (2) RESPONSE TO COMPLAINTS.—

5 (A) IN GENERAL.—Upon the filing of a
6 complaint under this subsection, the following
7 procedures shall apply:

8 (i) COMPLAINANT NOTICE.—The Di-
9 rector shall serve notice upon the com-
10 plainant acknowledging receipt of such fil-
11 ing and advising the complainant of the
12 time limits and procedures provided under
13 this section.

14 (ii) RESPONDENT NOTICE.—The Di-
15 rector shall, not later than 30 days after
16 receipt of such filing—

17 (I) serve on the respondent a no-
18 tice of the complaint, together with a
19 copy of the original complaint; and

20 (II) advise the respondent of the
21 procedural rights and obligations of
22 respondents under this section.

23 (iii) ANSWER.—The respondent may
24 file, not later than 60 days after receipt of

1 the notice from the Director, an answer to
2 such complaint.

3 (iv) INVESTIGATIVE DUTIES.—The Di-
4 rector shall—

5 (I) make an investigation of the
6 alleged provision of inequitable health
7 care; and

8 (II) complete such investigation
9 within 180 days (unless it is impracti-
10 cable to complete such investigation
11 within 180 days) after the filing of
12 the complaint.

13 (B) INVESTIGATIONS.—

14 (i) PATTERN OR PRACTICE.—In the
15 course of investigating the complaint, the
16 Director may seek records of care provided
17 to patients other than the complainant if
18 necessary to demonstrate or disprove an
19 allegation of provision of inequitable health
20 care or to determine whether there is a
21 pattern or practice of such care.

22 (ii) ACCOUNTING FOR SOCIAL DETER-
23 MINANTS OF HEALTH.—In investigating
24 the complaint and reaching a determina-
25 tion on the validity of the complaint, the

1 Director shall account for social deter-
2 minants of health and the effect of such
3 social determinants on health care out-
4 comes.

5 (iii) INABILITY TO COMPLETE INVES-
6 TIGATION.—If the Director is unable to
7 complete (or finds it is impracticable to
8 complete) the investigation within 180
9 days after the filing of the complaint (or,
10 if the Secretary takes further action under
11 paragraph (6)(B) with respect to a com-
12 plaint, within 180 days after the com-
13 mencement of such further action), the Di-
14 rector shall notify the complainant and re-
15 spondent in writing of the reasons in-
16 volved.

17 (iv) REPORT TO STATE LICENSING
18 AUTHORITIES.—On concluding each inves-
19 tigation under this subparagraph, the Di-
20 rector shall provide to the appropriate
21 State licensing authorities information
22 specifying the results of the investigation.

23 (C) REPORT.—

24 (i) FINAL REPORT.—On completing
25 each investigation under this paragraph,

1 the Director shall prepare a final investiga-
2 tive report.

3 (ii) MODIFICATION OF REPORT.—A
4 final report under this subparagraph may
5 be modified if additional evidence is later
6 discovered.

7 (3) CONCILIATION.—

8 (A) IN GENERAL.—During the period be-
9 ginning on the date on which a complaint is
10 filed under this subsection and ending on the
11 date of final disposition of such complaint (in-
12 cluding during an investigation under para-
13 graph (2)(B)), the Director shall, to the extent
14 feasible, engage in conciliation with respect to
15 such complaint.

16 (B) CONCILIATION AGREEMENT.—A con-
17 ciliation agreement arising out of such concilia-
18 tion shall be an agreement between the re-
19 spondent and the complainant, and shall be
20 subject to approval by the Director.

21 (C) RIGHTS PROTECTED.—The Director
22 shall approve a conciliation agreement only if
23 the agreement protects the rights of the com-
24 plainant and other persons similarly situated.

25 (D) PUBLICLY AVAILABLE AGREEMENT.—

1 (i) IN GENERAL.—Subject to clause
2 (ii), the Secretary shall make available to
3 the public a copy of a conciliation agree-
4 ment entered into pursuant to this sub-
5 section unless the complainant and re-
6 spondent otherwise agree, and the Sec-
7 retary determines, that disclosure is not re-
8 quired to further the purposes of this sub-
9 section.

10 (ii) LIMITATION.—A conciliation
11 agreement that is made available to the
12 public pursuant to clause (i) may not dis-
13 close individually identifiable health infor-
14 mation.

15 (4) FAILURE TO COMPLY WITH CONCILIATION
16 AGREEMENT.—Whenever the Director has reason-
17 able cause to believe that a respondent has breached
18 a conciliation agreement, the Director shall refer the
19 matter to the Attorney General to consider filing a
20 civil action to enforce such agreement.

21 (5) WRITTEN CONSENT FOR DISCLOSURE OF
22 INFORMATION.—Nothing said or done in the course
23 of conciliation under this subsection may be made
24 public, or used as evidence in a subsequent pro-

1 ceeding under this subsection, without the written
2 consent of the parties to the conciliation.

3 (6) PROMPT JUDICIAL ACTION.—

4 (A) IN GENERAL.—If the Director deter-
5 mines at any time following the filing of a com-
6 plaint under this subsection that prompt judi-
7 cial action is necessary to carry out the pur-
8 poses of this subsection, the Director may rec-
9 ommend that the Attorney General promptly
10 commence a civil action under subsection (d).

11 (B) IMMEDIATE SUIT.—If the Director de-
12 termines at any time following the filing of a
13 complaint under this subsection that the public
14 interest would be served by allowing the com-
15 plainant to bring a civil action under subsection
16 (c) in a State or Federal court immediately, the
17 Director shall certify that the administrative
18 process has concluded and that the complainant
19 may file such a suit immediately.

20 (7) ANNUAL REPORT.—Not later than 1 year
21 after the date of enactment of this Act, and annually
22 thereafter, the Director shall make publicly available
23 a report detailing the activities of the Office for Civil
24 Rights and Health Equity under this subsection, in-
25 cluding—

1 (A) the number of complaints filed and the
2 basis on which the complaints were filed;

3 (B) the number of investigations under-
4 taken as a result of such complaints; and

5 (C) the disposition of all such investiga-
6 tions.

7 (c) ENFORCEMENT BY PRIVATE PERSONS.—

8 (1) IN GENERAL.—

9 (A) CIVIL ACTION.—

10 (i) IN SUIT.—A complainant under
11 subsection (b) may commence a civil action
12 to obtain appropriate relief with respect to
13 an alleged violation of subsection (a), or
14 for breach of a conciliation agreement
15 under subsection (b), in an appropriate
16 district court of the United States or State
17 court—

18 (I) not sooner than the earliest
19 of—

20 (aa) the date a conciliation
21 agreement is reached under sub-
22 section (b);

23 (bb) the date of a final dis-
24 position of a complaint under
25 subsection (b); or

1 (cc) 180 days after the first
2 day of the alleged violation; and
3 (II) not later than 2 years after
4 the final day of the alleged violation.

5 (ii) STATUTE OF LIMITATIONS.—The
6 computation of such 2-year period shall
7 not include any time during which an ad-
8 ministrative proceeding (including inves-
9 tigation or conciliation) under subsection
10 (b) was pending with respect to a com-
11 plaint under such subsection.

12 (B) BARRING SUIT.—If the Director has
13 obtained a conciliation agreement under sub-
14 section (b) regarding an alleged violation of
15 subsection (a), no action may be filed under
16 this paragraph by the complainant involved
17 with respect to the alleged violation except for
18 the purpose of enforcing the terms of such an
19 agreement.

20 (2) RELIEF WHICH MAY BE GRANTED.—

21 (A) IN GENERAL.—In a civil action under
22 paragraph (1), if the court finds that a viola-
23 tion of subsection (a) or breach of a conciliation
24 agreement has occurred, the court may award
25 to the plaintiff actual and punitive damages,

1 and may grant as relief, as the court deter-
2 mines to be appropriate, any permanent or tem-
3 porary injunction, temporary restraining order,
4 or other order (including an order enjoining the
5 defendant from engaging in a practice violating
6 subsection (a) or ordering such affirmative ac-
7 tion as may be appropriate).

8 (B) FEES AND COSTS.—In a civil action
9 under paragraph (1), the court, in its discre-
10 tion, may allow the prevailing party, other than
11 the United States, a reasonable attorney's fee
12 and costs. The United States shall be liable for
13 such fees and costs to the same extent as a pri-
14 vate person.

15 (3) INTERVENTION BY ATTORNEY GENERAL.—
16 Upon timely application, the Attorney General may
17 intervene in a civil action under paragraph (1), if
18 the Attorney General certifies that the case is of
19 general public importance.

20 (d) ENFORCEMENT BY THE ATTORNEY GENERAL.—

21 (1) COMMENCEMENT OF ACTIONS.—

22 (A) PATTERN OR PRACTICE CASES.—The
23 Attorney General may commence a civil action
24 in any appropriate district court of the United
25 States if the Attorney General has reasonable

1 cause to believe that any health care provider
2 covered by subsection (a)—

3 (i) is engaged in a pattern or practice
4 that violates such subsection; or

5 (ii) is engaged in a violation of such
6 subsection that raises an issue of signifi-
7 cant public importance.

8 (B) CASES BY REFERRAL.—The Director
9 may determine, based on a pattern of com-
10 plaints, a pattern of violations, a review of data
11 reported by a health care provider covered by
12 subsection (a), or any other means, that there
13 is reasonable cause to believe a health care pro-
14 vider is engaged in a pattern or practice that
15 violates subsection (a). If the Director makes
16 such a determination, the Director shall refer
17 the related findings to the Attorney General. If
18 the Attorney General finds that such reasonable
19 cause exists, the Attorney General may com-
20 mence a civil action in any appropriate district
21 court of the United States.

22 (2) ENFORCEMENT OF SUBPOENAS.—The At-
23 torney General, on behalf of the Director, or another
24 party at whose request a subpoena is issued under
25 this subsection, may enforce such subpoena in ap-

1 appropriate proceedings in the district court of the
2 United States for the district in which the person to
3 whom the subpoena was addressed resides, was
4 served, or transacts business.

5 (3) RELIEF WHICH MAY BE GRANTED IN CIVIL
6 ACTIONS.—

7 (A) IN GENERAL.—In a civil action under
8 paragraph (1), the court—

(i) may award such preventive relief, including a permanent or temporary injunction, temporary restraining order, or other order against the person responsible for a violation of subsection (a) as is necessary to assure the full enjoyment of the rights granted by this subsection;

(ii) may award such other relief as the court determines to be appropriate, including monetary damages, to aggrieved persons; and

(iii) may, to vindicate the public interest, assess punitive damages against the respondent—

(I) in an amount not exceeding
\$500,000, for a first violation; and

1 (II) in an amount not exceeding
2 \$1,000,000, for any subsequent viola-
3 tion.

4 (B) FEES AND COSTS.—In a civil action
5 under this subsection, the court, in its discre-
6 tion, may allow the prevailing party, other than
7 the United States, a reasonable attorney’s fee
8 and costs. The United States shall be liable for
9 such fees and costs to the extent provided by
10 section 2412 of title 28, United States Code.

11 (4) INTERVENTION IN CIVIL ACTIONS.—Upon
12 timely application, any person may intervene in a
13 civil action commenced by the Attorney General
14 under paragraphs (1) and (2) if the action involves
15 an alleged violation of subsection (a) with respect to
16 which such person is an aggrieved person (including
17 a person who is a complainant under subsection (b))
18 or a conciliation agreement to which such person is
19 a party.

20 (e) DEFINITIONS.—In this section:

21 (1) AGGRIEVED PERSON.—The term “aggrieved
22 person” means—

23 (A) a person who believes that the person
24 was or will be injured in violation of subsection
25 (a); or

1 (B) the personal representative or estate of
2 a deceased person who was injured in violation
3 of subsection (a).

4 (2) DIRECTOR.—The term “Director” means
5 the Director for Civil Rights and Health Equity of
6 the Department of Health and Human Services.

7 (3) DISABILITY.—The term “disability” has the
8 meaning given such term in section 3 of the Ameri-
9 cans with Disabilities Act of 1990 (42 U.S.C.
10 12102).

11 (4) CONCILIATION.—The term “conciliation”
12 means the attempted resolution of issues raised by
13 a complaint, or by the investigation of such com-
14 plaint, through informal negotiations involving the
15 complainant, the respondent, and the Secretary.

16 (5) CONCILIATION AGREEMENT.—The term
17 “conciliation agreement” means a written agreement
18 setting forth the resolution of the issues in concilia-
19 tion.

20 (6) INDIVIDUALLY IDENTIFIABLE HEALTH IN-
21 FORMATION.—The term “individually identifiable
22 health information” means any information, includ-
23 ing demographic information collected from an indi-
24 vidual—

1 (A) that is created or received by a health
2 care provider covered by subsection (a), health
3 plan, employer, or health care clearinghouse;

4 (B) that relates to the past, present, or fu-
5 ture physical or mental health or condition of,
6 the provision of health care to, or the past,
7 present, or future payment for the provision of
8 health care to, the individual; and

9 (C)(i) that identifies the individual; or

10 (ii) with respect to which there is a reason-
11 able basis to believe that the information can be
12 used to identify the individual.

13 (7) PROVISION OF INEQUITABLE HEALTH
14 CARE.—The term “provision of inequitable health
15 care” means the provision of any health care service,
16 by a health care provider in a manner that—

17 (A) fails to meet a high-quality care stand-
18 ard, meaning the health care provider fails to—

19 (i) avoid harm to patients as a result
20 of the health services that are intended to
21 help the patient;

22 (ii) provide health services based on
23 scientific knowledge to all and to all pa-
24 tients who benefit;

1 (iii) refrain from providing services to
2 patients not likely to benefit;

3 (iv) provide care that is responsive to
4 patient preferences, needs, and values; and

5 (v) avoids waits or delays in care; and

6 (B) is discriminatory in intent or effect
7 based at least in part on a basis specified in
8 subsection (a).

9 (8) RESPONDENT.—The term “respondent”
10 means the person or other entity accused in a com-
11 plaint of a violation of subsection (a).

12 (9) SECRETARY.—The term “Secretary” means
13 the Secretary of Health and Human Services.

14 (10) SOCIAL DETERMINANTS OF HEALTH.—The
15 term “social determinants of health” means condi-
16 tions in the environments in which individuals live,
17 work, attend school, and worship, that affect a wide
18 range of health, functioning, and quality-of-life out-
19 comes and risks.

20 (f) RULE OF CONSTRUCTION.—Nothing in this sec-
21 tion shall be construed as repealing or limiting the effect
22 of title VI of the Civil Rights Act of 1964 (42 U.S.C.
23 2000d et seq.), section 1557 of the Patient Protection and
24 Affordable Care Act (42 U.S.C. 18116), section 504 of

1 the Rehabilitation Act of 1973 (29 U.S.C. 794), or the
2 Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.).

3 **SEC. 4507. FEDERAL HEALTH EQUITY COMMISSION.**

4 (a) ESTABLISHMENT OF COMMISSION.—

5 (1) IN GENERAL.—There is established the
6 Federal Health Equity Commission (in this section
7 referred to as the “Commission”).

8 (2) MEMBERSHIP.—

9 (A) IN GENERAL.—The Commission shall
10 be composed of—

11 (i) 8 voting members appointed under
12 subparagraph (B); and

13 (ii) the nonvoting, ex officio members
14 listed in subparagraph (C).

15 (B) VOTING MEMBERS.—Not more than 4
16 of the members described in subparagraph
17 (A)(i) shall at any one time be of the same po-
18 litical party. Such members shall have recog-
19 nized expertise in and personal experience with
20 racial and ethnic health inequities, health care
21 needs of vulnerable and marginalized popu-
22 lations, and health equity as a vehicle for im-
23 proving health status and health outcomes.
24 Such members shall be appointed to the Com-
25 mission as follows:

1 (i) 4 members of the Commission
2 shall be appointed by the President.

3 (ii) 2 members of the Commission
4 shall be appointed by the President pro
5 tempore of the Senate, upon the rec-
6 ommendations of the majority leader and
7 the minority leader of the Senate. Each
8 member appointed to the Commission
9 under this clause shall be appointed from
10 a different political party.

11 (iii) 2 members of the Commission
12 shall be appointed by the Speaker of the
13 House of Representatives upon the rec-
14 ommendations of the majority leader and
15 the minority leader of the House of Rep-
16 resentatives. Each member appointed to
17 the Commission under this clause shall be
18 appointed from a different political party.

19 (C) EX OFFICIO MEMBER.—The Commis-
20 sion shall have the following nonvoting, ex offi-
21 cio members:

22 (i) The Director for Civil Rights and
23 Health Equity of the Department of
24 Health and Human Services.

1 (ii) The Deputy Assistant Secretary
2 for Minority Health of the Department of
3 Health and Human Services.

4 (iii) The Director of the National In-
5 stitute on Minority Health and Health Dis-
6 parities.

7 (iv) The Chairperson of the Advisory
8 Committee on Minority Health established
9 under section 1707(c) of the Public Health
10 Service Act (42 U.S.C. 300u-6(c)).

11 (3) TERMS.—The term of office of each mem-
12 ber appointed under paragraph (2)(B) of the Com-
13 mission shall be 6 years.

14 (4) CHAIRPERSON; VICE CHAIRPERSON.—

15 (A) CHAIRPERSON.—The President shall,
16 with the concurrence of a majority of the mem-
17 bers of the Commission appointed under para-
18 graph (2)(B), designate a Chairperson from
19 among the members of the Commission ap-
20 pointed under such paragraph.

21 (B) VICE CHAIRPERSON.—

22 (i) DESIGNATION.—The Speaker of
23 the House of Representatives shall, in con-
24 sultation with the majority leaders and the
25 minority leaders of the Senate and the

1 House of Representatives and with the
2 concurrence of a majority of the members
3 of the Commission appointed under para-
4 graph (2)(B), designate a Vice Chairperson
5 from among the members of the Commis-
6 sion appointed under such paragraph. The
7 Vice Chairperson may not be a member of
8 the same political party as the Chair-
9 person.

10 (ii) DUTY.—The Vice Chairperson
11 shall act in place of the Chairperson in the
12 absence of the Chairperson.

13 (5) REMOVAL OF MEMBERS.—The President
14 may remove a member of the Commission only for
15 neglect of duty or malfeasance in office.

16 (6) QUORUM.—A majority of members of the
17 Commission appointed under paragraph (2)(B) shall
18 constitute a quorum of the Commission, but a lesser
19 number of members may hold hearings.

20 (b) DUTIES OF THE COMMISSION.—

21 (1) IN GENERAL.—The Commission shall—

22 (A) monitor and report on the implementa-
23 tion of this Act; and

1 (B) investigate, monitor, and report on
2 progress towards health equity and the elimi-
3 nation of health disparities.

4 (2) ANNUAL REPORT.—The Commission
5 shall—

6 (A) submit to the President and Congress
7 at least one report annually on health equity
8 and health disparities; and

9 (B) include in such report—

10 (i) a description of actions taken by
11 the Department of Health and Human
12 Services and any other Federal agency re-
13 lated to health equity or health disparities;
14 and

15 (ii) recommendations on ensuring eq-
16 uitable health care and eliminating health
17 disparities.

18 (c) POWERS.—

19 (1) HEARINGS.—

20 (A) IN GENERAL.—The Commission or, at
21 the direction of the Commission, any sub-
22 committee or member of the Commission, may,
23 for the purpose of carrying out this section, as
24 the Commission or the subcommittee or mem-
25 ber considers advisable—

1 (i) hold such hearings, meet and act
2 at such times and places, take such testi-
3 mony, receive such evidence, and admin-
4 ister such oaths; and

5 (ii) require, by subpoena or otherwise,
6 the attendance and testimony of such wit-
7 nesses and the production of such books,
8 records, correspondence, memoranda, pa-
9 pers, documents, tapes, and materials.

10 (B) LIMITATION ON HEARINGS.—The
11 Commission may hold a hearing under subpara-
12 graph (A)(i) only if the hearing is approved—

13 (i) by a majority of the members of
14 the Commission appointed under sub-
15 section (a)(2)(B); or

16 (ii) by a majority of such members
17 present at a meeting when a quorum is
18 present.

19 (2) ISSUANCE AND ENFORCEMENT OF SUB-
20 POENAS.—

21 (A) ISSUANCE.—A subpoena issued under
22 paragraph (1) shall—

23 (i) bear the signature of the Chair-
24 person of the Commission; and

1 (ii) be served by any person or class
2 of persons designated by the Chairperson
3 for that purpose.

4 (B) ENFORCEMENT.—In the case of contu-
5 macy or failure to obey a subpoena issued
6 under paragraph (1), the United States district
7 court for the district in which the subpoenaed
8 person resides, is served, or may be found may
9 issue an order requiring the person to appear at
10 any designated place to testify or to produce
11 documentary or other evidence.

12 (C) NONCOMPLIANCE.—Any failure to
13 obey the order of the court may be punished by
14 the court as a contempt of court.

15 (3) WITNESS ALLOWANCES AND FEES.—

16 (A) IN GENERAL.—Section 1821 of title
17 28, United States Code, shall apply to a witness
18 requested or subpoenaed to appear at a hearing
19 of the Commission.

20 (B) EXPENSES.—The per diem and mile-
21 age allowances for a witness shall be paid from
22 funds available to pay the expenses of the Com-
23 mission.

24 (4) POSTAL SERVICES.—The Commission may
25 use the United States mails in the same manner and

1 under the same conditions as other agencies of the
2 Federal Government.

3 (5) GIFTS.—The Commission may accept, use,
4 and dispose of gifts or donations of services or prop-
5 erty.

6 (d) ADMINISTRATIVE PROVISIONS.—

7 (1) STAFF.—

8 (A) DIRECTOR.—There shall be a full-time
9 staff director for the Commission who shall—

10 (i) serve as the administrative head of
11 the Commission; and

12 (ii) be appointed by the Chairperson
13 with the concurrence of the Vice Chair-
14 person.

15 (B) OTHER PERSONNEL.—The Commis-
16 sion may—

17 (i) appoint such other personnel as it
18 considers advisable, subject to the provi-
19 sions of title 5, United States Code, gov-
20 erning appointments in the competitive
21 service, and the provisions of chapter 51
22 and subchapter III of chapter 53 of that
23 title relating to classification and General
24 Schedule pay rates; and

1 (ii) may procure temporary and inter-
2 mittent services under section 3109(b) of
3 title 5, United States Code, at rates for in-
4 dividuals not in excess of the daily equiva-
5 lent paid for positions at the maximum
6 rate for GS-15 of the General Schedule
7 under section 5332 of title 5, United
8 States Code.

9 (2) COMPENSATION OF MEMBERS.—

10 (A) NON-FEDERAL EMPLOYEES.—Each
11 member of the Commission who is not an offi-
12 cer or employee of the Federal Government
13 shall be compensated at a rate equal to the
14 daily equivalent of the annual rate of basic pay
15 prescribed for level IV of the Executive Sched-
16 ule under section 5315 of title 5, United States
17 Code, for each day (including travel time) dur-
18 ing which the member is engaged in the per-
19 formance of the duties of the Commission.

20 (B) FEDERAL EMPLOYEES.—Each member
21 of the Commission who is an officer or em-
22 ployee of the Federal Government shall serve
23 without compensation in addition to the com-
24 pensation received for the services of the mem-

1 ber as an office or employee of the Federal
2 Government.

3 (C) TRAVEL EXPENSES.—A member of the
4 Commission shall be allowed travel expenses, in-
5 cluding per diem in lieu of subsistence, at rates
6 authorized for an employee of an agency under
7 subchapter I of chapter 57 of title 5, United
8 States Code, while away from the home or reg-
9 ular place of business of the member in the per-
10 formance of the duties of the Commission.

11 (3) COOPERATION.—The Commission may se-
12 cure directly from any Federal department or agency
13 such information as the Commission considers nec-
14 essary to carry out this Act. Upon request of the
15 Chairman of the Commission, the head of such de-
16 partment or agency shall furnish such information to
17 the Commission.

18 (e) PERMANENT COMMISSION.—Section 14 of the
19 Federal Advisory Committee Act (5 U.S.C. App.) shall not
20 apply to the Commission.

21 (f) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated for fiscal year 2022 and
23 each fiscal year thereafter such sums as may be necessary
24 to carry out the duties of the Commission.

1 **SEC. 4508. GRANTS FOR HOSPITALS TO PROMOTE EQUI-**
2 **TABLE HEALTH CARE AND OUTCOMES.**

3 (a) IN GENERAL.—Not later than 180 days after the
4 date of the enactment of this Act, the Secretary of Health
5 and Human Services (in this section referred to as the
6 “Secretary”) shall award grants to hospitals to promote
7 equitable health care treatment and services, and reduce
8 disparities in care and outcomes.

9 (b) CONSULTATION.—In establishing the criteria for
10 grants under this section and evaluating applications for
11 such grants, the Secretary shall consult with the Director
12 for Civil Rights and Health Equity of the Department of
13 Health and Human Services.

14 (c) USE OF FUNDS.—A hospital shall use funds re-
15 ceived from a grant under this section to establish or ex-
16 pand programs to provide equitable health care to all pa-
17 tients and to ensure equitable health care outcomes. Such
18 uses may include—

19 (1) providing explicit and implicit bias training
20 to medical providers and staff;

21 (2) providing translation or interpretation serv-
22 ices for patients;

23 (3) recruiting and training a diverse workforce;

24 (4) tracking data related to care and outcomes;

25 and

26 (5) training on cultural sensitivity.

1 (d) PRIORITY.—In awarding grants under this sec-
2 tion, the Secretary shall give priority to hospitals that
3 have received disproportionate share hospital payments
4 under section 1886(r) of the Social Security Act (42
5 U.S.C. 1395ww(r)) or section 1923 of such Act (42 U.S.C.
6 1396r-4) with respect to fiscal year 2021.

7 (e) SUPPLEMENT, NOT SUPPLANT.—Grants awarded
8 under this section shall be used to supplement, not sup-
9 plant, any nongovernment efforts, or other Federal, State,
10 or local funds provided to a recipient.

11 (f) EQUITABLE HEALTH CARE DEFINED.—The term
12 “equitable health care” has the meaning given such term
13 in section 1886(b)(3)(B)(viii)(XIII)(cc) of the Social Secu-
14 rity Act (42 U.S.C. 1395ww(b)(3)(B)(viii)(XIII)(cc)), as
15 added by section 4503(a).

16 (g) AUTHORIZATION OF APPROPRIATIONS.—To carry
17 out this section, there are authorized to be appropriated
18 such sums as may be necessary for each of fiscal years
19 2022 through 2027.

20 **Subtitle G—Investing in Equity**

21 **SEC. 4601. DEFINITIONS.**

22 In this subtitle:

23 (1) ADVISORY COUNCIL.—The term “Advisory
24 Council” means the Pay for Equity Council con-
25 vened under section 4603.

1 (2) SECRETARY.—The term “Secretary” means
2 the Secretary of Health and Human Services.

3 (3) STRATEGY.—The term “Strategy” means
4 the Pay for Equity Strategy set forth under section
5 4602.

6 **SEC. 4602. STRATEGY TO INCENTIVIZE HEALTH EQUITY.**

7 (a) IN GENERAL.—The Secretary, in consultation
8 with the heads of other appropriate Federal agencies, shall
9 develop jointly with the Advisory Council and submit to
10 the Committee on Finance of the Senate and the Com-
11 mittee on Energy and Commerce and the Committee on
12 Ways and Means of the House of Representatives, and
13 make publicly available on the internet website of the De-
14 partment of Health and Human Services, a Pay for Eq-
15 uity Strategy.

16 (b) CONTENTS.—The Strategy shall establish goals
17 for Federal programs, including those authorized under ti-
18 tles XVIII and XIX of the Social Security Act, to
19 incentivize health equity, which may include at least—

20 (1) incorporating measures of equity into all
21 payment models by 2025;

22 (2) tying a percentage of reimbursement in
23 value-based payment models to equity measure per-
24 formance by 2028; and

1 (3) increasing the number of safety net pro-
2 viders participating in value based payment by a set
3 percentage by 2030.

4 (c) DUTIES OF THE SECRETARY.—The Secretary, in
5 carrying out subsection (a), shall oversee the following:

6 (1) Collecting and making publicly available in-
7 formation submitted by the Advisory Council.

8 (2) Coordinating and assessing existing Federal
9 Government programs and activities to assess capac-
10 ity to meet equity goals.

11 (3) Providing technical assistance, as appro-
12 priate, such as disseminating identified best prac-
13 tices and information sharing based on reports de-
14 veloped as a result of this subtitle.

15 (d) INITIAL STRATEGY; UPDATES.—The Secretary
16 shall—

17 (1) not later than 18 months after the date of
18 enactment of this Act, develop, publish, and submit
19 to the Committee on Finance of the Senate and the
20 Committee on Energy and Commerce and the Com-
21 mittee on Ways and Means of the House of Rep-
22 resentatives the strategy outlined in subsection (a);
23 and

24 (2) biennially update, publish, and submit to
25 Congress an updated strategy to—

1 (A) reflect new developments, challenges,
2 opportunities, and solutions; and

3 (B) review progress and, based on the re-
4 sults of such review, recommend priority actions
5 for improving the implementation of such rec-
6 ommendations, as appropriate.

7 (e) PROCESS FOR PUBLIC INPUT.—The Secretary
8 shall establish a process for public input to inform the de-
9 velopment of, and updates to, the Strategy, including a
10 process for the public to submit recommendations to the
11 Advisory Council and an opportunity for public comment
12 on the proposed Strategy.

13 **SEC. 4603. PAY FOR EQUITY ADVISORY COUNCIL.**

14 (a) CONVENING.—The Secretary shall convene a Pay
15 for Equity Advisory Council to advise and provide rec-
16 ommendations, including identified best practices, to the
17 Secretary on the Pay for Equity Strategy.

18 (b) MEMBERSHIP.—

19 (1) IN GENERAL.—The members of the Advi-
20 sory Council shall consist of—

21 (A) the appointed members under para-
22 graph (2); and

23 (B) the Federal members under paragraph
24 (3).

1 (2) APPOINTED MEMBERS.—In addition to the
2 Federal members under paragraph (3), the Sec-
3 retary shall appoint not more than 15 voting mem-
4 bers of the Advisory Council who are not representa-
5 tives of Federal departments or agencies and who
6 shall include at least 1 representative of each of the
7 following:

8 (A) Beneficiaries of Medicare and Med-
9 icaid.

10 (B) Safety net health care providers.

11 (C) Value-based payment experts.

12 (D) Other members with expertise and
13 lived experience the Secretary deems appro-
14 priate.

15 (3) FEDERAL MEMBERS.—The Federal mem-
16 bers of the Advisory Council, who shall be nonvoting
17 members, shall consist of the following:

18 (A) The Administrator of the Centers for
19 Medicare & Medicaid Services (or the Adminis-
20 trator's designee).

21 (B) The Administrator of the Health Re-
22 sources and Services Administration.

23 (4) DIVERSE REPRESENTATION.—The Sec-
24 retary shall ensure that the membership of the Advi-

1 sory Council reflects the diversity of individuals im-
2 pacted by Federal health payment programs.

3 (c) MEETINGS.—The Advisory Council shall meet
4 quarterly during the 1-year period beginning on the date
5 of enactment of this Act and at least 3 times during each
6 year thereafter. Meetings of the Advisory Council shall be
7 open to the public.

8 **TITLE V—IMPROVING HEALTH**
9 **OUTCOMES FOR WOMEN,**
10 **CHILDREN, AND FAMILIES**
11 **Subtitle A—In General**

12 **SEC. 5001. GRANTS TO PROMOTE HEALTH FOR UNDER-**
13 **SERVED COMMUNITIES.**

14 Part Q of title III of the Public Health Service Act
15 (42 U.S.C. 280h et seq.) is amended by adding at the end
16 the following:

17 **“SEC. 399Z–3. GRANTS TO PROMOTE HEALTH FOR UNDER-**
18 **SERVED COMMUNITIES.**

19 “(a) GRANTS AUTHORIZED.—The Secretary, in col-
20 laboration with the Administrator of the Health Resources
21 and Services Administration and other Federal officials
22 determined appropriate by the Secretary, is authorized to
23 award grants to eligible entities—

24 “(1) to promote health for medically under-
25 served communities, with preference given to

1 projects that benefit racial and ethnic minority
2 women, racial and ethnic minority children, adoles-
3 cents, and lesbian, gay, bisexual, transgender, queer,
4 nonbinary, gender-nonconforming, or questioning
5 communities; and

6 “(2) to strengthen health outreach initiatives in
7 medically underserved communities, including lin-
8 guistically isolated populations.

9 “(b) USE OF FUNDS.—Grants awarded pursuant to
10 subsection (a) may be used to support the activities of
11 community health workers, including such activities—

12 “(1) to educate and provide outreach regarding
13 enrollment in health insurance including the State
14 Children’s Health Insurance Program under title
15 XXI of the Social Security Act, Medicare under title
16 XVIII of such Act, and Medicaid under title XIX of
17 such Act;

18 “(2) to educate and provide outreach in a com-
19 munity setting regarding health problems prevalent
20 among medically underserved communities, and es-
21 pecially among racial and ethnic minority women,
22 racial and ethnic minority children, adolescents, and
23 lesbian, gay, bisexual, transgender, queer, nonbinary,
24 gender-nonconforming, or questioning communities;

1 “(3) to educate and provide experiential learn-
2 ing opportunities and target risk factors and healthy
3 behaviors that impede or contribute to achieving
4 positive health outcomes, including—

5 “(A) healthy nutrition;

6 “(B) physical activity;

7 “(C) overweight or obesity;

8 “(D) tobacco use, including the use of e-
9 cigarettes and vaping;

10 “(E) alcohol and substance use;

11 “(F) injury and violence;

12 “(G) sexual health;

13 “(H) mental health;

14 “(I) musculoskeletal health and arthritis;

15 “(J) prenatal and postnatal care;

16 “(K) dental and oral health;

17 “(L) understanding informed consent;

18 “(M) stigma; and

19 “(N) environmental hazards;

20 “(4) to promote community wellness and aware-
21 ness; and

22 “(5) to educate and refer target populations to
23 appropriate health care agencies and community-
24 based programs and organizations in order to in-

1 crease access to quality health care services, includ-
2 ing preventive health services.

3 “(c) APPLICATION.—

4 “(1) IN GENERAL.—Each eligible entity that
5 desires to receive a grant under subsection (a) shall
6 submit an application to the Secretary, at such time,
7 in such manner, and accompanied by such additional
8 information as the Secretary may require.

9 “(2) CONTENTS.—Each application submitted
10 pursuant to paragraph (1) shall—

11 “(A) describe the activities for which as-
12 sistance under this section is sought;

13 “(B) contain an assurance that, with re-
14 spect to each community health worker pro-
15 gram receiving funds under the grant awarded,
16 such program provides in-language training and
17 supervision to community health workers to en-
18 able such workers to provide authorized pro-
19 gram activities in (at least) the most commonly
20 used languages within a particular geographic
21 region;

22 “(C) contain an assurance that the appli-
23 cant will evaluate the effectiveness of commu-
24 nity health worker programs receiving funds
25 under the grant;

1 “(D) contain an assurance that each com-
2 munity health worker program receiving funds
3 under the grant will provide culturally com-
4 petent services in the linguistic context most
5 appropriate for the individuals served by the
6 program;

7 “(E) contain a plan to document and dis-
8 seminate project descriptions and results to
9 other States and organizations as identified by
10 the Secretary; and

11 “(F) describe plans to enhance the capac-
12 ity of individuals to utilize health services and
13 health-related social services under Federal,
14 State, and local programs by—

15 “(i) assisting individuals in estab-
16 lishing eligibility under the programs and
17 in receiving the services or other benefits
18 of the programs; and

19 “(ii) providing other services, as the
20 Secretary determines to be appropriate,
21 which may include transportation and
22 translation services.

23 “(d) PRIORITY.—In awarding grants under sub-
24 section (a), the Secretary shall give priority to those appli-
25 cants—

1 “(1) who propose to target geographic areas
2 that—

3 “(A)(i) have a high percentage of residents
4 who are uninsured or underinsured (if the tar-
5 geted geographic area is located in a State that
6 has elected to make medical assistance available
7 under section 1902(a)(10)(A)(i)(VIII) of the
8 Social Security Act to individuals described in
9 such section);

10 “(ii) have a high percentage of under-
11 insured residents in a particular geographic
12 area (if the targeted geographic area is located
13 in a State that has not so elected); or

14 “(iii) have a high number of households ex-
15 periencing extreme poverty; and

16 “(B) have a high percentage of families for
17 whom English is not their primary language or
18 including smaller limited English-proficient
19 communities within the region that are not oth-
20 erwise reached by linguistically appropriate
21 health services;

22 “(2) with experience in providing health or
23 health-related social services to individuals who are
24 underserved with respect to such services; and

1 “(3) with documented community activity and
2 experience with community health workers.

3 “(e) COLLABORATION WITH ACADEMIC INSTITU-
4 TIONS.—The Secretary shall encourage community health
5 worker programs receiving funds under this section to col-
6 laborate with academic institutions, including minority-
7 serving institutions. Nothing in this section shall be con-
8 strued to require such collaboration.

9 “(f) QUALITY ASSURANCE AND COST EFFECTIVE-
10 NESS.—The Secretary shall establish guidelines for ensur-
11 ing the quality of the training and supervision of commu-
12 nity health workers under the programs funded under this
13 section and for ensuring the cost effectiveness of such pro-
14 grams.

15 “(g) MONITORING.—The Secretary shall monitor
16 community health worker programs identified in approved
17 applications and shall determine whether such programs
18 are in compliance with the guidelines established under
19 subsection (f).

20 “(h) TECHNICAL ASSISTANCE.—The Secretary may
21 provide technical assistance to community health worker
22 programs identified in approved applications with respect
23 to planning, developing, and operating programs under the
24 grant.

25 “(i) REPORT TO CONGRESS.—

1 “(1) IN GENERAL.—Not later than 4 years
2 after the date on which the Secretary first awards
3 grants under subsection (a), the Secretary shall sub-
4 mit to Congress a report regarding the grant
5 project.

6 “(2) CONTENTS.—The report required under
7 paragraph (1) shall include the following:

8 “(A) A description of the programs for
9 which grant funds were used.

10 “(B) The number of individuals served.

11 “(C) An evaluation of—

12 “(i) the effectiveness of these pro-
13 grams;

14 “(ii) the cost of these programs; and

15 “(iii) the impact of these programs on
16 the health outcomes of the community resi-
17 dents.

18 “(D) Recommendations for sustaining the
19 community health worker programs developed
20 or assisted under this section.

21 “(E) Recommendations regarding training
22 to enhance career opportunities for community
23 health workers.

24 “(j) DEFINITIONS.—In this section:

1 “(1) COMMUNITY HEALTH WORKER.—The term
2 ‘community health worker’ means an individual who
3 promotes health or nutrition within the community
4 in which the individual resides—

5 “(A) by serving as a liaison between com-
6 munities and health care agencies;

7 “(B) by providing guidance and social as-
8 sistance to community residents;

9 “(C) by enhancing community residents’
10 ability to effectively communicate with health
11 care providers;

12 “(D) by providing culturally and linguis-
13 tically appropriate health or nutrition edu-
14 cation;

15 “(E) by advocating for individual and com-
16 munity health, including dental, oral, mental,
17 and environmental health, or nutrition needs;

18 “(F) by taking into consideration the
19 needs of the communities served, including the
20 prevalence rates of risk factors that impede
21 achieving positive healthy outcomes among
22 pregnant, birthing, and postpartum people and
23 children, especially among racial and ethnic mi-
24 nority pregnant, birthing, and postpartum peo-
25 ple and children; and

1 “(G) by providing referral and followup
2 services.

3 “(2) COMMUNITY SETTING.—The term ‘commu-
4 nity setting’ means a home or a community organi-
5 zation that serves a population.

6 “(3) ELIGIBLE ENTITY.—The term ‘eligible en-
7 tity’ means—

8 “(A) a unit of State, territorial, local, or
9 Tribal government (including a federally recog-
10 nized Tribe or Alaska Native village); or

11 “(B) a community-based organization.

12 “(4) MEDICALLY UNDERSERVED COMMUNITY.—
13 The term ‘medically underserved community’ means
14 a community—

15 “(A) that has a substantial number of in-
16 dividuals who are members of a medically un-
17 derserved population, as defined by section
18 330(b)(3);

19 “(B) a significant portion of which is a
20 health professional shortage area as designated
21 under section 332; and

22 “(C) that includes populations that are lin-
23 guistically isolated, such as geographic areas
24 with a shortage of health professionals able to
25 provide linguistically appropriate services.

1 “(5) SUPPORT.—The term ‘support’ means the
2 provision of training, supervision, and materials
3 needed to effectively deliver the services described in
4 subsection (b), reimbursement for services, and
5 other benefits.

6 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated to carry out this section
8 \$15,000,000 for each of fiscal years 2023 through 2027.”.

9 **Subtitle B—Pregnancy Screening**

10 **SEC. 5101. PREGNANCY INTENTION SCREENING INITIATIVE**

11 **DEMONSTRATION PROGRAM.**

12 Part P of title III of the Public Health Service Act
13 (42 U.S.C. 280g et seq.) is amended by adding at the end
14 the following:

15 **“SEC. 399V-7. PREGNANCY INTENTION SCREENING INITIA-**

16 **TIVE DEMONSTRATION PROGRAM.**

17 “(a) PROGRAM ESTABLISHMENT.—The Secretary,
18 acting through the Director of the Centers for Disease
19 Control and Prevention, shall establish a demonstration
20 program to facilitate the clinical adoption of pregnancy in-
21 tention screening initiatives by health care and social serv-
22 ices providers.

23 “(b) GRANTS.—The Secretary may carry out the
24 demonstration program through awarding grants to eligi-

1 ble entities to implement pregnancy intention screening
2 initiatives, collect data, and evaluate such initiatives.

3 “(c) ELIGIBLE ENTITIES.—To be eligible to seek a
4 grant under this section, an entity shall—

5 “(1) provide non-directive, comprehensive,
6 medically accurate information; and

7 “(2) be a community-based organization, vol-
8 untary health organization, public health depart-
9 ment, community health center, or other interested
10 public or private primary, behavioral, or other health
11 care or social service provider or organization.

12 “(d) PREGNANCY INTENTION SCREENING INITIA-
13 TIVE.—For purposes of this section, the term ‘pregnancy
14 intention screening initiative’ means any initiative by an
15 eligible entity to routinely screen people with respect to
16 their pregnancy intentions and goals to either prevent un-
17 intended pregnancies or improve the likelihood of healthy
18 pregnancies, in order to better provide health care that
19 meets the contraceptive or pre-pregnancy needs and goals
20 of such people.

21 “(e) EVALUATION.—

22 “(1) IN GENERAL.—The Secretary, acting
23 through the Director of the Centers for Disease
24 Control and Prevention, shall, by grant or contract,
25 and after consultation as described in paragraph (2),

1 conduct an evaluation of the demonstration pro-
2 gram, with respect to pregnancy intention screening
3 initiatives, conducted under this section. Such eval-
4 uation shall include:

5 “(A) Assessment of the implementation of
6 pregnancy intention screening protocols among
7 a diverse group of patients and providers, in-
8 cluding collecting data on the experiences and
9 outcomes for diverse patient populations in a
10 variety of clinical settings.

11 “(B) Analysis of outcome measures that
12 will facilitate effective and widespread adoption
13 of such protocols by health care providers for
14 inquiring about and responding to pregnancy
15 goals of people with both contraceptive and pre-
16 pregnancy care.

17 “(C) Consideration of health inequities
18 among the population served.

19 “(D) Assessment of the equitable and vol-
20 untary application of such initiatives to minor-
21 ity and medically underserved communities.

22 “(E) Assessment of the training, capacity,
23 and ongoing technical assistance needed for
24 providers to effectively implement such preg-
25 nancy intention screening protocols.

1 “(F) Assessment of whether referral sys-
2 tems for selected protocols follow evidence-based
3 standards that ensure access to comprehensive
4 health services and appropriate follow-up care.

5 “(G) Measuring through rigorous methods
6 the effect of such initiatives on key health out-
7 comes.

8 “(2) CONSULTATION WITH INDEPENDENT, EX-
9 PERT ADVISORY PANEL.—In conducting the evalua-
10 tion under paragraph (1), the Director of the Cen-
11 ters for Disease Control and Prevention shall consult
12 with physicians, physician assistants, advanced prac-
13 tice registered nurses, nurse midwives, and other
14 health care providers who specialize in women’s
15 health, and other experts in public health, clinical
16 practice, program evaluation, and research.

17 “(3) REPORT.—Not later than one year after
18 the last day of the demonstration program under
19 this section, the Director of the Centers for Disease
20 Control and Prevention shall—

21 “(A) submit to Congress a report on the
22 results of the evaluation conducted under para-
23 graph (1); and

24 “(B) make the report publicly available.

25 “(f) FUNDING.—

1 “(1) AUTHORIZATION OF APPROPRIATIONS.—

2 To carry out this section, there is authorized to be
3 appropriated \$10,000,000 for each of fiscal years
4 2023 through 2027.

5 “(2) LIMITATION.—Not more than 20 percent
6 of funds appropriated to carry out this section pur-
7 suant to paragraph (1) for a fiscal year may be used
8 for purposes of the evaluation under subsection
9 (e).”.

10 **SEC. 5102. BIRTH DEFECTS PREVENTION, RISK REDUCTION,**
11 **AND AWARENESS.**

12 (a) IN GENERAL.—The Secretary shall establish and
13 implement a birth defects prevention and public awareness
14 program, consisting of the activities described in sub-
15 sections (c) and (d).

16 (b) DEFINITIONS.—In this section:

17 (1) MATERNAL.—The term “maternal” refers
18 to people who are pregnant or breastfeeding.

19 (2) PREGNANCY AND BREASTFEEDING INFOR-
20 MATION SERVICES.—The term “pregnancy and
21 breastfeeding information services” includes only—

22 (A) information services to provide accu-
23 rate, evidence-based, clinical information re-
24 garding maternal exposures during pregnancy
25 or breastfeeding that may be associated with

1 birth defects, health risks to a breastfed infant,
2 or other health risks, such as exposures to
3 medications, chemicals, infections, foodborne
4 pathogens, illnesses, nutrition, lifestyle, or
5 climate- and weather-related factors;

6 (B) the provision of accurate, evidence-
7 based information weighing risks of exposures
8 during breastfeeding against the benefits of
9 breastfeeding; and

10 (C) the provision of information described
11 in subparagraph (A) or (B) through counselors,
12 websites, fact sheets, telephonic or electronic
13 communication, community outreach efforts, or
14 other appropriate means.

15 (3) SECRETARY.—The term “Secretary” means
16 the Secretary of Health and Human Services, acting
17 through the Director of the Centers for Disease
18 Control and Prevention.

19 (c) NATIONWIDE MEDIA CAMPAIGN.—In carrying out
20 subsection (a), the Secretary shall conduct or support a
21 nationwide media campaign to increase awareness among
22 health care providers and at-risk populations about preg-
23 nancy and breastfeeding information services.

24 (d) GRANTS FOR PREGNANCY AND BREASTFEEDING
25 INFORMATION SERVICES.—

1 (1) IN GENERAL.—In carrying out subsection
2 (a), the Secretary shall award grants to State or re-
3 gional agencies or organizations for any of the fol-
4 lowing:

5 (A) INFORMATION SERVICES.—The provi-
6 sion of, or campaigns to increase awareness
7 about, pregnancy and breastfeeding information
8 services.

9 (B) SURVEILLANCE AND RESEARCH.—The
10 conduct or support of—

11 (i) surveillance of or research on—

12 (I) maternal exposures and ma-
13 ternal health conditions that may in-
14 fluence the risk of birth defects, pre-
15 maturity, or other adverse pregnancy
16 outcomes; and

17 (II) maternal exposures that may
18 influence health risks to a breastfed
19 infant; or

20 (ii) networking to facilitate surveil-
21 lance or research described in this sub-
22 paragraph.

23 (2) PREFERENCE FOR CERTAIN STATES.—The
24 Secretary, in making any grant under this sub-
25 section, shall give preference to States, otherwise

1 equally qualified, that have pregnancy and
2 breastfeeding information services in place.

3 (3) MATCHING FUNDS.—The Secretary may
4 only award a grant under this subsection to a State
5 or regional agency or organization that agrees, with
6 respect to the costs to be incurred in carrying out
7 the grant activities, to make available (directly or
8 through donations from public or private entities)
9 non-Federal funds toward such costs in an amount
10 equal to not less than 25 percent of the amount of
11 the grant.

12 (4) COORDINATION.—The Secretary shall en-
13 sure that activities funded through a grant under
14 this subsection are coordinated, to the maximum ex-
15 tent practicable, with other birth defects prevention
16 and environmental health activities of the Federal
17 Government, including with respect to pediatric envi-
18 ronmental health specialty units and children’s envi-
19 ronmental health centers.

20 (e) EVALUATION.—The Secretary shall provide for an
21 evaluation of pregnancy and breastfeeding information
22 services carried out by States to identify efficient and ef-
23 fective models of—

24 (1) providing information;

1 (2) raising awareness and increasing knowledge
2 about birth defects prevention measures and tar-
3 geting education to at-risk groups;

4 (3) modifying risk behaviors; or

5 (4) other outcome measures as determined ap-
6 propriate by the Secretary.

7 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
8 out this section, there are authorized to be appropriated—

9 (1) \$5,000,000 for fiscal year 2023;

10 (2) \$6,000,000 for fiscal year 2024;

11 (3) \$7,000,000 for fiscal year 2025;

12 (4) \$8,000,000 for fiscal year 2026; and

13 (5) \$9,000,000 for fiscal year 2027.

14 **Subtitle C—Pregnancy-Related**
15 **Care**

16 **SEC. 5201. MOTHERS AND OFFSPRING MORTALITY AND**
17 **MORBIDITY AWARENESS.**

18 (a) IMPROVING FEDERAL EFFORTS WITH RESPECT
19 TO PREVENTION OF MATERNAL MORTALITY.—

20 (1) TECHNICAL ASSISTANCE FOR STATES WITH
21 RESPECT TO REPORTING MATERNAL MORTALITY.—

22 Not later than one year after the date of enactment
23 of this Act, the Director of the Centers for Disease
24 Control and Prevention (referred to in this section
25 as the “Director”), in consultation with the Admin-

1 istrator of the Health Resources and Services Ad-
2 ministration, shall provide technical assistance to
3 States that elect to report comprehensive data on
4 maternal mortality and factors relating to such mor-
5 tality (including oral and mental health), intimate
6 partner violence, and breastfeeding health informa-
7 tion, for the purpose of encouraging uniformity in
8 the reporting of such data and to encourage the
9 sharing of such data among the respective States.

10 (2) BEST PRACTICES RELATING TO PREVEN-
11 TION OF MATERNAL MORTALITY.—

12 (A) IN GENERAL.—Not later than one year
13 after the date of enactment of this Act—

14 (i) the Director, in consultation with
15 relevant patient and provider groups, shall
16 issue best practices to State maternal mor-
17 tality review committees on how best to
18 identify and review maternal mortality
19 cases, taking into account any data made
20 available by States relating to maternal
21 mortality, including data on oral, mental,
22 and breastfeeding health, and utilization of
23 any emergency services; and

24 (ii) the Director, working in collabora-
25 tion with the Health Resources and Serv-

1 ices Administration, shall issue best prac-
2 tices to hospitals, State professional society
3 groups, and perinatal quality collaboratives
4 on how best to prevent maternal mortality.

5 (B) AUTHORIZATION OF APPROPRIA-
6 TIONS.—For purposes of carrying out this
7 paragraph, there is authorized to be appro-
8 priated \$5,000,000 for each of fiscal years
9 2023 through 2027.

10 (3) ALLIANCE FOR INNOVATION ON MATERNAL
11 HEALTH GRANT PROGRAM.—

12 (A) IN GENERAL.—Not later than one year
13 after the date of enactment of this Act, the Sec-
14 retary of Health and Human Services, acting
15 through the Associate Administrator of the Ma-
16 ternal and Child Health Bureau of the Health
17 Resources and Services Administration (re-
18 ferred to in this paragraph as the “Secretary”),
19 shall establish a grant program to be known as
20 the Alliance for Innovation on Maternal Health
21 Grant Program (referred to in this subsection
22 as “AIM”) under which the Secretary shall
23 award grants to eligible entities for the purpose
24 of—

1 (i) directing widespread adoption and
2 implementation of maternal safety bundles
3 through collaborative State-based teams;
4 and

5 (ii) collecting and analyzing process,
6 structure, and outcome data to drive con-
7 tinuous improvement in the implementa-
8 tion of such safety bundles by such State-
9 based teams with the ultimate goal of
10 eliminating preventable maternal mortality
11 and severe maternal morbidity in the
12 United States.

13 (B) ELIGIBLE ENTITIES.—In order to be
14 eligible for a grant under subparagraph (A), an
15 entity shall—

16 (i) submit to the Secretary an applica-
17 tion at such time, in such manner, and
18 containing such information as the Sec-
19 retary may require; and

20 (ii) demonstrate in such application
21 that the entity is an interdisciplinary,
22 multi-stakeholder, national organization
23 with a national data-driven maternal safety
24 and quality improvement initiative based
25 on implementation approaches that have

1 been proven to improve maternal safety
2 and outcomes in the United States.

3 (C) USE OF FUNDS.—An eligible entity
4 that receives a grant under subparagraph (A)
5 shall use such grant funds—

6 (i) to develop and implement, through
7 a robust, multi-stakeholder process, mater-
8 nal safety bundles to assist States,
9 perinatal quality collaboratives, and health
10 care systems in aligning national, State,
11 and hospital-level quality improvement ef-
12 forts to improve maternal health outcomes,
13 specifically the reduction of maternal mor-
14 tality and severe maternal morbidity;

15 (ii) to ensure, in developing and im-
16 plementing maternal safety bundles under
17 clause (i), that such maternal safety bun-
18 dles—

19 (I) satisfy the quality improve-
20 ment needs of a State, perinatal qual-
21 ity collaborative, or health care system
22 by factoring in the results and find-
23 ings of relevant data reviews, such as
24 reviews conducted by a State maternal
25 mortality review committee; and

1 (II) address topics which may in-
2 clude—

3 (aa) information on evi-
4 dence-based practices to improve
5 the quality and safety of mater-
6 nal health care in hospitals and
7 other health care settings of a
8 State or health care system, in-
9 cluding by addressing topics com-
10 monly associated with health
11 complications or risks related to
12 prenatal care, labor care, birth-
13 ing, and postpartum care;

14 (bb) best practices for im-
15 proving maternal health care
16 based on data findings and re-
17 views conducted by a State ma-
18 ternal mortality review committee
19 that address topics of relevance
20 to common complications or
21 health risks related to prenatal
22 care, labor care, birthing, and
23 postpartum care;

24 (cc) information on address-
25 ing determinants of health that

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1 impact maternal health outcomes
2 for people before, during, and
3 after pregnancy;
4 (dd) obstetric hemorrhage;
5 (ee) obstetric and
6 postpartum care for people with
7 substance use disorders, includ-
8 ing opioid use disorder;
9 (ff) maternal cardiovascular
10 system;
11 (gg) maternal mental health;
12 (hh) postpartum care basics
13 for maternal safety;
14 (ii) reduction of peripartum
15 racial and ethnic inequities;
16 (jj) reduction of primary
17 caesarean birth;
18 (kk) severe hypertension in
19 pregnancy;
20 (ll) severe maternal mor-
21 bidity reviews;
22 (mm) support after a severe
23 maternal morbidity event;
24 (nn) thromboembolism;

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- 1 (oo) optimization of support
2 for breastfeeding;
3 (pp) maternal oral health;
4 and
5 (qq) intimate partner vio-
6 lence; and
7 (iii) to provide ongoing technical as-
8 sistance at the national and State levels to
9 support implementation of maternal safety
10 bundles under clause (i).

11 (D) MATERNAL SAFETY BUNDLE DE-
12 FINED.—For purposes of this paragraph, the
13 term “maternal safety bundle” means standard-
14 ized, evidence-informed processes for maternal
15 health care.

16 (E) AUTHORIZATION OF APPROPRIA-
17 TIONS.—For purposes of carrying out this
18 paragraph, there is authorized to be appro-
19 priated \$10,000,000 for each of fiscal years
20 2023 through 2027.

21 (4) FUNDING FOR STATE-BASED PERINATAL
22 QUALITY COLLABORATIVES DEVELOPMENT AND SUS-
23 TAINABILITY.—

24 (A) IN GENERAL.—Not later than one year
25 after the date of enactment of this Act, the Sec-

1 retary of Health and Human Services (referred
2 to in this paragraph as the “Secretary”), acting
3 through the Division of Reproductive Health of
4 the Centers for Disease Control and Prevention,
5 shall establish a grant program to be known as
6 the State-Based Perinatal Quality Collaborative
7 grant program under which the Secretary
8 awards grants to eligible entities for the pur-
9 pose of development and sustainability of
10 perinatal quality collaboratives in every State,
11 the District of Columbia, and eligible terri-
12 tories, in order to measurably improve perinatal
13 care and perinatal health outcomes for preg-
14 nant and postpartum people and their infants.

15 (B) GRANT AMOUNTS.—Grants awarded
16 under this paragraph shall be in amounts not to
17 exceed \$250,000 per year, for the duration of
18 the grant period.

19 (C) STATE-BASED PERINATAL QUALITY
20 COLLABORATIVE DEFINED.—For purposes of
21 this paragraph, the term “State-based perinatal
22 quality collaborative” means a network of teams
23 that—

1 (i) is multidisciplinary in nature and
2 includes the full range of perinatal and
3 maternity care providers;

4 (ii) works to improve measurable out-
5 comes for maternal and infant health by
6 advancing evidence-informed clinical prac-
7 tices using quality improvement principles;

8 (iii) works with hospital-based or out-
9 patient facility-based clinical teams, ex-
10 perts, and stakeholders, including patients
11 and families, to spread best practices and
12 optimize resources to improve perinatal
13 care and outcomes;

14 (iv) employs strategies that include
15 the use of the collaborative learning model
16 to provide opportunities for hospitals and
17 clinical teams to collaborate on improve-
18 ment strategies, rapid-response data to
19 provide timely feedback to hospital and
20 other clinical teams to track progress, and
21 quality improvement science to provide
22 support and coaching to hospital and clin-
23 ical teams;

1 (v) has the goal of improving popu-
2 lation-level outcomes in maternal and in-
3 fant health; and

4 (vi) has the goal of improving out-
5 comes of all birthing people, through the
6 coordination, integration, and collaboration
7 across birth settings.

8 (D) AUTHORIZATION OF APPROPRIA-
9 TIONS.—For purposes of carrying out this
10 paragraph, there is authorized to be appro-
11 priated \$14,000,000 per year for each of fiscal
12 years 2023 through 2027.

13 (5) EXPANSION OF MEDICAID AND CHIP COV-
14 ERAGE FOR PREGNANT AND POSTPARTUM PEO-
15 PLE.—

16 (A) REQUIRING COVERAGE OF ORAL
17 HEALTH SERVICES FOR PREGNANT AND
18 POSTPARTUM PEOPLE.—

19 (i) MEDICAID.—Section 1905 of the
20 Social Security Act (42 U.S.C. 1396d), as
21 previously amended by this Act, is amend-
22 ed—

23 (I) in subsection (a)(4), by in-
24 serting “and ; (G) oral health services
25 for pregnant and postpartum people

1 (as defined in subsection (mm))” be-
2 fore the semicolon at the end; and

3 (II) by adding at the end the fol-
4 lowing new subsection:

5 “(mm) ORAL HEALTH SERVICES FOR PREGNANT
6 AND POSTPARTUM PEOPLE.—

7 “(1) IN GENERAL.—For purposes of this title,
8 the term ‘oral health services for pregnant and
9 postpartum people’ means dental services necessary
10 to prevent disease and promote oral health, restore
11 oral structures to health and function, and treat
12 emergency conditions that are furnished to a person
13 during pregnancy (or during the 1-year period be-
14 ginning on the last day of the pregnancy).

15 “(2) COVERAGE REQUIREMENTS.—To satisfy
16 the requirement to provide oral health services for
17 pregnant and postpartum people, a State shall pro-
18 vide coverage for preventive, diagnostic, periodontal,
19 and restorative care consistent with recommenda-
20 tions for perinatal oral health care and dental care
21 during pregnancy from the American Academy of
22 Pediatric Dentistry and the American College of Ob-
23 stetricians and Gynecologists.”.

24 (ii) CHIP.—Section 2103(c)(6)(A) of
25 the Social Security Act (42 U.S.C.

1 1397cc(c)(6)(A)) is amended by inserting
2 “or a targeted low-income pregnant per-
3 son” after “targeted low-income child”.

4 (B) EXTENDING MEDICAID COVERAGE FOR
5 PREGNANT AND POSTPARTUM PEOPLE.—Sec-
6 tion 1902 of the Social Security Act (42 U.S.C.
7 1396a) is amended—

8 (i) in subsection (e)—

9 (I) in paragraph (5)—

10 (aa) by inserting “(including
11 oral health services for pregnant
12 and postpartum people (as de-
13 fined in section 1905(mm)))”
14 after “postpartum medical assist-
15 ance under the plan”; and

16 (bb) by striking “60-day”
17 and inserting “1-year”; and

18 (II) in paragraph (6), by striking
19 “60-day” and inserting “1-year”; and

20 (ii) in subsection (l)(1)(A), by striking
21 “60-day” and inserting “1-year”.

22 (C) EXTENDING CHIP COVERAGE FOR
23 PREGNANT AND POSTPARTUM PEOPLE.—Sec-
24 tion 2112(d)(2)(A) of the Social Security Act

1 (42 U.S.C. 1397ll(d)(2)(A)) is amended by
2 striking “60-day” and inserting “1-year”.

3 (D) CONFORMING AMENDMENTS.—

4 (i) Section 1902(e)(16) of the Social
5 Security Act (42 U.S.C. 1396a(e)(16)) is
6 amended—

7 (I) in subparagraph (A), by strik-
8 ing “may provide” and all that follows
9 through the period and inserting the
10 following: “may provide that the State
11 will provide the medical assistance de-
12 scribed in subparagraph (B) to an in-
13 dividual who, while pregnant, is eligi-
14 ble for and has received medical as-
15 sistance under the State plan ap-
16 proved under this title (or a waiver of
17 such plan), including during a period
18 of retroactive eligibility under sub-
19 section (a)(34) and through the end
20 of the month in which the 1-year pe-
21 riod beginning on the last day of the
22 individual’s pregnancy ends.”; and

23 (II) in subparagraph (B), by
24 striking “12-month” each place it ap-
25 pears and inserting “1-year”.

1 (ii) Section 1905(a) of the Social Se-
2 curity Act (42 U.S.C. 1396d(a)) is amend-
3 ed, in the fifth sentence, by striking “60-
4 day” and inserting “1-year”.

5 (E) MAINTENANCE OF EFFORT.—

6 (i) MEDICAID.—Section 1902(l) of the
7 Social Security Act (42 U.S.C. 1396a(l)) is
8 amended by adding at the end the fol-
9 lowing new paragraph:

10 “(5) During the period that begins on the date of
11 enactment of this paragraph and ends on the date that
12 is 5 years after such date of enactment, as a condition
13 for receiving any Federal payments under section 1903(a)
14 for calendar quarters occurring during such period, a
15 State shall not have in effect, with respect to people who
16 are eligible for medical assistance under the State plan
17 or under a waiver of such plan on the basis of being preg-
18 nant or having been pregnant, eligibility standards, meth-
19 odologies, or procedures under the State plan or waiver
20 that are more restrictive than the eligibility standards,
21 methodologies, or procedures, respectively, under such
22 plan or waiver that are in effect on the date of enactment
23 of this paragraph.”.

24 (ii) CHIP.—Section 2105(d) of the
25 Social Security Act (42 U.S.C. 1397ee(d))

1 is amended by adding at the end the fol-
2 lowing new paragraph:

3 “(4) ELIGIBILITY STANDARDS FOR TARGETED
4 LOW-INCOME PREGNANT PEOPLE.—During the pe-
5 riod that begins on the date of enactment of this
6 paragraph and ends on the date that is five years
7 after such date of enactment, as a condition of re-
8 ceiving payments under subsection (a) and section
9 1903(a), a State that elects to provide assistance to
10 people on the basis of being pregnant (including
11 pregnancy-related assistance provided to targeted
12 low-income pregnant people (as defined in section
13 2112(d)), pregnancy-related assistance provided to
14 people who are eligible for such assistance through
15 application of section 1902(v)(4)(A) under section
16 2107(e)(1), or any other assistance under the State
17 child health plan (or a waiver of such plan) which
18 is provided to people on the basis of being pregnant)
19 shall not have in effect, with respect to such people,
20 eligibility standards, methodologies, or procedures
21 under such plan (or waiver) that are more restrictive
22 than the eligibility standards, methodologies, or pro-
23 cedures, respectively, under such plan (or waiver)
24 that are in effect on the date of enactment of this
25 paragraph.”.

1 (F) INFORMATION ON BENEFITS.—The
2 Secretary of Health and Human Services shall
3 make publicly available on the internet website
4 of the Department of Health and Human Serv-
5 ices, information regarding benefits available to
6 pregnant and postpartum people and under the
7 Medicaid program and the Children’s Health
8 Insurance Program, including information on—

9 (i) benefits that States are required to
10 provide to pregnant and postpartum people
11 under such programs;

12 (ii) optional benefits that States may
13 provide to pregnant and postpartum people
14 under such programs; and

15 (iii) the availability of different kinds
16 of benefits for pregnant and postpartum
17 people, including oral health and mental
18 health benefits, under such programs.

19 (G) FEDERAL FUNDING FOR COST OF EX-
20 TENDED MEDICAID AND CHIP COVERAGE FOR
21 POSTPARTUM PEOPLE.—

22 (i) MEDICAID.—Section 1905 of the
23 Social Security Act (42 U.S.C. 1396d), as
24 previously amended by this Act, is further
25 amended—

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1 (I) in subsection (b), by striking
2 “and (ll)” and inserting “(ll), and
3 (nn)”; and

4 (II) by adding at the end the fol-
5 lowing:

6 “(nn) INCREASED FMAP FOR EXTENDED MEDICAL
7 ASSISTANCE FOR POSTPARTUM PEOPLE.—Notwith-
8 standing subsection (b), the Federal medical assistance
9 percentage for a State, with respect to amounts expended
10 by such State for medical assistance for a person who is
11 eligible for such assistance on the basis of being pregnant
12 or having been pregnant that is provided during the 305-
13 day period that begins on the 60th day after the last day
14 of their pregnancy (including any such assistance provided
15 during the month in which such period ends), shall be
16 equal to—

17 “(1) 100 percent for the first 20 calendar quar-
18 ters during which this subsection is in effect; and

19 “(2) 90 percent for calendar quarters there-
20 after.”.

21 (ii) CHIP.—Section 2105(c) of the
22 Social Security Act (42 U.S.C. 1397ee(c))
23 is amended by adding at the end the fol-
24 lowing new paragraph:

1 “(13) ENHANCED PAYMENT FOR EXTENDED
2 ASSISTANCE PROVIDED TO PREGNANT PEOPLE.—
3 Notwithstanding subsection (b), the enhanced
4 FMAP, with respect to payments under subsection
5 (a) for expenditures under the State child health
6 plan (or a waiver of such plan) for assistance pro-
7 vided under the plan (or waiver) to a person who is
8 eligible for such assistance on the basis of being
9 pregnant (including pregnancy-related assistance
10 provided to a targeted low-income pregnant person
11 (as defined in section 2112(d)), pregnancy-related
12 assistance provided to a person who is eligible for
13 such assistance through application of section
14 1902(v)(4)(A) under section 2107(e)(1), or any
15 other assistance under the plan (or waiver) provided
16 to a person who is eligible for such assistance on the
17 basis of being pregnant) during the 305-day period
18 that begins on the 60th day after the last day of her
19 pregnancy (including any such assistance provided
20 during the month in which such period ends), shall
21 be equal to—

22 “(A) 100 percent for the first 20 calendar
23 quarters during which this paragraph is in ef-
24 fect; and

1 “(B) 90 percent for calendar quarters
2 thereafter.”.

3 (H) GUIDANCE ON STATE OPTIONS FOR
4 MEDICAID COVERAGE OF DOULA SERVICES.—
5 Not later than 1 year after the date of the en-
6 actment of this Act, the Secretary of Health
7 and Human Services, acting through the Ad-
8 ministrators of the Centers for Medicare & Med-
9 icaid Services, shall issue guidance for the
10 States concerning options for Medicaid coverage
11 and payment for support services provided by
12 doulas.

13 (I) EFFECTIVE DATE.—

14 (i) IN GENERAL.—Subject to clause
15 (ii), the amendments made by this para-
16 graph shall take effect on the first day of
17 the first calendar quarter that begins on or
18 after the date that is one year after the
19 date of enactment of this Act.

20 (ii) EXCEPTION FOR STATE LEGISLA-
21 TION.—In the case of a State plan under
22 title XIX of the Social Security Act or a
23 State child health plan under title XXI of
24 such Act that the Secretary of Health and
25 Human Services determines requires State

1 legislation in order for the respective plan
2 to meet any requirement imposed by
3 amendments made by this paragraph, the
4 respective plan shall not be regarded as
5 failing to comply with the requirements of
6 such title solely on the basis of its failure
7 to meet such an additional requirement be-
8 fore the first day of the first calendar
9 quarter beginning after the close of the
10 first regular session of the State legislature
11 that begins after the date of enactment of
12 this Act. For purposes of the previous sen-
13 tence, in the case of a State that has a 2-
14 year legislative session, each year of the
15 session shall be considered to be a separate
16 regular session of the State legislature.

17 (6) REGIONAL CENTERS OF EXCELLENCE.—
18 Part P of title III of the Public Health Service Act
19 (42 U.S.C. 280g et seq.), as amended by section
20 5101, is further amended by adding at the end the
21 following new section:

1 **“SEC. 399V-8. REGIONAL CENTERS OF EXCELLENCE AD-**
2 **DRESSING IMPLICIT BIAS AND CULTURAL**
3 **COMPETENCY IN PATIENT-PROVIDER INTER-**
4 **ACTIONS EDUCATION.**

5 “(a) IN GENERAL.—Not later than one year after the
6 date of enactment of this section, the Secretary, in con-
7 sultation with such other agency heads as the Secretary
8 determines appropriate, shall award cooperative agree-
9 ments for the establishment or support of regional centers
10 of excellence addressing implicit bias, cultural competency,
11 and respectful care practices in patient-provider inter-
12 actions education for the purpose of enhancing and im-
13 proving how health care professionals are educated in im-
14 plicit bias and delivering culturally competent health care.

15 “(b) ELIGIBILITY.—To be eligible to receive a cooper-
16 ative agreement under subsection (a), an entity shall—

17 “(1) be a public or other nonprofit entity speci-
18 fied by the Secretary that provides educational and
19 training opportunities for students and health care
20 professionals, which may be a health system, teach-
21 ing hospital, community health center, medical
22 school, school of public health, school of nursing,
23 dental school, social work school, school of profes-
24 sional psychology, or any other health professional
25 school or program at an institution of higher edu-
26 cation (as defined in section 101 of the Higher Edu-

1 cation Act of 1965) focused on the prevention, treat-
2 ment, or recovery of health conditions that con-
3 tribute to maternal mortality and the prevention of
4 maternal mortality and severe maternal morbidity;

5 “(2) demonstrate community engagement and
6 participation, such as through partnerships with
7 home visiting and case management programs;

8 “(3) demonstrate engagement with groups en-
9 gaged in the implementation of health care profes-
10 sional training in implicit bias and delivering cul-
11 turally competent care, such as departments of pub-
12 lic health, perinatal quality collaboratives, hospital
13 systems, and health care professional groups, in
14 order to obtain input on resources needed for effec-
15 tive implementation strategies; and

16 “(4) provide to the Secretary such information,
17 at such time and in such manner, as the Secretary
18 may require.

19 “(c) DIVERSITY.—In awarding a cooperative agree-
20 ment under subsection (a), the Secretary shall take into
21 account any regional differences among eligible entities
22 and make an effort to ensure geographic diversity among
23 award recipients.

24 “(d) DISSEMINATION OF INFORMATION.—

1 “(1) PUBLIC AVAILABILITY.—The Secretary
2 shall make publicly available on the internet website
3 of the Department of Health and Human Services
4 information submitted to the Secretary under sub-
5 section (b)(4).

6 “(2) EVALUATION.—The Secretary shall evalu-
7 ate each regional center of excellence established or
8 supported pursuant to subsection (a) and dissemi-
9 nate the findings resulting from each such evalua-
10 tion to the appropriate public and private entities.

11 “(3) DISTRIBUTION.—The Secretary shall share
12 evaluations and overall findings with State depart-
13 ments of health and other relevant State level offices
14 to inform State and local best practices.

15 “(e) MATERNAL MORTALITY DEFINED.—In this sec-
16 tion, the term ‘maternal mortality’ means death of a per-
17 son that occurs during pregnancy or within the one-year
18 period following the end of such pregnancy.

19 “(f) AUTHORIZATION OF APPROPRIATIONS.—For
20 purposes of carrying out this section, there is authorized
21 to be appropriated \$5,000,000 for each of fiscal years
22 2023 through 2027.”.

23 (7) SPECIAL SUPPLEMENTAL NUTRITION PRO-
24 GRAM FOR PEOPLE, INFANTS, AND CHILDREN.—Sec-

1 tion 17(d)(3)(A)(ii) of the Child Nutrition Act of
2 1966 (42 U.S.C. 1786(d)(3)(A)(ii)) is amended—

3 (A) by striking the clause designation and
4 heading and all that follows through “A State”
5 and inserting the following:

6 “(ii) PREGNANT AND POSTPARTUM
7 PEOPLE.—

8 “(I) BREASTFEEDING PEOPLE.—
9 A State”;

10 (B) in subclause (I) (as so designated), by
11 striking “1 year” and all that follows through
12 “earlier” and inserting “2 years postpartum”;
13 and

14 (C) by adding at the end the following:

15 “(II) POSTPARTUM PEOPLE.—A
16 State may elect to certify a
17 postpartum person for a period of 2
18 years.”.

19 (8) DEFINITIONS.—In this subsection:

20 (A) MATERNAL MORTALITY.—The term
21 “maternal mortality” means death of a person
22 that occurs during pregnancy or within the one-
23 year period following the end of such preg-
24 nancy.

1 (B) PREGNANCY RELATED DEATH.—The
2 term “pregnancy related death” includes the
3 death of a person during pregnancy or within
4 one year of the end of pregnancy from a preg-
5 nancy complication, a chain of events initiated
6 by pregnancy, or the aggravation of an unre-
7 lated condition by the physiologic effects of
8 pregnancy.

9 (C) SEVERE MATERNAL MORBIDITY.—The
10 term “severe maternal morbidity” includes un-
11 expected outcomes of labor and delivery that re-
12 sult in significant short-term or long-term con-
13 sequences to a person’s health.

14 (b) INCREASE IN TAX ON CERTAIN TOBACCO PROD-
15 UCTS AND IMPOSITION OF TAX ON NICOTINE.—

16 (1) INCREASING TAX ON CIGARETTES.—

17 (A) SMALL CIGARETTES.—Section
18 5701(b)(1) of the Internal Revenue Code of
19 1986 is amended by striking “\$50.33” and in-
20 serting “\$100.66”.

21 (B) LARGE CIGARETTES.—Section
22 5701(b)(2) of such Code is amended by striking
23 “\$105.69” and inserting “\$211.39”.

1 (2) TAX PARITY FOR SMALL CIGARS.—Section
2 5701(a)(1) of such Code is amended by striking
3 “\$50.33” and inserting “\$100.66”.

4 (3) TAX PARITY FOR LARGE CIGARS.—Section
5 5701(a)(2) of such Code is amended by striking
6 “52.75 percent” and all that follows through the pe-
7 riod and inserting “\$49.56 per pound and a propor-
8 tionate tax at the like rate on all fractional parts of
9 a pound but not less than 10.06 cents per cigar.”.

10 (4) TAX PARITY FOR SMOKELESS TOBACCO.—

11 (A) Section 5701(e) of such Code is
12 amended—

13 (i) in paragraph (1), by striking
14 “\$1.51” and inserting “\$26.84”,

15 (ii) in paragraph (2), by striking
16 “50.33 cents” and inserting “\$10.70”, and

17 (iii) by adding at the end the fol-
18 lowing new paragraph:

19 “(3) SMOKELESS TOBACCO SOLD IN DISCRETE
20 SINGLE-USE UNITS.—On discrete single-use units,
21 \$100 per thousand.”.

22 (B) Section 5702(m) of such Code is
23 amended—

1 (i) in paragraph (1), by striking “or
2 chewing tobacco” and inserting “, chewing
3 tobacco, or discrete single-use unit”,

4 (ii) in paragraphs (2) and (3), by in-
5 serting “and that is not a discrete single-
6 use unit” before the period at the end of
7 each such paragraph, and

8 (iii) by adding at the end the fol-
9 lowing new paragraph:

10 “(4) DISCRETE SINGLE-USE UNIT.—The term
11 ‘discrete single-use unit’ means any product con-
12 taining tobacco that—

13 “(A) is not intended to be smoked, and

14 “(B) is in the form of a lozenge, tablet,
15 pill, pouch, dissolvable strip, or other discrete
16 single-use or single-dose unit.”.

17 (5) TAX PARITY FOR PIPE TOBACCO.—Section
18 5701(f) of such Code is amended by striking
19 “\$2.8311 cents” and inserting “\$49.56”.

20 (6) TAX PARITY FOR ROLL-YOUR-OWN TO-
21 BACCO.—Section 5701(g) of such Code is amended
22 by striking “\$24.78” and inserting “\$49.56”.

23 (7) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO
24 AND CERTAIN PROCESSED TOBACCO.—Section
25 5702(o) of such Code is amended by inserting “,

1 and includes processed tobacco that is removed for
2 delivery or delivered to a person other than a person
3 with a permit provided under section 5713, but does
4 not include removals of processed tobacco for expor-
5 tation” after “wrappers thereof”.

6 (8) IMPOSITION OF TAX ON NICOTINE FOR USE
7 IN VAPING, ETC.—

8 (A) IN GENERAL.—Section 5701 of such
9 Code is amended by redesignating subsection
10 (h) as subsection (i) and by inserting after sub-
11 section (g) the following new subsection:

12 “(h) NICOTINE.—On taxable nicotine, manufactured
13 in or imported into the United States, there shall be im-
14 posed a tax equal to the dollar amount specified in section
15 5701(b)(1) per 1,810 milligrams of nicotine (and a pro-
16 portionate tax at the like rate on any fractional part there-
17 of).”.

18 (B) TAXABLE NICOTINE.—Section 5702 of
19 such Code is amended by adding at the end the
20 following new subsection:

21 “(q) TAXABLE NICOTINE.—

22 “(1) IN GENERAL.—Except as otherwise pro-
23 vided in this subsection, the term ‘taxable nicotine’
24 means any nicotine which has been extracted, con-
25 centrated, or synthesized.

1 “(2) EXCEPTION FOR PRODUCTS APPROVED BY
2 FOOD AND DRUG ADMINISTRATION.—Such term
3 shall not include any nicotine if the manufacturer or
4 importer thereof demonstrates to the satisfaction of
5 the Secretary of Health and Human Services that
6 such nicotine will be used in—

7 “(A) a drug—

8 “(i) that is approved under section
9 505 of the Federal Food, Drug, and Cos-
10 metic Act or licensed under section 351 of
11 the Public Health Service Act, or

12 “(ii) for which an investigational use
13 exemption has been authorized under sec-
14 tion 505(i) of the Federal Food, Drug, and
15 Cosmetic Act or under section 351(a) of
16 the Public Health Service Act, or

17 “(B) a combination product (as described
18 in section 503(g) of the Federal Food, Drug,
19 and Cosmetic Act), the constituent parts of
20 which were approved or cleared under section
21 505, 510(k), or 515 of such Act.

22 “(3) COORDINATION WITH TAXATION OF OTHER
23 TOBACCO PRODUCTS.—Tobacco products meeting
24 the definition of cigars, cigarettes, smokeless to-
25 bacco, pipe tobacco, and roll-your-own tobacco in

1 this section shall be classified and taxed as such de-
2 spite any concentration of the nicotine inherent in
3 those products or any addition of nicotine to those
4 products during the manufacturing process.

5 “(4) REGULATIONS.—The Secretary shall pre-
6 scribe such regulations or other guidance as is nec-
7 essary or appropriate to carry out the purposes of
8 this subsection, including regulations or other guid-
9 ance for coordinating the taxation of tobacco prod-
10 ucts and taxable nicotine to protect revenue and pre-
11 vent double taxation.”.

12 (C) TAXABLE NICOTINE TREATED AS A TO-
13 BACCO PRODUCT.—Section 5702(c) of such
14 Code is amended by striking “and roll-your-own
15 tobacco” and inserting “roll-your-own tobacco,
16 and taxable nicotine”.

17 (D) MANUFACTURER OF TAXABLE NICO-
18 TINE.—Section 5702 of such Code, as amended
19 by subparagraph (B), is amended by adding at
20 the end the following new subsection:

21 “(r) MANUFACTURER OF TAXABLE NICOTINE.—

22 “(1) IN GENERAL.—Any person who extracts,
23 concentrates, or synthesizes nicotine shall be treated
24 as a manufacturer of taxable nicotine (and as manu-
25 facturing such taxable nicotine).

1 “(2) APPLICATION OF RULES RELATED TO
2 MANUFACTURERS OF TOBACCO PRODUCTS.—Any
3 reference to a manufacturer of tobacco products, or
4 to manufacturing tobacco products, shall be treated
5 as including a reference to a manufacturer of tax-
6 able nicotine, or to manufacturing taxable nicotine,
7 respectively.”.

8 (9) REPEAL OF SPECIAL RULES FOR DETER-
9 MINING PRICE OF CIGARS.—Section 5702 of such
10 Code is amended by striking subsection (l).

11 (10) FLOOR STOCKS TAXES.—

12 (A) IMPOSITION OF TAX.—On covered to-
13 bacco products, and cigarette papers and tubes,
14 manufactured in or imported into the United
15 States which are removed before the tax in-
16 crease date and held on such date for sale by
17 any person, there is hereby imposed a tax in an
18 amount equal to the excess of—

19 (i) the tax which would be imposed
20 under section 5701 of the Internal Rev-
21 enue Code of 1986 on the article if the ar-
22 ticle had been removed on such date, over
23 (ii) the prior tax (if any) imposed
24 under section 5701 of such Code on such
25 article.

1 (B) COVERED TOBACCO PRODUCTS.—For
2 purposes of this paragraph, the term “covered
3 tobacco products” means any tobacco product
4 other than—

5 (i) cigars described in section
6 5701(a)(2) of the Internal Revenue Code
7 of 1986,

8 (ii) discrete single-use units (as de-
9 fined in section 5702(m)(4) of such Code,
10 as amended by this subsection), and

11 (iii) taxable nicotine (as defined in
12 section 5702(q) of such Code, as amended
13 by this subsection).

14 (C) CREDIT AGAINST TAX.—Each person
15 shall be allowed as a credit against the taxes
16 imposed by subparagraph (A) an amount equal
17 to the lesser of \$1,000 or the amount of such
18 taxes. For purposes of the preceding sentence,
19 all persons treated as a single employer under
20 subsection (b), (c), (m), or (o) of section 414 of
21 the Internal Revenue Code of 1986 shall be
22 treated as 1 person for purposes of this sub-
23 paragraph.

24 (D) LIABILITY FOR TAX AND METHOD OF
25 PAYMENT.—

1 (i) LIABILITY FOR TAX.—The person
2 referred to in subparagraph (A) shall be
3 liable for the tax imposed by such subpara-
4 graph.

5 (ii) METHOD OF PAYMENT.—The tax
6 imposed by subparagraph (A) shall be paid
7 in such manner as the Secretary may pro-
8 vide.

9 (E) ARTICLES IN FOREIGN TRADE
10 ZONES.—

11 (i) IN GENERAL.—Notwithstanding
12 the Act of June 18, 1934 (commonly
13 known as the Foreign Trade Zone Act, 48
14 Stat. 998, 19 U.S.C. 81a et seq.) or any
15 other provision of law, any covered tobacco
16 products, or cigarette papers and tubes,
17 which are located in a foreign trade zone
18 on the tax increase date, shall be subject
19 to the tax imposed by subparagraph (A)
20 if—

21 (I) internal revenue taxes have
22 been determined, or customs duties
23 liquidated, with respect to such article
24 before such date pursuant to a re-

1 quest made under the 1st proviso of
2 section 3(a) of such Act, or

3 (II) such article is held on such
4 date under the supervision of an offi-
5 cer of the United States Customs and
6 Border Protection of the Department
7 of Homeland Security pursuant to the
8 2d proviso of such section 3(a).

9 (F) TAX INCREASE DATE.—For purposes
10 of this paragraph, the term “tax increase date”
11 means the first day of the first calendar quarter
12 described in paragraph (11)(A).

13 (G) CERTAIN OTHER DEFINITIONS.—
14 Terms used in this paragraph which are also
15 used in section 5702 of the Internal Revenue
16 Code of 1986 shall have the same meaning as
17 when used in such section.

18 (11) EFFECTIVE DATE.—

19 (A) IN GENERAL.—Except as otherwise
20 provided in this paragraph, the amendments
21 made by this subsection shall apply to articles
22 removed in calendar quarters beginning after
23 the date of the enactment of this Act.

24 (B) DELAYED EFFECTIVE DATE FOR CER-
25 TAIN PRODUCTS.—The amendments made by

1 paragraphs (3), (4)(A)(iii), (4)(B), and (8)
2 shall apply to articles removed in calendar
3 quarters beginning after the date which is 180
4 days after the date of the enactment of this
5 Act.

6 (12) TRANSITION RULE FOR PERMIT AND BOND
7 REQUIREMENTS.—A person which is lawfully en-
8 gaged in business as a manufacturer or importer of
9 taxable nicotine (within the meaning of subchapter
10 A of chapter 52 of the Internal Revenue Code of
11 1986, as amended by this subsection) on the date of
12 the enactment of this Act, first becomes subject to
13 the requirements of subchapter B of chapter 52 of
14 such Code by reason of the amendments made by
15 this subsection, and submits an application under
16 such subchapter B to engage in such business not
17 later than 90 days after the date of the enactment
18 of this Act, shall not be denied the right to carry on
19 such business by reason of such requirements before
20 final action on such application.

21 **SEC. 5202. MOMMIES.**

22 (a) GAO STUDY AND REPORT.—

23 (1) IN GENERAL.—Not later than 1 year after
24 the date of the enactment of this Act, the Comp-
25 troller General of the United States shall submit to

1 Congress a report on the gaps in coverage with re-
2 spect to—

3 (A) pregnant individuals enrolled under a
4 State plan (or waiver of such plan) under title
5 XIX of the Social Security Act (42 U.S.C. 1396
6 et seq.) and the Children’s Health Insurance
7 Program under title XXI of the Social Security
8 Act (42 U.S.C. 1397aa et seq.); and

9 (B) postpartum individuals enrolled under
10 a State plan (or waiver of such plan) under title
11 XIX of the Social Security Act (42 U.S.C. 1396
12 et seq.) and the Children’s Health Insurance
13 Program under title XXI of the Social Security
14 Act (42 U.S.C. 1397aa et seq.) who received as-
15 sistance under either such program during their
16 pregnancy.

17 (2) CONTENT OF REPORT.—The report re-
18 quired under this paragraph shall include the fol-
19 lowing:

20 (A) Information about the abilities and
21 successes of State Medicaid agencies in deter-
22 mining whether pregnant and postpartum indi-
23 viduals are eligible under another insurance af-
24 fordability program, and in transitioning any
25 such individuals who are so eligible to coverage

1 under such a program at the end of their period
2 of eligibility for medical assistance, pursuant to
3 section 435.1200 of the title 42, Code of Fed-
4 eral Regulations (as in effect on September 1,
5 2018).

6 (B) Information on factors contributing to
7 gaps in coverage that disproportionately impact
8 underserved populations, including low-income
9 individuals, Black, Indigenous, and other indi-
10 viduals of color, individuals who reside in a
11 health professional shortage area (as defined in
12 section 332(a)(1)(A) of the Public Health Serv-
13 ice Act (42 U.S.C. 254e(a)(1)(A))) or individ-
14 uals who are members of a medically under-
15 served population (as defined by section
16 330(b)(3) of such Act (42 U.S.C.
17 254b(b)(3)(A))).

18 (C) Recommendations for addressing and
19 reducing such gaps in coverage.

20 (D) Such other information as the Comp-
21 troller General deems necessary.

22 (3) DATA DISAGGREGATION.—To the greatest
23 extent possible, the Comptroller General shall
24 disaggregate data presented in the report, including

1 by age, gender identity, race, ethnicity, income level,
2 and other demographic factors.

3 (b) MATERNITY CARE HOME DEMONSTRATION
4 PROJECT.—Title XIX of the Social Security Act (42
5 U.S.C. 1396 et seq.) is amended by inserting the following
6 new section after section 1947:

7 **“SEC. 1948. MATERNITY CARE HOME DEMONSTRATION**
8 **PROJECT.**

9 “(a) IN GENERAL.—Not later than 1 year after the
10 date of the enactment of this section, the Secretary shall
11 establish a demonstration project (in this section referred
12 to as the ‘demonstration project’) under which the Sec-
13 retary shall provide grants to States to enter into arrange-
14 ments with eligible entities to implement or expand a ma-
15 ternity care home model for eligible individuals.

16 “(b) GOALS OF DEMONSTRATION PROJECT.—The
17 goals of the demonstration project are the following:

18 “(1) To improve—

19 “(A) maternity and infant care outcomes;

20 “(B) birth equity;

21 “(C) health equity for—

22 “(i) Black, Indigenous, and other peo-
23 ple of color;

1 “(ii) lesbian, gay, bisexual,
2 transgender, queer, non-binary, and gender
3 nonconfirming individuals;

4 “(iii) people with disabilities; and

5 “(iv) other underserved populations;

6 “(D) communication by maternity, infant
7 care, and social services providers;

8 “(E) integration of perinatal support serv-
9 ices, including community health workers,
10 doulas, social workers, public health nurses,
11 peer lactation counselors, lactation consultants,
12 childbirth educators, peer mental health work-
13 ers, and others, into health care entities and or-
14 ganizations;

15 “(F) care coordination between maternity,
16 infant care, oral health services, and social serv-
17 ices providers within the community;

18 “(G) the quality and safety of maternity
19 and infant care;

20 “(H) the experience of individuals receiv-
21 ing maternity care, including by increasing the
22 ability of an individual to develop and follow
23 their own birthing plans; and

24 “(I) access to adequate prenatal and
25 postpartum care, including—

1 “(i) prenatal care that is initiated in
2 a timely manner;

3 “(ii) not fewer than 5 post-pregnancy
4 visits to a maternity care provider; and

5 “(iii) interpregnancy care.

6 “(2) To provide coordinated, evidence-based, re-
7 spectful, culturally and linguistically appropriate,
8 and person-centered maternity care management.

9 “(3) To decrease—

10 “(A) severe and preventable maternal mor-
11 bidity and maternal mortality;

12 “(B) overall health care spending;

13 “(C) unnecessary emergency department
14 visits;

15 “(D) inequities in maternal and infant care
16 outcomes, including racial, economic, disability,
17 gender-based, and geographical inequities;

18 “(E) racial, gender, economic, and other
19 discrimination among health care professionals;

20 “(F) racism, discrimination, disrespect,
21 and abuse in maternity care settings;

22 “(G) the rate of cesarean deliveries for
23 low-risk pregnancies;

24 “(H) the rate of pre-term births and in-
25 fants born with low birth weight; and

1 “(I) the rate of avoidable maternal and
2 newborn hospitalizations and admissions to in-
3 tensive care units.

4 “(c) CONSULTATION.—In designing and imple-
5 menting the demonstration project the Secretary shall
6 consult with stakeholders, including—

7 “(1) States;

8 “(2) organizations representing relevant health
9 care professionals, including oral health services pro-
10 fessionals;

11 “(3) organizations, particularly reproductive
12 justice and birth justice organizations led by people
13 of color, that represent consumers of maternal
14 health care, including consumers of maternal health
15 care who are disproportionately impacted by poor
16 maternal health outcomes;

17 “(4) representatives with experience imple-
18 menting other maternity care home models, includ-
19 ing representatives from the Center for Medicare
20 and Medicaid Innovation;

21 “(5) community-based health care professionals,
22 including doulas, lactation consultants, and other
23 stakeholders;

24 “(6) experts in promoting health equity and
25 combating racial bias in health care settings; and

1 “(7) Black, Indigenous, and other maternal
2 health care consumers of color who have experienced
3 severe maternal morbidity.

4 “(d) APPLICATION AND SELECTION OF STATES.—

5 “(1) IN GENERAL.—A State seeking to partici-
6 pate in the demonstration project shall submit an
7 application to the Secretary at such time and in
8 such manner as the Secretary shall require.

9 “(2) SELECTION OF STATES.—

10 “(A) IN GENERAL.—The Secretary shall
11 select at least 10 States to participate in the
12 demonstration project.

13 “(B) SELECTION REQUIREMENTS.—In se-
14 lecting States to participate in the demonstra-
15 tion project, the Secretary shall—

16 “(i) ensure that there is geographic
17 and regional diversity in the areas in which
18 activities will be carried out under the
19 project;

20 “(ii) ensure that States with signifi-
21 cant inequities in maternal and infant
22 health outcomes, including severe maternal
23 morbidity, and other inequities based on
24 race, income, or access to maternity care,
25 are included; and

1 “(iii) ensure that at least 1 territory
2 is included.

3 “(e) GRANTS.—

4 “(1) IN GENERAL.—From amounts appro-
5 priated under subsection (l), the Secretary shall
6 award 1 grant for each year of the demonstration
7 project to each State that is selected to participate
8 in the demonstration project.

9 “(2) USE OF GRANT FUNDS.—A State may use
10 funds received under this section to—

11 “(A) award grants or make payments to
12 eligible entities as part of an arrangement de-
13 scribed in subsection (f)(2);

14 “(B) provide financial incentives to health
15 care professionals, including community-based
16 health care workers and community-based
17 doulas, who participate in the State’s maternity
18 care home model;

19 “(C) provide adequate training for health
20 care professionals, including community-based
21 health care workers, doulas, and care coordina-
22 tors, who participate in the State’s maternity
23 care home model, which may include training
24 for cultural humility and antiracism, racial bias,
25 health equity, reproductive and birth justice,

1 trauma-informed care, home visiting skills, and
2 respectful communication and listening skills,
3 particularly in regards to maternal health;

4 “(D) pay for personnel and administrative
5 expenses associated with designing, imple-
6 menting, and operating the State’s maternity
7 care home model;

8 “(E) pay for items and services that are
9 furnished under the State’s maternity care
10 home model and for which payment is otherwise
11 unavailable under this title;

12 “(F) pay for services and materials to en-
13 sure culturally and linguistically appropriate
14 communication, including—

15 “(i) language services such as inter-
16 preters and translation of written mate-
17 rials; and

18 “(ii) development of culturally and lin-
19 guistically appropriate materials; and aux-
20 iliary aids and services; and

21 “(G) pay for other costs related to the
22 State’s maternity care home model, as deter-
23 mined by the Secretary.

24 “(3) GRANT FOR NATIONAL INDEPENDENT
25 EVALUATOR.—

1 “(A) IN GENERAL.—From the amounts
2 appropriated under subsection (l), prior to
3 awarding any grants under paragraph (1), the
4 Secretary shall enter into a contract with a na-
5 tional external entity to create a single, uniform
6 process to—

7 “(i) ensure that States that receive
8 grants under paragraph (1) comply with
9 the requirements of this section; and

10 “(ii) evaluate the outcomes of the
11 demonstration project in each participating
12 State.

13 “(B) ANNUAL REPORT.—The contract de-
14 scribed in subparagraph (A) shall require the
15 national external entity to submit to the Sec-
16 retary—

17 “(i) a yearly evaluation report for
18 each year of the demonstration project;
19 and

20 “(ii) a final impact report after the
21 demonstration project has concluded.

22 “(C) SECRETARY’S AUTHORITY.—Nothing
23 in this paragraph shall prevent the Secretary
24 from making a determination that a State is
25 not in compliance with the requirements of this

1 section without the national external entity
2 making such a determination.

3 “(f) PARTNERSHIP WITH ELIGIBLE ENTITIES.—

4 “(1) IN GENERAL.—As a condition of receiving
5 a grant under this section, a State shall enter into
6 an arrangement with one or more eligible entities
7 that meets the requirements of paragraph (2).

8 “(2) ARRANGEMENTS WITH ELIGIBLE ENTI-
9 TIES.—Under an arrangement between a State and
10 an eligible entity under this subsection, the eligible
11 entity shall perform the following functions, with re-
12 spect to eligible individuals enrolled with the entity
13 under the State’s maternity care home model—

14 “(A) provide culturally and linguistically
15 appropriate congruent care, which may include
16 prenatal care, family planning services, medical
17 care, mental and behavioral care, postpartum
18 care, and oral health services to such eligible in-
19 dividuals through a team of health care profes-
20 sionals, which may include obstetrician-gyne-
21 cologists, maternal-fetal medicine specialists,
22 family physicians, primary care providers, oral
23 health providers, physician assistants, advanced
24 practice registered nurses such as nurse practi-
25 tioners and certified nurse midwives, certified

1 midwives, certified professional midwives, phys-
2 ical therapists, social workers, traditional and
3 community-based doulas, lactation consultants,
4 childbirth educators, community health workers,
5 peer mental health supporters, and other health
6 care professionals;

7 “(B) conduct a risk assessment of each
8 such eligible individual to determine if their
9 pregnancy is high or low risk, and establish a
10 tailored pregnancy care plan, which takes into
11 consideration the individual’s own preferences
12 and pregnancy care and birthing plans and de-
13 termines the appropriate support services to re-
14 duce the individual’s medical, social, and envi-
15 ronmental risk factors, for each such eligible in-
16 dividual based on the results of such risk as-
17 sessment;

18 “(C) assign each such eligible individual to
19 a culturally and linguistically appropriate care
20 coordinator, which may be a nurse, social work-
21 er, traditional or community-based doula, com-
22 munity health worker, midwife, or other health
23 care provider, who is responsible for ensuring
24 that such eligible individual receives the nec-

1 essary medical care and connections to essential
2 support services;

3 “(D) provide, or arrange for the provision
4 of, essential support services, such as services
5 that address—

6 “(i) food access, nutrition, and exer-
7 cise;

8 “(ii) smoking cessation;

9 “(iii) substance use disorder and ad-
10 diction treatment;

11 “(iv) anxiety, depression, trauma, and
12 other mental and behavioral health issues;

13 “(v) breast feeding, chestfeeding, or
14 other infant feeding options supports, initi-
15 ation, continuation, and duration;

16 “(vi) stable, affordable, safe, and
17 healthy housing;

18 “(vii) transportation;

19 “(viii) intimate partner violence;

20 “(ix) community and police violence;

21 “(x) home visiting services;

22 “(xi) childbirth and newborn care edu-
23 cation;

24 “(xii) oral health education;

25 “(xiii) continuous labor support;

1 “(xiv) group prenatal care;

2 “(xv) family planning and contracep-
3 tive care and supplies; and

4 “(xvi) affordable child care;

5 “(E) as appropriate, facilitate connections
6 to a usual primary care provider, which may be
7 a reproductive health care provider;

8 “(F) refer to guidelines and opinions of
9 medical associations when determining whether
10 an elective delivery should be performed on an
11 eligible individual before 39 weeks of gestation;

12 “(G) provide such eligible individual with
13 evidence-based and culturally and linguistically
14 appropriate education and resources to identify
15 potential warning signs of pregnancy and
16 postpartum complications and when and how to
17 obtain medical attention;

18 “(H) provide, or arrange for the provision
19 of, culturally and linguistically appropriate
20 pregnancy and postpartum health services, in-
21 cluding family planning counseling and services,
22 to eligible individuals;

23 “(I) track and report postpartum health
24 and birth outcomes of such eligible individuals
25 and their children;

1 “(J) ensure that care is person-centered,
2 culturally and linguistically appropriate, and
3 patient-led, including by engaging eligible indi-
4 viduals in their own care, including through
5 communication and education; and

6 “(K) ensure adequate training for appro-
7 priately serving the population of individuals el-
8 igible for medical assistance under the State
9 plan (or waiver of such plan), including through
10 reproductive justice, birth justice, birth equity,
11 and anti-racist frameworks, home visiting skills,
12 and knowledge of social services.

13 “(g) TERM OF DEMONSTRATION PROJECT.—The
14 Secretary shall conduct the demonstration project for a
15 period of 5 years.

16 “(h) REPORT.—Not later than 18 months after the
17 date of the enactment of this section and annually there-
18 after for each year of the demonstration project term, the
19 Secretary shall submit a report to Congress on the results
20 of the demonstration project, including—

21 “(1) the results of the final report of the na-
22 tional external entity required under subsection
23 (e)(3)(B)(ii); and

24 “(2) recommendations on whether the model
25 studied in the demonstration project should be con-

1 tinued or more widely adopted, including by private
2 health plans.

3 “(i) WAIVER AUTHORITY.—To the extent that the
4 Secretary determines necessary in order to carry out the
5 demonstration project, the Secretary may waive section
6 1902(a)(1) (relating to statewideness) and section
7 1902(a)(10)(B) (relating to comparability).

8 “(j) TECHNICAL ASSISTANCE.—The Secretary shall
9 establish a process to provide technical assistance to
10 States that are awarded grants under this section and to
11 eligible entities and other providers participating in a
12 State maternity care home model funded by such a grant.

13 “(k) DEFINITIONS.—In this section:

14 “(1) ELIGIBLE ENTITY.—The term ‘eligible en-
15 tity’ means an entity or organization that provides
16 medically accurate, comprehensive maternity services
17 to individuals who are eligible for medical assistance
18 under a State plan under this title or a waiver of
19 such a plan, and may include:

20 “(A) A freestanding birth center.

21 “(B) An entity or organization receiving
22 assistance under section 330 of the Public
23 Health Service Act.

24 “(C) A federally qualified health center.

25 “(D) A rural health clinic.

1 “(E) A health facility operated by an In-
2 dian tribe or tribal organization (as those terms
3 are defined in section 4 of the Indian Health
4 Care Improvement Act).

5 “(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible
6 individual’ means a pregnant individual or a for-
7 merly pregnant individual during the 1-year period
8 beginning on the last day of the pregnancy, or such
9 longer period beginning on such day as a State may
10 elect, who is—

11 “(A) enrolled in a State plan under this
12 title, a waiver of such a plan, or a State child
13 health plan under title XXI; and

14 “(B) a patient of an eligible entity which
15 has entered into an arrangement with a State
16 under subsection (g).

17 “(1) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated to the Secretary, for
19 each of fiscal years 2023 through 2030, such sums as may
20 be necessary to carry out this section.”.

21 (c) REAPPLICATION OF MEDICARE PAYMENT RATE
22 FLOOR TO PRIMARY CARE SERVICES FURNISHED UNDER
23 MEDICAID AND INCLUSION OF ADDITIONAL PRO-
24 VIDERS.—

1 (1) REAPPLICATION OF PAYMENT FLOOR; ADDI-
2 TIONAL PROVIDERS.—

3 (A) IN GENERAL.—Section 1902(a)(13) of
4 the Social Security Act (42 U.S.C.
5 1396a(a)(13)) is amended—

6 (i) in subparagraph (B), by striking “;
7 and” and inserting a semicolon;

8 (ii) in subparagraph (C), by striking
9 the semicolon and inserting “; and”; and

10 (iii) by adding at the end the fol-
11 lowing new subparagraph:

12 “(D) payment for primary care services (as
13 defined in subsection (jj)(1)) furnished in the
14 period that begins on the first day of the first
15 month that begins after the date of enactment
16 of this subparagraph by a provider described in
17 subsection (jj)(2)—

18 “(i) at a rate that is not less than 100
19 percent of the payment rate that applies to
20 such services and the provider of such
21 services under part B of title XVIII (or, if
22 greater, the payment rate that would be
23 applicable under such part if the conver-
24 sion factor under section 1848(d) for the

1 year were the conversion factor under such
2 section for 2009);

3 “(ii) in the case of items and services
4 that are not items and services provided
5 under such part, at a rate to be established
6 by the Secretary; and

7 “(iii) in the case of items and services
8 that are furnished in rural areas (as de-
9 fined in section 1886(d)(2)(D)), health
10 professional shortage areas (as defined in
11 section 332(a)(1)(A) of the Public Health
12 Service Act (42 U.S.C. 254e(a)(1)(A))), or
13 medically underserved areas (according to
14 a designation under section 330(b)(3)(A)
15 of the Public Health Service Act (42
16 U.S.C. 254b(b)(3)(A))), at the rate other-
17 wise applicable to such items or services
18 under clause (i) or (ii) increased, at the
19 Secretary’s discretion, by not more than 25
20 percent;”.

21 (B) CONFORMING AMENDMENTS.—

22 (i) Section 1902(a)(13)(C) of the So-
23 cial Security Act (42 U.S.C.
24 1396a(a)(13)(C)) is amended by striking

1 “subsection (jj)” and inserting “subsection
2 (jj)(1)”.

3 (ii) Section 1905(dd) of the Social Se-
4 curity Act (42 U.S.C. 1396d(dd)) is
5 amended—

6 (I) by striking “Notwith-
7 standing” and inserting the following:
8 “(1) IN GENERAL.—Notwithstanding”;

9 (II) by striking “section
10 1902(a)(13)(C)” and inserting “sub-
11 paragraph (C) of section
12 1902(a)(13)”;

13 (III) by inserting “or for services
14 described in subparagraph (D) of sec-
15 tion 1902(a)(13) furnished during an
16 additional period specified in para-
17 graph (2),” after “2015,”;

18 (IV) by striking “under such sec-
19 tion” and inserting “under subpara-
20 graph (C) or (D) of section
21 1902(a)(13), as applicable”; and

22 (V) by adding at the end the fol-
23 lowing:

24 “(2) ADDITIONAL PERIODS.—For purposes of
25 paragraph (1), the following are additional periods:

1 “(A) The period that begins on the first
2 day of the first month that begins after the
3 date of enactment of the this paragraph.”.

4 (2) IMPROVED TARGETING OF PRIMARY
5 CARE.—Section 1902(jj) of the Social Security Act
6 (42 U.S.C. 1396a(jj)) is amended—

7 (A) by redesignating paragraphs (1) and
8 (2) as clauses (i) and (ii), respectively, and re-
9 aligning the left margins accordingly;

10 (B) by striking “For purposes of sub-
11 section (a)(13)(C)” and inserting the following:
12 “(1) IN GENERAL.—

13 “(A) DEFINITION.—For purposes of sub-
14 paragraphs (C) and (D) of subsection (a)(13)”;
15 and

16 (C) by inserting after clause (ii) (as so re-
17 designated) the following:

18 “(B) EXCLUSIONS.—Such term does not
19 include any services described in subparagraph
20 (A) or (B) of paragraph (1) if such services are
21 provided in an emergency department of a hos-
22 pital.

23 “(2) ADDITIONAL PROVIDERS.—For purposes
24 of subparagraph (D) of subsection (a)(13), a pro-

1 vider described in this paragraph is any of the fol-
2 lowing:

3 “(A) A physician with a primary specialty
4 designation of family medicine, general internal
5 medicine, or pediatric medicine, or obstetrics
6 and gynecology.

7 “(B) An advanced practice clinician, as de-
8 fined by the Secretary, that works under the
9 supervision of—

10 “(i) a physician that satisfies the cri-
11 teria specified in subparagraph (A);

12 “(ii) a nurse practitioner or a physi-
13 cian assistant (as such terms are defined
14 in section 1861(aa)(5)(A)) who is working
15 in accordance with State law; or

16 “(iii) or a certified nurse-midwife (as
17 defined in section 1861(gg)) or a certified
18 professional midwife who is working in ac-
19 cordance with State law.

20 “(C) A rural health clinic, federally quali-
21 fied health center, health center that receives
22 funding under title X of the Public Health
23 Service Act, or other health clinic that receives
24 reimbursement on a fee schedule applicable to
25 a physician.

1 “(D) An advanced practice clinician super-
2 vised by a physician described in subparagraph
3 (A), another advanced practice clinician, or a
4 certified nurse-midwife.

5 “(E) A midwife who is working in accord-
6 ance with State law.”.

7 (3) ENSURING PAYMENT BY MANAGED CARE
8 ENTITIES.—

9 (A) IN GENERAL.—Section 1903(m)(2)(A)
10 of the Social Security Act (42 U.S.C.
11 1396b(m)(2)(A)) is amended—

12 (i) in clause (xii), by striking “and”
13 after the semicolon;

14 (ii) by realigning the left margin of
15 clause (xiii) so as to align with the left
16 margin of clause (xii) and by striking the
17 period at the end of clause (xiii) and in-
18 serting “; and”; and

19 (iii) by inserting after clause (xiii) the
20 following:

21 “(xiv) such contract provides that (I) payments
22 to providers specified in section 1902(a)(13)(D) for
23 primary care services (as defined in section 1902(jj))
24 that are furnished during a year or period (as speci-
25 fied in section 1902(a)(13)(D) and section

1 1905(dd)) are at least equal to the amounts set
2 forth and required by the Secretary by regulation;
3 (II) the entity shall, upon request, provide docu-
4 mentation to the State, sufficient to enable the State
5 and the Secretary to ensure compliance with sub-
6 clause (I); and (III) the Secretary shall approve pay-
7 ments described in subclause (I) that are furnished
8 through an agreed upon capitation, partial capita-
9 tion, or other value-based payment arrangement if
10 the capitation, partial capitation, or other value-
11 based payment arrangement is based on a reason-
12 able methodology and the entity provides docu-
13 mentation to the State sufficient to enable the State
14 and the Secretary to ensure compliance with sub-
15 clause (I).”.

16 (B) CONFORMING AMENDMENT.—Section
17 1932(f) of the Social Security Act (42 U.S.C.
18 1396u–2(f)) is amended—

19 (i) by striking “section
20 1902(a)(13)(C)” and inserting “sub-
21 sections (C) and (D) of section
22 1902(a)(13)”; and

23 (ii) by inserting “, and clause (xiv) of
24 section 1903(m)(2)(A)” before the period.

1 (d) MACPAC REPORT AND CMS GUIDANCE ON IN-
2 CREASING ACCESS TO DOULA SERVICES FOR MEDICAID
3 BENEFICIARIES.—

4 (1) MACPAC REPORT.—

5 (A) IN GENERAL.—Not later than 1 year
6 after the date of the enactment of this Act, the
7 Medicaid and CHIP Payment and Access Com-
8 mission (referred to in this subsection as
9 “MACPAC”) shall publish a report on the cov-
10 erage of doula services under State Medicaid
11 programs, which shall at a minimum include
12 the following:

13 (i) Information about coverage for
14 doula services under State Medicaid pro-
15 grams that currently provide coverage for
16 such care, including the type of doula serv-
17 ices offered (such as prenatal, labor and
18 delivery, postpartum support, and also
19 community-based and traditional doula
20 services).

21 (ii) An analysis of barriers to covering
22 doula services under State Medicaid pro-
23 grams.

24 (iii) An identification of effective
25 strategies to increase the use of doula serv-

ices in order to provide better care and achieve better maternal and infant health outcomes, including strategies that States may use to recruit, train, and certify a diverse doula workforce, particularly from underserved communities, communities of color, and communities facing linguistic or cultural barriers.

(iv) Recommendations for legislative and administrative actions to increase access to doula services in State Medicaid programs, including actions that ensure doulas may earn a living wage that accounts for their time and costs associated with providing care and community-based doula program administration and operation.

(B) STAKEHOLDER CONSULTATION.—In developing the report required under subparagraph (A), MACPAC shall consult with relevant stakeholders, including—

(i) States;

(ii) organizations, especially reproductive justice and birth justice organizations led by people of color, representing con-

1 sumers of maternal health care, including
2 those that are disproportionately impacted
3 by poor maternal health outcomes;

4 (iii) organizations and individuals rep-
5 resenting doulas, including community-
6 based doula programs and those who serve
7 underserved communities, including com-
8 munities of color, and communities facing
9 linguistic or cultural barriers;

10 (iv) organizations representing health
11 care providers; and

12 (v) Black, Indigenous, and other ma-
13 ternal health care consumers of color who
14 have experienced severe maternal mor-
15 bidity.

16 (2) CMS GUIDANCE.—

17 (A) IN GENERAL.—Not later than 1 year
18 after the date that MACPAC publishes the re-
19 port required under paragraph (1)(A), the Ad-
20 ministrators of the Centers for Medicare & Med-
21 icaid Services shall issue guidance to States on
22 increasing access to doula services under Med-
23 icaid. Such guidance shall at a minimum in-
24 clude—

1 (i) options for States to provide med-
2 ical assistance for doula services under
3 State Medicaid programs;

4 (ii) best practices for ensuring that
5 doulas, including community-based doulas,
6 receive reimbursement for doula services
7 provided under a State Medicaid program,
8 at a level that allows doulas to earn a liv-
9 ing wage that accounts for their time and
10 costs associated with providing care and
11 community-based doula program adminis-
12 tration; and

13 (iii) best practices for increasing ac-
14 cess to doula services, including services
15 provided by community-based doulas,
16 under State Medicaid programs.

17 (B) STAKEHOLDER CONSULTATION.—In
18 developing the guidance required under sub-
19 paragraph (A), the Administrator of the Cen-
20 ters for Medicare & Medicaid Services shall con-
21 sult with MACPAC and other relevant stake-
22 holders, including—

23 (i) State Medicaid officials;

24 (ii) organizations representing con-
25 sumers of maternal health care, including

1 those that are disproportionately impacted
2 by poor maternal health outcomes;

3 (iii) organizations representing doulas,
4 including community-based doulas and
5 those who serve underserved communities,
6 such as communities of color and commu-
7 nities facing linguistic or cultural barriers;
8 and

9 (iv) organizations representing med-
10 ical professionals.

11 (e) GAO REPORT ON STATE MEDICAID PROGRAMS'
12 USE OF TELEHEALTH TO INCREASE ACCESS TO MATER-
13 NITY CARE.—Not later than 1 year after the date of the
14 enactment of this Act, the Comptroller General of the
15 United States shall submit a report to Congress on State
16 Medicaid programs' use of telehealth to increase access to
17 maternity care. Such report shall include the following:

18 (1) The number of State Medicaid programs
19 that utilize telehealth that increases access to mater-
20 nity care.

21 (2) With respect to State Medicaid programs
22 that utilize telehealth that increases access to mater-
23 nity care, information about—

1 (A) common characteristics of such pro-
2 grams' approaches to utilizing telehealth that
3 increases access to maternity care;

4 (B) differences in States' approaches to
5 utilizing telehealth to improve access to mater-
6 nity care, and the resulting differences in State
7 maternal health outcomes, as determined by
8 factors described in subsection (C); and

9 (C) when compared to patients who receive
10 maternity care in-person, what is known
11 about—

12 (i) the demographic characteristics,
13 such as race, ethnicity, sex, sexual orienta-
14 tion, gender identity, disability status, age,
15 and preferred language of the individuals
16 enrolled in such programs who use tele-
17 health to access maternity care;

18 (ii) health outcomes for such individ-
19 uals, including frequency of mortality and
20 severe morbidity, as compared to individ-
21 uals with similar characteristics who did
22 not use telehealth to access maternity care;

23 (iii) the services provided to individ-
24 uals through telehealth, including family

1 planning services, mental health care serv-
2 ices, and oral health services;

3 (iv) the devices and equipment pro-
4 vided to individuals for remote patient
5 monitoring and telehealth, including blood
6 pressure monitors and blood glucose mon-
7 itors;

8 (v) the quality of maternity care pro-
9 vided through telehealth, including whether
10 maternity care provided through telehealth
11 is culturally and linguistically appropriate;

12 (vi) the level of patient satisfaction
13 with maternity care provided through tele-
14 health to individuals enrolled in State Med-
15 icaid programs;

16 (vii) the impact of utilizing telehealth
17 to increase access to maternity care on
18 spending, cost savings, access to care, and
19 utilization of care under State Medicaid
20 programs; and

21 (viii) the accessibility and effectiveness
22 of telehealth for maternity care during the
23 COVID–19 pandemic.

1 (3) An identification and analysis of the bar-
2 riers to using telehealth to increase access to mater-
3 nity care under State Medicaid programs.

4 (4) Recommendations for such legislative and
5 administrative actions related to increasing access to
6 telehealth maternity services under Medicaid as the
7 Comptroller General deems appropriate.

8 **SEC. 5203. JUSTICE FOR INCARCERATED MOMS.**

9 (a) SENSE OF CONGRESS.—It is the sense of Con-
10 gress that—

11 (1) the respect and proper care that birthing
12 people deserve is inclusive; and

13 (2) regardless of race, ethnicity, gender iden-
14 tity, sexual orientation, religion, marital status, fa-
15 miliar status, socioeconomic status, immigration sta-
16 tus, incarceration status, or disability, all deserve
17 dignity.

18 (b) ENDING THE SHACKLING OF PREGNANT INDI-
19 VIDUALS.—

20 (1) IN GENERAL.—For each fiscal year that be-
21 gins on or after the date that is 180 days after the
22 date of enactment of this Act, for each State that
23 receives a grant under subpart 1 of part E of title
24 I of the Omnibus Crime Control and Safe Streets
25 Act of 1968 (34 U.S.C. 10151 et seq.) (commonly

1 referred to as the “Edward Byrne Memorial Justice
2 Assistance Grant Program”) and that does not have
3 in effect throughout the State for such fiscal year
4 laws restricting the use of restraints on pregnant in-
5 dividuals in correctional facilities that provide rights,
6 procedures, requirements, effects, and penalties that
7 are substantially similar to those set forth in section
8 4322 of title 18, United States Code, the amount of
9 such grant that would otherwise be allocated to such
10 State under such subpart for the fiscal year shall be
11 decreased by 25 percent.

12 (2) REALLOCATION.—Amounts not allocated to
13 a State for failure to comply with paragraph (1)
14 shall be reallocated in accordance with subpart 1 of
15 part E of title I of the Omnibus Crime Control and
16 Safe Streets Act of 1968 (34 U.S.C. 10151 et seq.)
17 to States that have complied with such paragraph.

18 (c) CREATING MODEL PROGRAMS FOR THE CARE OF
19 INCARCERATED INDIVIDUALS IN THE PRENATAL AND
20 POSTPARTUM PERIODS.—

21 (1) IN GENERAL.—Not later than 1 year after
22 the date of enactment of this Act, the Attorney Gen-
23 eral, acting through the Director of the Bureau of
24 Prisons (in this subsection referred to as the “Direc-
25 tor”), shall establish, in not fewer than 6 Bureau of

1 Prisons facilities, programs to optimize maternal
2 health outcomes for pregnant and postpartum indi-
3 viduals incarcerated in such facilities. The Attorney
4 General shall establish such programs in consulta-
5 tion with stakeholders such as—

6 (A) Federal Public Defenders and Execu-
7 tive Directors of Community Defender Organi-
8 zations;

9 (B) relevant community-based organiza-
10 tions, particularly organizations that represent
11 incarcerated and formerly incarcerated individ-
12 uals and organizations that seek to improve ma-
13 ternal health outcomes for pregnant and
14 postpartum individuals from racial and ethnic
15 minority groups;

16 (C) relevant organizations representing pa-
17 tients, with a particular focus on patients from
18 racial and ethnic minority groups;

19 (D) organizations representing maternity
20 care providers and maternal health care edu-
21 cation programs;

22 (E) perinatal health workers; and

23 (F) researchers and policy experts in fields
24 related to maternal health care for incarcerated
25 individuals.

1 (2) START DATE.—Each facility selected under
2 paragraph (1) shall begin the programs to optimize
3 maternal health outcomes for pregnant and
4 postpartum individuals incarcerated in such facilities
5 not later than 18 months after the date of enact-
6 ment of this Act.

7 (3) FACILITY PRIORITY.—In carrying out para-
8 graph (1), the Director, in consultation with the
9 stakeholders described in paragraph (1), shall give
10 priority to a facility based on—

11 (A) the number of pregnant and
12 postpartum individuals incarcerated in such fa-
13 cility and, among such individuals, the number
14 of pregnant and postpartum individuals from
15 racial and ethnic minority groups; and

16 (B) the extent to which the leaders of such
17 facility have demonstrated a commitment to de-
18 veloping exemplary programs for pregnant and
19 postpartum individuals incarcerated in such fa-
20 cility.

21 (4) PROGRAM DURATION.—The programs es-
22 tablished under this subsection shall be carried out
23 for a 5-year period.

24 (5) PROGRAMS.—Bureau of Prisons facilities
25 selected by the Director shall establish programs for

1 pregnant and postpartum incarcerated individuals,
2 and such programs may—

3 (A) provide access to perinatal health
4 workers from pregnancy through the
5 postpartum period;

6 (B) provide access to healthy foods and
7 counseling on nutrition, recommended activity
8 levels, and safety measures throughout preg-
9 nancy;

10 (C) train correctional officers to ensure
11 that pregnant incarcerated individuals receive
12 safe and respectful treatment;

13 (D) train medical personnel to ensure that
14 pregnant incarcerated individuals receive trau-
15 ma-informed, culturally congruent care that
16 promotes the health and safety of the pregnant
17 individuals;

18 (E) provide counseling and treatment for
19 individuals who have suffered from—

20 (i) diagnosed mental or behavioral
21 health conditions, including trauma and
22 substance use disorders;

23 (ii) trauma or violence, including do-
24 mestic violence;

25 (iii) human immunodeficiency virus;

1 (iv) sexual abuse;

2 (v) pregnancy or infant loss; or

3 (vi) chronic conditions;

4 (F) provide evidence-based pregnancy and
5 childbirth education, parenting support, and
6 other relevant forms of health literacy;

7 (G) provide clinical education opportunities
8 to maternity care providers in training to ex-
9 pand pathways into maternal health care ca-
10 reers serving incarcerated individuals;

11 (H) offer opportunities for postpartum in-
12 dividuals to maintain contact with the individ-
13 ual's newborn child to promote bonding, includ-
14 ing enhanced visitation policies, access to prison
15 nursery programs, or breastfeeding support;

16 (I) provide reentry assistance, particularly
17 to—

18 (i) ensure access to health insurance
19 coverage and transfer of health records to
20 community providers if an incarcerated in-
21 dividual exits the criminal justice system
22 during such individual's pregnancy or in
23 the postpartum period; and

24 (ii) connect individuals exiting the
25 criminal justice system during pregnancy

1 or in the postpartum period to community-
2 based resources, such as referrals to health
3 care providers, substance use disorder
4 treatments, and social services that ad-
5 dress social determinants of maternal
6 health; or

7 (J) establish partnerships with local public
8 entities, private community entities, community-
9 based organizations, Indian Tribes and tribal
10 organizations (as such terms are defined in sec-
11 tion 4 of the Indian Self-Determination and
12 Education Assistance Act (25 U.S.C. 5304)),
13 and urban Indian organizations (as such term
14 is defined in section 4 of the Indian Health
15 Care Improvement Act (25 U.S.C. 1603)) to es-
16 tablish or expand pretrial diversion programs as
17 an alternative to incarceration for pregnant and
18 postpartum individuals, including—

19 (i) evidence-based childbirth education
20 or parenting classes;

21 (ii) prenatal health coordination;

22 (iii) family and individual counseling;

23 (iv) evidence-based screenings, edu-
24 cation, and, as needed, treatment for men-

1 tal and behavioral health conditions, in-
2 cluding drug and alcohol treatments;
3 (v) family case management services;
4 (vi) domestic violence education and
5 prevention;
6 (vii) physical and sexual abuse coun-
7 seling; and
8 (viii) programs to address social de-
9 terminants of health such as employment,
10 housing, education, transportation, and nu-
11 trition.

12 (6) IMPLEMENTATION AND REPORTING.—A fa-
13 cility selected under paragraph (1) shall be respon-
14 sible for—

15 (A) implementing programs, which may in-
16 clude the programs described in paragraph (5);
17 and

18 (B) not later than 3 years after the date
19 of enactment of this Act, and not later than 6
20 years after the date of enactment of this Act,
21 reporting results of the programs to the Direc-
22 tor, including information describing—

23 (i) relevant quantitative indicators of
24 success in improving the standard of care
25 and health outcomes for pregnant and

1 postpartum incarcerated individuals in the
2 facility, including data stratified by race,
3 ethnicity, sex, gender, age, geography, dis-
4 ability status, the category of the criminal
5 charge against such individual, rates of
6 pregnancy-related deaths, pregnancy-asso-
7 ciated deaths, cases of infant mortality and
8 morbidity, rates of pre-term births and
9 low-birthweight births, cases of severe ma-
10 ternal morbidity, cases of violence against
11 pregnant or postpartum individuals, diag-
12 noses of maternal mental or behavioral
13 health conditions, and other such informa-
14 tion as appropriate;

15 (ii) relevant qualitative and quan-
16 titative evaluations from pregnant and
17 postpartum incarcerated individuals who
18 participated in such programs, including
19 measures of patient-reported experience of
20 care; and

21 (iii) strategies to sustain such pro-
22 grams after fiscal year 2028 and expand
23 such programs to other facilities.

24 (7) REPORT.—Not later than 6 years after the
25 date of enactment of this Act, the Director shall

1 submit to the Attorney General and Congress a re-
2 port describing the results of the programs carried
3 out under this subsection.

4 (8) OVERSIGHT.—Not later than 1 year after
5 the date of enactment of this Act, the Attorney Gen-
6 eral shall award a contract to an independent orga-
7 nization or independent organizations to conduct
8 oversight of the programs described in paragraph
9 (5).

10 (9) AUTHORIZATION OF APPROPRIATIONS.—
11 There is authorized to be appropriated to carry out
12 this subsection \$10,000,000 for each of fiscal years
13 2024 through 2028.

14 (d) GRANT PROGRAM TO IMPROVE MATERNAL
15 HEALTH OUTCOMES FOR INDIVIDUALS IN STATE AND
16 LOCAL CORRECTIONAL FACILITIES.—

17 (1) ESTABLISHMENT.—Not later than 1 year
18 after the date of enactment of this Act, the Attorney
19 General, acting through the Director of the Bureau
20 of Justice Assistance (in this subsection referred to
21 as the “Director”), shall award Justice for Incarcer-
22 ated Moms grants to States to establish or expand
23 programs in State and local correctional facilities for
24 pregnant and postpartum incarcerated individuals.

1 The Attorney General shall award such grants in
2 consultation with stakeholders such as—

3 (A) Federal Public Defenders and Execu-
4 tive Directors of Community Defender Organi-
5 zations;

6 (B) relevant community-based organiza-
7 tions, particularly organizations that represent
8 incarcerated and formerly incarcerated individ-
9 uals and organizations that seek to improve ma-
10 ternal health outcomes for pregnant and
11 postpartum individuals from racial and ethnic
12 minority groups;

13 (C) relevant organizations representing pa-
14 tients, with a particular focus on patients from
15 racial and ethnic minority groups;

16 (D) organizations representing maternity
17 care providers and maternal health care edu-
18 cation programs;

19 (E) perinatal health workers; and

20 (F) researchers and policy experts in fields
21 related to maternal health care for incarcerated
22 individuals.

23 (2) APPLICATIONS.—Each State desiring a
24 grant under this subsection shall submit to the Di-
25 rector an application at such time, in such manner,

1 and containing such information as the Director
2 may require.

3 (3) USE OF FUNDS.—A State that is awarded
4 a grant under this subsection shall use such grant
5 to establish or expand programs for pregnant and
6 postpartum incarcerated individuals, and such pro-
7 grams may—

8 (A) provide access to perinatal health
9 workers from pregnancy through the
10 postpartum period;

11 (B) provide access to healthy foods and
12 counseling on nutrition, recommended activity
13 levels, and safety measures throughout preg-
14 nancy;

15 (C) train correctional officers to ensure
16 that pregnant incarcerated individuals receive
17 safe and respectful treatment;

18 (D) train medical personnel to ensure that
19 pregnant incarcerated individuals receive trau-
20 ma-informed, culturally congruent care that
21 promotes the health and safety of the pregnant
22 individuals;

23 (E) provide counseling and treatment for
24 individuals who have suffered from—

1 (i) diagnosed mental or behavioral
2 health conditions, including trauma and
3 substance use disorders;

4 (ii) trauma or violence, including do-
5 mestic violence;

6 (iii) human immunodeficiency virus;

7 (iv) sexual abuse;

8 (v) pregnancy or infant loss; or

9 (vi) chronic conditions;

10 (F) provide evidence-based pregnancy and
11 childbirth education, parenting support, and
12 other relevant forms of health literacy;

13 (G) provide clinical education opportunities
14 to maternity care providers in training to ex-
15 pand pathways into maternal health care ca-
16 reers serving incarcerated individuals;

17 (H) offer opportunities for postpartum in-
18 dividuals to maintain contact with the individ-
19 ual's newborn child to promote bonding, includ-
20 ing enhanced visitation policies, access to prison
21 nursery programs, or breastfeeding support;

22 (I) provide reentry assistance, particularly
23 to—

24 (i) ensure access to health insurance
25 coverage and transfer of health records to

1 community providers if an incarcerated in-
2 dividual exits the criminal justice system
3 during such individual's pregnancy or in
4 the postpartum period; and

5 (ii) connect individuals exiting the
6 criminal justice system during pregnancy
7 or in the postpartum period to community-
8 based resources, such as referrals to health
9 care providers, substance use disorder
10 treatments, and social services that ad-
11 dress social determinants of maternal
12 health; or

13 (J) establish partnerships with local public
14 entities, private community entities, community-
15 based organizations, Indian Tribes and tribal
16 organizations (as such terms are defined in sec-
17 tion 4 of the Indian Self-Determination and
18 Education Assistance Act (25 U.S.C. 5304)),
19 and urban Indian organizations (as such term
20 is defined in section 4 of the Indian Health
21 Care Improvement Act (25 U.S.C. 1603)) to es-
22 tablish or expand pretrial diversion programs as
23 an alternative to incarceration for pregnant and
24 postpartum individuals, including—

- 1 (i) evidence-based childbirth education
- 2 or parenting classes;
- 3 (ii) prenatal health coordination;
- 4 (iii) family and individual counseling;
- 5 (iv) evidence-based screenings, edu-
- 6 cation, and, as needed, treatment for men-
- 7 tal and behavioral health conditions, in-
- 8 cluding drug and alcohol treatments;
- 9 (v) family case management services;
- 10 (vi) domestic violence education and
- 11 prevention;
- 12 (vii) physical and sexual abuse coun-
- 13 seling; and
- 14 (viii) programs to address social de-
- 15 terminants of health such as employment,
- 16 housing, education, transportation, and nu-
- 17 trition.

18 (4) PRIORITY.—In awarding grants under this
19 subsection, the Director shall give priority to appli-
20 cants based on—

- 21 (A) the number of pregnant and
- 22 postpartum individuals incarcerated in the
- 23 State and, among such individuals, the number
- 24 of pregnant and postpartum individuals from
- 25 racial and ethnic minority groups; and

1 (B) the extent to which the State has dem-
2 onstrated a commitment to developing exem-
3 plary programs for pregnant and postpartum
4 individuals incarcerated in the correctional fa-
5 cilities in such State.

6 (5) GRANT DURATION.—A grant awarded under
7 this subsection shall be for a 5-year period.

8 (6) IMPLEMENTING AND REPORTING.—A State
9 that receives a grant under this subsection shall be
10 responsible for—

11 (A) implementing the program funded by
12 the grant; and

13 (B) not later than 3 years after the date
14 of enactment of this Act, and not later than 6
15 years after the date of enactment of this Act,
16 reporting results of such program to the Attor-
17 ney General, including information describing—

18 (i) relevant quantitative indicators of
19 the program's success in improving the
20 standard of care and health outcomes for
21 pregnant and postpartum incarcerated in-
22 dividuals in the facility, including data
23 stratified by race, ethnicity, sex, gender,
24 age, geography, disability status, category
25 of the criminal charge against such indi-

1 vidual, incidence rates of pregnancy-related
2 deaths, pregnancy-associated deaths, cases
3 of infant mortality and morbidity, rates of
4 pre-term births and low-birthweight births,
5 cases of severe maternal morbidity, cases
6 of violence against pregnant or postpartum
7 individuals, diagnoses of maternal mental
8 or behavioral health conditions, and other
9 such information as appropriate;

10 (ii) relevant qualitative and quan-
11 titative evaluations from pregnant and
12 postpartum incarcerated individuals who
13 participated in such programs, including
14 measures of patient-reported experience of
15 care; and

16 (iii) strategies to sustain such pro-
17 grams beyond the duration of the grant
18 and expand such programs to other facili-
19 ties.

20 (7) REPORT.—Not later than 6 years after the
21 date of enactment of this Act, the Attorney General
22 shall submit to Congress a report describing the re-
23 sults of programs carried out using grants under
24 this subsection.

1 (8) OVERSIGHT.—Not later than 1 year after
2 the date of enactment of this Act, the Attorney Gen-
3 eral shall award a contract to an independent orga-
4 nization or independent organizations to conduct
5 oversight of the programs described in paragraph
6 (3).

7 (9) AUTHORIZATION OF APPROPRIATIONS.—
8 There is authorized to be appropriated to carry out
9 this subsection \$10,000,000 for each of fiscal years
10 2024 through 2028.

11 (e) GAO REPORT.—

12 (1) IN GENERAL.—Not later than 2 years after
13 the date of enactment of this Act, the Comptroller
14 General of the United States shall submit to Con-
15 gress a report on adverse maternal and infant health
16 outcomes among incarcerated individuals and infants
17 born to such individuals, with a particular focus on
18 racial and ethnic inequities in maternal and infant
19 health outcomes for incarcerated individuals.

20 (2) CONTENTS OF REPORT.—The report de-
21 scribed in this subsection shall include—

22 (A) to the extent practicable—

23 (i) the number of pregnant individuals
24 who are incarcerated in Bureau of Prisons
25 facilities;

1 (ii) the number of incarcerated indi-
2 viduals, including those incarcerated in
3 Federal, State, and local correctional facili-
4 ties, who have experienced a pregnancy-re-
5 lated death, pregnancy-associated death, or
6 the death of an infant in the most recent
7 10 years of available data;

8 (iii) the number of cases of severe ma-
9 ternal morbidity among incarcerated indi-
10 viduals, including those incarcerated in
11 Federal, State, and local correctional facili-
12 ties, in the most recent 10 years of avail-
13 able data;

14 (iv) the number of pre-term and low-
15 birthweight births of infants born to incar-
16 cerated individuals, including those incar-
17 cerated in Federal, State, and local correc-
18 tional facilities, in the most recent 10
19 years of available data; and

20 (v) statistics on the racial and ethnic
21 inequities in maternal and infant health
22 outcomes and severe maternal morbidity
23 rates among incarcerated individuals, in-
24 cluding those incarcerated in Federal,
25 State, and local correctional facilities;

1 (B) in the case that the Comptroller Gen-
2 eral of the United States is unable to determine
3 the information required in clauses (i) through
4 (v) of subparagraph (A), an assessment of the
5 barriers to determining such information and
6 recommendations for improvements in tracking
7 maternal health outcomes among incarcerated
8 individuals, including those incarcerated in Fed-
9 eral, State, and local correctional facilities;

10 (C) a discussion of causes of adverse ma-
11 ternal health outcomes that are unique to incar-
12 cerated individuals, including those incarcerated
13 in Federal, State, and local correctional facili-
14 ties;

15 (D) a discussion of causes of adverse ma-
16 ternal health outcomes and severe maternal
17 morbidity that are unique to incarcerated indi-
18 viduals from racial and ethnic minority groups;

19 (E) recommendations to reduce maternal
20 mortality and severe maternal morbidity among
21 incarcerated individuals and to address racial
22 and ethnic inequities in maternal health out-
23 comes for incarcerated individuals in Bureau of
24 Prisons facilities and State and local correc-
25 tional facilities; and

1 (F) such other information as may be ap-
2 propriate to reduce the occurrence of adverse
3 maternal health outcomes among incarcerated
4 individuals and to address racial and ethnic in-
5 equities in maternal health outcomes for such
6 individuals.

7 (f) MACPAC REPORT.—

8 (1) IN GENERAL.—Not later than 2 years after
9 the date of enactment of this section, the Medicaid
10 and CHIP Payment and Access Commission (re-
11 ferred to in this subsection as “MACPAC”) shall
12 publish a report on the implications of pregnant and
13 postpartum incarcerated individuals being ineligible
14 for medical assistance under a State plan under title
15 XIX of the Social Security Act (42 U.S.C. 1396 et
16 seq.) that contains the information described in
17 paragraph (2).

18 (2) INFORMATION DESCRIBED.—For purposes
19 of paragraph (1), the information described in this
20 paragraph includes—

21 (A) information on the effect of ineligibility
22 for medical assistance under a State plan under
23 title XIX of the Social Security Act (42 U.S.C.
24 1396 et seq.) on maternal health outcomes for
25 pregnant and postpartum incarcerated individ-

1 uals, concentrating on the effects of such ineli-
2 gibility for pregnant and postpartum individuals
3 from racial and ethnic minority groups; and

4 (B) the potential implications on maternal
5 health outcomes resulting from suspending eli-
6 gibility for medical assistance under a State
7 plan under such title of such Act when a preg-
8 nant or postpartum individual is incarcerated.

9 (g) DEFINITIONS.—In this section:

10 (1) CULTURALLY CONGRUENT.—The term “cul-
11 turally congruent” means that the care, maternity
12 care, health care services, provider, or non-clinical
13 support made available is in agreement with the pre-
14 ferred cultural values, beliefs, worldview, language,
15 and practices of the health care consumer and other
16 stakeholders.

17 (2) MATERNITY CARE PROVIDER.—The term
18 “maternity care provider” means a health care pro-
19 vider who—

20 (A) is a physician, physician assistant,
21 midwife who meets at a minimum the inter-
22 national definition of the midwife and global
23 standards for midwifery education as estab-
24 lished by the International Confederation of

1 Midwives, nurse practitioner, or clinical nurse
2 specialist; and

3 (B) has a focus on maternal or perinatal
4 health.

5 (3) MATERNAL MORTALITY.—The term “mater-
6 nal mortality” means a death occurring during or
7 within a one-year period after pregnancy that is
8 caused by pregnancy-related or childbirth complica-
9 tions, including a suicide, overdose, or other death
10 resulting from a mental health or substance use dis-
11 order attributed to or aggravated by pregnancy-re-
12 lated or childbirth complications.

13 (4) PERINATAL HEALTH WORKER.—The term
14 “perinatal health worker” means a doula, commu-
15 nity health worker, peer supporter, breastfeeding
16 and lactation educator or counselor, nutritionist or
17 dietitian, childbirth educator, social worker, home
18 visitor, language interpreter, or navigator.

19 (5) POSTPARTUM AND POSTPARTUM PERIOD.—
20 The terms “postpartum” and “postpartum period”
21 refer to the 1-year period beginning on the last day
22 of the pregnancy of an individual.

23 (6) PREGNANCY-ASSOCIATED DEATH.—The
24 term “pregnancy-associated death” means a death of
25 a pregnant or postpartum individual, by any cause,

1 that occurs during, or within 1 year following, the
2 individual's pregnancy, regardless of the outcome,
3 duration, or site of the pregnancy.

4 (7) PREGNANCY-RELATED DEATH.—The term
5 “pregnancy-related death” means a death of a preg-
6 nant or postpartum individual that occurs during, or
7 within 1 year following, the individual's pregnancy,
8 from a pregnancy complication, a chain of events
9 initiated by pregnancy, or the aggravation of an un-
10 related condition by the physiologic effects of preg-
11 nancy.

12 (8) RACIAL AND ETHNIC MINORITY GROUP.—
13 The term “racial and ethnic minority group” has the
14 meaning given such term in section 1707(g)(1) of
15 the Public Health Service Act (42 U.S.C. 300u-
16 6(g)(1)).

17 (9) SEVERE MATERNAL MORBIDITY.—The term
18 “severe maternal morbidity” means a health condi-
19 tion, including mental health conditions and sub-
20 stance use disorders, attributed to or aggravated by
21 pregnancy or childbirth that results in significant
22 short-term or long-term consequences to the health
23 of the individual who was pregnant.

24 (10) SOCIAL DETERMINANTS OF MATERNAL
25 HEALTH.—The term “social determinants of mater-

1 nal health” means non-clinical factors that impact
2 maternal health outcomes, including—

3 (A) economic factors, which may include
4 poverty, employment, food security, support for
5 and access to lactation and other infant feeding
6 options, housing stability, and related factors;

7 (B) neighborhood factors, which may in-
8 clude quality of housing, access to transpor-
9 tation, access to child care, availability of
10 healthy foods and nutrition counseling, avail-
11 ability of clean water, air and water quality,
12 ambient temperatures, neighborhood crime and
13 violence, access to broadband, and related fac-
14 tors;

15 (C) social and community factors, which
16 may include systemic racism, gender discrimi-
17 nation or discrimination based on other pro-
18 tected classes, workplace conditions, incarcer-
19 ation, and related factors;

20 (D) household factors, which may include
21 ability to conduct lead testing and abatement,
22 car seat installation, indoor air temperatures,
23 and related factors;

1 (E) education access and quality factors,
2 which may include educational attainment, lan-
3 guage and literacy, and related factors; and

4 (F) health care access factors, including
5 health insurance coverage, access to culturally
6 congruent health care services, providers, and
7 non-clinical support, access to home visiting
8 services, access to wellness and stress manage-
9 ment programs, health literacy, access to tele-
10 health and items required to receive telehealth
11 services, and related factors.

12 (11) STATE.—The term “State” means any
13 State of the United States, the District of Columbia,
14 or any territory or possession of the United States.

15 **SEC. 5204. IMPACT TO SAVE MOMS ACT.**

16 (a) PERINATAL CARE ALTERNATIVE PAYMENT
17 MODEL DEMONSTRATION PROJECT.—

18 (1) IN GENERAL.—For the period of fiscal
19 years 2023 through 2027, the Secretary of Health
20 and Human Services (referred to in this subsection
21 as the “Secretary”), acting through the Adminis-
22 trator of the Centers for Medicare & Medicaid Serv-
23 ices, shall establish and implement, in accordance
24 with the requirements of this subsection, a dem-
25 onstration project, to be known as the Perinatal

1 Care Alternative Payment Model Demonstration
2 Project (referred to in this subsection as the “Dem-
3 onstration Project”), for purposes of allowing States
4 to test payment models under their State plans
5 under title XIX of the Social Security Act (42
6 U.S.C. 1396 et seq.) and State child health plans
7 under title XXI of such Act (42 U.S.C. 1397aa et
8 seq.) with respect to maternity care provided to
9 pregnant and postpartum individuals enrolled in
10 such State plans and State child health plans.

11 (2) COORDINATION.—In establishing the Dem-
12 onstration Project, the Secretary shall coordinate
13 with stakeholders such as—

14 (A) State Medicaid programs;

15 (B) relevant organizations representing
16 maternal health care providers;

17 (C) relevant organizations representing pa-
18 tients, with a particular focus on individuals
19 from demographic groups with disproportionate
20 rates of adverse maternal health outcomes;

21 (D) relevant community-based organiza-
22 tions, particularly organizations that seek to
23 improve maternal health outcomes for individ-
24 uals from demographic groups with dispropor-

1 tionate rates of adverse maternal health out-
2 comes;

3 (E) non-clinical perinatal health workers
4 such as doulas, community health workers, peer
5 supporters, certified lactation consultants, nu-
6 tritionists and dieticians, social workers, home
7 visitors, and navigators;

8 (F) relevant health insurance issuers;

9 (G) hospitals, health systems, freestanding
10 birth centers (as such term is defined in para-
11 graph (3)(B) of section 1905(l) of the Social
12 Security Act (42 U.S.C. 1396d(l))), Federally-
13 qualified health centers (as such term is defined
14 in paragraph (2)(B) of such section), and rural
15 health clinics (as such term is defined in section
16 1861(aa) of such Act (42 U.S.C. 1395x(aa)));

17 (H) researchers and policy experts in fields
18 related to maternity care payment models; and

19 (I) any other stakeholders as the Secretary
20 determines appropriate, with a particular focus
21 on stakeholders from demographic groups with
22 disproportionate rates of adverse maternal
23 health outcomes.

1 (3) CONSIDERATIONS.—In establishing the
2 Demonstration Project, the Secretary shall consider
3 each of the following:

4 (A) Findings from any evaluations of the
5 Strong Start for Mothers and Newborns initia-
6 tive carried out by the Centers for Medicare &
7 Medicaid Services, the Health Resources and
8 Services Administration, and the Administra-
9 tion on Children and Families.

10 (B) Any alternative payment model that—

11 (i) is designed to improve maternal
12 health outcomes for racial and ethnic
13 groups with disproportionate rates of ad-
14 verse maternal health outcomes;

15 (ii) includes methods for stratifying
16 patients by pregnancy risk level and, as
17 appropriate, adjusting payments under
18 such model to take into account pregnancy
19 risk level;

20 (iii) establishes evidence-based quality
21 metrics for such payments;

22 (iv) includes consideration of non-hos-
23 pital birth settings such as freestanding
24 birth centers (as so defined);

1 (v) includes consideration of social de-
2 terminants of health that are relevant to
3 maternal health outcomes such as housing,
4 transportation, nutrition, and other non-
5 clinical factors that influence maternal
6 health outcomes; or

7 (vi) includes diverse maternity care
8 teams that include—

9 (I) maternity care providers, in-
10 cluding obstetrician-gynecologists,
11 family physicians, physician assist-
12 ants, midwives who meet, at a min-
13 imum, the international definition of
14 the term “midwife” and global stand-
15 ards for midwifery education (as es-
16 tablished by the International Confed-
17 eration of Midwives), and nurse prac-
18 titioners—

19 (aa) from racially, eth-
20 nically, and professionally diverse
21 backgrounds;

22 (bb) with experience prac-
23 ticing in racially and ethnically
24 diverse communities; or

1 (cc) who have undergone
2 trainings on racism, implicit bias,
3 and explicit bias; and

4 (II) non-clinical perinatal health
5 workers such as doulas, community
6 health workers, peer supporters, cer-
7 tified lactation consultants, nutrition-
8 ists and dieticians, social workers,
9 home visitors, and navigators.

10 (4) ELIGIBILITY.—To be eligible to participate
11 in the Demonstration Project, a State shall submit
12 an application to the Secretary at such time, in such
13 manner, and containing such information as the Sec-
14 retary may require.

15 (5) EVALUATION.—The Secretary shall conduct
16 an evaluation of the Demonstration Project to deter-
17 mine the impact of the Demonstration Project on—

18 (A) maternal health outcomes, with data
19 stratified by race, ethnicity, socioeconomic indi-
20 cators, and any other factors as the Secretary
21 determines appropriate;

22 (B) spending on maternity care by States
23 participating in the Demonstration Project;

24 (C) to the extent practicable, subjective
25 measures of patient experience; and

1 (D) any other areas of assessment that the
2 Secretary determines relevant.

3 (6) REPORT.—Not later than one year after the
4 completion or termination date of the Demonstration
5 Project, the Secretary shall submit to the Committee
6 on Energy and Commerce, the Committee on Ways
7 and Means, and the Committee on Education and
8 Labor of the House of Representatives and the Com-
9 mittee on Finance and the Committee on Health,
10 Education, Labor, and Pensions of the Senate, and
11 make publicly available, a report containing—

12 (A) the results of any evaluation conducted
13 under paragraph (5); and

14 (B) a recommendation regarding whether
15 the Demonstration Project should be continued
16 after fiscal year 2026 and expanded on a na-
17 tional basis.

18 (7) AUTHORIZATION OF APPROPRIATIONS.—
19 There are authorized to be appropriated such sums
20 as are necessary to carry out this subsection.

21 (8) DEFINITIONS.—In this subsection:

22 (A) ALTERNATIVE PAYMENT MODEL.—The
23 term “alternative payment model” has the
24 meaning given such term in section

1 1833(z)(3)(C) of the Social Security Act (42
2 U.S.C. 1395l(z)(3)(C)).

3 (B) PERINATAL.—The term “perinatal”
4 means the period beginning on the day a person
5 becomes pregnant and ending on the last day of
6 the 1-year period beginning on the last day of
7 such person’s pregnancy.

8 (b) MACPAC REPORT.—

9 (1) IN GENERAL.—Not later than two years
10 after the date of the enactment of this section, the
11 Medicaid and CHIP Payment and Access Commis-
12 sion shall publish a report on issues relating to the
13 continuity of coverage under State plans under title
14 XIX of the Social Security Act (42 U.S.C. 1396 et
15 seq.) and State child health plans under title XXI of
16 such Act (42 U.S.C. 1397aa et seq.) for pregnant
17 and postpartum individuals. Such report shall, at a
18 minimum, include the following:

19 (A) An assessment of any existing policies
20 under such State plans and such State child
21 health plans regarding presumptive eligibility
22 for pregnant individuals while their application
23 for enrollment in such a State plan or such a
24 State child health plan is being processed.

1 (B) An assessment of any existing policies
2 under such State plans and such State child
3 health plans regarding measures to ensure con-
4 tinuity of coverage under such a State plan or
5 such a State child health plan for pregnant and
6 postpartum individuals, including such individ-
7 uals who need to change their health insurance
8 coverage during their pregnancy or the
9 postpartum period following their pregnancy.

10 (C) An assessment of any existing policies
11 under such State plans and such State child
12 health plans regarding measures to automati-
13 cally reenroll individuals who are eligible to en-
14 roll under such a State plan or such a State
15 child health plan as a parent.

16 (D) If determined appropriate by the Com-
17 mission, any recommendations for the Depart-
18 ment of Health and Human Services, or such
19 State plans and such State child health plans,
20 to ensure continuity of coverage under such a
21 State plan or such a State child health plan for
22 pregnant and postpartum people.

23 (2) POSTPARTUM DEFINED.—In this sub-
24 section, the term “postpartum” means the 1-year

1 period beginning on the last day of a person's preg-
2 nancy.

3 **SEC. 5205. PROTECTING MOMS AND BABIES AGAINST CLI-**
4 **MATE CHANGE.**

5 (a) GRANT PROGRAM TO PROTECT VULNERABLE
6 MOTHERS AND BABIES FROM CLIMATE CHANGE
7 RISKS.—

8 (1) IN GENERAL.—Not later than 180 days
9 after the date of the enactment of this section, the
10 Secretary of Health and Human Services (in this
11 section referred to as the “Secretary”) shall estab-
12 lish a grant program (in this subsection referred to
13 as the “Program”) to protect vulnerable individuals
14 from risks associated with climate change.

15 (2) GRANT AUTHORITY.—In carrying out the
16 Program, the Secretary may award, on a competitive
17 basis, grants to 10 covered entities.

18 (3) APPLICATIONS.—To be eligible for a grant
19 under the Program, a covered entity shall submit to
20 the Secretary an application at such time, in such
21 form, and containing such information as the Sec-
22 retary may require, which shall include, at a min-
23 imum, a description of the following:

24 (A) Plans for the use of grant funds
25 awarded under the Program and how patients

1 and stakeholder organizations were involved in
2 the development of such plans.

3 (B) How such grant funds will be targeted
4 to geographic areas that have disproportionately
5 high levels of risks associated with climate
6 change for vulnerable individuals.

7 (C) How such grant funds will be used to
8 address racial and ethnic inequities in—

9 (i) adverse maternal and infant health
10 outcomes; and

11 (ii) exposure to risks associated with
12 climate change for vulnerable individuals.

13 (D) Strategies to prevent an initiative as-
14 sisted with such grant funds from causing—

15 (i) adverse environmental impacts;

16 (ii) displacement of residents and
17 businesses;

18 (iii) rent and housing price increases;

19 or

20 (iv) disproportionate adverse impacts
21 on racial and ethnic minority groups and
22 other underserved populations.

23 (4) SELECTION OF GRANT RECIPIENTS.—

24 (A) TIMING.—Not later than 270 days
25 after the date of the enactment of this Act, the

1 Secretary shall select the recipients of grants
2 under the Program.

3 (B) CONSULTATION.—In selecting covered
4 entities for grants under the Program, the Sec-
5 retary shall consult with—

6 (i) representatives of stakeholder or-
7 ganizations;

8 (ii) the Administrator of the Environ-
9 mental Protection Agency;

10 (iii) the Administrator of the National
11 Oceanic and Atmospheric Administration;
12 and

13 (iv) from the Department of Health
14 and Human Services—

15 (I) the Deputy Assistant Sec-
16 retary for Minority Health;

17 (II) the Administrator of the
18 Centers for Medicare & Medicaid
19 Services;

20 (III) the Administrator of the
21 Health Resources and Services Ad-
22 ministration;

23 (IV) the Director of the National
24 Institutes of Health; and

1 (V) the Director of the Centers
2 for Disease Control and Prevention.

3 (C) PRIORITY.—In selecting a covered en-
4 tity to be awarded a grant under the Program,
5 the Secretary shall give priority to covered enti-
6 ties that serve a county—

7 (i) designated, or located in an area
8 designated, as a nonattainment area pur-
9 suant to section 107 of the Clean Air Act
10 (42 U.S.C. 7407) for any air pollutant for
11 which air quality criteria have been issued
12 under section 108(a) of such Act (42
13 U.S.C. 7408(a));

14 (ii) with a level of vulnerability of
15 moderate-to-high or higher, according to
16 the Social Vulnerability Index of the Cen-
17 ters for Disease Control and Prevention; or

18 (iii) with temperatures that pose a
19 risk to human health, as determined by the
20 Secretary, in consultation with the Admin-
21 istrator of the National Oceanic and At-
22 mospheric Administration and the Chair of
23 the United States Global Change Research
24 Program, based on the best available
25 science.

1 (D) LIMITATION.—A recipient of grant
2 funds under the Program may not use such
3 grant funds to serve a county that is served by
4 any other recipient of a grant under the Pro-
5 gram.

6 (5) USE OF FUNDS.—A covered entity awarded
7 grant funds under the Program may only use such
8 grant funds for the following:

9 (A) Initiatives to identify risks associated
10 with climate change for vulnerable individuals
11 and to provide services and support to such in-
12 dividuals that address such risks, which may in-
13 clude—

14 (i) training for health care providers,
15 doulas, and other employees in hospitals,
16 birth centers, midwifery practices, and
17 other health care practices that provide
18 prenatal or labor and delivery services to
19 vulnerable individuals on the identification
20 of, and patient counseling relating to, risks
21 associated with climate change for vulner-
22 able individuals;

23 (ii) hiring, training, or providing re-
24 sources to community health workers and
25 perinatal health workers who can help

1 identify risks associated with climate
2 change for vulnerable individuals, provide
3 patient counseling about such risks, and
4 carry out the distribution of relevant serv-
5 ices and support;

6 (iii) enhancing the monitoring of risks
7 associated with climate change for vulner-
8 able individuals, including by—

9 (I) collecting data on such risks
10 in specific census tracts, neighbor-
11 hoods, or other geographic areas; and

12 (II) sharing such data with local
13 health care providers, doulas, and
14 other employees in hospitals, birth
15 centers, midwifery practices, and
16 other health care practices that pro-
17 vide prenatal or labor and delivery
18 services to local vulnerable individuals;
19 and

20 (iv) providing vulnerable individuals—

21 (I) air conditioning units, resi-
22 dential weatherization support, filtra-
23 tion systems, household appliances, or
24 related items;

635

1 (II) direct financial assistance;
2 and

3 (III) services and support, in-
4 cluding housing and transportation
5 assistance, to prepare for or recover
6 from extreme weather events, which
7 may include floods, hurricanes,
8 wildfires, droughts, and related
9 events.

10 (B) Initiatives to mitigate levels of and ex-
11 posure to risks associated with climate change
12 for vulnerable individuals, which shall be based
13 on the best available science and which may in-
14 clude initiatives to—

15 (i) develop, maintain, or expand urban
16 or community forestry initiatives and tree
17 canopy coverage initiatives;

18 (ii) improve infrastructure, including
19 buildings and paved surfaces;

20 (iii) develop or improve community
21 outreach networks to provide culturally
22 and linguistically appropriate information
23 and notifications about risks associated
24 with climate change for vulnerable individ-
25 uals; and

1 (iv) provide enhanced services to ra-
2 cial and ethnic minority groups and other
3 underserved populations.

4 (6) LENGTH OF AWARD.—A grant under this
5 subsection shall be disbursed over 4 fiscal years.

6 (7) TECHNICAL ASSISTANCE.—The Secretary
7 shall provide technical assistance to a covered entity
8 awarded a grant under the Program to support the
9 development, implementation, and evaluation of ac-
10 tivities funded with such grant.

11 (8) REPORTS TO SECRETARY.—

12 (A) ANNUAL REPORT.—For each fiscal
13 year during which a covered entity is disbursed
14 grant funds under the Program, such covered
15 entity shall submit to the Secretary a report
16 that summarizes the activities carried out by
17 such covered entity with such grant funds dur-
18 ing such fiscal year, which shall include a de-
19 scription of the following:

20 (i) The involvement of stakeholder or-
21 ganizations in the implementation of initia-
22 tives assisted with such grant funds.

23 (ii) Relevant health and environmental
24 data, disaggregated, to the extent prac-

1 ticable, by race, ethnicity, gender, and
2 pregnancy status.

3 (iii) Qualitative feedback received
4 from vulnerable individuals with respect to
5 initiatives assisted with such grant funds.

6 (iv) Criteria used in selecting the geo-
7 graphic areas assisted with such grant
8 funds.

9 (v) Efforts to address racial and eth-
10 nic inequities in adverse maternal and in-
11 fant health outcomes and in exposure to
12 risks associated with climate change for
13 vulnerable individuals.

14 (vi) Any negative and unintended im-
15 pacts of initiatives assisted with such grant
16 funds, including—

17 (I) adverse environmental im-
18 pacts;

19 (II) displacement of residents
20 and businesses;

21 (III) rent and housing price in-
22 creases; and

23 (IV) disproportionate adverse im-
24 pacts on racial and ethnic minority

1 groups and other underserved popu-
2 lations.

3 (vii) How the covered entity will ad-
4 dress and prevent any impacts described in
5 clause (vi).

6 (B) PUBLICATION.—Not later than 30
7 days after the date on which a report is sub-
8 mitted under subparagraph (A), the Secretary
9 shall publish such report on a public website of
10 the Department of Health and Human Services.

11 (9) REPORT TO CONGRESS.—Not later than the
12 date that is 5 years after the date on which the Pro-
13 gram is established, the Secretary shall submit to
14 Congress and publish on a public website of the De-
15 partment of Health and Human Services a report on
16 the results of the Program, including the following:

17 (A) Summaries of the annual reports sub-
18 mitted under paragraph (8).

19 (B) Evaluations of the initiatives assisted
20 with grant funds under the Program.

21 (C) An assessment of the effectiveness of
22 the Program in—

23 (i) identifying risks associated with
24 climate change for vulnerable individuals;

1 (ii) providing services and support to
2 such individuals;

3 (iii) mitigating levels of and exposure
4 to such risks; and

5 (iv) addressing racial and ethnic in-
6 equities in adverse maternal and infant
7 health outcomes and in exposure to such
8 risks.

9 (D) A description of how the Program
10 could be expanded, including—

11 (i) monitoring efforts or data collec-
12 tion that would be required to identify
13 areas with high levels of risks associated
14 with climate change for vulnerable individ-
15 uals;

16 (ii) how such areas could be identified
17 using the strategy developed under sub-
18 section (d); and

19 (iii) recommendations for additional
20 funding.

21 (10) COVERED ENTITY DEFINED.—In this sub-
22 section, the term “covered entity” means a consor-
23 tium of organizations serving a county that—

24 (A) shall include a community-based orga-
25 nization; and

1 (B) may include—

2 (i) another stakeholder organization;

3 (ii) the government of such county;

4 (iii) the governments of one or more
5 municipalities within such county;

6 (iv) a State or local public health de-
7 partment or emergency management agen-
8 cy;

9 (v) a local health care practice, which
10 may include a licensed and accredited hos-
11 pital, birth center, midwifery practice, or
12 other health care practice that provides
13 prenatal or labor and delivery services to
14 vulnerable individuals;

15 (vi) an Indian tribe or tribal organiza-
16 tion (as such terms are defined in section
17 4 of the Indian Self-Determination and
18 Education Assistance Act (25 U.S.C.
19 5304));

20 (vii) an Urban Indian organization (as
21 defined in section 4 of the Indian Health
22 Care Improvement Act (25 U.S.C. 1603));
23 and

24 (viii) an institution of higher edu-
25 cation.

1 (11) AUTHORIZATION OF APPROPRIATIONS.—

2 There is authorized to be appropriated to carry out
3 this subsection \$100,000,000 for fiscal years 2023
4 through 2026.

5 (b) GRANT PROGRAM FOR EDUCATION AND TRAIN-
6 ING AT HEALTH PROFESSION SCHOOLS.—

7 (1) IN GENERAL.—Not later than 1 year after
8 the date of the enactment of this Act, the Secretary
9 shall establish a grant program (in this subsection
10 referred to as the “Program”) to provide funds to
11 health profession schools to support the development
12 and integration of education and training programs
13 for identifying and addressing risks associated with
14 climate change for vulnerable individuals.

15 (2) GRANT AUTHORITY.—In carrying out the
16 Program, the Secretary may award, on a competitive
17 basis, grants to health profession schools.

18 (3) APPLICATION.—To be eligible for a grant
19 under the Program, a health profession school shall
20 submit to the Secretary an application at such time,
21 in such form, and containing such information as
22 the Secretary may require, which shall include, at a
23 minimum, a description of the following:

24 (A) How such health profession school will
25 engage with vulnerable individuals, and stake-

1 holder organizations representing such individ-
2 uals, in developing and implementing the edu-
3 cation and training programs supported by
4 grant funds awarded under the Program.

5 (B) How such health profession school will
6 ensure that such education and training pro-
7 grams will address racial and ethnic inequities
8 in exposure to, and the effects of, risks associ-
9 ated with climate change for vulnerable individ-
10 uals.

11 (4) USE OF FUNDS.—A health profession school
12 awarded a grant under the Program shall use the
13 grant funds to develop, and integrate into the cur-
14 riculum and continuing education of such health
15 profession school, education and training on each of
16 the following:

17 (A) Identifying risks associated with cli-
18 mate change for vulnerable individuals and indi-
19 viduals with the intent to become pregnant.

20 (B) How risks associated with climate
21 change affect vulnerable individuals and individ-
22 uals with the intent to become pregnant.

23 (C) Racial and ethnic inequities in expo-
24 sure to, and the effects of, risks associated with

1 climate change for vulnerable individuals and
2 individuals with the intent to become pregnant.

3 (D) Patient counseling and mitigation
4 strategies relating to risks associated with cli-
5 mate change for vulnerable individuals.

6 (E) Relevant services and support for vul-
7 nerable individuals relating to risks associated
8 with climate change and strategies for ensuring
9 vulnerable individuals have access to such serv-
10 ices and support.

11 (F) Implicit and explicit bias, racism, and
12 discrimination.

13 (G) Related topics identified by such
14 health profession school based on the engage-
15 ment of such health profession school with vul-
16 nerable individuals and stakeholder organiza-
17 tions representing such individuals.

18 (5) PARTNERSHIPS.—In carrying out activities
19 with grant funds, a health profession school awarded
20 a grant under the Program may partner with one or
21 more of the following:

22 (A) A State or local public health depart-
23 ment.

24 (B) A health care professional membership
25 organization.

1 (C) A stakeholder organization.

2 (D) A health profession school.

3 (E) An institution of higher education.

4 (6) REPORTS TO SECRETARY.—

5 (A) ANNUAL REPORT.—For each fiscal
6 year during which a health profession school is
7 disbursed grant funds under the Program, such
8 health profession school shall submit to the Sec-
9 retary a report that describes the activities car-
10 ried out with such grant funds during such fis-
11 cal year.

12 (B) FINAL REPORT.—Not later than the
13 date that is 1 year after the end of the last fis-
14 cal year during which a health profession school
15 is disbursed grant funds under the Program,
16 the health profession school shall submit to the
17 Secretary a final report that summarizes the
18 activities carried out with such grant funds.

19 (7) REPORT TO CONGRESS.—Not later than the
20 date that is 6 years after the date on which the Pro-
21 gram is established, the Secretary shall submit to
22 Congress and publish on a public website of the De-
23 partment of Health and Human Services a report
24 that includes the following:

1 (A) A summary of the reports submitted
2 under paragraph (6).

3 (B) Recommendations to improve edu-
4 cation and training programs at health profes-
5 sion schools with respect to identifying and ad-
6 dressing risks associated with climate change
7 for vulnerable individuals.

8 (8) HEALTH PROFESSION SCHOOL DEFINED.—
9 In this subsection, the term “health profession
10 school” means an accredited—

11 (A) medical school;

12 (B) school of nursing;

13 (C) midwifery program;

14 (D) physician assistant education program;

15 (E) teaching hospital;

16 (F) residency or fellowship program; or

17 (G) other school or program determined
18 appropriate by the Secretary.

19 (9) AUTHORIZATION OF APPROPRIATIONS.—
20 There is authorized to be appropriated to carry out
21 this subsection \$5,000,000 for fiscal years 2023
22 through 2026.

23 (c) NIH CONSORTIUM ON BIRTH AND CLIMATE
24 CHANGE RESEARCH.—

(1) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this Act, the Director of the National Institutes of Health (in this subsection referred to as the “Director of NIH”) shall establish the Consortium on Birth and Climate Change Research (in this subsection referred to as the “Consortium”).

8 (2) DUTIES.—

9 (A) IN GENERAL.—The Consortium shall
10 coordinate, across the institutes, centers, and
11 offices of the National Institutes of Health, re-
12 search on the risks associated with climate
13 change for vulnerable individuals.

14 (B) REQUIRED ACTIVITIES.—In carrying
15 out subparagraph (A), the Consortium shall—

16 (i) establish research priorities, in-
17 cluding by prioritizing research that—

(I) identifies the risks associated with climate change for vulnerable individuals with a particular focus on inequities in such risks among racial and ethnic minority groups and other underserved populations; and

(II) identifies strategies to reduce levels of, and exposure to, such risks,

1 with a particular focus on risks
2 among racial and ethnic minority
3 groups and other underserved popu-
4 lations;

5 (ii) identify gaps in available data re-
6 lated to such risks;

7 (iii) identify gaps in, and opportuni-
8 ties for, research collaborations;

9 (iv) identify funding opportunities for
10 community-based organizations and re-
11 searchers from racially, ethnically, and
12 geographically diverse backgrounds; and

13 (v) publish annual reports on the
14 work and findings of the Consortium on a
15 public website of the National Institutes of
16 Health.

17 (3) MEMBERSHIP.—The Director of NIH shall
18 appoint to the Consortium representatives of such
19 institutes, centers, and offices of the National Insti-
20 tutes of Health as the Director of NIH considers ap-
21 propriate, including, at a minimum, representatives
22 of—

23 (A) the National Institute of Environ-
24 mental Health Sciences;

1 (B) the National Institute on Minority
2 Health and Health Disparities;

3 (C) the Eunice Kennedy Shriver National
4 Institute of Child Health and Human Develop-
5 ment;

6 (D) the National Institute of Nursing Re-
7 search; and

8 (E) the Office of Research on Women's
9 Health.

10 (4) CHAIRPERSON.—The Chairperson of the
11 Consortium shall be designated by the Director of
12 NIH and selected from among the representatives
13 appointed under paragraph (3).

14 (5) CONSULTATION.—In carrying out the duties
15 described in paragraph (2), the Consortium shall
16 consult with—

17 (A) the heads of relevant Federal agencies,
18 including—

19 (i) the Environmental Protection
20 Agency;

21 (ii) the National Oceanic and Atmos-
22 pheric Administration;

23 (iii) the Occupational Safety and
24 Health Administration; and

1 (iv) from the Department of Health
2 and Human Services—

3 (I) the Office of Minority Health
4 in the Office of the Secretary;

5 (II) the Centers for Medicare &
6 Medicaid Services;

7 (III) the Health Resources and
8 Services Administration;

9 (IV) the Centers for Disease
10 Control and Prevention;

11 (V) the Indian Health Service;
12 and

13 (VI) the Administration for Chil-
14 dren and Families; and

15 (B) representatives of—

16 (i) stakeholder organizations;

17 (ii) health care providers and profes-
18 sional membership organizations with ex-
19 pertise in maternal health or environ-
20 mental justice;

21 (iii) State and local public health de-
22 partments;

23 (iv) licensed and accredited hospitals,
24 birth centers, midwifery practices, or other
25 health care practices that provide prenatal

1 or labor and delivery services to vulnerable
2 individuals; and

3 (v) institutions of higher education,
4 including such institutions that are minor-
5 ity-serving institutions or have expertise in
6 maternal health or environmental justice.

7 (d) STRATEGY FOR IDENTIFYING CLIMATE CHANGE
8 RISK ZONES FOR VULNERABLE MOTHERS AND BABIES.—

9 (1) IN GENERAL.—The Secretary, acting
10 through the Director of the Centers for Disease
11 Control and Prevention, shall develop a strategy (in
12 this subsection referred to as the “Strategy”) for
13 designating areas that the Secretary determines to
14 have a high risk of adverse maternal and infant
15 health outcomes among vulnerable individuals as a
16 result of risks associated with climate change.

17 (2) STRATEGY REQUIREMENTS.—

18 (A) IN GENERAL.—In developing the
19 Strategy, the Secretary shall establish a process
20 to identify areas where vulnerable individuals
21 are exposed to a high risk of adverse maternal
22 and infant health outcomes as a result of risks
23 associated with climate change in conjunction
24 with other factors that can impact such health
25 outcomes, including—

1 (i) the incidence of diseases associated
2 with air pollution, extreme heat, and other
3 environmental factors;

4 (ii) the availability and accessibility of
5 maternal and infant health care providers;

6 (iii) English-language proficiency
7 among people of reproductive age;

8 (iv) the health insurance status of
9 people of reproductive age;

10 (v) the number of people of reproduc-
11 tive age who are members of racial or eth-
12 nic groups with disproportionately high
13 rates of adverse maternal and infant
14 health outcomes;

15 (vi) the socioeconomic status of people
16 of reproductive age, including with respect
17 to—

18 (I) poverty;

19 (II) unemployment;

20 (III) household income; and

21 (IV) educational attainment; and

22 (vii) access to quality housing, trans-
23 portation, and nutrition.

1 (B) RESOURCES.—In developing the Strat-
2 egy, the Secretary shall identify, and incor-
3 porate a description of, the following:

4 (i) Existing mapping tools or Federal
5 programs that identify—

6 (I) risks associated with climate
7 change for vulnerable individuals; and

8 (II) other factors that can influ-
9 ence maternal and infant health out-
10 comes, including the factors described
11 in subparagraph (A).

12 (ii) Environmental, health, socio-
13 economic, and demographic data relevant
14 to identifying risks associated with climate
15 change for vulnerable individuals.

16 (iii) Existing monitoring networks
17 that collect data described in clause (ii),
18 and any gaps in such networks.

19 (iv) Federal, State, and local stake-
20 holders involved in maintaining monitoring
21 networks identified under clause (iii), and
22 how such stakeholders are coordinating
23 their monitoring efforts.

24 (v) Additional monitoring networks,
25 and enhancements to existing monitoring

1 networks, that would be required to ad-
2 dress gaps identified under clause (iii), in-
3 cluding at the subcounty and census tract
4 level.

5 (vi) Funding amounts required to es-
6 tablish the monitoring networks identified
7 under clause (v) and recommendations for
8 Federal, State, and local coordination with
9 respect to such networks.

10 (vii) Potential uses for data collected
11 and generated as a result of the Strategy,
12 including how such data may be used in
13 determining recipients of grants under the
14 program established by subsection (a) or
15 other similar programs.

16 (viii) Other information the Secretary
17 considers relevant for the development of
18 the Strategy.

19 (3) COORDINATION AND CONSULTATION.—In
20 developing the Strategy, the Secretary shall—

21 (A) coordinate with the Administrator of
22 the Environmental Protection Agency and the
23 Administrator of the National Oceanic and At-
24 mospheric Administration; and

25 (B) consult with—

1 (i) stakeholder organizations;
2 (ii) health care providers and profes-
3 sional membership organizations with ex-
4 pertise in maternal health or environ-
5 mental justice;

6 (iii) State and local public health de-
7 partments;

8 (iv) licensed and accredited hospitals,
9 birth centers, midwifery practices, or other
10 health care providers that provide prenatal
11 or labor and delivery services to vulnerable
12 individuals; and

13 (v) institutions of higher education,
14 including such institutions that are minor-
15 ity-serving institutions or have expertise in
16 maternal health or environmental justice.

17 (4) NOTICE AND COMMENT.—At least 240 days
18 before the date on which the Strategy is published
19 in accordance with paragraph (5), the Secretary
20 shall provide—

21 (A) notice of the Strategy on a public
22 website of the Department of Health and
23 Human Services; and

24 (B) an opportunity for public comment of
25 at least 90 days.

1 (5) PUBLICATION.—Not later than 18 months
2 after the date of the enactment of this Act, the Sec-
3 retary shall publish on a public website of the De-
4 partment of Health and Human Services—

5 (A) the Strategy;

6 (B) the public comments received under
7 paragraph (4); and

8 (C) the responses of the Secretary to such
9 public comments.

10 (e) DEFINITIONS.—In this section, the following defi-
11 nitions apply:

12 (1) ADVERSE MATERNAL AND INFANT HEALTH
13 OUTCOMES.—The term “adverse maternal and in-
14 fant health outcomes” includes the outcomes of pre-
15 term birth, low birth weight, stillbirth, infant or ma-
16 ternal mortality, and severe maternal morbidity.

17 (2) INSTITUTION OF HIGHER EDUCATION.—The
18 term “institution of higher education” has the
19 meaning given such term in section 101 of the High-
20 er Education Act of 1965 (20 U.S.C. 1001).

21 (3) MINORITY-SERVING INSTITUTION.—The
22 term “minority-serving institution” means an entity
23 specified in any of paragraphs (1) through (7) of
24 section 371(a) of the Higher Education Act of 1965
25 (20 U.S.C. 1067q(a)).

1 (4) RACIAL AND ETHNIC MINORITY GROUP.—

2 The term “racial and ethnic minority group” has the
3 meaning given such term in section 1707(g) of the
4 Public Health Service Act (42 U.S.C. 300u–6(g)).

5 (5) RISKS ASSOCIATED WITH CLIMATE
6 CHANGE.—The term “risks associated with climate
7 change” includes risks associated with extreme heat,
8 air pollution, extreme weather events, and other en-
9 vironmental issues associated with climate change
10 that can result in adverse maternal and infant
11 health outcomes.

12 (6) STAKEHOLDER ORGANIZATION.—The term
13 “stakeholder organization” means—

14 (A) a community-based organization with
15 expertise in providing assistance to vulnerable
16 individuals;

17 (B) a nonprofit organization with expertise
18 in maternal or infant health or environmental
19 justice; and

20 (C) a patient advocacy organization rep-
21 resenting vulnerable individuals.

22 (7) VULNERABLE INDIVIDUAL.—The term “vul-
23 nerable individual” means—

24 (A) an individual who is pregnant;

1 (B) an individual who was pregnant during
2 any portion of the preceding 1-year period; and

3 (C) an individual under 3 years of age.

4 **SEC. 5206. TECH TO SAVE MOMS.**

5 (a) DEFINITIONS.—In this section:

6 (1) POSTPARTUM AND POSTPARTUM PERIOD.—

7 The terms “postpartum” and “postpartum period”
8 refer to the 1-year period beginning on the last day
9 of the pregnancy of an individual.

10 (2) RACIAL AND ETHNIC MINORITY GROUP.—

11 The term “racial and ethnic minority group” has the
12 meaning given such term in section 1707(g)(1) of
13 the Public Health Service Act (42 U.S.C. 300u–
14 6(g)(1)).

15 (3) SEVERE MATERNAL MORBIDITY.—The term

16 “severe maternal morbidity” means a health condi-
17 tion, including mental health conditions and sub-
18 stance use disorders, attributed to or aggravated by
19 pregnancy or childbirth that results in significant
20 short-term or long-term consequences to the health
21 of the individual who was pregnant.

22 (4) SOCIAL DETERMINANTS OF MATERNAL

23 HEALTH.—The term “social determinants of mater-
24 nal health” means non-clinical factors that impact
25 maternal health outcomes, including—

1 (A) economic factors, which may include
2 poverty, employment, food security, support for
3 and access to lactation and other infant feeding
4 options, housing stability, and related factors;

5 (B) neighborhood factors, which may in-
6 clude quality of housing, access to transpor-
7 tation, access to child care, availability of
8 healthy foods and nutrition counseling, avail-
9 ability of clean water, air and water quality,
10 ambient temperatures, neighborhood crime and
11 violence, access to broadband, and related fac-
12 tors;

13 (C) social and community factors, which
14 may include systemic racism, gender discrimi-
15 nation or discrimination based on other pro-
16 tected classes, workplace conditions, incarcer-
17 ation, and related factors;

18 (D) household factors, which may include
19 ability to conduct lead testing and abatement,
20 car seat installation, indoor air temperatures,
21 and related factors;

22 (E) education access and quality factors,
23 which may include educational attainment, lan-
24 guage and literacy, and related factors; and

1 (F) health care access factors, including
2 health insurance coverage, access to culturally
3 congruent health care services, providers, and
4 non-clinical support, access to home visiting
5 services, access to wellness and stress manage-
6 ment programs, health literacy, access to tele-
7 health and items required to receive telehealth
8 services, and related factors.

9 (b) INTEGRATED TELEHEALTH MODELS IN MATER-
10 NITY CARE SERVICES.—

11 (1) IN GENERAL.—Section 1115A(b)(2)(B) of
12 the Social Security Act (42 U.S.C. 1315a(b)(2)(B))
13 is amended by adding at the end the following:

14 “(xxviii) Focusing on title XIX, pro-
15 viding for the adoption of and use of tele-
16 health tools that allow for screening, moni-
17 toring, and management of common health
18 complications with respect to an individual
19 receiving medical assistance during such
20 individual’s pregnancy and for not more
21 than a 1-year period beginning on the last
22 day of the pregnancy.”.

23 (2) EFFECTIVE DATE.—The amendment made
24 by paragraph (1) shall take effect 1 year after the
25 date of the enactment of this section.

1 (c) GRANTS TO EXPAND THE USE OF TECHNOLOGY-
2 ENABLED COLLABORATIVE LEARNING AND CAPACITY
3 MODELS FOR PREGNANT AND POSTPARTUM INDIVID-
4 UALS.—Title III of the Public Health Service Act is
5 amended by inserting after section 330N (42 U.S.C.
6 254c–20) the following new section:

7 **“SEC. 330N–1. EXPANDING CAPACITY FOR MATERNAL**
8 **HEALTH OUTCOMES.**

9 “(a) ESTABLISHMENT.—Beginning not later than 1
10 year after the date of enactment of this section, the Sec-
11 retary shall award grants to eligible entities to evaluate,
12 develop, and expand the use of technology-enabled collabo-
13 rative learning and capacity building models and improve
14 maternal health outcomes—

15 “(1) in health professional shortage areas;

16 “(2) in areas with high rates of maternal mor-
17 tality and severe maternal morbidity;

18 “(3) in areas with significant racial and ethnic
19 inequities in maternal health outcomes; and

20 “(4) for medically underserved populations and
21 American Indians and Alaska Natives, including In-
22 dian Tribes, Tribal organizations, and Urban Indian
23 organizations.

24 “(b) USE OF FUNDS.—

1 “(1) REQUIRED USES.—Recipients of grants
2 under this section shall use the grants to—

3 “(A) train maternal health care providers,
4 students, and other similar professionals
5 through models that include—

6 “(i) methods to increase safety and
7 health care quality;

8 “(ii) training to increase awareness of,
9 and eliminate implicit bias, racism, and
10 discrimination in, the provision of health
11 care;

12 “(iii) best practices in screening for
13 and, as needed, evaluating and treating
14 maternal mental health conditions and
15 substance use disorders;

16 “(iv) training on best practices in ma-
17 ternity care for pregnant and postpartum
18 individuals during the COVID–19 public
19 health emergency or future public health
20 emergencies;

21 “(v) methods to screen for social de-
22 terminants of maternal health risks in the
23 prenatal and postpartum periods; and

24 “(vi) the use of remote patient moni-
25 toring tools for pregnancy-related com-

1 plications described in section
2 1115A(b)(2)(B)(xxviii) of the Social Secu-
3 rity Act;

4 “(B) evaluate and collect information on
5 the effect of such models on—

6 “(i) access to, and quality of, care;

7 “(ii) outcomes with respect to the
8 health of an individual; and

9 “(iii) the experience of individuals who
10 receive pregnancy-related health care;

11 “(C) develop qualitative and quantitative
12 measures to identify best practices for the ex-
13 pansion and use of such models;

14 “(D) study the effect of such models on
15 patient outcomes and maternity care providers;
16 and

17 “(E) conduct any other activity, as deter-
18 mined by the Secretary.

19 “(2) PERMISSIBLE USES.—Recipients of grants
20 under this section may use grants to support—

21 “(A) the use and expansion of technology-
22 enabled collaborative learning and capacity
23 building models, including hardware and soft-
24 ware that—

1 “(i) enable distance learning and tech-
2 nical support; and

3 “(ii) support the secure exchange of
4 electronic health information; and

5 “(B) maternity care providers, students,
6 and other similar professionals in the provision
7 of maternity care through such models.

8 “(c) APPLICATION.—

9 “(1) IN GENERAL.—An eligible entity seeking a
10 grant under subsection (a) shall submit to the Sec-
11 retary an application, at such time, in such manner,
12 and containing such information as the Secretary
13 may require.

14 “(2) ASSURANCE.—An application under para-
15 graph (1) shall include an assurance that such entity
16 shall collect information on, and assess the effect of,
17 the use of technology-enabled collaborative learning
18 and capacity building models, including with respect
19 to—

20 “(A) maternal health outcomes;

21 “(B) access to maternal health care serv-
22 ices;

23 “(C) quality of maternal health care; and

1 “(D) retention of maternity care providers
2 serving areas and populations described in sub-
3 section (a).

4 “(d) LIMITATIONS.—

5 “(1) NUMBER.—The Secretary may not award
6 more than 1 grant under this section to an eligible
7 entity.

8 “(2) DURATION.—A grant awarded under this
9 section shall be for a 5-year period.

10 “(e) ACCESS TO BROADBAND.—In administering
11 grants under this section, the Secretary may coordinate
12 with other agencies to ensure that funding opportunities
13 are available to support access to reliable, high-speed
14 internet for grantees.

15 “(f) TECHNICAL ASSISTANCE.—The Secretary shall
16 provide (either directly or by contract) technical assistance
17 to eligible entities, including recipients of grants under
18 subsection (a), on the development, use, and sustainability
19 of technology-enabled collaborative learning and capacity
20 building models to expand access to maternal health care
21 services provided by such entities, including—

22 “(1) in health professional shortage areas;

23 “(2) in areas with high rates of maternal mor-
24 tality and severe maternal morbidity or significant

1 racial and ethnic inequities in maternal health out-
2 comes; and

3 “(3) for medically underserved populations or
4 American Indians and Alaska Natives.

5 “(g) RESEARCH AND EVALUATION.—The Secretary,
6 in consultation with experts, shall develop a strategic plan
7 to research and evaluate the evidence for such models.

8 “(h) REPORTING.—

9 “(1) ELIGIBLE ENTITIES.—An eligible entity
10 that receives a grant under subsection (a) shall sub-
11 mit to the Secretary a report, at such time, in such
12 manner, and containing such information as the Sec-
13 retary may require.

14 “(2) SECRETARY.—Not later than 4 years after
15 the date of enactment of this section, the Secretary
16 shall submit to the Congress, and make available on
17 the website of the Department of Health and
18 Human Services, a report that includes—

19 “(A) a description of grants awarded
20 under subsection (a) and the purpose and
21 amounts of such grants;

22 “(B) a summary of—

23 “(i) the evaluations conducted under
24 subsection (b)(1)(B);

1 “(ii) any technical assistance provided
2 under subsection (f); and

3 “(iii) the activities conducted under
4 subsection (a); and

5 “(C) a description of any significant find-
6 ings with respect to—

7 “(i) patient outcomes; and

8 “(ii) best practices for expanding,
9 using, or evaluating technology-enabled col-
10 laborative learning and capacity building
11 models.

12 “(i) AUTHORIZATION OF APPROPRIATIONS.—There is
13 authorized to be appropriated to carry out this section,
14 \$6,000,000 for each of fiscal years 2023 through 2027.

15 “(j) DEFINITIONS.—In this section:

16 “(1) ELIGIBLE ENTITY.—

17 “(A) IN GENERAL.—The term ‘eligible en-
18 tity’ means an entity that provides, or supports
19 the provision of, maternal health care services
20 or other evidence-based services for pregnant
21 and postpartum individuals—

22 “(i) in health professional shortage
23 areas;

24 “(ii) in areas with high rates of ad-
25 verse maternal health outcomes or signifi-

1 cant racial and ethnic inequities in mater-
2 nal health outcomes; or

3 “(iii) who are—

4 “(I) members of medically under-
5 served populations; or

6 “(II) American Indians and Alas-
7 ka Natives, including Indian Tribes,
8 Tribal organizations, and Urban In-
9 dian organizations.

10 “(B) INCLUSIONS.—An eligible entity may
11 include entities that lead, or are capable of
12 leading, a technology-enabled collaborative
13 learning and capacity building model.

14 “(2) HEALTH PROFESSIONAL SHORTAGE
15 AREA.—The term ‘health professional shortage area’
16 means a health professional shortage area des-
17 ignated under section 332.

18 “(3) INDIAN TRIBE.—The term ‘Indian Tribe’
19 has the meaning given such term in section 4 of the
20 Indian Self-Determination and Education Assistance
21 Act.

22 “(4) MATERNAL MORTALITY.—The term ‘ma-
23 ternal mortality’ means a death occurring during or
24 within the 1-year period after pregnancy caused by
25 pregnancy-related or childbirth complications, in-

1 cluding a suicide, overdose, or other death resulting
2 from a mental health or substance use disorder at-
3 tributed to or aggravated by pregnancy or childbirth
4 complications.

5 “(5) MEDICALLY UNDERSERVED POPU-
6 LATION.—The term ‘medically underserved popu-
7 lation’ has the meaning given such term in section
8 330(b)(3).

9 “(6) POSTPARTUM.—The term ‘postpartum’
10 means the 1-year period beginning on the last date
11 of an individual’s pregnancy.

12 “(7) SEVERE MATERNAL MORBIDITY.—The
13 term ‘severe maternal morbidity’ means a health
14 condition, including a mental health or substance
15 use disorder, attributed to or aggravated by preg-
16 nancy or childbirth that results in significant short-
17 term or long-term consequences to the health of the
18 individual who was pregnant.

19 “(8) TECHNOLOGY-ENABLED COLLABORATIVE
20 LEARNING AND CAPACITY BUILDING MODEL.—The
21 term ‘technology-enabled collaborative learning and
22 capacity building model’ means a distance health
23 education model that connects health care profes-
24 sionals, and other specialists, through simultaneous
25 interactive videoconferencing for the purpose of fa-

1 cilitating case-based learning, disseminating best
2 practices, and evaluating outcomes in the context of
3 maternal health care.

4 “(9) TRIBAL ORGANIZATION.—The term ‘Tribal
5 organization’ has the meaning given such term in
6 section 4 of the Indian Self-Determination and Edu-
7 cation Assistance Act.

8 “(10) URBAN INDIAN ORGANIZATION.—The
9 term ‘Urban Indian organization’ has the meaning
10 given such term in section 4 of the Indian Health
11 Care Improvement Act.”.

12 (d) GRANTS TO PROMOTE EQUITY IN MATERNAL
13 HEALTH OUTCOMES THROUGH DIGITAL TOOLS.—

14 (1) IN GENERAL.—Beginning not later than 1
15 year after the date of the enactment of this Act, the
16 Secretary of Health and Human Services shall make
17 grants to eligible entities to reduce racial and ethnic
18 inequities in maternal health outcomes by increasing
19 access to digital tools related to maternal health
20 care.

21 (2) APPLICATIONS.—To be eligible to receive a
22 grant under this subsection, an eligible entity shall
23 submit to the Secretary an application at such time,
24 in such manner, and containing such information as
25 the Secretary may require.

1 (3) PRIORITIZATION.—In awarding grants
2 under this subsection, the Secretary shall prioritize
3 an eligible entity—

4 (A) in an area with high rates of adverse
5 maternal health outcomes or significant racial
6 and ethnic inequities in maternal health out-
7 comes;

8 (B) in a health professional shortage area
9 designated under section 332 of the Public
10 Health Service Act (42 U.S.C. 254e); and

11 (C) that promotes technology that address-
12 es racial and ethnic inequities in maternal
13 health outcomes.

14 (4) LIMITATIONS.—

15 (A) NUMBER.—The Secretary may award
16 not more than 1 grant under this subsection to
17 an eligible entity.

18 (B) DURATION.—A grant awarded under
19 this subsection shall be for a 5-year period.

20 (5) TECHNICAL ASSISTANCE.—The Secretary
21 shall provide technical assistance to an eligible entity
22 on the development, use, evaluation, and post-grant
23 sustainability of digital tools for purposes of pro-
24 moting equity in maternal health outcomes.

25 (6) REPORTING.—

1 (A) ELIGIBLE ENTITIES.—An eligible enti-
2 ty that receives a grant under paragraph (1)
3 shall submit to the Secretary a report, at such
4 time, in such manner, and containing such in-
5 formation as the Secretary may require.

6 (B) SECRETARY.—Not later than 4 years
7 after the date of the enactment of this Act, the
8 Secretary shall submit to Congress a report
9 that includes—

10 (i) an evaluation on the effectiveness
11 of grants awarded under this subsection to
12 improve health outcomes for pregnant and
13 postpartum individuals from racial and
14 ethnic minority groups;

15 (ii) recommendations on new grant
16 programs that promote the use of tech-
17 nology to improve such maternal health
18 outcomes; and

19 (iii) recommendations with respect
20 to—

21 (I) technology-based privacy and
22 security safeguards in maternal health
23 care;

24 (II) reimbursement rates for ma-
25 ternal telehealth services;

1 (III) the use of digital tools to
2 analyze large data sets to identify po-
3 tential pregnancy-related complica-
4 tions;

5 (IV) barriers that prevent mater-
6 nity care providers from providing
7 telehealth services across States;

8 (V) the use of consumer digital
9 tools such as mobile phone applica-
10 tions, patient portals, and wearable
11 technologies to improve maternal
12 health outcomes;

13 (VI) barriers that prevent access
14 to telehealth services, including a lack
15 of access to reliable, high-speed inter-
16 net or electronic devices;

17 (VII) barriers to data sharing be-
18 tween the Special Supplemental Nu-
19 trition Program for Women, Infants,
20 and Children program and maternity
21 care providers, and recommendations
22 for addressing such barriers; and

23 (VIII) lessons learned from ex-
24 panded access to telehealth related to

1 maternity care during the COVID–19
2 public health emergency.

3 (7) AUTHORIZATION OF APPROPRIATIONS.—

4 There is authorized to be appropriated to carry out
5 this subsection \$6,000,000 for each of fiscal years
6 2023 through 2027.

7 (e) REPORT ON THE USE OF TECHNOLOGY IN MA-
8 TERNITY CARE.—

9 (1) IN GENERAL.—Not later than 60 days after
10 the date of enactment of this Act, the Secretary of
11 Health and Human Services shall enter into an
12 agreement with the National Academies of Sciences,
13 Engineering, and Medicine (referred to in this sec-
14 tion as the “National Academies”) under which the
15 National Academies shall conduct a study on the use
16 of technology and patient monitoring devices in ma-
17 ternity care.

18 (2) CONTENT.—The agreement entered into
19 pursuant to paragraph (1) shall provide for the
20 study of the following:

21 (A) The use of innovative technology (in-
22 cluding artificial intelligence) in maternal
23 health care, including the extent to which such
24 technology has affected racial or ethnic biases
25 in maternal health care.

1 (B) The use of patient monitoring devices
2 (including pulse oximeter devices) in maternal
3 health care, including the extent to which such
4 devices have affected racial or ethnic biases in
5 maternal health care.

6 (C) Best practices for reducing and pre-
7 venting racial or ethnic biases in the use of in-
8 novative technology and patient monitoring de-
9 vices in maternity care.

10 (D) Best practices in the use of innovative
11 technology and patient monitoring devices for
12 pregnant and postpartum individuals from ra-
13 cial and ethnic minority groups.

14 (E) Best practices with respect to privacy
15 and security safeguards in such use.

16 (3) REPORT.—Not later than 24 months after
17 the date of enactment of this Act, the National
18 Academies shall complete the study under this sub-
19 section, and transmit a report the results of such
20 study to Congress.

21 **SEC. 5207. SOCIAL DETERMINANTS FOR MOMS.**

22 (a) TASK FORCE TO DEVELOP A STRATEGY TO AD-
23 DRESS SOCIAL DETERMINANTS OF MATERNAL
24 HEALTH.—

1 (1) IN GENERAL.—The Secretary of Health and
2 Human Services shall convene a task force (in this
3 subsection referred to as the “Task Force”) to de-
4 velop a strategy to coordinate efforts between Fed-
5 eral agencies to address social determinants of ma-
6 ternal health with respect to pregnant and
7 postpartum individuals.

8 (2) EX OFFICIO MEMBERS.—The ex officio
9 members of the Task Force shall consist of the fol-
10 lowing:

11 (A) The Secretary of Health and Human
12 Services (or a designee thereof).

13 (B) The Secretary of Housing and Urban
14 Development (or a designee thereof).

15 (C) The Secretary of Transportation (or a
16 designee thereof).

17 (D) The Secretary of Agriculture (or a
18 designee thereof).

19 (E) The Secretary of Labor (or a designee
20 thereof).

21 (F) The Administrator of the Environ-
22 mental Protection Agency (or a designee there-
23 of).

1 (G) The Assistant Secretary for the Ad-
2 ministration for Children and Families (or a
3 designee thereof).

4 (H) The Administrator of the Centers for
5 Medicare & Medicaid Services (or a designee
6 thereof).

7 (I) The Director of the Indian Health
8 Service (or a designee thereof).

9 (J) The Director of the National Institutes
10 of Health (or a designee thereof).

11 (K) The Administrator of the Health Re-
12 sources and Services Administration (or a des-
13 ignee thereof).

14 (L) The Deputy Assistant Secretary for
15 Minority Health of the Department of Health
16 and Human Services (or a designee thereof).

17 (M) The Deputy Assistant Secretary for
18 Women's Health of the Department of Health
19 and Human Services (or a designee thereof).

20 (N) The Director of the Centers for Dis-
21 ease Control and Prevention (or a designee
22 thereof).

23 (O) The Director of the Office on Violence
24 Against Women of the Department of Justice
25 (or a designee thereof).

1 (3) APPOINTED MEMBERS.—In addition to the
2 ex officio members of the Task Force, the Secretary
3 of Health and Human Services shall appoint the fol-
4 lowing members of the Task Force:

5 (A) At least two representatives of pa-
6 tients, to include—

7 (i) a representative of patients who
8 have suffered from severe maternal mor-
9 bidity; or
10 (ii) a representative of patients who is
11 a family member of an individual who suf-
12 fered a pregnancy-related death.

13 (B) At least two leaders of community-
14 based organizations that address maternal mor-
15 tality and severe maternal morbidity with a spe-
16 cific focus on racial and ethnic inequities. In
17 appointing such leaders under this subpara-
18 graph, the Secretary of Health and Human
19 Services shall give priority to individuals who
20 are leaders of organizations led by individuals
21 from racial and ethnic minority groups.

22 (C) At least two perinatal health workers.

23 (D) A professionally diverse panel of ma-
24 ternity care providers.

(4) CHAIR.—The Secretary of Health and Human Services shall select the chair of the Task Force from among the members of the Task Force.

(5) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Task Force shall submit to Congress a report on—

(A) the strategy developed under para-
graph (1);

9 (B) recommendations on funding amounts
10 with respect to implementing such strategy; and

(C) recommendations for how to expand coverage of social services to address social determinants of maternal health under Medicaid managed care organizations and State Medicaid programs.

(6) **TERMINATION.**—Section 14 of the Federal
Advisory Committee Act (5 U.S.C. App.) shall not
apply to the Task Force with respect to termination.

19 (b) HOUSING FOR MOMS GRANT PROGRAM.—

20 (1) DEFINITIONS.—In this subsection:

21 (A) ELIGIBLE ENTITY.—The term “eligible
22 entity” means—

23 (i) a community-based organization;

1 (ii) a State or local governmental enti-
2 ty, including a State or local public health
3 department;

4 (iii) an Indian tribe or Tribal organi-
5 zation (as such terms are defined in sec-
6 tion 4 of the Indian Self-Determination
7 and Education Assistance Act (25 U.S.C.
8 5304)); or

9 (iv) an Urban Indian organization (as
10 such term is defined in section 4 of the In-
11 dian Health Care Improvement Act (25
12 U.S.C. 1603)).

13 (B) SECRETARY.—The term “Secretary”
14 means the Secretary of Housing and Urban De-
15 velopment.

16 (2) ESTABLISHMENT.—The Secretary shall es-
17 tablish a Housing for Moms grant program to make
18 grants to eligible entities to increase access to safe,
19 stable, affordable, and adequate housing for preg-
20 nant and postpartum individuals and their families.

21 (3) APPLICATION.—To be eligible to receive a
22 grant under this subsection, an eligible entity shall
23 submit to the Secretary an application at such time,
24 in such manner, and containing such information as
25 the Secretary may provide.

1 (4) PRIORITY.—In awarding grants under this
2 subsection, the Secretary shall give priority to an eli-
3 gible entity that—

4 (A) is a community-based organization or
5 will partner with a community-based organiza-
6 tion to implement initiatives to increase access
7 to safe, stable, affordable, and adequate hous-
8 ing for pregnant and postpartum individuals
9 and their families;

10 (B) is operating in an area with high rates
11 of adverse maternal health outcomes or signifi-
12 cant racial or ethnic inequities in maternal
13 health outcomes, to the extent such data are
14 available; and

15 (C) is operating in an area with a high
16 poverty rate or a significant number of individ-
17 uals who lack consistent access to safe, stable,
18 affordable, and adequate housing.

19 (5) USE OF FUNDS.—An eligible entity that re-
20 ceives a grant under this subsection shall use funds
21 from the grant for the purposes of—

22 (A) identifying and conducting outreach to
23 pregnant and postpartum individuals who are
24 low-income and lack consistent access to safe,
25 stable, affordable, and adequate housing;

1 (B) providing safe, stable, affordable, and
2 adequate housing options to such individuals;

3 (C) connecting such individuals with local
4 organizations offering safe, stable, affordable,
5 and adequate housing options;

6 (D) providing application assistance to
7 such individuals seeking to enroll in programs
8 offering safe, stable, affordable, and adequate
9 housing options;

10 (E) providing direct financial assistance to
11 such individuals for the purposes of maintaining
12 safe, stable, and adequate housing for the dura-
13 tion of the individual's pregnancy and
14 postpartum periods; and

15 (F) working with relevant stakeholders to
16 ensure that local housing and homeless shelter
17 infrastructure is supportive to pregnant and
18 postpartum individuals, including through—

19 (i) health-promoting housing codes;

20 (ii) enforcement of housing codes;

21 (iii) proactive rental inspection pro-
22 grams;

23 (iv) code enforcement officer training;

24 and

1 (v) partnerships between regional of-
2 fices of the Department of Housing and
3 Urban Development and community-based
4 organizations to ensure housing laws are
5 understood and violations are discovered.

6 (6) REPORTING.—

7 (A) ELIGIBLE ENTITIES.—The Secretary
8 shall require each eligible entity receiving a
9 grant under this subsection to annually submit
10 to the Secretary and make publicly available a
11 report on the status of activities conducted
12 using the grant.

13 (B) SECRETARY.—Not later than the end
14 of each fiscal year in which grants are made
15 under this subsection, the Secretary shall sub-
16 mit to Congress and make publicly available a
17 report that—

18 (i) summarizes the reports received
19 under subparagraph (A);

20 (ii) evaluates the effectiveness of
21 grants awarded under this subsection in
22 increasing access to safe, stable, afford-
23 able, and adequate housing for pregnant
24 and postpartum individuals and their fami-
25 lies; and

1 (iii) makes recommendations with re-
2 spect to ensuring activities described para-
3 graph (5) continue after grant amounts
4 made available under this subsection are
5 expended.

6 (7) AUTHORIZATION OF APPROPRIATIONS.—
7 There is authorized to be appropriated to carry out
8 this subsection \$10,000,000 for fiscal year 2023,
9 which shall remain available until expended.

10 (c) DEPARTMENT OF TRANSPORTATION.—

11 (1) REPORT.—Not later than 1 year after the
12 date of enactment of this Act, the Secretary of
13 Transportation shall submit to Congress and make
14 publicly available a report containing—

15 (A) an assessment of transportation bar-
16 riers preventing individuals from attending pre-
17 natal and postpartum appointments, accessing
18 maternal health care services, or accessing serv-
19 ices and resources related to social deter-
20 minants of maternal health;

21 (B) recommendations on how to overcome
22 the barriers assessed under subparagraph (A);
23 and

1 (C) an assessment of transportation safety
2 risks for pregnant individuals and recommenda-
3 tions on how to mitigate those risks.

4 (2) CONSIDERATIONS.—In carrying out para-
5 graph (1), the Secretary of Transportation shall give
6 special consideration to solutions for—

7 (A) pregnant and postpartum individuals
8 living in a health professional shortage area
9 designated under section 332 of the Public
10 Health Service Act (42 U.S.C. 254e);

11 (B) pregnant and postpartum individuals
12 living in areas with high maternal mortality or
13 severe morbidity rates or significant racial or
14 ethnic inequities in maternal health outcomes;
15 and

16 (C) pregnant and postpartum individuals
17 with a disability that impacts mobility.

18 (d) DEPARTMENT OF AGRICULTURE.—

19 (1) SPECIAL SUPPLEMENTAL NUTRITION PRO-
20 GRAM FOR WOMEN, INFANTS, AND CHILDREN.—

21 (A) EXTENSION OF POSTPARTUM PE-
22 RIOD.—Section 17(b)(10) of the Child Nutri-
23 tion Act of 1966 (42 U.S.C. 1786(b)(10)) is
24 amended by striking “six” and inserting “24”.

1 (B) REPORT.—Not later than 2 years after
2 the date of enactment of this Act, the Secretary
3 shall submit to Congress a report that evaluates
4 the effect of the amendment made by subpara-
5 graph (A) on—

6 (i) maternal and infant health out-
7 comes, including racial and ethnic inequi-
8 ties with respect to those outcomes;

9 (ii) breastfeeding rates among
10 postpartum individuals;

11 (iii) qualitative evaluations of family
12 experiences under the special supplemental
13 nutrition program for women, infants, and
14 children established under section 17 of
15 the Child Nutrition Act of 1966 (42
16 U.S.C. 1786); and

17 (iv) other relevant information as de-
18 termined by the Secretary.

19 (2) GRANT PROGRAM FOR HEALTHY FOOD AND
20 CLEAN WATER FOR PREGNANT AND POSTPARTUM
21 INDIVIDUALS.—

22 (A) IN GENERAL.—The Secretary shall es-
23 tablish a program (referred to in this paragraph
24 as the “program”) to award grants, on a com-

1 petitive basis, to eligible entities to carry out
2 the activities described in subparagraph (D).

3 (B) APPLICATION.—To be eligible for a
4 grant under the program, an eligible entity
5 shall submit to the Secretary an application at
6 such time, in such manner, and containing such
7 information as the Secretary determines appro-
8 priate.

9 (C) PRIORITY.—In awarding grants under
10 the program, the Secretary shall give priority to
11 an eligible entity that—

12 (i) is, or will partner with, an eligible
13 entity described in paragraph (3)(A)(i);
14 and

15 (ii) is operating in an area with a high
16 rate of—

17 (I) adverse maternal health out-
18 comes; or

19 (II) significant racial or ethnic
20 inequities in maternal health out-
21 comes.

22 (D) USE OF FUNDS.—An eligible entity
23 shall use a grant awarded under the program to
24 deliver healthy food, infant formula, clean
25 water, or diapers to pregnant and postpartum

1 individuals located in areas that are food
2 deserts, as determined by the Secretary using
3 data from the Food Access Research Atlas of
4 the Department of Agriculture.

5 (E) REPORTS.—

6 (i) ELIGIBLE ENTITIES.—Not later
7 than 1 year after the date on which an eli-
8 gible entity receives a grant under the pro-
9 gram, and annually thereafter, the eligible
10 entity shall submit to the Secretary a re-
11 port on the status of activities conducted
12 using the grant, which shall contain such
13 information as the Secretary may require.

14 (ii) SECRETARY.—

15 (I) IN GENERAL.—Not later than
16 2 years after the date on which the
17 first grant is awarded under the pro-
18 gram, the Secretary shall submit to
19 Congress a report that includes—

20 (aa) a summary of the re-
21 ports submitted by eligible enti-
22 ties under clause (i);

23 (bb) an assessment of the
24 extent to which food distributed
25 using grants awarded under the

688

1 program was purchased from
2 local and regional food systems;

3 (cc) an evaluation of the ef-
4 fect of the program on maternal
5 and infant health outcomes, in-
6 cluding racial and ethnic inequi-
7 ties with respect to those out-
8 comes; and

9 (dd) recommendations with
10 respect to ensuring the activities
11 described in subparagraph (D)
12 continue after the grant period
13 funding those activities expires.

14 (II) PUBLICATION.—The Sec-
15 retary shall make the report sub-
16 mitted under subclause (I) publicly
17 available on the website of the De-
18 partment of Agriculture.

19 (F) AUTHORIZATION OF APPROPRIA-
20 TIONS.—There is authorized to be appropriated
21 to carry out the program \$5,000,000 for the
22 period of fiscal years 2022 through 2024.

23 (3) DEFINITIONS.—In this subsection:

24 (A) ELIGIBLE ENTITY.—The term “eligible
25 entity” means—

- 1 (i) a community based organization;
2 (ii) a State or local governmental enti-
3 ty, including a State or local public health
4 department;
5 (iii) an Indian Tribe or Tribal organi-
6 zation (as those terms are defined in sec-
7 tion 4 of the Indian Self-Determination
8 and Education Assistance Act (25 U.S.C.
9 5304)); and
10 (iv) an Urban Indian organization (as
11 defined in section 4 of the Indian Health
12 Care Improvement Act (25 U.S.C. 1603)).

13 (B) SECRETARY.—The term “Secretary”
14 means the Secretary of Agriculture.

15 (e) ENVIRONMENTAL STUDY THROUGH NATIONAL
16 ACADEMIES.—

17 (1) IN GENERAL.—Not later than 60 days after
18 the date of enactment of this Act, the Administrator
19 of the Environmental Protection Agency shall seek
20 to enter into an agreement with the National Acad-
21 emies of Sciences, Engineering, and Medicine (re-
22 ferred to in this subsection as the “National Acad-
23 emies”) under which the National Academies agree
24 to conduct a study on the impacts of, with respect
25 to maternal and infant health incomes, water and

1 air quality, exposure to extreme temperatures, envi-
2 ronmental chemicals, environmental risks in the
3 workplace and the home, and pollution levels.

4 (2) STUDY REQUIREMENTS.—The agreement
5 under paragraph (1) shall direct the National Acad-
6 emies to make recommendations for—

7 (A) improving environmental conditions to
8 improve maternal and infant health outcomes;
9 and

10 (B) reducing or eliminating racial and eth-
11 nic inequities in those outcomes.

12 (3) REPORT.—The agreement under paragraph
13 (1) shall direct the National Academies to complete
14 the study under this subsection, and submit to Con-
15 gress and make publicly available a report on the re-
16 sults of the study, not later than 1 year after the
17 date of enactment of this Act.

18 (f) CHILD CARE ACCESS.—

19 (1) GRANT PROGRAM.—The Secretary of
20 Health and Human Services (in this subsection re-
21 ferred to as the “Secretary”) shall award grants to
22 eligible organizations to carry out programs to pro-
23 vide pregnant and postpartum individuals with free
24 and accessible drop-in child care services during pre-
25 natal and postpartum appointments.

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

6 (3) ELIGIBLE ORGANIZATIONS.—

7 (A) ELIGIBILITY.—To be eligible to receive
8 a grant under this subsection, an organization
9 shall be an organization that—

10 (i) provides child care services; and

11 (ii) can carry out a program providing
12 pregnant and postpartum individuals with
13 free and accessible drop-in child care serv-
14 ices during prenatal and postpartum ap-
15 pointments.

16 (B) PRIORITIZATION.—In selecting grant
17 recipients under this subsection, the Secretary
18 shall give priority to eligible organizations that
19 operate in an area that has, to the extent data
20 with respect to such an area are available—

21 (i) high rates of adverse maternal
22 health outcomes; or

23 (ii) significant racial or ethnic inequi-
24 ties in maternal health outcomes.

1 (4) TIMING.—The Secretary shall commence
2 the grant program under paragraph (1) not later
3 than 1 year after the date of enactment of this Act.

4 (5) REPORTING.—

5 (A) GRANTEES.—Each recipient of a grant
6 under this subsection shall annually submit to
7 the Secretary and make publicly available a re-
8 port on the status of activities conducted using
9 the grant. Each such report shall include—

10 (i) an analysis of the effect of the
11 funded program on prenatal and
12 postpartum appointment attendance rates;

13 (ii) summaries of qualitative assess-
14 ments of the funded program from—

15 (I) pregnant and postpartum in-
16 dividuals participating in the pro-
17 gram; and

18 (II) the families of such individ-
19 uals; and

20 (iii) such additional information as
21 the Secretary may require.

22 (B) SECRETARY.—Not later than the end
23 of fiscal year 2024, the Secretary shall submit
24 to the Congress, and make publicly available, a
25 report containing each of the following:

1 (i) A summary of the reports received
2 under subparagraph (A).

3 (ii) An assessment of the effects, if
4 any, of the funded programs on maternal
5 health outcomes, with a specific focus on
6 racial and ethnic inequities in such out-
7 comes.

8 (iii) A description of actions the Sec-
9 retary can take to ensure that pregnant
10 and postpartum individuals eligible for
11 medical assistance under a State plan
12 under title XIX of the Social Security Act
13 (42 U.S.C. 1936 et seq.) have access to
14 free and accessible drop-in child care serv-
15 ices during prenatal and postpartum ap-
16 pointments, including identification of the
17 funding necessary to carry out such ac-
18 tions.

19 (6) DROP-IN CHILD CARE SERVICES DE-
20 FINED.—In this subsection, the term “drop-in child
21 care services” means child care (including early
22 childhood education) services that are—

23 (A) delivered at a facility that meets the
24 requirements of all applicable laws and regula-
25 tions of the State or local government in which

1 it is located, including the requirements for li-
2 censing of the facility as a child care facility;
3 and

4 (B) provided in single encounters without
5 requiring full-time enrollment of a person in a
6 child care program.

7 (7) AUTHORIZATION OF APPROPRIATIONS.—To
8 carry out this subsection, there is authorized to be
9 appropriated \$5,000,000 for the period of fiscal
10 years 2023 through 2025.

11 (g) GRANTS TO LOCAL ENTITIES ADDRESSING SO-
12 CIAL DETERMINANTS OF MATERNAL HEALTH.—

13 (1) IN GENERAL.—The Secretary of Health and
14 Human Services (in this subsection referred to as
15 the “Secretary”) shall award grants to eligible enti-
16 ties to—

17 (A) address social determinants of mater-
18 nal health for pregnant and postpartum individ-
19 uals; and

20 (B) eliminate racial and ethnic inequities
21 in maternal health outcomes.

22 (2) APPLICATION.—To be eligible to receive a
23 grant under this subsection an eligible entity shall
24 submit to the Secretary an application at such time,

1 in such manner, and containing such information as
2 the Secretary may provide.

3 (3) PRIORITIZATION.—In awarding grants
4 under paragraph (1), the Secretary shall give pri-
5 ority to an eligible entity that—

6 (A) is a community-based organization, or
7 will partner with a community-based organiza-
8 tion to carry out the activities under paragraph
9 (4);

10 (B) is operating in an area with high rates
11 of adverse maternal health outcomes or signifi-
12 cant racial or ethnic inequities in maternal
13 health outcomes; and

14 (C) is operating in an area with a high
15 poverty rate.

16 (4) ACTIVITIES.—An eligible entity that re-
17 ceives a grant under this subsection may use funds
18 received through the grant to—

19 (A) hire and retain staff;

20 (B) develop and distribute a list of avail-
21 able resources with respect to social service pro-
22 grams in a community;

23 (C) establish a resource center that pro-
24 vides multiple social service programs in a sin-
25 gle location;

1 (D) offer programs and resources in the
2 communities in which the respective eligible en-
3 tities are located to address social determinants
4 of health for pregnant and postpartum individ-
5 uals; and

6 (E) consult with such pregnant and
7 postpartum individuals to conduct an assess-
8 ment of the activities under this paragraph.

9 (5) TECHNICAL ASSISTANCE.—The Secretary
10 shall provide to grant recipients under this sub-
11 section technical assistance to plan for sustaining
12 programs to address social determinants of maternal
13 health among pregnant and postpartum individuals
14 after the period of the grant.

15 (6) REPORTING.—

16 (A) GRANTEES.—Not later than 1 year
17 after the date on which an eligible entity first
18 receives a grant under this subsection, and an-
19 nually thereafter, an eligible entity shall submit
20 to the Secretary, and make publicly available, a
21 report on the status of activities conducted
22 using the grant. Each such report shall include
23 data on the effects of such activities,
24 disaggregated by race, ethnicity, gender, and
25 other relevant factors.

1 (B) SECRETARY.—Not later than the end
2 of fiscal year 2026, the Secretary shall submit
3 to Congress a report that includes—

4 (i) a summary of the reports received
5 under subparagraph (A); and

6 (ii) recommendations for—

7 (I) improving maternal health
8 outcomes; and
9 (II) reducing or eliminating ra-
10 cial and ethnic inequities in maternal
11 health outcomes.

12 (7) AUTHORIZATION OF APPROPRIATIONS.—
13 There is authorized to be appropriated to carry out
14 this subsection \$15,000,000 for each of fiscal years
15 2023 through 2027.

16 (h) DEFINITIONS.—In this section:

17 (1) CULTURALLY CONGRUENT.—The term “cul-
18 turally congruent”, with respect to care or maternity
19 care provided to a health care consumer, means care
20 that is in agreement with the preferred cultural val-
21 ues, beliefs, worldview, language, and practices of
22 the health care consumer and other relevant stake-
23 holders.

1 (2) MATERNITY CARE PROVIDER.—The term
2 “maternity care provider” means a health care pro-
3 vider who—

4 (A) is a physician, physician assistant,
5 midwife who meets at a minimum the inter-
6 national definition of the midwife and global
7 standards for midwifery education as estab-
8 lished by the International Confederation of
9 Midwives, nurse practitioner, or clinical nurse
10 specialist; and

11 (B) has a focus on maternal or perinatal
12 health.

13 (3) MATERNAL MORTALITY.—The term “mater-
14 nal mortality” means a death occurring during or
15 within a one-year period after pregnancy, caused by
16 pregnancy-related or childbirth complications, in-
17 cluding a suicide, overdose, or other death resulting
18 from a mental health or substance use disorder at-
19 tributed to or aggravated by pregnancy-related or
20 childbirth complications.

21 (4) PERINATAL HEALTH WORKER.—The term
22 “perinatal health worker” means a doula, commu-
23 nity health worker, peer supporter, breastfeeding
24 and lactation educator or counselor, nutritionist or

1 dietitian, childbirth educator, social worker, home
2 visitor, language interpreter, or navigator.

3 (5) POSTPARTUM AND POSTPARTUM PERIOD.—

4 The terms “postpartum” and “postpartum period”
5 refer to the 1-year period beginning on the last day
6 of the pregnancy of an individual.

7 (6) RACIAL AND ETHNIC MINORITY GROUP.—

8 The term “racial and ethnic minority group” has the
9 meaning given such term in section 1707(g)(1) of
10 the Public Health Service Act (42 U.S.C. 300u–
11 6(g)(1)).

12 (7) SEVERE MATERNAL MORBIDITY.—The term

13 “severe maternal morbidity” means a health condi-
14 tion, including mental health conditions and sub-
15 stance use disorders, attributed to or aggravated by
16 pregnancy or childbirth that results in significant
17 short-term or long-term consequences to the health
18 of the individual who was pregnant.

19 (8) SOCIAL DETERMINANTS OF MATERNAL

20 HEALTH DEFINED.—The term “social determinants

21 of maternal health” means non-clinical factors that

22 impact maternal health outcomes, including—

23 (A) economic factors, which may include

24 poverty, employment, food security, support for

1 and access to lactation and other infant feeding
2 options, housing stability, and related factors;

3 (B) neighborhood factors, which may in-
4 clude quality of housing, access to transpor-
5 tation, access to child care, availability of
6 healthy foods and nutrition counseling, avail-
7 ability of clean water, air and water quality,
8 ambient temperatures, neighborhood crime and
9 violence, access to broadband, and related fac-
10 tors;

11 (C) social and community factors, which
12 may include systemic racism, gender discrimi-
13 nation or discrimination based on other pro-
14 tected classes, workplace conditions, incarcer-
15 ation, and related factors;

16 (D) household factors, which may include
17 ability to conduct lead testing and abatement,
18 car seat installation, indoor air temperatures,
19 and related factors;

20 (E) education access and quality factors,
21 which may include educational attainment, lan-
22 guage and literacy, and related factors; and

23 (F) health care access factors, including
24 health insurance coverage, access to culturally
25 congruent health care services, providers, and

1 non-clinical support, access to home visiting
2 services, access to wellness and stress manage-
3 ment programs, health literacy, access to tele-
4 health and items required to receive telehealth
5 services, and related factors.

6 **SEC. 5208. DATA TO SAVE MOMS.**

7 (a) SHORT TITLE.—This section may be cited as the
8 “Data to Save Moms Act”.

9 (b) FUNDING FOR MATERNAL MORTALITY REVIEW
10 COMMITTEES TO PROMOTE REPRESENTATIVE COMMU-
11 NITY ENGAGEMENT.—

12 (1) IN GENERAL.—Section 317K(d) of the Pub-
13 lic Health Service Act (42 U.S.C. 247b–12(d)) is
14 amended by adding at the end the following:

15 “(9) GRANTS TO PROMOTE REPRESENTATIVE
16 COMMUNITY ENGAGEMENT IN MATERNAL MOR-
17 TALITY REVIEW COMMITTEES.—

18 “(A) IN GENERAL.—The Secretary may,
19 using funds made available pursuant to sub-
20 paragraph (C), provide assistance to an applica-
21 ble maternal mortality review committee of a
22 State, Indian tribe, tribal organization, or
23 Urban Indian organization (as such term is de-
24 fined in section 4 of the Indian Health Care
25 Improvement Act (25 U.S.C. 1603))—

1 “(i) to select for inclusion in the mem-
2 bership of such a committee community
3 members from the State, Indian tribe, trib-
4 al organization, or Urban Indian organiza-
5 tion by—

6 “(I) prioritizing community mem-
7 bers who can increase the diversity of
8 the committee’s membership with re-
9 spect to race and ethnicity, location,
10 and professional background, includ-
11 ing members with non-clinical experi-
12 ences; and

13 “(II) to the extent applicable,
14 using funds reserved under subsection
15 (f), to address barriers to maternal
16 mortality review committee participa-
17 tion for community members, includ-
18 ing through providing required train-
19 ing, reducing transportation barriers,
20 providing compensation, and providing
21 other supports as may be necessary;

22 “(ii) to establish initiatives to conduct
23 outreach and community engagement ef-
24 forts within communities throughout the
25 State or Indian tribe to seek input from

1 community members on the work of such
2 maternal mortality review committee, with
3 a particular focus on outreach to people
4 who are members of minority groups; and
5 “(iii) to release public reports assess-
6 ing—

7 “(I) the pregnancy-related death
8 and pregnancy-associated death review
9 processes of the maternal mortality
10 review committee, with a particular
11 focus on the maternal mortality re-
12 view committee’s sensitivity to the
13 unique circumstances of pregnant and
14 postpartum individuals from racial
15 and ethnic minority groups (as such
16 term is defined in section 1707(g)(1))
17 who have suffered pregnancy-related
18 deaths; and

19 “(II) the impact of the use of
20 funds made available pursuant to
21 paragraph (C) on increasing the diver-
22 sity of the maternal mortality review
23 committee membership and promoting
24 community engagement efforts
25 throughout the State or Indian tribe.

1 “(B) TECHNICAL ASSISTANCE.—The Sec-
2 retary shall provide (either directly through the
3 Department of Health and Human Services or
4 by contract) technical assistance to any mater-
5 nal mortality review committee receiving a
6 grant under this paragraph on best practices
7 for increasing the diversity of the maternal
8 mortality review committee’s membership and
9 for conducting effective community engagement
10 throughout the State or Indian tribe.

11 “(C) AUTHORIZATION OF APPROPRIA-
12 TIONS.—In addition to any funds made avail-
13 able under subsection (f), there are authorized
14 to be appropriated to carry out this paragraph
15 \$10,000,000 for each of fiscal years 2023
16 through 2027.”.

17 (2) RESERVATION OF FUNDS.—Section 317K(f)
18 of the Public Health Service Act (42 U.S.C. 247b–
19 12(f)) is amended by adding at the end the fol-
20 lowing: “Of the amount made available under the
21 preceding sentence for a fiscal year, not less than
22 \$1,500,000 shall be reserved for grants awarded
23 under subsection (d)(9) to Indian tribes, tribal orga-
24 nizations, or Urban Indian organizations (as those

1 terms are defined in section 4 of the Indian Health
2 Care Improvement Act (25 U.S.C. 1603)).”.

3 (c) DATA COLLECTION AND REVIEW.—Section
4 317K(d)(3)(A)(i) of the Public Health Service Act (42
5 U.S.C. 247b–12(d)(3)(A)(i)) is amended—

6 (1) by redesignating subclauses (II) and (III)
7 as subclauses (V) and (VI), respectively; and

8 (2) by inserting after subclause (I) the fol-
9 lowing:

10 “(II) to the extent practicable,
11 reviewing cases of severe maternal
12 morbidity, according to the most up-
13 to-date indicators;

14 “(III) to the extent practicable,
15 reviewing deaths during pregnancy or
16 up to 1 year after the end of a preg-
17 nancy from suicide, overdose, or other
18 death from a mental health condition
19 or substance use disorder attributed
20 to, or aggravated by, pregnancy or
21 childbirth complications;

22 “(IV) to the extent practicable,
23 consulting with local community-based
24 organizations representing pregnant
25 and postpartum individuals from de-

1 mographic groups disproportionately
2 impacted by poor maternal health out-
3 comes to ensure that, in addition to
4 clinical factors, non-clinical factors
5 that might have contributed to a preg-
6 nancy-related death are appropriately
7 considered;”.

8 (d) REVIEW OF MATERNAL HEALTH DATA COLLEC-
9 TION PROCESSES AND QUALITY MEASURES.—

10 (1) IN GENERAL.—The Secretary of Health and
11 Human Services, acting through the Administrator
12 for the Centers for Medicare & Medicaid Services
13 and the Director of the Agency for Healthcare Re-
14 search and Quality, shall consult with relevant stake-
15 holders—

16 (A) to review existing maternal health data
17 collection processes and quality measures; and

18 (B) to make recommendations to improve
19 such processes and measures, including topics
20 described under paragraph (3).

21 (2) COLLABORATION.—In carrying out this sub-
22 section, the Secretary shall consult with a diverse
23 group of maternal health stakeholders, which may
24 include—

1 (A) pregnant and postpartum individuals
2 and their family members, and nonprofit orga-
3 nizations representing such individuals, with a
4 particular focus on patients from racial and
5 ethnic minority groups;

6 (B) community-based organizations that
7 provide support for pregnant and postpartum
8 individuals, with a particular focus on patients
9 from racial and ethnic minority groups;

10 (C) membership organizations for mater-
11 nity care providers;

12 (D) organizations representing perinatal
13 health workers;

14 (E) organizations that focus on maternal
15 mental or behavioral health;

16 (F) organizations that focus on intimate
17 partner violence;

18 (G) institutions of higher education, with a
19 particular focus on minority-serving institu-
20 tions;

21 (H) licensed and accredited hospitals, birth
22 centers, midwifery practices, or other medical
23 practices that provide maternal health care
24 services to pregnant and postpartum patients;

1 (I) relevant State and local public agencies,
2 including State maternal mortality review com-
3 mittees; and

4 (J) the National Quality Forum, or such
5 other standard-setting organizations specified
6 by the Secretary.

7 (3) TOPICS.—The review of maternal health
8 data collection processes and recommendations to
9 improve such processes and measures required under
10 paragraph (1) shall assess all available relevant in-
11 formation, including information from State-level
12 sources, and shall consider at least the following:

13 (A) Current State and Tribal practices for
14 maternal health, maternal mortality, and severe
15 maternal morbidity data collection and dissemi-
16 nation, including consideration of—

17 (i) the timeliness of processes for
18 amending a death certificate when new in-
19 formation pertaining to the death becomes
20 available to reflect whether the death was
21 a pregnancy-related death;

22 (ii) relevant data collected with elec-
23 tronic health records, including data on
24 race, ethnicity, socioeconomic status, insur-

1 ance type, and other relevant demographic
2 information;

3 (iii) maternal health data collected
4 and publicly reported by hospitals, health
5 systems, midwifery practices, and birth
6 centers;

7 (iv) the barriers preventing States
8 from correlating maternal outcome data
9 with race and ethnicity data;

10 (v) processes for determining the
11 cause of a pregnancy-associated death in
12 States that do not have a maternal mor-
13 tality review committee;

14 (vi) whether maternal mortality review
15 committees include multidisciplinary and
16 diverse membership (as described in sec-
17 tion 317K(d)(1)(A) of the Public Health
18 Service Act (42 U.S.C. 247b-
19 12(d)(1)(A)));

20 (vii) whether members of maternal
21 mortality review committees participate in
22 trainings on bias, racism, or discrimina-
23 tion, and the quality of such trainings;

24 (viii) the extent to which States have
25 implemented systematic processes of listen-

1 ing to the stories of pregnant and
2 postpartum individuals and their family
3 members, with a particular focus on preg-
4 nant and postpartum individuals from ra-
5 cial and ethnic minority groups and their
6 family members, to fully understand the
7 causes of, and inform potential solutions
8 to, the maternal mortality and severe ma-
9 ternal morbidity crisis within their respec-
10 tive States;

11 (ix) the extent to which maternal mor-
12 tality review committees are considering
13 social determinants of maternal health
14 when examining the causes of pregnancy-
15 associated and pregnancy-related deaths;

16 (x) the extent to which maternal mor-
17 tality review committees are making ac-
18 tionable recommendations based on their
19 reviews of adverse maternal health out-
20 comes and the extent to which such rec-
21 ommendations are being implemented by
22 appropriate stakeholders;

23 (xi) the legal and administrative bar-
24 riers preventing the collection, collation,

1 and dissemination of State maternity care
2 data;

3 (xii) the effectiveness of data collec-
4 tion and reporting processes in separating
5 pregnancy-associated deaths from preg-
6 nancy-related deaths; and

7 (xiii) the current Federal, State, local,
8 and Tribal funding support for the activi-
9 ties referred to in clauses (i) through (xii).

10 (B) Whether the funding support referred
11 to in subparagraph (A)(xiii) is adequate for
12 States to carry out optimal data collection and
13 dissemination processes with respect to mater-
14 nal health, maternal mortality, and severe ma-
15 ternal morbidity.

16 (C) Current quality measures for mater-
17 nity care, including prenatal measures, labor
18 and delivery measures, and postpartum meas-
19 ures, including topics such as—

20 (i) effective quality measures for ma-
21 ternity care used by hospitals, health sys-
22 tems, midwifery practices, birth centers,
23 health plans, and other relevant entities;

24 (ii) the sufficiency of current outcome
25 measures used to evaluate maternity care

1 for driving improved care, experiences, and
2 outcomes in maternity care payment and
3 delivery system models;

4 (iii) maternal health quality measures
5 that other countries effectively use;

6 (iv) validated measures that have been
7 used for research purposes that could be
8 tested, refined, and submitted for national
9 endorsement;

10 (v) barriers preventing maternity care
11 providers and insurers from implementing
12 quality measures that are aligned with best
13 practices;

14 (vi) the frequency with which mater-
15 nity care quality measures are reviewed
16 and revised;

17 (vii) the strengths and weaknesses of
18 the Prenatal and Postpartum Care meas-
19 ures of the Health Plan Employer Data
20 and Information Set measures established
21 by the National Committee for Quality As-
22 surance;

23 (viii) the strengths and weaknesses of
24 maternity care quality measures under the
25 Medicaid program under title XIX of the

1 Social Security Act (42 U.S.C. 1396 et
2 seq.) and the Children's Health Insurance
3 Program under title XXI of such Act (42
4 U.S.C. 1397aa et seq.), including the ex-
5 tent to which States voluntarily report rel-
6 evant measures;

7 (ix) the extent to which maternity
8 care quality measures are informed by pa-
9 tient experiences that include measures of
10 patient-reported experience of care;

11 (x) the current processes for collecting
12 stratified data on the race and ethnicity of
13 pregnant and postpartum individuals in
14 hospitals, health systems, midwifery prac-
15 tices, and birth centers, and for incor-
16 porating such racially and ethnically strati-
17 fied data in maternity care quality meas-
18 ures;

19 (xi) the extent to which maternity
20 care quality measures account for the
21 unique experiences of pregnant and
22 postpartum individuals from racial and
23 ethnic minority groups; and

24 (xii) the extent to which hospitals,
25 health systems, midwifery practices, and

1 birth centers are implementing existing
2 maternity care quality measures.

3 (D) Recommendations on authorizing addi-
4 tional funds and providing additional technical
5 assistance to improve maternal mortality review
6 committees and State and Tribal maternal
7 health data collection and reporting processes.

8 (E) Recommendations for new authorities
9 that may be granted to maternal mortality re-
10 view committees to be able to—

11 (i) access records from other Federal
12 and State agencies and departments that
13 may be necessary to identify causes of
14 pregnancy-associated and pregnancy-re-
15 lated deaths that are unique to pregnant
16 and postpartum individuals from specific
17 populations, such as veterans and individ-
18 uals who are incarcerated; and

19 (ii) work with relevant experts who
20 are not members of the maternal mortality
21 review committee to assist in the review of
22 pregnancy-associated deaths of pregnant
23 and postpartum individuals from specific
24 populations, such as veterans and individ-
25 uals who are incarcerated.

1 (F) Recommendations to improve and
2 standardize current quality measures for mater-
3 nity care, with a particular focus on racial and
4 ethnic inequities in maternal health outcomes.

5 (G) Recommendations to improve the co-
6 ordination by the Department of Health and
7 Human Services of the efforts undertaken by
8 the agencies and organizations within the De-
9 partment related to maternal health data and
10 quality measures.

11 (4) REPORT.—Not later than 1 year after the
12 date of the enactment of this Act, the Secretary
13 shall submit to the Congress, and make publicly
14 available, a report on the results of the review of
15 maternal health data collection processes and quality
16 measures and recommendations to improve such
17 processes and measures required under paragraph
18 (1).

19 (5) DEFINITIONS.—In this subsection:

20 (A) MATERNAL MORTALITY REVIEW COM-
21 MITTEE.—The term “maternal mortality review
22 committee” means a maternal mortality review
23 committee duly authorized by a State and re-
24 ceiving funding under section 317K(a)(2)(D) of

1 the Public Health Service Act (42 U.S.C. 247b–
2 12(a)(2)(D)).

3 (B) PREGNANCY-ASSOCIATED DEATH.—

4 The term “pregnancy-associated”, with respect
5 to a death, means a death of a pregnant or
6 postpartum individual, by any cause, that oc-
7 curs during, or within 1 year following, the in-
8 dividual’s pregnancy, regardless of the outcome,
9 duration, or site of the pregnancy.

10 (C) PREGNANCY-RELATED DEATH.—The

11 term “pregnancy-related”, with respect to a
12 death, means a death of a pregnant or
13 postpartum individual that occurs during, or
14 within 1 year following, the individual’s preg-
15 nancy, from a pregnancy complication, a chain
16 of events initiated by pregnancy, or the aggra-
17 vation of an unrelated condition by the physio-
18 logic effects of pregnancy.

19 (6) AUTHORIZATION OF APPROPRIATIONS.—

20 There are authorized to be appropriated such sums
21 as may be necessary to carry out this subsection for
22 each of fiscal years 2023 through 2027.

23 (e) INDIAN HEALTH SERVICE STUDY ON MATERNAL
24 MORTALITY AND SEVERE MATERNAL MORBIDITY.—

1 (1) IN GENERAL.—The Director of the Indian
2 Health Service (referred to in this subsection as the
3 “Director”) shall, in coordination with entities de-
4 scribed in paragraph (2)—

5 (A) not later than 90 days after the date
6 of enactment of this Act, enter into a contract
7 with an independent research organization or
8 Tribal Epidemiology Center to conduct a com-
9 prehensive study on maternal mortality and se-
10 vere maternal morbidity in the populations of
11 American Indian and Alaska Native individuals;
12 and

13 (B) not later than 3 years after the date
14 of the enactment of this Act, submit to Con-
15 gress a report on such study that contains rec-
16 ommendations for policies and practices that
17 can be adopted to improve maternal health out-
18 comes for pregnant and postpartum American
19 Indian and Alaska Native individuals.

20 (2) PARTICIPATING ENTITIES.—The entities de-
21 scribed in this paragraph shall consist of 12 mem-
22 bers, selected by the Director from among individ-
23 uals nominated by Indian Tribes and Tribal organi-
24 zations (as such terms are defined in section 4 of
25 the Indian Self-Determination and Education Assist-

1 ance Act (25 U.S.C. 5304)), and Urban Indian or-
2 ganizations (as such term is defined in section 4 of
3 the Indian Health Care Improvement Act (25 U.S.C.
4 1603)). In selecting such members, the Director
5 shall ensure that each of the 12 service areas of the
6 Indian Health Service is represented.

7 (3) CONTENTS OF STUDY.—The study con-
8 ducted pursuant to paragraph (1) shall—

9 (A) examine the causes of maternal mor-
10 tality and severe maternal morbidity that are
11 unique to American Indian and Alaska Native
12 individuals;

13 (B) include a systematic process of listen-
14 ing to the stories of American Indian and Alas-
15 ka Native pregnant and postpartum individuals
16 to fully understand the causes of, and inform
17 potential solutions to, the maternal mortality
18 and severe maternal morbidity crisis within
19 their respective communities;

20 (C) distinguish between the causes of,
21 landscape of maternity care at, and rec-
22 ommendations to improve maternal health out-
23 comes within, the different settings in which
24 American Indian and Alaska Native pregnant

1 and postpartum individuals receive maternity
2 care, such as—

3 (i) facilities operated by the Indian
4 Health Service;

5 (ii) an Indian health program oper-
6 ated by an Indian Tribe or Tribal organi-
7 zation pursuant to a contract, grant, coop-
8 erative agreement, or compact with the In-
9 dian Health Service pursuant to the Indian
10 Self-Determination Act; and

11 (iii) an Urban Indian health program
12 operated by an Urban Indian organization
13 pursuant to a grant or contract with the
14 Indian Health Service pursuant to title V
15 of the Indian Health Care Improvement
16 Act;

17 (D) review processes for coordinating pro-
18 grams of the Indian Health Service with social
19 services provided through other programs ad-
20 ministered by the Secretary of Health and
21 Human Services (other than the Medicare pro-
22 gram under title XVIII of the Social Security
23 Act (42 U.S.C. 1395 et seq.), the Medicaid pro-
24 gram under title XIX of such Act (42 U.S.C.
25 1396 et seq.), and the Children's Health Insur-

1 ance Program under title XXI of such Act (42
2 U.S.C. 1397aa et seq.));

3 (E) review current data collection and
4 quality measurement processes and practices;

5 (F) assess causes and frequency of mater-
6 nal mental health conditions and substance use
7 disorders;

8 (G) consider social determinants of health,
9 including poverty, lack of health insurance, un-
10 employment, sexual violence, and environmental
11 conditions in Tribal areas;

12 (H) consider the role that historical mis-
13 treatment of American Indian and Alaska Na-
14 tive people has played in causing currently high
15 rates of maternal mortality and severe maternal
16 morbidity;

17 (I) consider how current funding of the In-
18 dian Health Service affects the ability of the
19 Service to deliver quality maternity care;

20 (J) consider the extent to which the deliv-
21 ery of maternity care services is culturally ap-
22 propriate for American Indian and Alaska Na-
23 tive pregnant and postpartum individuals;

24 (K) make recommendations to reduce
25 misclassification of American Indian and Alaska

1 Native pregnant and postpartum individuals,
2 including consideration of best practices in
3 training for maternal mortality review com-
4 mittee members to be able to correctly classify
5 American Indian and Alaska Native individuals;
6 and

7 (L) make recommendations informed by
8 the stories shared by American Indian and
9 Alaska Native pregnant and postpartum indi-
10 viduals pursuant to subparagraph (B) to im-
11 prove maternal health outcomes for such indi-
12 viduals.

13 (4) REPORT.—The agreement entered into
14 under paragraph (1) with an independent research
15 organization or Tribal Epidemiology Center shall re-
16 quire that the organization or center transmit to
17 Congress a report on the results of the study con-
18 ducted pursuant to that agreement not later than 36
19 months after the date of the enactment of this Act.

20 (5) AUTHORIZATION OF APPROPRIATIONS.—
21 There is authorized to be appropriated to carry out
22 this subsection \$2,000,000 for each of fiscal years
23 2023 through 2025.

24 (f) GRANTS TO MINORITY-SERVING INSTITUTIONS TO
25 STUDY MATERNAL MORTALITY, SEVERE MATERNAL

1 MORBIDITY, AND OTHER ADVERSE MATERNAL HEALTH
2 OUTCOMES.—

3 (1) IN GENERAL.—The Secretary of Health and
4 Human Services shall establish a program under
5 which the Secretary shall award grants to research
6 centers, health professions schools and programs,
7 and other entities at minority-serving institutions to
8 study specific aspects of the maternal health crisis
9 among pregnant and postpartum individuals from
10 racial and ethnic minority groups. Such research
11 may—

12 (A) include the development and imple-
13 mentation of systematic processes of listening
14 to the stories of pregnant and postpartum indi-
15 viduals from racial and ethnic minority groups,
16 and perinatal health workers supporting such
17 individuals, to fully understand the causes of,
18 and inform potential solutions to, the maternal
19 mortality and severe maternal morbidity crisis
20 within their respective communities;

21 (B) assess the potential causes of relatively
22 low rates of maternal mortality among Hispanic
23 individuals, including potential racial
24 misclassification and other data collection and
25 reporting issues that might be misrepresenting

1 maternal mortality rates among Hispanic indi-
2 viduals in the United States; and

3 (C) assess differences in rates of adverse
4 maternal health outcomes among subgroups
5 identifying as Hispanic.

6 (2) APPLICATION.—To be eligible to receive a
7 grant under paragraph (1), an entity described in
8 such paragraph shall submit to the Secretary an ap-
9 plication at such time, in such manner, and con-
10 taining such information as the Secretary may re-
11 quire.

12 (3) TECHNICAL ASSISTANCE.—The Secretary
13 may use not more than 10 percent of the funds
14 made available under paragraph (7)—

15 (A) to conduct outreach to minority-serv-
16 ing institutions to raise awareness of the avail-
17 ability of grants under paragraph (1);

18 (B) to provide technical assistance in the
19 application process for such a grant; and

20 (C) to promote capacity building, as need-
21 ed to enable entities described in such para-
22 graph to submit such an application.

23 (4) REPORTING REQUIREMENT.—Each entity
24 awarded a grant under this subsection shall periodi-

1 cally submit to the Secretary a report on the status
2 of activities conducted using the grant.

3 (5) EVALUATION.—Beginning one year after
4 the date on which the first grant is awarded under
5 this subsection, the Secretary shall submit to Con-
6 gress an annual report summarizing the findings of
7 research conducted using funds made available
8 under this subsection.

9 (6) MINORITY-SERVING INSTITUTIONS DE-
10 FINED.—In this subsection, the term “minority-serv-
11 ing institution” means an eligible institution de-
12 scribed in section 371(a) of the Higher Education
13 Act of 1965 (20 U.S.C. 1067q(a)).

14 (7) AUTHORIZATION OF APPROPRIATIONS.—
15 There are authorized to be appropriated to carry out
16 this subsection \$10,000,000 for each of fiscal years
17 2023 through 2027.

18 (g) DEFINITIONS.—In this section:

19 (1) CULTURALLY CONGRUENT.—The term “cul-
20 turally congruent”, with respect to care or maternity
21 care, means care that is in agreement with the pre-
22 ferred cultural values, beliefs, worldview, language,
23 and practices of the health care consumer and other
24 stakeholders.

1 (2) MATERNITY CARE PROVIDER.—The term
2 “maternity care provider” means a health care pro-
3 vider who—

4 (A) is a physician, physician assistant,
5 midwife who meets at a minimum the inter-
6 national definition of the midwife and global
7 standards for midwifery education as estab-
8 lished by the International Confederation of
9 Midwives, nurse practitioner, or clinical nurse
10 specialist; and

11 (B) has a focus on maternal or perinatal
12 health.

13 (3) MATERNAL MORTALITY.—The term “mater-
14 nal mortality” means a death occurring during or
15 within a one-year period after pregnancy, caused by
16 pregnancy-related or childbirth complications, in-
17 cluding a suicide, overdose, or other death resulting
18 from a mental health or substance use disorder at-
19 tributed to or aggravated by pregnancy-related or
20 childbirth complications.

21 (4) PERINATAL HEALTH WORKER.—The term
22 “perinatal health worker” means a doula, commu-
23 nity health worker, peer supporter, breastfeeding
24 and lactation educator or counselor, nutritionist or

1 dietitian, childbirth educator, social worker, home
2 visitor, language interpreter, or navigator.

3 (5) POSTPARTUM AND POSTPARTUM PERIOD.—

4 The terms “postpartum” and “postpartum period”
5 refer to the 1-year period beginning on the last day
6 of the pregnancy of an individual.

7 (6) PREGNANCY-ASSOCIATED DEATH.—The

8 term “pregnancy-associated death” means a death of
9 a pregnant or postpartum individual, by any cause,
10 that occurs during, or within 1 year following, the
11 individual’s pregnancy, regardless of the outcome,
12 duration, or site of the pregnancy.

13 (7) PREGNANCY-RELATED DEATH.—The term

14 “pregnancy-related death” means a death of a preg-
15 nant or postpartum individual that occurs during, or
16 within 1 year following, the individual’s pregnancy,
17 from a pregnancy complication, a chain of events
18 initiated by pregnancy, or the aggravation of an un-
19 related condition by the physiologic effects of preg-
20 nancy.

21 (8) RACIAL AND ETHNIC MINORITY GROUP.—

22 The term “racial and ethnic minority group” has the
23 meaning given such term in section 1707(g)(1) of
24 the Public Health Service Act (42 U.S.C. 300u–
25 6(g)(1)).

1 (9) SEVERE MATERNAL MORBIDITY.—The term
2 “severe maternal morbidity” means a health condi-
3 tion, including mental health conditions and sub-
4 stance use disorders, attributed to or aggravated by
5 pregnancy or childbirth that results in significant
6 short-term or long-term consequences to the health
7 of the individual who was pregnant.

8 (10) SOCIAL DETERMINANTS OF MATERNAL
9 HEALTH DEFINED.—The term “social determinants
10 of maternal health” means non-clinical factors that
11 impact maternal health outcomes, including—

12 (A) economic factors, which may include
13 poverty, employment, food security, support for
14 and access to lactation and other infant feeding
15 options, housing stability, and related factors;

16 (B) neighborhood factors, which may in-
17 clude quality of housing, access to transpor-
18 tation, access to child care, availability of
19 healthy foods and nutrition counseling, avail-
20 ability of clean water, air and water quality,
21 ambient temperatures, neighborhood crime and
22 violence, access to broadband, and related fac-
23 tors;

24 (C) social and community factors, which
25 may include systemic racism, gender discrimi-

1 nation or discrimination based on other pro-
2 tected classes, workplace conditions, incarcer-
3 ation, and related factors;

4 (D) household factors, which may include
5 ability to conduct lead testing and abatement,
6 car seat installation, indoor air temperatures,
7 and related factors;

8 (E) education access and quality factors,
9 which may include educational attainment, lan-
10 guage and literacy, and related factors; and

11 (F) health care access factors, including
12 health insurance coverage, access to culturally
13 congruent health care services, providers, and
14 non-clinical support, access to home visiting
15 services, access to wellness and stress manage-
16 ment programs, health literacy, access to tele-
17 health and items required to receive telehealth
18 services, and related factors.

19 **SEC. 5209. KIRA JOHNSON ACT.**

20 (a) INVESTMENTS IN COMMUNITY-BASED ORGANIZA-
21 TIONS TO IMPROVE BLACK MATERNAL HEALTH OUT-
22 COMES.—

23 (1) AWARDS.—Following the 1-year period de-
24 scribed in paragraph (3), the Secretary of Health
25 and Human Services (in this subsection referred to

1 as the “Secretary”) shall award grants to eligible
2 entities to establish or expand programs to prevent
3 maternal mortality and severe maternal morbidity
4 among Black pregnant and postpartum individuals.

5 (2) ELIGIBILITY.—To be eligible to seek a
6 grant under this subsection, an entity shall be a
7 community-based organization offering programs
8 and resources aligned with evidence-based practices
9 for improving maternal health outcomes for Black
10 pregnant and postpartum individuals.

11 (3) OUTREACH AND TECHNICAL ASSISTANCE
12 PERIOD.—During the 1-year period beginning on the
13 date of enactment of this Act, the Secretary shall—

14 (A) conduct outreach to encourage eligible
15 entities to apply for grants under this sub-
16 section; and

17 (B) provide technical assistance to eligible
18 entities on best practices for applying for grants
19 under this subsection.

20 (4) SPECIAL CONSIDERATION.—

21 (A) OUTREACH.—In conducting outreach
22 under paragraph (3), the Secretary shall give
23 special consideration to eligible entities that—

24 (i) are based in, and provide support
25 for, communities with high rates of adverse

1 maternal health outcomes or significant ra-
2 cial and ethnic inequities in maternal
3 health outcomes, to the extent such data
4 are available;

5 (ii) are led by Black people; and

6 (iii) offer programs and resources that
7 are aligned with evidence-based practices
8 for improving maternal health outcomes
9 for Black pregnant and postpartum indi-
10 viduals.

11 (B) AWARDS.—In awarding grants under
12 this subsection, the Secretary shall give special
13 consideration to eligible entities that—

14 (i) are described in clauses (i), (ii),
15 and (iii) of subparagraph (A);

16 (ii) offer programs and resources de-
17 signed in consultation with and intended
18 for Black pregnant and postpartum indi-
19 viduals; and

20 (iii) offer programs and resources in
21 the communities in which the respective el-
22 igible entities are located that—

23 (I) promote maternal mental
24 health and maternal substance use
25 disorder treatments and supports that

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1 are aligned with evidence-based prac-
2 tices for improving maternal mental
3 and behavioral health outcomes for
4 Black pregnant and postpartum indi-
5 viduals;

6 (II) address social determinants
7 of maternal health for pregnant and
8 postpartum individuals;

9 (III) promote evidence-based
10 health literacy and pregnancy, child-
11 birth, and parenting education for
12 pregnant and postpartum individuals;

13 (IV) provide support from
14 perinatal health workers to pregnant
15 and postpartum individuals;

16 (V) provide culturally congruent
17 training to perinatal health workers;

18 (VI) conduct or support research
19 on maternal health issues dispropor-
20 tionately impacting Black pregnant
21 and postpartum individuals;

22 (VII) provide support to family
23 members of individuals who suffered a
24 pregnancy-associated death or preg-
25 nancy-related death;

1 (VIII) operate midwifery prac-
2 tices that provide culturally congruent
3 maternal health care and support, in-
4 cluding for the purposes of—

5 (aa) supporting additional
6 education, training, and certifi-
7 cation programs, including sup-
8 port for distance learning;

9 (bb) providing financial sup-
10 port to current and future mid-
11 wives to address education costs,
12 debts, and other needs;

13 (cc) clinical site investments;

14 (dd) supporting preceptor
15 development trainings;

16 (ee) expanding the mid-
17 wifery practice; or

18 (ff) related needs identified
19 by the midwifery practice and de-
20 scribed in the practice's applica-
21 tion; or

22 (IX) have developed other pro-
23 grams and resources that address
24 community-specific needs for pregnant
25 and postpartum individuals and are

1 aligned with evidence-based practices
2 for improving maternal health out-
3 comes for Black pregnant and
4 postpartum individuals.

5 (5) TECHNICAL ASSISTANCE.—The Secretary
6 shall provide to grant recipients under this sub-
7 section technical assistance on—

8 (A) capacity building to establish or ex-
9 pand programs to prevent adverse maternal
10 health outcomes among Black pregnant and
11 postpartum individuals;

12 (B) best practices in data collection, meas-
13 urement, evaluation, and reporting; and

14 (C) planning for sustaining programs to
15 prevent maternal mortality and severe maternal
16 morbidity among Black pregnant and
17 postpartum individuals after the period of the
18 grant.

19 (6) EVALUATION.—Not later than the end of
20 fiscal year 2026, the Secretary shall submit to the
21 Congress an evaluation of the grant program under
22 this subsection that—

23 (A) assesses the effectiveness of outreach
24 efforts during the application process in diversi-
25 fying the pool of grant recipients;

1 (B) makes recommendations for future
2 outreach efforts to diversify the pool of grant
3 recipients for Department of Health and
4 Human Services grant programs and funding
5 opportunities related to maternal health;

6 (C) assesses the effectiveness of programs
7 funded by grants under this subsection in im-
8 proving maternal health outcomes for Black
9 pregnant and postpartum individuals, to the ex-
10 tent practicable; and

11 (D) makes recommendations for future
12 Department of Health and Human Services
13 grant programs and funding opportunities that
14 deliver funding to community-based organiza-
15 tions that provide programs and resources that
16 are aligned with evidence-based practices for
17 improving maternal health outcomes for Black
18 pregnant and postpartum individuals.

19 (7) AUTHORIZATION OF APPROPRIATIONS.—To
20 carry out this subsection, there is authorized to be
21 appropriated \$10,000,000 for each of fiscal years
22 2023 through 2027.

23 (b) INVESTMENTS IN COMMUNITY-BASED ORGANIZA-
24 TIONS TO IMPROVE MATERNAL HEALTH OUTCOMES IN
25 UNDERSERVED COMMUNITIES.—

1 (1) AWARDS.—Following the 1-year period de-
2 scribed in paragraph (3), the Secretary of Health
3 and Human Services (in this subsection referred to
4 as the “Secretary”) shall award grants to eligible
5 entities to establish or expand programs to prevent
6 maternal mortality and severe maternal morbidity
7 among underserved groups.

8 (2) ELIGIBILITY.—To be eligible to seek a
9 grant under this subsection, an entity shall be a
10 community-based organization offering programs
11 and resources aligned with evidence-based practices
12 for improving maternal health outcomes for preg-
13 nant and postpartum individuals.

14 (3) OUTREACH AND TECHNICAL ASSISTANCE
15 PERIOD.—During the 1-year period beginning on the
16 date of enactment of this Act, the Secretary shall—

17 (A) conduct outreach to encourage eligible
18 entities to apply for grants under this sub-
19 section; and

20 (B) provide technical assistance to eligible
21 entities on best practices for applying for grants
22 under this subsection.

23 (4) SPECIAL CONSIDERATION.—

1 (A) OUTREACH.—In conducting outreach
2 under paragraph (3), the Secretary shall give
3 special consideration to eligible entities that—

4 (i) are based in, and provide support
5 for, communities with high rates of adverse
6 maternal health outcomes or significant ra-
7 cial and ethnic inequities in maternal
8 health outcomes, to the extent such data
9 are available;

10 (ii) are led by individuals from ra-
11 cially, ethnically, and geographically di-
12 verse backgrounds; and

13 (iii) offer programs and resources that
14 are aligned with evidence-based practices
15 for improving maternal health outcomes
16 for pregnant and postpartum individuals.

17 (B) AWARDS.—In awarding grants under
18 this subsection, the Secretary shall give special
19 consideration to eligible entities that—

20 (i) are described in clauses (i), (ii),
21 and (iii) of subparagraph (A);

22 (ii) offer programs and resources de-
23 signed in consultation with and intended
24 for pregnant and postpartum individuals
25 from underserved groups; and

1 (iii) offer programs and resources in
2 the communities in which the respective el-
3 igible entities are located that—

4 (I) promote maternal mental
5 health and maternal substance use
6 disorder treatments and support that
7 are aligned with evidence-based prac-
8 tices for improving maternal mental
9 and behavioral health outcomes for
10 pregnant and postpartum individuals;

11 (II) address social determinants
12 of maternal health for pregnant and
13 postpartum individuals;

14 (III) promote evidence-based
15 health literacy and pregnancy, child-
16 birth, and parenting education for
17 pregnant and postpartum individuals;

18 (IV) provide support from
19 perinatal health workers to pregnant
20 and postpartum individuals;

21 (V) provide culturally congruent
22 training to perinatal health workers;

23 (VI) conduct or support research
24 on maternal health outcomes and in-
25 equities;

1 (VII) provide support to family
2 members of individuals who suffered a
3 pregnancy-associated death or preg-
4 nancy-related death;

5 (VIII) operate midwifery prac-
6 tices that provide culturally congruent
7 maternal health care and support, in-
8 cluding for the purposes of—

9 (aa) supporting additional
10 education, training, and certifi-
11 cation programs, including sup-
12 port for distance learning;

13 (bb) providing financial sup-
14 port to current and future mid-
15 wives to address education costs,
16 debts, and other needs;

17 (cc) clinical site investments;

18 (dd) supporting preceptor
19 development trainings;

20 (ee) expanding the mid-
21 wifery practice; or

22 (ff) related needs identified
23 by the midwifery practice and de-
24 scribed in the practice's applica-
25 tion; or

1 (iv) have developed other programs
2 and resources that address community-spe-
3 cific needs for pregnant and postpartum
4 individuals and are aligned with evidence-
5 based practices for improving maternal
6 health outcomes for pregnant and
7 postpartum individuals.

8 (5) TECHNICAL ASSISTANCE.—The Secretary
9 shall provide to grant recipients under this sub-
10 section technical assistance on—

11 (A) capacity building to establish or ex-
12 pand programs to prevent adverse maternal
13 health outcomes among pregnant and
14 postpartum individuals from underserved
15 groups;

16 (B) best practices in data collection, meas-
17 urement, evaluation, and reporting; and

18 (C) planning for sustaining programs to
19 prevent maternal mortality and severe maternal
20 morbidity among pregnant and postpartum in-
21 dividuals from underserved groups after the pe-
22 riod of the grant.

23 (6) EVALUATION.—Not later than the end of
24 fiscal year 2026, the Secretary shall submit to the

1 Congress an evaluation of the grant program under
2 this subsection that—

3 (A) assesses the effectiveness of outreach
4 efforts during the application process in diversi-
5 fying the pool of grant recipients;

6 (B) makes recommendations for future
7 outreach efforts to diversify the pool of grant
8 recipients for Department of Health and
9 Human Services grant programs and funding
10 opportunities related to maternal health;

11 (C) assesses the effectiveness of programs
12 funded by grants under this subsection in im-
13 proving maternal health outcomes for pregnant
14 and postpartum individuals from underserved
15 groups, to the extent practicable; and

16 (D) makes recommendations for future
17 Department of Health and Human Services
18 grant programs and funding opportunities that
19 deliver funding to community-based organiza-
20 tions that provide programs and resources that
21 are aligned with evidence-based practices for
22 improving maternal health outcomes for preg-
23 nant and postpartum individuals.

1 (7) DEFINITION.—In this subsection, the term
2 “underserved groups” refers to pregnant and
3 postpartum individuals—

4 (A) from racial and ethnic minority
5 groups;

6 (B) whose household income is equal to or
7 less than 150 percent of the Federal poverty
8 line;

9 (C) who live in health professional shortage
10 areas (as such term is defined in section 332 of
11 the Public Health Service Act (42 U.S.C.
12 254e));

13 (D) who live in counties with no hospital
14 offering obstetric care, no birth center, and no
15 obstetric provider; or

16 (E) who live in counties with a level of vul-
17 nerability of moderate-to-high or higher, accord-
18 ing to the Social Vulnerability Index of the Cen-
19 ters for Disease Control and Prevention.

20 (8) AUTHORIZATION OF APPROPRIATIONS.—To
21 carry out this subsection, there is authorized to be
22 appropriated \$10,000,000 for each of fiscal years
23 2023 through 2027.

24 (c) RESPECTFUL MATERNITY CARE TRAINING FOR
25 ALL EMPLOYEES IN MATERNITY CARE SETTINGS.—Part

1 B of title VII of the Public Health Service Act (42 U.S.C.
2 293 et seq.), as amended by section 3002, is further
3 amended by adding at the end the following new section:

4 **“SEC. 743. RESPECTFUL MATERNITY CARE TRAINING FOR**
5 **ALL EMPLOYEES IN MATERNITY CARE SET-**
6 **TINGS.**

7 “(a) GRANTS.—The Secretary shall award grants for
8 programs to reduce and prevent bias, racism, and dis-
9 crimination in maternity care settings and to advance re-
10 spectful, culturally congruent, trauma-informed care.

11 “(b) SPECIAL CONSIDERATION.—In awarding grants
12 under subsection (a), the Secretary shall give special con-
13 sideration to applications for programs that would—

14 “(1) apply to all maternity care providers and
15 any employees who interact with pregnant and
16 postpartum individuals in the provider setting, in-
17 cluding front desk employees, sonographers, sched-
18 ulers, health care professionals, hospital or health
19 system administrators, security staff, and other em-
20 ployees;

21 “(2) emphasize periodic, as opposed to one-
22 time, trainings for all birthing professionals and em-
23 ployees described in paragraph (1);

24 “(3) address implicit bias, racism, and cultural
25 humility;

1 “(4) be delivered in ongoing education settings
2 for providers maintaining their licenses, with a pref-
3 erence for trainings that provide continuing edu-
4 cation units;

5 “(5) include trauma-informed care best prac-
6 tices and an emphasis on shared decision making be-
7 tween providers and patients;

8 “(6) include antiracism training and programs;

9 “(7) be delivered in undergraduate programs
10 that funnel into health professions schools;

11 “(8) be delivered in settings that apply to pro-
12 viders of the special supplemental nutrition program
13 for women, infants, and children under section 17 of
14 the Child Nutrition Act of 1966;

15 “(9) integrate bias training in obstetric emer-
16 gency simulation trainings or related trainings;

17 “(10) include training for emergency depart-
18 ment employees and emergency medical technicians
19 on recognizing warning signs for severe pregnancy-
20 related complications;

21 “(11) offer training to all maternity care pro-
22 viders on the value of racially, ethnically, and profes-
23 sionally diverse maternity care teams to provide cul-
24 turally congruent care; or

1 “(12) be based on one or more programs de-
2 signed by a historically Black college or university or
3 other minority-serving institution.

4 “(c) APPLICATION.—To seek a grant under sub-
5 section (a), an entity shall submit an application at such
6 time, in such manner, and containing such information as
7 the Secretary may require.

8 “(d) REPORTING TO SECRETARY.—Each recipient of
9 a grant under this section shall annually submit to the
10 Secretary a report on the status of activities conducted
11 using the grant, including, as applicable, a description of
12 the impact of training provided through the grant on pa-
13 tient outcomes and patient experience for pregnant and
14 postpartum individuals from racial and ethnic minority
15 groups and their families.

16 “(e) DISSEMINATION OF FINDINGS.—Based on the
17 annual reports submitted pursuant to subsection (d), the
18 Secretary—

19 “(1) shall produce an annual report on the find-
20 ings resulting from programs funded through this
21 section;

22 “(2) shall disseminate such report to all recipi-
23 ents of grants under this section and to the public;
24 and

1 “(3) may include in such report findings on
2 best practices for improving patient outcomes and
3 patient experience for pregnant and postpartum in-
4 dividuals from racial and ethnic minority groups and
5 their families in maternity care settings.

6 “(f) DEFINITIONS.—In this section:

7 “(1) The term ‘postpartum’ means the one-year
8 period beginning on the last day of an individual’s
9 pregnancy.

10 “(2) The term ‘culturally congruent’ means in
11 agreement with the preferred cultural values, beliefs,
12 world view, language, and practices of the health
13 care consumer and other stakeholders.

14 “(3) The term ‘maternity care provider’ means
15 a health care provider who—

16 “(A) is a physician, physician assistant,
17 midwife who meets at a minimum the inter-
18 national definition of the midwife and global
19 standards for midwifery education as estab-
20 lished by the International Confederation of
21 Midwives, nurse practitioner, or clinical nurse
22 specialist; and

23 “(B) has a focus on maternal or perinatal
24 health.

1 “(4) The term ‘racial and ethnic minority
2 group’ has the meaning given such term in section
3 1707(g)(1).

4 “(g) AUTHORIZATION OF APPROPRIATIONS.—To
5 carry out this section, there is authorized to be appro-
6 priated \$5,000,000 for each of fiscal years 2023 through
7 2027.”.

8 (d) STUDY ON REDUCING AND PREVENTING BIAS,
9 RACISM, AND DISCRIMINATION IN MATERNITY CARE SET-
10 TINGS.—

11 (1) IN GENERAL.—The Secretary of Health and
12 Human Services shall seek to enter into an agree-
13 ment, not later than 90 days after the date of enact-
14 ment of this Act, with the National Academies of
15 Sciences, Engineering, and Medicine (referred to in
16 this subsection as the “National Academies”) under
17 which the National Academies agree to—

18 (A) conduct a study on the design and im-
19 plementation of programs to reduce and prevent
20 bias, racism, and discrimination in maternity
21 care settings and to advance respectful, cul-
22 turally congruent, trauma-informed care; and

23 (B) not later than 24 months after the
24 date of the enactment of this Act—

25 (i) complete the study; and

1 (ii) transmit a report on the results of
2 the study to the Congress.

3 (2) POSSIBLE TOPICS.—The agreement entered
4 into pursuant to paragraph (1) may provide for the
5 study of any of the following:

6 (A) The development of a scorecard or
7 other evaluation standards for programs de-
8 signed to reduce and prevent bias, racism, and
9 discrimination in maternity care settings to as-
10 sess the effectiveness of such programs in im-
11 proving patient outcomes and patient experi-
12 ence for pregnant and postpartum individuals
13 from racial and ethnic minority groups and
14 their families.

15 (B) Determination of the types and fre-
16 quency of training to reduce and prevent bias,
17 racism, and discrimination in maternity care
18 settings that are demonstrated to improve pa-
19 tient outcomes or patient experience for preg-
20 nant and postpartum individuals from racial
21 and ethnic minority groups and their families.

22 (e) RESPECTFUL MATERNITY CARE COMPLIANCE
23 PROGRAM.—

24 (1) IN GENERAL.—The Secretary of Health and
25 Human Services (referred to in this subsection as

1 the “Secretary”) shall award grants to accredited
2 hospitals, health systems, and other maternity care
3 settings to establish as an integral part of quality
4 implementation initiatives within one or more hos-
5 pitals or other birth settings a respectful maternity
6 care compliance program.

7 (2) PROGRAM REQUIREMENTS.—A respectful
8 maternity care compliance program funded through
9 a grant under this subsection shall—

10 (A) institutionalize mechanisms to allow
11 patients receiving maternity care services, the
12 families of such patients, or perinatal health
13 workers supporting such patients to report in-
14 stances of racism or evidence of bias on the
15 basis of race, ethnicity, or another protected
16 class;

17 (B) institutionalize response mechanisms
18 through which representatives of the program
19 can directly follow up with the patient, if pos-
20 sible, and the patient’s family in a timely man-
21 ner;

22 (C) prepare, and make publicly available, a
23 hospital- or health system-wide strategy to re-
24 duce bias on the basis of race, ethnicity, or an-

1 other protected class in the delivery of mater-
2 nity care that includes—

3 (i) information on the training pro-
4 grams to reduce and prevent bias, racism,
5 and discrimination on the basis of race,
6 ethnicity, or another protected class for all
7 employees in maternity care settings;

8 (ii) information on the number of
9 cases reported to the compliance program;
10 and

11 (iii) the development of methods to
12 routinely assess the extent to which bias,
13 racism, or discrimination on the basis of
14 race, ethnicity, or another protected class
15 are present in the delivery of maternity
16 care to patients from racial and ethnic mi-
17 nority groups;

18 (D) develop mechanisms to routinely col-
19 lect and publicly report hospital-level data re-
20 lated to patient-reported experience of care; and

21 (E) provide annual reports to the Sec-
22 retary with information about each case re-
23 ported to the compliance program over the
24 course of the year containing such information
25 as the Secretary may require, such as—

1 (i) de-identified demographic informa-
2 tion on the patient in the case, such as
3 race, ethnicity, gender identity, and pri-
4 mary language;

5 (ii) the content of the report from the
6 patient or the family of the patient to the
7 compliance program;

8 (iii) the response from the compliance
9 program; and

10 (iv) to the extent applicable, institu-
11 tional changes made as a result of the
12 case.

13 (3) SECRETARY REQUIREMENTS.—

14 (A) PROCESSES.—Not later than 180 days
15 after the date of the enactment of this Act, the
16 Secretary shall establish processes for—

17 (i) disseminating best practices for es-
18 tablishing and implementing a respectful
19 maternity care compliance program within
20 a hospital or other birth setting;

21 (ii) promoting coordination and col-
22 laboration between hospitals, health sys-
23 tems, and other maternity care delivery
24 settings on the establishment and imple-

mentation of respectful maternity care compliance programs; and

(iii) evaluating the effectiveness of respectful maternity care compliance programs on maternal health outcomes and patient and family experiences, especially for patients from racial and ethnic minority groups and their families.

(B) STUDY.—

(i) IN GENERAL.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall, through a contract with an independent research organization, conduct a study on strategies to address—

(I) racism or bias on the basis of race, ethnicity, or another protected class in the delivery of maternity care services; and

(II) successful implementation of respectful care initiatives.

(ii) COMPONENTS OF STUDY.—The study shall include the following:

(I) An assessment of the reports submitted to the Secretary from the

1 respectful maternity care compliance
2 programs pursuant to paragraph
3 (2)(E).

4 (II) Based on such assessment,
5 recommendations for potential ac-
6 countability mechanisms related to
7 cases of racism or bias on the basis of
8 race, ethnicity, or another protected
9 class in the delivery of maternity care
10 services at hospitals and other birth
11 settings. Such recommendations shall
12 take into consideration medical and
13 non-medical factors that contribute to
14 adverse patient experiences and ma-
15 ternal health outcomes.

16 (iii) REPORT.—The Secretary shall
17 submit to the Congress, and make publicly
18 available, a report on the results of the
19 study under this subparagraph.

20 (4) AUTHORIZATION OF APPROPRIATIONS.—To
21 carry out this subsection, there is authorized to be
22 appropriated such sums as may be necessary for fis-
23 cal years 2023 through 2028.

24 (f) GAO REPORT.—

1 (1) IN GENERAL.—Not later than 2 years after
2 the date of enactment of this Act and annually
3 thereafter, the Comptroller General of the United
4 States shall submit to the Congress, and make publicly available, a report on the establishment of respectful maternity care compliance programs within
5 hospitals, health systems, and other maternity care
6 settings.

7 (2) MATTERS INCLUDED.—The report under
8 paragraph (1) shall include the following:

9 (A) Information regarding the extent to
10 which hospitals, health systems, and other maternity care settings have elected to establish respectful maternity care compliance programs,
11 including—

12 (i) which hospitals and other birth
13 settings elect to establish compliance programs and when such programs are established;
14

15 (ii) to the extent practicable, impacts
16 of the establishment of such programs on
17 maternal health outcomes and patient and
18 family experiences in the hospitals and
19 other birth settings that have established
20 such programs, especially for patients from
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1 racial and ethnic minority groups and their
2 families;

3 (iii) information on geographic areas,
4 and types of hospitals or other birth set-
5 tings, where respectful maternity care com-
6 pliance programs are not being established
7 and information on factors contributing to
8 decisions to not establish such programs;
9 and

10 (iv) recommendations for establishing
11 respectful maternity care compliance pro-
12 grams in geographic areas, and types of
13 hospitals or other birth settings, where
14 such programs are not being established.

15 (B) Whether the funding made available to
16 carry out this subsection has been sufficient
17 and, if applicable, recommendations for addi-
18 tional appropriations to carry out this sub-
19 section.

20 (C) Such other information as the Comp-
21 troller General determines appropriate.

22 (g) DEFINITIONS.—In this section:

23 (1) CULTURALLY CONGRUENT.—The term “cul-
24 turally congruent”, with respect to care or maternity
25 care, means care that is in agreement with the pre-

1 ferred cultural values, beliefs, worldview, language,
2 and practices of the health care consumer and other
3 stakeholders.

4 (2) MATERNITY CARE PROVIDER.—The term
5 “maternity care provider” means a health care pro-
6 vider who—

7 (A) is a physician, physician assistant,
8 midwife who meets at a minimum the inter-
9 national definition of the midwife and global
10 standards for midwifery education as estab-
11 lished by the International Confederation of
12 Midwives, nurse practitioner, or clinical nurse
13 specialist; and

14 (B) has a focus on maternal or perinatal
15 health.

16 (3) MATERNAL MORTALITY.—The term “mater-
17 nal mortality” means a death occurring during or
18 within a one-year period after pregnancy, caused by
19 pregnancy-related or childbirth complications, in-
20 cluding a suicide, overdose, or other death resulting
21 from a mental health or substance use disorder at-
22 tributed to or aggravated by pregnancy-related or
23 childbirth complications.

24 (4) PERINATAL HEALTH WORKER.—The term
25 “perinatal health worker” means a doula, commu-

1 nity health worker, peer supporter, breastfeeding
2 and lactation educator or counselor, nutritionist or
3 dietitian, childbirth educator, social worker, home
4 visitor, language interpreter, or navigator.

5 (5) POSTPARTUM AND POSTPARTUM PERIOD.—

6 The terms “postpartum” and “postpartum period”
7 refer to the 1-year period beginning on the last day
8 of the pregnancy of an individual.

9 (6) PREGNANCY-ASSOCIATED DEATH.—The
10 term “pregnancy-associated death” means a death of
11 a pregnant or postpartum individual, by any cause,
12 that occurs during, or within 1 year following, the
13 individual’s pregnancy, regardless of the outcome,
14 duration, or site of the pregnancy.

15 (7) PREGNANCY-RELATED DEATH.—The term
16 “pregnancy-related death” means a death of a preg-
17 nant or postpartum individual that occurs during, or
18 within 1 year following, the individual’s pregnancy,
19 from a pregnancy complication, a chain of events
20 initiated by pregnancy, or the aggravation of an un-
21 related condition by the physiologic effects of preg-
22 nancy.

23 (8) RACIAL AND ETHNIC MINORITY GROUP.—

24 The term “racial and ethnic minority group” has the
25 meaning given such term in section 1707(g)(1) of

1 the Public Health Service Act (42 U.S.C. 300u–
2 6(g)(1)).

3 (9) SEVERE MATERNAL MORBIDITY.—The term
4 “severe maternal morbidity” means a health condi-
5 tion, including mental health conditions and sub-
6 stance use disorders, attributed to or aggravated by
7 pregnancy or childbirth that results in significant
8 short-term or long-term consequences to the health
9 of the individual who was pregnant.

10 (10) SOCIAL DETERMINANTS OF MATERNAL
11 HEALTH DEFINED.—The term “social determinants
12 of maternal health” means non-clinical factors that
13 impact maternal health outcomes, including—

14 (A) economic factors, which may include
15 poverty, employment, food security, support for
16 and access to lactation and other infant feeding
17 options, housing stability, and related factors;

18 (B) neighborhood factors, which may in-
19 clude quality of housing, access to transpor-
20 tation, access to child care, availability of
21 healthy foods and nutrition counseling, avail-
22 ability of clean water, air and water quality,
23 ambient temperatures, neighborhood crime and
24 violence, access to broadband, and related fac-
25 tors;

1 (C) social and community factors, which
2 may include systemic racism, gender discrimi-
3 nation or discrimination based on other pro-
4 tected classes, workplace conditions, incarcer-
5 ation, and related factors;

6 (D) household factors, which may include
7 ability to conduct lead testing and abatement,
8 car seat installation, indoor air temperatures,
9 and related factors;

10 (E) education access and quality factors,
11 which may include educational attainment, lan-
12 guage and literacy, and related factors; and

13 (F) health care access factors, including
14 health insurance coverage, access to culturally
15 congruent health care services, providers, and
16 non-clinical support, access to home visiting
17 services, access to wellness and stress manage-
18 ment programs, health literacy, access to tele-
19 health and items required to receive telehealth
20 services, and related factors.

21 **SEC. 5210. MOMS MATTER.**

22 (a) MATERNAL MENTAL HEALTH EQUITY GRANT
23 PROGRAM.—

24 (1) IN GENERAL.—The Secretary of Health and
25 Human Services, acting through the Assistant Sec-

1 retary for Mental Health and Substance Use, shall
2 establish a program to award grants to eligible enti-
3 ties to address maternal mental health conditions
4 and substance use disorders with respect to preg-
5 nant and postpartum individuals, with a focus on ra-
6 cial and ethnic minority groups.

7 (2) APPLICATION.—To be eligible to receive a
8 grant under this subsection, an eligible entity shall
9 submit to the Secretary an application at such time,
10 in such manner, and containing such information as
11 the Secretary may provide, including how such entity
12 will use funds for activities described in paragraph
13 (4) that are culturally congruent.

14 (3) PRIORITY.—In awarding grants under this
15 subsection, the Secretary shall give priority to an eli-
16 gible entity that—

17 (A) is, or will partner with, a community-
18 based organization to address maternal mental
19 health conditions and substance use disorders
20 described in paragraph (1);

21 (B) is operating in an area with high rates
22 of—

23 (i) adverse maternal health outcomes;
24 or

1 (ii) significant racial or ethnic inequi-
2 ties in maternal health outcomes; and

3 (C) is operating in a health professional
4 shortage area designated under section 332 of
5 the Public Health Service Act (42 U.S.C.
6 254e).

7 (4) USE OF FUNDS.—An eligible entity that re-
8 ceives a grant under this subsection shall use funds
9 for the following:

10 (A) Establishing or expanding maternity
11 care programs to improve the integration of
12 maternal health and behavioral health care
13 services into primary care settings where preg-
14 nant individuals regularly receive health care
15 services.

16 (B) Establishing or expanding group pre-
17 natal care programs or postpartum care pro-
18 grams.

19 (C) Expanding existing programs that im-
20 prove maternal mental and behavioral health
21 during the prenatal and postpartum periods,
22 with a focus on individuals from racial and eth-
23 nic minority groups.

24 (D) Providing services and support for
25 pregnant and postpartum individuals with ma-

1 ternal mental health conditions and substance
2 use disorders, including referrals to addiction
3 treatment centers that offer evidence-based
4 treatment options.

5 (E) Addressing stigma associated with ma-
6 ternal mental health conditions and substance
7 use disorders, with a focus on racial and ethnic
8 minority groups.

9 (F) Raising awareness of warning signs of
10 maternal mental health conditions and sub-
11 stance use disorders, with a focus on pregnant
12 and postpartum individuals from racial and eth-
13 nic minority groups.

14 (G) Establishing or expanding programs to
15 prevent suicide or self-harm among pregnant
16 and postpartum individuals.

17 (H) Offering evidence-aligned programs at
18 freestanding birth centers that provide maternal
19 mental and behavioral health care education,
20 treatments, and services, and other services for
21 individuals throughout the prenatal and
22 postpartum period.

23 (I) Establishing or expanding programs to
24 provide education and training to maternity
25 care providers with respect to—

1 (i) identifying potential warning signs
2 for maternal mental health conditions or
3 substance use disorders in pregnant and
4 postpartum individuals, with a focus on in-
5 dividuals from racial and ethnic minority
6 groups; and

7 (ii) in the case where such providers
8 identify such warning signs, offering refer-
9 rals to mental and behavioral health care
10 professionals.

11 (J) Developing a website, or other source,
12 that includes information on health care pro-
13 viders who treat maternal mental health condi-
14 tions and substance use disorders.

15 (K) Establishing or expanding programs in
16 communities to improve coordination between
17 maternity care providers and mental and behav-
18 ioral health care providers who treat maternal
19 mental health conditions and substance use dis-
20 orders, including through the use of toll-free
21 hotlines.

22 (L) Carrying out other programs aligned
23 with evidence-based practices for addressing
24 maternal mental health conditions and sub-
25 stance use disorders for pregnant and

1 postpartum individuals from racial and ethnic
2 minority groups.

3 (5) REPORTING.—

4 (A) ELIGIBLE ENTITIES.—An eligible enti-
5 ty that receives a grant under paragraph (1)
6 shall submit annually to the Secretary, and
7 make publicly available, a report on the activi-
8 ties conducted using funds received through a
9 grant under this subsection. Such reports shall
10 include quantitative and qualitative evaluations
11 of such activities, including the experience of in-
12 dividuals who received health care through such
13 grant.

14 (B) SECRETARY.—Not later than the end
15 of fiscal year 2024, the Secretary shall submit
16 to Congress a report that includes—

17 (i) a summary of the reports received
18 under subparagraph (A);

19 (ii) an evaluation of the effectiveness
20 of grants awarded under this subsection;

21 (iii) recommendations with respect to
22 expanding coverage of evidence-based
23 screenings and treatments for maternal
24 mental health conditions and substance use
25 disorders; and

1 (iv) recommendations with respect to
2 ensuring activities described under para-
3 graph (4) continue after the end of a grant
4 period.

5 (6) DEFINITIONS.—In this subsection:

6 (A) CULTURALLY CONGRUENT.—The term
7 “culturally congruent”, with respect to care or
8 maternity care, means care that is in agreement
9 with the preferred cultural values, beliefs,
10 worldview, language, and practices of the health
11 care consumer and other stakeholders.

12 (B) ELIGIBLE ENTITY.—The term “eligible
13 entity” means—

14 (i) a community-based organization
15 serving pregnant and postpartum individ-
16 uals, including such organizations serving
17 individuals from racial and ethnic minority
18 groups and other underserved populations;

19 (ii) a nonprofit or patient advocacy
20 organization with expertise in maternal
21 mental and behavioral health;

22 (iii) a maternity care provider;

23 (iv) a mental or behavioral health care
24 provider who treats maternal mental health
25 conditions or substance use disorders;

1 (v) a State or local governmental enti-
2 ty, including a State or local public health
3 department;

4 (vi) an Indian Tribe or Tribal organi-
5 zation (as such terms are defined in sec-
6 tion 4 of the Indian Self-Determination
7 and Education Assistance Act (25 U.S.C.
8 5304)); and

9 (vii) an Urban Indian organization (as
10 such term is defined in section 4 of the In-
11 dian Health Care Improvement Act (25
12 U.S.C. 1603)).

13 (C) FREESTANDING BIRTH CENTER.—The
14 term “freestanding birth center” has the mean-
15 ing given that term under section 1905(l) of the
16 Social Security Act (42 U.S.C. 1396d(1)).

17 (D) MATERNITY CARE PROVIDER.—The
18 term “maternity care provider” means a health
19 care provider who—

20 (i) is a physician, physician assistant,
21 midwife who meets at a minimum the
22 international definition of the midwife and
23 global standards for midwifery education
24 as established by the International Confed-

1 eration of Midwives, nurse practitioner, or
2 clinical nurse specialist; and

3 (ii) has a focus on maternal or
4 perinatal health.

5 (E) SECRETARY.—The term “Secretary”
6 means the Secretary of Health and Human
7 Services.

8 (7) AUTHORIZATION OF APPROPRIATIONS.—To
9 carry out this subsection, there is authorized to be
10 appropriated \$25,000,000 for each of fiscal years
11 2023 through 2026.

12 (b) GRANTS TO GROW AND DIVERSIFY THE MATER-
13 NAL MENTAL AND BEHAVIORAL HEALTH CARE WORK-
14 FORCE.—Title VII of the Public Health Service Act is
15 amended by inserting after section 757 of such Act (42
16 U.S.C. 294f) the following new section:

17 **“SEC. 758. MATERNAL MENTAL AND BEHAVIORAL HEALTH**
18 **CARE WORKFORCE GRANTS.**

19 “(a) IN GENERAL.—The Secretary may award grants
20 to entities to establish or expand programs described in
21 subsection (b) to grow and diversify the maternal mental
22 and behavioral health care workforce.

23 “(b) USE OF FUNDS.—Recipients of grants under
24 this section shall use the grants to grow and diversify the

1 maternal mental and behavioral health care workforce
2 by—

3 “(1) establishing schools or programs that pro-
4 vide education and training to individuals seeking
5 appropriate licensing or certification as mental or
6 behavioral health care providers who will specialize
7 in maternal mental health conditions or substance
8 use disorders; or

9 “(2) expanding the capacity of existing schools
10 or programs described in paragraph (1), for the pur-
11 poses of increasing the number of students enrolled
12 in such schools or programs, including by awarding
13 scholarships for students.

14 “(c) PRIORITIZATION.—In awarding grants under
15 this section, the Secretary shall give priority to any entity
16 that—

17 “(1) has demonstrated a commitment to re-
18 cruiting and retaining students and faculty from ra-
19 cial and ethnic minority groups;

20 “(2) has developed a strategy to recruit and re-
21 tain a diverse pool of students into the maternal
22 mental or behavioral health care workforce program
23 or school supported by funds received through the
24 grant, particularly from racial and ethnic minority
25 groups and other underserved populations;

1 “(3) has developed a strategy to recruit and re-
2 tain students who plan to practice in a health pro-
3 fessional shortage area designated under section
4 332;

5 “(4) has developed a strategy to recruit and re-
6 tain students who plan to practice in an area with
7 significant racial and ethnic inequities in maternal
8 health outcomes, to the extent practicable; and

9 “(5) includes in the standard curriculum for all
10 students within the maternal mental or behavioral
11 health care workforce program or school a bias, rac-
12 ism, or discrimination training program that in-
13 cludes training on implicit bias and racism.

14 “(d) REPORTING.—As a condition on receipt of a
15 grant under this section for a maternal mental or behav-
16 ioral health care workforce program or school, an entity
17 shall agree to submit to the Secretary an annual report
18 on the activities conducted through the grant, including—

19 “(1) the number and demographics of students
20 participating in the program or school;

21 “(2) the extent to which students in the pro-
22 gram or school are entering careers in—

23 “(A) health professional shortage areas
24 designated under section 332; and

1 “(B) areas with significant racial and eth-
2 nic inequities in maternal health outcomes, to
3 the extent such data are available; and

4 “(3) whether the program or school has in-
5 cluded in the standard curriculum for all students a
6 bias, racism, or discrimination training program that
7 includes training on implicit bias and racism, and if
8 so the effectiveness of such training program.

9 “(e) PERIOD OF GRANTS.—The period of a grant
10 under this section shall be up to 5 years.

11 “(f) APPLICATION.—To seek a grant under this sec-
12 tion, an entity shall submit to the Secretary an application
13 at such time, in such manner, and containing such infor-
14 mation as the Secretary may require, including any infor-
15 mation necessary for prioritization under subsection (c).

16 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
17 provide, directly or by contract, technical assistance to en-
18 tities seeking or receiving a grant under this section on
19 the development, use, evaluation, and post-grant period
20 sustainability of the maternal mental or behavioral health
21 care workforce programs or schools proposed to be, or
22 being, established or expanded through the grant.

23 “(h) REPORT BY THE SECRETARY.—Not later than
24 4 years after the date of enactment of this section, the
25 Secretary shall prepare and submit to the Congress, and

1 post on the internet website of the Department of Health
2 and Human Services, a report on the effectiveness of the
3 grant program under this section at—

4 “(1) recruiting students from racial and ethnic
5 minority groups and other underserved populations;

6 “(2) increasing the number of mental or behav-
7 ioral health care providers specializing in maternal
8 mental health conditions or substance use disorders
9 from racial and ethnic minority groups and other
10 underserved populations;

11 “(3) increasing the number of mental or behav-
12 ioral health care providers specializing in maternal
13 mental health conditions or substance use disorders
14 working in health professional shortage areas des-
15 ignated under section 332; and

16 “(4) increasing the number of mental or behav-
17 ioral health care providers specializing in maternal
18 mental health conditions or substance use disorders
19 working in areas with significant racial and ethnic
20 inequities in maternal health outcomes, to the extent
21 such data are available.

22 “(i) DEFINITIONS.—In this section:

23 “(1) RACIAL AND ETHNIC MINORITY GROUP.—
24 The term ‘racial and ethnic minority group’ has the
25 meaning given such term in section 1707(g)(1).

1 “(2) MENTAL OR BEHAVIORAL HEALTH CARE
2 PROVIDER.—The term ‘mental or behavioral health
3 care provider’ refers to a health care provider in the
4 field of mental and behavioral health, including sub-
5 stance use disorders, acting in accordance with State
6 law.

7 “(j) AUTHORIZATION OF APPROPRIATIONS.—To
8 carry out this section, there is authorized to be appro-
9 priated \$15,000,000 for each of fiscal years 2023 through
10 2027.”.

11 **SEC. 5211. TASKFORCE RECOMMENDING IMPROVEMENTS**
12 **FOR UNADDRESSED MENTAL PERINATAL &**
13 **POSTPARTUM HEALTH (TRIUMPH) FOR NEW**
14 **MOMS.**

15 Part B of title III of the Public Health Service Act
16 (42 U.S.C. 243 et seq.) is amended by inserting after sec-
17 tion 317L–1 (42 U.S.C. 247b–13a) the following:

18 **“SEC. 317L–2. TASK FORCE ON MATERNAL MENTAL**
19 **HEALTH.**

20 “(a) ESTABLISHMENT.—Not later than 90 days after
21 the date of enactment of this section, the Secretary shall
22 establish a task force, to be known as the Task Force on
23 Maternal Mental Health (in this section referred to as the
24 ‘Task Force’) to identify, evaluate, and make rec-

1 ommendations to coordinate and improve, Federal re-
2 sponses to maternal mental health conditions.

3 “(b) MEMBERSHIP.—

4 “(1) COMPOSITION.—The Task Force shall be
5 composed of—

6 “(A) the Assistant Secretary for Health of
7 the Department of Health and Human Services
8 (or the Assistant Secretary’s designee) who
9 shall serve as the Chair of the Task Force;

10 “(B) the Federal members under para-
11 graph (2); and

12 “(C) the non-Federal members under para-
13 graph (3).

14 “(2) FEDERAL MEMBERS.—In addition to the
15 Assistant Secretary for Health, the Federal mem-
16 bers of the Task Force shall consist of the heads of
17 the following Federal departments and agencies (or
18 their designees):

19 “(A) The Administration for Children and
20 Families.

21 “(B) The Agency for Healthcare Research
22 and Quality.

23 “(C) The Centers for Disease Control and
24 Prevention.

1 “(D) The Centers for Medicare & Medicaid
2 Services.

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

5 “(F) The Food and Drug Administration.

6 “(G) The Indian Health Service.

7 “(H) The Office of the Assistant Secretary
8 for Planning and Evaluation of the Department
9 of Health and Human Services.

10 “(I) The Office of Minority Health of the
11 Department of Health and Human Services.

12 “(J) The Office of the Surgeon General of
13 the Department of Health and Human Services.

14 “(K) The Office on Women’s Health of the
15 Department of Health and Human Services.

16 “(L) The National Institutes of Health.

17 “(M) The Substance Abuse and Mental
18 Health Services Administration.

19 “(N) Such other Federal departments and
20 agencies as the Secretary determines that serve
21 individuals with maternal mental health condi-
22 tions, such as the Department of Veterans Af-
23 fairs, the Department of Justice, the Depart-
24 ment of Labor, the Department of Housing and

1 Urban Development, and the Department of
2 Defense.

3 “(3) NON-FEDERAL MEMBERS.—The non-Fed-
4 eral members of the Task Force shall—

5 “(A) compose not more than one-half, and
6 not less than one-third, of the total membership
7 of the Task Force;

8 “(B) be appointed by the Secretary; and

9 “(C) include—

10 “(i) representatives of medical soci-
11 eties with expertise in maternal or mental
12 health;

13 “(ii) representatives of nonprofit orga-
14 nizations with expertise in maternal or
15 mental health;

16 “(iii) relevant industry representa-
17 tives; and

18 “(iv) other representatives, as appro-
19 priate.

20 “(4) DEADLINE FOR DESIGNATING DES-
21 IGNEES.—If the Assistant Secretary for Health, or
22 the head of a Federal department or agency serving
23 as a member of the Task Force under paragraph
24 (2), chooses to be represented on the Task Force by
25 a designee, the Assistant Secretary or head shall

1 designate such designee not later than 90 days after
2 the date of the enactment of this section.

3 “(c) DUTIES.—The Task Force shall—

4 “(1) create and regularly update a report that
5 identifies, analyzes, and evaluates the state of na-
6 tional maternal mental health policy and programs
7 at the Federal, State, and local levels, and identifies
8 best practices including—

9 “(A) a set of evidence-based, evidence-in-
10 formed, and promising practices with respect
11 to—

12 “(i) prevention strategies for individ-
13 uals at risk of experiencing a maternal
14 mental health condition, including strate-
15 gies and recommendations to address so-
16 cial determinants of health;

17 “(ii) the identification, screening, di-
18 agnosis, intervention, and treatment of in-
19 dividuals and families affected by a mater-
20 nal mental health condition;

21 “(iii) the expeditious referral to, and
22 implementation of, practices and supports
23 that prevent and mitigate the effects of a
24 maternal mental health condition, includ-
25 ing strategies and recommendations to

1 eliminate the racial and ethnic inequities
2 that exist in maternal mental health; and
3 “(iv) community-based or
4 multigenerational practices that support
5 individuals and families affected by a ma-
6 ternal mental health condition; and

7 “(B) Federal and State programs and ac-
8 tivities to prevent, screen, diagnose, intervene,
9 and treat maternal mental health conditions;

10 “(2) develop and regularly update a national
11 strategy for maternal mental health, taking into con-
12 sideration the findings of the reports under para-
13 graph (1), on how the Task Force and Federal de-
14 partments and agencies represented on the Task
15 Force will prioritize options for, and implement a co-
16 ordinated approach to, addressing maternal mental
17 health conditions, including by—

18 “(A) increasing prevention, screening, di-
19 agnosis, intervention, treatment, and access to
20 care, including clinical and nonclinical care such
21 as peer-support and community health workers,
22 through the public and private sectors;

23 “(B) providing support for pregnant or
24 postpartum individuals who are at risk for or

1 experiencing a maternal mental health condi-
2 tion, and their families as appropriate;

3 “(C) reducing racial, ethnic, geographic,
4 and other health inequities for prevention, diag-
5 nosis, intervention, treatment, and access to
6 care;

7 “(D) identifying opportunities for local-
8 and State-level partnerships;

9 “(E) identifying options for modifying,
10 strengthening, and coordinating Federal pro-
11 grams and activities, including existing infant
12 and maternity programs, such as the Medicaid
13 program under title XIX of the Social Security
14 Act and the State Children’s Health Insurance
15 Program under title XXI of such Act, in order
16 to increase research, prevention, identification,
17 intervention, and treatment with respect to ma-
18 ternal mental health;

19 “(F) providing recommendations to ensure
20 research, services, supports, and prevention ac-
21 tivities are not unnecessarily duplicative; and

22 “(G) planning, data sharing, and commu-
23 nication within and across Federal depart-
24 ments, agencies, offices, and programs;

1 “(3) solicit public comments from stakeholders
2 for the report under paragraph (1) and the national
3 strategy under paragraph (2), including comments
4 from frontline service providers, mental health pro-
5 fessionals, researchers, experts in maternal mental
6 health, institutions of higher education, public health
7 agencies (including maternal and child health pro-
8 grams), and industry representatives, in order to in-
9 form the activities and reports of the Task Force;
10 and

11 “(4) disaggregate any data collected under this
12 section by race, ethnicity, geographical location, age,
13 marital status, socioeconomic level, and other factors
14 as determined appropriate by the Secretary.

15 “(d) MEETINGS.—The Task Force shall—

16 “(1) meet not less than two times each year;
17 and

18 “(2) convene public meetings, as appropriate, to
19 fulfill its duties under this section.

20 “(e) REPORTS TO PUBLIC AND FEDERAL LEAD-
21 ERS.—The Task Force shall make publicly available and
22 submit to the heads of relevant Federal departments and
23 agencies, the Committee on Energy and Commerce of the
24 House of Representatives, the Committee on Health, Edu-

1 cation, Labor, and Pensions of the Senate, and other rel-
2 evant congressional committees, the following:

3 “(1) Not later than 1 year after the first meet-
4 ing of the Task Force, an initial report under sub-
5 section (c)(1).

6 “(2) Not later than 2 years after the first meet-
7 ing of the Task Force, an initial national strategy
8 under subsection (c)(2).

9 “(3) Each year thereafter—

10 “(A) an updated report under subsection
11 (c)(1);

12 “(B) an updated national strategy under
13 subsection (c)(2); or

14 “(C) if no such update is made, a report
15 summarizing the activities of the Task Force.

16 “(f) REPORTS TO GOVERNORS.—Upon finalizing the
17 initial national strategy under subsection (c)(2), and upon
18 making relevant updates to such strategy, the Task Force
19 shall submit a report to the Governors of all States de-
20 scribing opportunities for local- and State-level partner-
21 ships identified under subsection (c)(2)(D).

22 “(g) SUNSET.—The Task Force shall terminate on
23 the date that is 6 years after the date on which the Task
24 Force is established under subsection (a).”.

1 **SEC. 5212. PROTECT MOMS FROM DOMESTIC VIOLENCE.**

2 (a) STUDY BY DEPARTMENT OF HEALTH AND
3 HUMAN SERVICES.—

4 (1) STUDY.—The Secretary, in collaboration
5 with the Health Resources and Services Administra-
6 tion, the Substance Abuse and Mental Health Serv-
7 ices Administration, and the Administration for
8 Children and Families, and in consultation with the
9 Attorney General of the United States, the Director
10 of the Indian Health Service, and stakeholders (in-
11 cluding community-based organizations, culturally
12 specific organizations, and Tribal public health au-
13 thorities), shall conduct a study on the extent to
14 which individuals are more at risk of maternal mor-
15 tality or severe maternal morbidity as a result of
16 being a victim of domestic violence, dating violence,
17 sexual assault, stalking, human trafficking, sex traf-
18 ficking, child sexual abuse, or forced marriage.

19 (2) REPORTS.—Not later than 2 years after the
20 date of enactment of this Act, the Secretary shall
21 complete the study under paragraph (1) and submit
22 a report to the Congress on the results of such
23 study. Such report shall include—

24 (A) an analysis of the extent to which do-
25 mestic violence, dating violence, sexual assault,
26 stalking, human trafficking, sex trafficking,

1 child sexual abuse, and forced marriage con-
2 tribute to, or result in, maternal mortality;

3 (B) an analysis of the impact of domestic
4 violence, dating violence, sexual assault, stalk-
5 ing, human trafficking, sex trafficking, child
6 sexual abuse, and forced marriage on access to
7 health care (including mental health care) and
8 substance use disorder treatment and recovery
9 support;

10 (C) a breakdown (including by race and
11 ethnicity) of categories of individuals who are
12 disproportionately victims of domestic violence,
13 dating violence, sexual assault, stalking, human
14 trafficking, sex trafficking, child sexual abuse,
15 or forced marriage that contributes to, or re-
16 sults in, pregnancy-related death;

17 (D) an analysis of the impact on health,
18 mental health, and substance use resulting from
19 domestic violence, dating violence, sexual as-
20 sault, stalking, human trafficking, sex traf-
21 ficking, child sexual abuse, and forced marriage
22 among Alaskan Natives, Native Hawaiians, and
23 American Indians during the prenatal and
24 postpartum period;

1 (E) an assessment of the factors that in-
2 crease or decrease risks for maternal mortality
3 or severe maternal morbidity among victims of
4 domestic violence, dating violence, sexual as-
5 sault, stalking, human trafficking, sex traf-
6 ficking, child sexual abuse, or forced marriage;

7 (F) an assessment of increased risk of ma-
8 ternal mortality or severe maternal morbidity
9 stemming from suicide, substance use disorders,
10 or drug overdose due to domestic violence, dat-
11 ing violence, sexual assault, stalking, human
12 trafficking, sex trafficking, child sexual abuse,
13 or forced marriage;

14 (G) recommendations for legislative or pol-
15 icy changes—

16 (i) to reduce maternal mortality rates;

17 and

18 (ii) to address health inequities that
19 contribute to inequities in such rates and
20 deaths;

21 (H) best practices to reduce maternal mor-
22 tality and severe maternal morbidity among vic-
23 tims of domestic violence, dating violence, sex-
24 ual assault, stalking, human trafficking, sex

1 trafficking, child sexual abuse, and forced mar-
2 riage, including—

3 (i) reducing reproductive coercion,
4 mental health conditions, and substance
5 use coercion; and

6 (ii) routinely assessing pregnant peo-
7 ple for domestic violence and other forms
8 of reproductive violence; and

9 (I) any other information on maternal
10 mortality or severe maternal morbidity the Sec-
11 retary determines appropriate to include in the
12 report.

13 (b) STUDY BY NATIONAL ACADEMY OF MEDICINE.—

14 (1) IN GENERAL.—The Secretary shall seek to
15 enter into an arrangement with the National Acad-
16 emy of Medicine (or, if the Academy declines to
17 enter into such arrangement, another appropriate
18 entity) to study—

19 (A) the impact of domestic violence, dating
20 violence, sexual assault, stalking, human traf-
21 ficking, sex trafficking, child sexual abuse, and
22 forced marriage on an individual's health; rel-
23 ative to

24 (B) maternal mortality and severe mater-
25 nal morbidity.

1 (2) TOPICS.—The study under paragraph (1)
2 shall—

3 (A) examine—

4 (i) whether domestic violence, dating
5 violence, sexual assault, stalking, human
6 trafficking, sex trafficking, child sexual
7 abuse, or forced marriage, or generational
8 intimate partner violence, trauma, and psy-
9 chiatric disorders, increase the risk of sui-
10 cide, substance use, and drug overdose
11 among pregnant and postpartum persons;
12 and

13 (ii) the intersection of domestic vio-
14 lence, dating violence, sexual assault, stalk-
15 ing, human trafficking, sex trafficking,
16 child sexual abuse, and forced marriage as
17 a social determinant of health; and

18 (B) give particular focus to impacts among
19 African American, American Indian, Native Ha-
20 waiian, Alaskan Native, and LGBTQ birthing
21 persons.

22 (c) GRANTS FOR INNOVATIVE APPROACHES.—

23 (1) IN GENERAL.—The Secretary, acting
24 through the Administrator of the Health Resources
25 and Services Administration, and in collaboration

1 with the Administration for Children and Families,
2 the Indian Health Service, and the Substance Abuse
3 and Mental Health Services Administration, shall
4 award grants to eligible entities for developing and
5 implementing innovative approaches to improve ma-
6 ternal and child health outcomes of victims of do-
7 mestic violence, dating violence, sexual assault,
8 stalking, human trafficking, sex trafficking, child
9 sexual abuse, or forced marriage.

10 (2) ELIGIBLE ENTITY.—To seek a grant under
11 this subsection, an entity shall be—

12 (A) a State, local, or federally recognized
13 Tribal government;

14 (B) a nonprofit organization or commu-
15 nity-based organization that provides prevention
16 or intervention services related to domestic vio-
17 lence, dating violence, sexual assault, stalking,
18 human trafficking, sex trafficking, child sexual
19 abuse, or forced marriage;

20 (C) a tribal organization or Urban Indian
21 organization (as such terms are defined in sec-
22 tion 4 of the Indian Health Care Improvement
23 Act (25 U.S.C. 1603));

24 (D) an entity, the principal purpose of
25 which is to provide health care, such as a hos-

1 pital, clinic, health department, freestanding
2 birthing center, perinatal health worker, or ma-
3 ternity care provider;

4 (E) an institution of higher education; or

5 (F) a comprehensive substance use dis-
6 order parenting program.

7 (3) PRIORITY.—In awarding grants under this
8 subsection, the Secretary shall give priority to appli-
9 cants proposing to address—

10 (A) mental health and substance use dis-
11 orders among pregnant persons; or

12 (B) pregnant and postpartum persons ex-
13 periencing intimate partner violence.

14 (4) FREESTANDING BIRTH CENTER DEFINED.—
15 In this subsection, the term “freestanding birth cen-
16 ter” has the meaning given that term in section
17 1905(l) of the Social Security Act (42 U.S.C.
18 1396d(1)).

19 (5) AUTHORIZATION OF APPROPRIATIONS.—To
20 carry out this subsection, there is authorized to be
21 appropriated \$25,000,000 for the period of fiscal
22 years 2023 through 2025.

23 (d) GUIDANCE.—Not later than 2 years after the
24 date of enactment of this Act, the Secretary shall issue

1 and disseminate guidance to States, Tribes, territories,
2 maternity care providers, and managed care entities on—

3 (1) providing universal education on healthy re-
4 lationships and intimate partner violence;

5 (2) developing protocols on—

6 (A) routine assessment of intimate partner
7 violence; and

8 (B) health promotion and strategies for
9 trauma-informed care plans; and

10 (3) creating sustainable partnerships with com-
11 munity-based organizations that address domestic vi-
12 olence, dating violence, sexual assault, stalking,
13 human trafficking, sex trafficking, child sexual
14 abuse, or forced marriage.

15 (e) DEFINITIONS.—In this section:

16 (1) The term “maternal mortality”—

17 (A) means death that—

18 (i) occurs during, or within the 1-year
19 period after, pregnancy; and

20 (ii) is attributed to or aggravated by
21 pregnancy-related or childbirth complica-
22 tions; and

23 (B) includes a suicide, drug overdose
24 death, homicide (including a domestic violence-
25 related homicide), or other death resulting from

1 a mental health or substance use disorder at-
2 tributed to or aggravated by pregnancy-related
3 or childbirth complications.

4 (2) The term “maternity care provider” means
5 a health care provider who—

6 (A) is a physician, physician assistant,
7 nurse, midwife who meets at a minimum the
8 international definition of the midwife and glob-
9 al standards for midwifery education as estab-
10 lished by the International Confederation of
11 Midwives, nurse practitioner, or clinical nurse
12 specialist; and

13 (B) has a focus on maternal or perinatal
14 health.

15 (3) The term “perinatal health worker” means
16 a worker who—

17 (A) is a doula, community health worker,
18 peer supporter, breastfeeding and lactation edu-
19 cator or counselor, nutritionist or dietitian,
20 childbirth educator, social worker, home visitor,
21 language interpreter, or navigator; and

22 (B) provides assistance with perinatal
23 health.

24 (4) The term “postpartum” refers to the 12-
25 month period following childbirth.

1 (5) The term “Secretary” means the Secretary
2 of Health and Human Services.

3 (6) The term “severe maternal morbidity”
4 means a health condition, including a mental health
5 condition or substance use disorder, that—

6 (A) is attributed to or aggravated by preg-
7 nancy or childbirth; and

8 (B) results in significant short-term or
9 long-term consequences to the health of the in-
10 dividual who was pregnant.

11 **SEC. 5213. PERINATAL WORKFORCE.**

12 (a) HHS AGENCY DIRECTIVES.—

13 (1) GUIDANCE TO STATES.—

14 (A) IN GENERAL.—Not later than 2 years
15 after the date of enactment of this Act, the Sec-
16 retary of Health and Human Services shall
17 issue and disseminate guidance to States to
18 educate providers, managed care entities, and
19 other insurers about the value and process of
20 delivering respectful maternal health care
21 through diverse and multidisciplinary care pro-
22 vider models.

23 (B) CONTENTS.—The guidance required
24 by subparagraph (A) shall address how States
25 can encourage and incentivize hospitals, health

1 systems, midwifery practices, freestanding birth
2 centers, other maternity care provider groups,
3 managed care entities, and other insurers—

4 (i) to recruit and retain maternity
5 care providers, mental and behavioral
6 health care providers acting in accordance
7 with State law, registered dietitians or nu-
8 trition professionals (as such term is de-
9 fined in section 1861(vv)(2) of the Social
10 Security Act (42 U.S.C. 1395x(vv)(2))),
11 and lactation consultants certified by the
12 International Board of Lactation Consult-
13 ants Examiners—

14 (I) from racially, ethnically, and
15 linguistically diverse backgrounds;

16 (II) with experience practicing in
17 racially and ethnically diverse commu-
18 nities; and

19 (III) who have undergone train-
20 ing on implicit bias and racism;

21 (ii) to incorporate into maternity care
22 teams—

23 (I) midwives who meet, at a min-
24 imum, the international definition of
25 the midwife and global standards for

1 midwifery education, as established by
2 the International Confederation of
3 Midwives; and

4 (II) perinatal health workers;

5 (iii) to provide collaborative, culturally
6 congruent care; and

7 (iv) to provide opportunities for indi-
8 viduals enrolled in accredited midwifery
9 education programs to participate in job
10 shadowing with maternity care teams in
11 hospitals, health systems, midwifery prac-
12 tices, and freestanding birth centers.

13 (2) STUDY ON RESPECTFUL AND CULTURALLY
14 CONGRUENT MATERNITY CARE.—

15 (A) STUDY.—The Secretary of Health and
16 Human Services, acting through the Director of
17 the National Institutes of Health (in this para-
18 graph referred to as the “Secretary”), shall
19 conduct a study on best practices in respectful
20 and culturally congruent maternity care.

21 (B) REPORT.—Not later than 2 years after
22 the date of enactment of this Act, the Secretary
23 shall—

24 (i) complete the study required by
25 subparagraph (A);

1 (ii) submit to the Congress, and make
2 publicly available, a report on the results
3 of such study; and

4 (iii) include in such report—

5 (I) a compendium of examples of
6 hospitals, health systems, midwifery
7 practices, freestanding birth centers,
8 other maternity care provider groups,
9 managed care entities, and other in-
10 surers that are delivering respectful
11 and culturally congruent maternal
12 health care;

13 (II) a compendium of examples
14 of hospitals, health systems, midwifery
15 practices, freestanding birth centers,
16 other maternity care provider groups,
17 managed care entities, and other in-
18 surers that have made progress in re-
19 ducing inequities in maternal health
20 outcomes and improving birthing ex-
21 periences for pregnant and
22 postpartum individuals from racial
23 and ethnic minority groups; and

24 (III) recommendations to hos-
25 pitals, health systems, midwifery prac-

1 tices, freestanding birth centers, other
2 maternity care provider groups, man-
3 aged care entities, and other insurers,
4 for best practices in respectful and
5 culturally congruent maternity care.

(b) GRANTS TO GROW AND DIVERSIFY THE PERINATAL WORKFORCE.—Title VII of the Public Health Service Act is amended by inserting after section 758, as added by section 5210(b), the following new section:

10 **“SEC. 758A. PERINATAL WORKFORCE GRANTS.**

11 “(a) IN GENERAL.—The Secretary shall award
12 grants to entities to establish or expand programs de-
13 scribed in subsection (b) to grow and diversify the
14 perinatal workforce.

15 “(b) USE OF FUNDS.—Recipients of grants under
16 this section shall use the grants to grow and diversify the
17 perinatal workforce by—

18 “(1) establishing schools or programs that pro-
19 vide education and training to individuals seeking
20 appropriate licensing or certification as—

21 “(A) physician assistants who will complete
22 clinical training in the field of maternal and
23 perinatal health; or

24 “(B) perinatal health workers; and

1 “(2) expanding the capacity of existing schools
2 or programs described in paragraph (1), for the pur-
3 poses of increasing the number of students enrolled
4 in such schools or programs, including by awarding
5 scholarships for students.

6 “(c) PRIORITIZATION.—In awarding grants under
7 this section, the Secretary shall give priority to any entity
8 that—

9 “(1) has demonstrated a commitment to re-
10 cruiting and retaining students and faculty from ra-
11 cial and ethnic minority groups;

12 “(2) has developed a strategy to recruit and re-
13 tain a diverse pool of students into the perinatal
14 workforce program or school supported by funds re-
15 ceived through the grant, particularly from racial
16 and ethnic minority groups and other underserved
17 populations;

18 “(3) has developed a strategy to recruit and re-
19 tain students who plan to practice in a health pro-
20 fessional shortage area designated under section
21 332;

22 “(4) has developed a strategy to recruit and re-
23 tain students who plan to practice in an area with
24 significant racial and ethnic inequities in maternal
25 health outcomes, to the extent practicable; and

1 “(5) includes in the standard curriculum for all
2 students within the perinatal workforce program or
3 school a bias, racism, or discrimination training pro-
4 gram that includes training on implicit bias and rac-
5 ism.

6 “(d) REPORTING.—As a condition on receipt of a
7 grant under this section for a perinatal workforce program
8 or school, an entity shall agree to submit to the Secretary
9 an annual report on the activities conducted through the
10 grant, including—

11 “(1) the number and demographics of students
12 participating in the program or school;

13 “(2) the extent to which students in the pro-
14 gram or school are entering careers in—

15 “(A) health professional shortage areas
16 designated under section 332; and

17 “(B) areas with significant racial and eth-
18 nic inequities in maternal health outcomes, to
19 the extent such data are available; and

20 “(3) whether the program or school has in-
21 cluded in the standard curriculum for all students a
22 bias, racism, or discrimination training program that
23 includes explicit and implicit bias, and if so the ef-
24 fectiveness of such training program.

1 “(e) PERIOD OF GRANTS.—The period of a grant
2 under this section shall not exceed 5 years.

3 “(f) APPLICATION.—To seek a grant under this sec-
4 tion, an entity shall submit to the Secretary an application
5 at such time, in such manner, and containing such infor-
6 mation as the Secretary may require, including any infor-
7 mation necessary for prioritization under subsection (c).

8 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
9 provide, directly or by contract, technical assistance to en-
10 tities seeking or receiving a grant under this section on
11 the development, use, evaluation, and post-grant period
12 sustainability of the perinatal workforce programs or
13 schools proposed to be, or being, established or expanded
14 through the grant.

15 “(h) REPORT BY THE SECRETARY.—Not later than
16 4 years after the date of enactment of this section, the
17 Secretary shall prepare and submit to the Congress, and
18 post on the internet website of the Department of Health
19 and Human Services, a report on the effectiveness of the
20 grant program under this section at—

21 “(1) recruiting students from racial and ethnic
22 minority groups;

23 “(2) increasing the number of physician assist-
24 ants who will complete clinical training in the field
25 of maternal and perinatal health, and perinatal

1 health workers, from racial and ethnic minority
2 groups and other underserved populations;

3 “(3) increasing the number of physician assist-
4 ants who will complete clinical training in the field
5 of maternal and perinatal health, and perinatal
6 health workers, working in health professional short-
7 age areas designated under section 332; and

8 “(4) increasing the number of physician assist-
9 ants who will complete clinical training in the field
10 of maternal and perinatal health, and perinatal
11 health workers, working in areas with significant ra-
12 cial and ethnic inequities in maternal health out-
13 comes, to the extent such data are available.

14 “(i) DEFINITION.—In this section, the term ‘racial
15 and ethnic minority group’ has the meaning given such
16 term in section 1707(g).

17 “(j) AUTHORIZATION OF APPROPRIATIONS.—To
18 carry out this section, there is authorized to be appro-
19 priated \$15,000,000 for each of fiscal years 2023 through
20 2027.”.

21 (c) GRANTS TO GROW AND DIVERSIFY THE NURSING
22 WORKFORCE IN MATERNAL AND PERINATAL HEALTH.—
23 Title VIII of the Public Health Service Act is amended
24 by inserting after section 811 of that Act (42 U.S.C. 296j)
25 the following:

1 **“SEC. 812. PERINATAL NURSING WORKFORCE GRANTS.**

2 “(a) IN GENERAL.—The Secretary shall award
3 grants to schools of nursing to grow and diversify the
4 perinatal nursing workforce.

5 “(b) USE OF FUNDS.—Recipients of grants under
6 this section shall use the grants to grow and diversify the
7 perinatal nursing workforce by providing scholarships to
8 students seeking to become—

9 “(1) nurse practitioners whose education in-
10 cludes a focus on maternal and perinatal health; or

11 “(2) clinical nurse specialists whose education
12 includes a focus on maternal and perinatal health.

13 “(c) PRIORITIZATION.—In awarding grants under
14 this section, the Secretary shall give priority to any school
15 of nursing that—

16 “(1) has developed a strategy to recruit and re-
17 tain a diverse pool of students seeking to enter ca-
18 reers focused on maternal and perinatal health, par-
19 ticularly students from racial and ethnic minority
20 groups and other underserved populations;

21 “(2) has developed a partnership with a prac-
22 tice setting in a health professional shortage area
23 designated under section 332 for the clinical place-
24 ments of the school’s students;

25 “(3) has developed a strategy to recruit and re-
26 tain students who plan to practice in an area with

1 significant racial and ethnic inequities in maternal
2 health outcomes, to the extent practicable; and

3 “(4) includes in the standard curriculum for all
4 students seeking to enter careers focused on mater-
5 nal and perinatal health a bias, racism, or discrimi-
6 nation training program that includes education on
7 implicit bias and racism.

8 “(d) REPORTING.—As a condition on receipt of a
9 grant under this section, a school of nursing shall agree
10 to submit to the Secretary an annual report on the activi-
11 ties conducted through the grant, including, to the extent
12 practicable—

13 “(1) the number and demographics of students
14 in the school of nursing seeking to enter careers fo-
15 cused on maternal and perinatal health;

16 “(2) the extent to which such students are pre-
17 paring to enter careers in—

18 “(A) health professional shortage areas
19 designated under section 332; and

20 “(B) areas with significant racial and eth-
21 nic inequities in maternal health outcomes, to
22 the extent such data are available; and

23 “(3) whether the standard curriculum for all
24 students seeking to enter careers focused on mater-
25 nal and perinatal health includes a bias, racism, or

1 discrimination training program that includes edu-
2 cation on implicit bias and racism.

3 “(e) PERIOD OF GRANTS.—The period of a grant
4 under this section shall be up to 5 years.

5 “(f) APPLICATION.—To seek a grant under this sec-
6 tion, an entity shall submit to the Secretary an applica-
7 tion, at such time, in such manner, and containing such
8 information as the Secretary may require, including any
9 information necessary for prioritization under subsection
10 (c).

11 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
12 provide, directly or by contract, technical assistance to
13 schools of nursing seeking or receiving a grant under this
14 section on the processes of awarding and evaluating schol-
15 arships through the grant.

16 “(h) REPORT BY THE SECRETARY.—Not later than
17 4 years after the date of enactment of this section, the
18 Secretary shall prepare and submit to the Congress, and
19 post on the internet website of the Department of Health
20 and Human Services, a report on the effectiveness of the
21 grant program under this section at—

22 “(1) recruiting students from racial and ethnic
23 minority groups and other underserved populations;

24 “(2) increasing the number of nurse practi-
25 tioners and clinical nurse specialists entering careers

1 focused on maternal and perinatal health from racial
2 and ethnic minority groups and other underserved
3 populations;

4 “(3) increasing the number of nurse practi-
5 tioners and clinical nurse specialists entering careers
6 focused on maternal and perinatal health working in
7 health professional shortage areas designated under
8 section 332; and

9 “(4) increasing the number of nurse practi-
10 tioners and clinical nurse specialists entering careers
11 focused on maternal and perinatal health working in
12 areas with significant racial and ethnic inequities in
13 maternal health outcomes, to the extent such data
14 are available.

15 “(i) AUTHORIZATION OF APPROPRIATIONS.—To
16 carry out this section, there is authorized to be appro-
17 priated \$15,000,000 for each of fiscal years 2023 through
18 2027.”.

19 (d) GAO REPORT.—

20 (1) IN GENERAL.—Not later than 2 years after
21 the date of enactment of this Act, and every 5 years
22 thereafter, the Comptroller General of the United
23 States shall submit to Congress a report on barriers
24 to maternal health education and access to care in
25 the United States. Such report shall include the in-

1 formation and recommendations described in para-
2 graph (2).

3 (2) CONTENT OF REPORT.—The report under
4 paragraph (1) shall include—

5 (A) an assessment of current barriers to
6 entering accredited midwifery education pro-
7 grams, and recommendations for addressing
8 such barriers, particularly for low-income people
9 and people from racial and ethnic minority
10 groups;

11 (B) an assessment of current barriers to
12 entering and successfully completing accredited
13 education programs for other health profes-
14 sional careers related to maternity care, includ-
15 ing maternity care providers, mental and behav-
16 ioral health care providers acting in accordance
17 with State law, registered dietitians or nutrition
18 professionals (as such term is defined in section
19 1861(vv)(2) of the Social Security Act (42
20 U.S.C. 1395x(vv)(2)), and lactation consultants
21 certified by the International Board of Lacta-
22 tion Consultants Examiners, particularly for
23 low-income people and people from racial and
24 ethnic minority groups;

1 (C) an assessment of current barriers that
2 prevent midwives from meeting the inter-
3 national definition of the midwife and global
4 standards for midwifery education as estab-
5 lished by the International Confederation of
6 Midwives, and recommendations for addressing
7 such barriers, particularly for low-income people
8 and people from racial and ethnic minority
9 groups;

10 (D) an assessment of inequities in access
11 to maternity care providers, mental or behav-
12 ioral health care providers acting in accordance
13 with State law, registered dietitians or nutrition
14 professionals (as such term is defined in section
15 1861(vv)(2) of the Social Security Act (42
16 U.S.C. 1395x(vv)(2))), lactation consultants
17 certified by the International Board of Lacta-
18 tion Consultants Examiners, and perinatal
19 health workers, stratified by race, ethnicity,
20 gender identity, geographic location, and insur-
21 ance type and recommendations to promote
22 greater access equity; and

23 (E) recommendations to promote greater
24 equity in compensation for perinatal health
25 workers under public and private insurers, par-

1 ticularly for such individuals from racially and
2 ethnically diverse backgrounds.

3 (e) DEFINITIONS.—In this section:

4 (1) CULTURALLY CONGRUENT.—The term “cul-
5 turally congruent”, with respect to care or maternity
6 care, means care that is in agreement with the pre-
7 ferred cultural values, beliefs, worldview, language,
8 and practices of the health care consumer and other
9 stakeholders.

10 (2) MATERNITY CARE PROVIDER.—The term
11 “maternity care provider” means a health care pro-
12 vider who—

13 (A) is a physician, physician assistant,
14 midwife who meets at a minimum the inter-
15 national definition of the midwife and global
16 standards for midwifery education as estab-
17 lished by the International Confederation of
18 Midwives, nurse practitioner, or clinical nurse
19 specialist; and

20 (B) has a focus on maternal or perinatal
21 health.

22 (3) PERINATAL HEALTH WORKER.—The term
23 “perinatal health worker” means a doula, commu-
24 nity health worker, peer supporter, breastfeeding
25 and lactation educator or counselor, nutritionist or

1 dietitian, childbirth educator, social worker, home
2 visitor, language interpreter, or navigator.

3 (4) POSTPARTUM AND POSTPARTUM PERIOD.—

4 The terms “postpartum” and “postpartum period”
5 refer to the 1-year period beginning on the last day
6 of the pregnancy of an individual.

7 (5) RACIAL AND ETHNIC MINORITY GROUP.—

8 The term “racial and ethnic minority group” has the
9 meaning given such term in section 1707(g)(1) of
10 the Public Health Service Act (42 U.S.C. 300u–
11 6(g)(1)).

12 **SEC. 5214. MIDWIVES SCHOOLS AND PROGRAMS EXPAN-**
13 **SION.**

14 (a) MIDWIFERY SCHOOLS AND PROGRAMS.—

15 (1) IN GENERAL.—Title VII of the Public
16 Health Service Act is amended by inserting after
17 section 760 of such Act (42 U.S.C. 294k) the fol-
18 lowing:

19 **“SEC. 760A. MIDWIFERY SCHOOLS AND PROGRAMS.**

20 “(a) IN GENERAL.—The Secretary may award grants
21 to institutions of higher education (as defined in sub-
22 sections (a) and (b) of section 101 of the Higher Edu-
23 cation Act of 1965) for the following:

24 “(1) Direct support of students in an accredited
25 midwifery school or program.

1 “(2) Establishment or expansion of an accred-
2 ited midwifery school or program.

3 “(3) Securing, preparing, or providing support
4 for increasing the number of, qualified preceptors
5 for training the students of an accredited midwifery
6 school or program.

7 “(b) SPECIAL CONSIDERATIONS.—In awarding
8 grants under subsection (a), the Secretary shall give spe-
9 cial consideration to any institution of higher education
10 that—

11 “(1) agrees to prioritize students who plan to
12 practice in a health professional shortage area des-
13 ignated under section 332; and

14 “(2) demonstrates a focus on increasing racial
15 and ethnic minority representation in midwifery edu-
16 cation.

17 “(c) RESTRICTION.—The Secretary shall not provide
18 any assistance under this section to be used with respect
19 to a midwifery school or program within a school of nurs-
20 ing (as defined in section 801).

21 “(d) AUTHORIZATION OF APPROPRIATIONS.—

22 “(1) IN GENERAL.—There is authorized to be
23 appropriated to carry out this section \$15,000,000
24 for the period of fiscal years 2023 through 2027.

1 “(2) ALLOCATION.—Of the amounts made
2 available to carry out this section for any fiscal year,
3 the Secretary shall use—

4 “(A) 50 percent to award grants for pur-
5 poses specified in subsection (a)(1);

6 “(B) 25 percent to award grants for pur-
7 poses specified in subsection (a)(2); and

8 “(C) 25 percent to award grants for pur-
9 poses specified in subsection (a)(3).”.

10 (2) DEFINITIONS.—

11 (A) MIDWIFERY SCHOOL OR PROGRAM.—
12 Section 799B(1)(A) of the Public Health Serv-
13 ice Act (42 U.S.C. 295p(1)(A)) is amended—

14 (i) by inserting “‘midwifery school or
15 program’,” before “and ‘school of chiro-
16 practic’”;

17 (ii) by inserting “a degree or certifi-
18 cate in midwifery or an equivalent degree
19 or certificate,” before “and a degree of
20 doctor of chiropractic or an equivalent de-
21 gree”; and

22 (iii) by striking “any such school” and
23 inserting “any such school or program”.

24 (B) ACCREDITED.—Section 799B(1)(E) of
25 the Public Health Service Act (42 U.S.C.

1 295p(1)(E)) is amended by inserting “ a mid-
2 wifery school or program,” before “or a grad-
3 uate program in health administration”.

4 (b) NURSE-MIDWIVES.—Title VIII of the Public
5 Health Service Act, as amended by section 5213, is fur-
6 ther amended by inserting after section 812 of that Act,
7 as added by section 5213, the following:

8 **“SEC. 812A. MIDWIFERY EXPANSION PROGRAM.**

9 “(a) IN GENERAL.—The Secretary may award grants
10 to schools of nursing for the following:

11 “(1) Direct support of students in an accredited
12 nurse-midwifery school or program.

13 “(2) Establishment or expansion of an accred-
14 ited nurse-midwifery school or program.

15 “(3) Securing, preparing, or providing support
16 for increasing the numbers of, preceptors at clinical
17 training sites to precept students training to become
18 certified nurse-midwives.

19 “(b) SPECIAL CONSIDERATIONS.—In awarding
20 grants under subsection (a), the Secretary shall give spe-
21 cial consideration to any school of nursing that—

22 “(1) agrees to prioritize students who choose to
23 pursue an advanced education degree in nurse-mid-
24 wifery to practice in a health professional shortage
25 area designated under section 332; and

1 “(2) demonstrates a focus on increasing racial
2 and ethnic minority representation in nurse-mid-
3 wifery education.

4 “(c) AUTHORIZATION OF APPROPRIATIONS.—

5 “(1) IN GENERAL.—To carry out this section,
6 there is authorized to be appropriated \$20,000,000
7 for the period of fiscal years 2023 through 2027.

8 “(2) ALLOCATION.—Of the amounts made
9 available to carry out this section for any fiscal year,
10 the Secretary shall use—

11 “(A) 50 percent to award grants for pur-
12 poses specified in subsection (a)(1);

13 “(B) 25 to award grants for purposes
14 specified in subsection (a)(2); and

15 “(C) 25 percent to award grants for pur-
16 poses specified in subsection (a)(3).”.

17 **SEC. 5215. GESTATIONAL DIABETES.**

18 Part B of title III of the Public Health Service Act
19 (42 U.S.C. 243 et seq.) is amended by adding after section
20 317H the following:

21 **“SEC. 317H-1. GESTATIONAL DIABETES.**

22 “(a) UNDERSTANDING AND MONITORING GESTA-
23 TIONAL DIABETES.—

24 “(1) IN GENERAL.—The Secretary, acting
25 through the Director of the Centers for Disease

1 Control and Prevention, in consultation with the Di-
2 abetes Mellitus Interagency Coordinating Committee
3 established under section 429 and representatives of
4 appropriate national health organizations, shall de-
5 velop a multisite gestational diabetes research
6 project within the diabetes program of the Centers
7 for Disease Control and Prevention to expand and
8 enhance surveillance data and public health research
9 on gestational diabetes.

10 “(2) AREAS TO BE ADDRESSED.—The research
11 project developed under paragraph (1) shall ad-
12 dress—

13 “(A) procedures to establish accurate and
14 efficient systems for the collection of gestational
15 diabetes data within each State and common-
16 wealth, territory, or possession of the United
17 States;

18 “(B) the progress of collaborative activities
19 with the National Vital Statistics System, the
20 National Center for Health Statistics, and
21 State health departments with respect to the
22 standard birth certificate, in order to improve
23 surveillance of gestational diabetes;

24 “(C) postpartum methods of tracking indi-
25 viduals with gestational diabetes after delivery

1 as well as targeted interventions proven to
2 lower the incidence of type 2 diabetes in that
3 population;

4 “(D) variations in the distribution of diag-
5 nosed and undiagnosed gestational diabetes,
6 and of impaired fasting glucose tolerance and
7 impaired fasting glucose, within and among
8 groups of pregnant individuals; and

9 “(E) factors and culturally sensitive inter-
10 ventions that influence risks and reduce the in-
11 cidence of gestational diabetes and related com-
12 plications during childbirth, including cultural,
13 behavioral, racial, ethnic, geographic, demo-
14 graphic, socioeconomic, and genetic factors.

15 “(3) REPORT.—Not later than 2 years after the
16 date of the enactment of this section, and annually
17 thereafter, the Secretary shall generate a report on
18 the findings and recommendations of the research
19 project including prevalence of gestational diabetes
20 in the multisite area and disseminate the report to
21 the appropriate Federal and non-Federal agencies.

22 “(b) EXPANSION OF GESTATIONAL DIABETES RE-
23 SEARCH.—

1 “(1) IN GENERAL.—The Secretary shall expand
2 and intensify public health research regarding gesta-
3 tional diabetes. Such research may include—

4 “(A) developing and testing novel ap-
5 proaches for improving postpartum diabetes
6 testing or screening and for preventing type 2
7 diabetes in individuals who can become preg-
8 nant with a history of gestational diabetes; and

9 “(B) conducting public health research to
10 further understanding of the epidemiologic,
11 socioenvironmental, behavioral, translation, and
12 biomedical factors and health systems that in-
13 fluence the risk of gestational diabetes and the
14 development of type 2 diabetes in individuals
15 who can become pregnant with a history of ges-
16 tational diabetes.

17 “(2) AUTHORIZATION OF APPROPRIATIONS.—
18 There is authorized to be appropriated to carry out
19 this subsection \$5,000,000 for each of fiscal years
20 2023 through 2027.

21 “(c) DEMONSTRATION GRANTS TO LOWER THE
22 RATE OF GESTATIONAL DIABETES.—

23 “(1) IN GENERAL.—The Secretary, acting
24 through the Director of the Centers for Disease
25 Control and Prevention, shall award grants, on a

1 competitive basis, to eligible entities for demonstra-
2 tion projects that implement evidence-based inter-
3 ventions to reduce the incidence of gestational diabe-
4 tes, the recurrence of gestational diabetes in subse-
5 quent pregnancies, and the development of type 2 di-
6 abetes in individuals who can become pregnant with
7 a history of gestational diabetes.

8 “(2) PRIORITY.—In making grants under this
9 subsection, the Secretary shall give priority to
10 projects focusing on—

11 “(A) helping individuals who can become
12 pregnant who have 1 or more risk factors for
13 developing gestational diabetes;

14 “(B) working with individuals who can be-
15 come pregnant with a history of gestational dia-
16 betes during a previous pregnancy;

17 “(C) providing postpartum care for indi-
18 viduals who can become pregnant with gesta-
19 tional diabetes;

20 “(D) tracking cases where individuals who
21 can become pregnant with a history of gesta-
22 tional diabetes developed type 2 diabetes;

23 “(E) educating mothers with a history of
24 gestational diabetes about the increased risk of
25 their child developing diabetes;

1 “(F) working to prevent gestational diabe-
2 tes and prevent or delay the development of
3 type 2 diabetes in individuals who can become
4 pregnant with a history of gestational diabetes;
5 and

6 “(G) achieving outcomes designed to assess
7 the efficacy and cost-effectiveness of interven-
8 tions that can inform decisions on long-term
9 sustainability, including third-party reimburse-
10 ment.

11 “(3) APPLICATION.—An eligible entity desiring
12 to receive a grant under this subsection shall submit
13 to the Secretary—

14 “(A) an application at such time, in such
15 manner, and containing such information as the
16 Secretary may require; and

17 “(B) a plan to—

18 “(i) lower the rate of gestational dia-
19 betes during pregnancy; or

20 “(ii) develop methods of tracking indi-
21 viduals who can become pregnant with a
22 history of gestational diabetes and develop
23 effective interventions to lower the inci-
24 dence of the recurrence of gestational dia-

1 betes in subsequent pregnancies and the
2 development of type 2 diabetes.

3 “(4) USES OF FUNDS.—An eligible entity re-
4 ceiving a grant under this subsection shall use the
5 grant funds to carry out demonstration projects de-
6 scribed in paragraph (1), including—

7 “(A) expanding community-based health
8 promotion education, activities, and incentives
9 focused on the prevention of gestational diabe-
10 tes and development of type 2 diabetes in indi-
11 viduals who can become pregnant with a history
12 of gestational diabetes;

13 “(B) aiding State- and Tribal-based diabe-
14 tes prevention and control programs to collect,
15 analyze, disseminate, and report surveillance
16 data on individuals who can become pregnant
17 with, and at risk for, gestational diabetes, the
18 recurrence of gestational diabetes in subsequent
19 pregnancies, and, for individuals who can be-
20 come pregnant with a history of gestational dia-
21 betes, the development of type 2 diabetes; and

22 “(C) training and encouraging health care
23 providers—

24 “(i) to promote risk assessment, high-
25 quality care, and self-management for ges-

1 tational diabetes and the recurrence of ges-
2 tational diabetes in subsequent preg-
3 nancies; and

4 “(ii) to prevent the development of
5 type 2 diabetes in individuals who can be-
6 come pregnant with a history of gesta-
7 tional diabetes, and its complications in the
8 practice settings of the health care pro-
9 viders.

10 “(5) REPORT.—Not later than 4 years after the
11 date of the enactment of this section, the Secretary
12 shall prepare and submit to the Congress a report
13 concerning the results of the demonstration projects
14 conducted through the grants awarded under this
15 subsection.

16 “(6) DEFINITION OF ELIGIBLE ENTITY.—In
17 this subsection, the term ‘eligible entity’ means a
18 nonprofit organization (such as a nonprofit academic
19 center or community health center) or a State, Trib-
20 al, or local health agency.

21 “(7) AUTHORIZATION OF APPROPRIATIONS.—
22 There is authorized to be appropriated to carry out
23 this subsection \$5,000,000 for each of fiscal years
24 2023 through 2027.

1 “(d) POSTPARTUM FOLLOWUP REGARDING GESTA-
2 TIONAL DIABETES.—The Secretary, acting through the
3 Director of the Centers for Disease Control and Preven-
4 tion, shall work with the State- and Tribal-based diabetes
5 prevention and control programs assisted by the Centers
6 to encourage postpartum followup after gestational diabe-
7 tes, as medically appropriate, for the purpose of reducing
8 the incidence of gestational diabetes, the recurrence of
9 gestational diabetes in subsequent pregnancies, the devel-
10 opment of type 2 diabetes in individuals with a history
11 of gestational diabetes, and related complications.”.

12 **SEC. 5216. CONSUMER EDUCATION CAMPAIGN.**

13 Section 229(b) of the Public Health Service Act (42
14 U.S.C. 237a(b)), as amended—

15 (1) in paragraph (6), at the end, by striking
16 “and”;

17 (2) in paragraph (7), at the end, by striking the
18 period and inserting a semicolon; and

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

20 “(8) not later than one year after the date of
21 the enactment of this paragraph, develop and imple-
22 ment a 4-year culturally and linguistically appro-
23 priate multimedia consumer education campaign
24 that is designed to promote understanding and ac-
25 ceptance of evidence-based maternity practices and

1 models of care for optimal maternity outcomes
2 among individuals of childbearing ages and families
3 of such individuals and that—

4 “(A) highlights the importance of pro-
5 tecting, promoting, and supporting the innate
6 capacities of childbearing individuals and their
7 newborns for childbirth, breastfeeding, and at-
8 tachment;

9 “(B) promotes understanding of the impor-
10 tance of using obstetric interventions when
11 medically necessary and when supported by
12 strong, high-quality evidence;

13 “(C) highlights the widespread overuse of
14 maternity practices that have been shown to
15 have benefit when used appropriately in situa-
16 tions of medical necessity, but which can expose
17 pregnant individuals, infants, or both to risk of
18 harm if used routinely and indiscriminately;

19 “(D) emphasizes the noninvasive maternity
20 practices that have proven correlation or may
21 be associated with improvement in outcomes
22 with no detrimental side effects, and are signifi-
23 cantly underused in the United States, includ-
24 ing smoking cessation programs in pregnancy,
25 group model prenatal care, continuous labor

1 support, nonsupine positions for birth, and ex-
2 ternal version to turn breech babies at term;

3 “(E) educates consumers about—

4 “(i) the qualifications of licensed pro-
5 viders of maternity care, including obstetri-
6 cian-gynecologists, family physicians, cer-
7 tified nurse-midwives, certified midwives,
8 and certified professional midwives; and

9 “(ii) the best evidence about the safe-
10 ty, satisfaction, outcomes, and costs of
11 such providers;

12 “(F) informs consumers about the best
13 available research comparing birth center
14 births, planned home births, and hospital
15 births, including information about each set-
16 ting’s safety, satisfaction, outcomes, and costs;

17 “(G) fosters participation in high-quality,
18 evidence-based childbirth education that pro-
19 motes a healthy and safe approach to preg-
20 nancy, childbirth, and early parenting; is taught
21 by certified educators, peer counselors, and
22 health professionals; and promotes informed de-
23 cision making by childbearing individuals;

24 “(H) informs consumers about—

1 “(i) the effects of systemic, institu-
2 tional, and interpersonal racism on the
3 health, well-being, and outcomes of birth-
4 ing people;

5 “(ii) the importance of respectful, cul-
6 turally and linguistically appropriate, and
7 culturally congruent care; and

8 “(iii) the value of community-based
9 and community-led maternal care and sup-
10 port; and

11 “(I) is pilot tested for consumer com-
12 prehension, cultural sensitivity, and acceptance
13 of the messages across geographically, racially,
14 ethnically, and linguistically diverse popu-
15 lations;”.

16 **SEC. 5217. BIBLIOGRAPHIC DATABASE OF SYSTEMATIC RE-**
17 **VIEWS FOR CARE OF CHILDBEARING INDIV-**
18 **VIDUALS AND NEWBORNS.**

19 (a) IN GENERAL.—Not later than one year after the
20 date of the enactment of this Act, the Secretary of Health
21 and Human Services, acting through the Director of the
22 Agency for Healthcare Research and Quality, shall—

23 (1) make publicly available an online biblio-
24 graphic database identifying systematic reviews, in-
25 cluding an explanation of the level and quality of

1 evidence, for care of childbearing individuals and
2 newborns; and

3 (2) initiate regular updates that incorporate
4 newly issued and updated systematic reviews.

5 (b) SOURCES.—To aim for a comprehensive inventory
6 of systematic reviews relevant to maternal and newborn
7 care, the database shall identify reviews from diverse
8 sources, including—

9 (1) scientific peer-reviewed journals;

10 (2) databases, including the Cochrane Database
11 of Systematic Reviews; and

12 (3) internet websites of agencies and organiza-
13 tions throughout the world that produce such sys-
14 tematic reviews.

15 (c) FEATURES.—The database shall—

16 (1) provide bibliographic citations for each
17 record within the database, and for each such cita-
18 tion include an explanation of the level and quality
19 of evidence;

20 (2) include abstracts, as available;

21 (3) provide reference to companion documents
22 as may exist for each review, such as evidence tables
23 and guidelines or consumer educational materials de-
24 veloped from the review;

1 (4) provide links to the source of the full review
2 and to any companion documents;

3 (5) provide links to the source of a previous
4 version or update of the review;

5 (6) be searchable by intervention or other topic
6 of the review, reported outcomes, author, title, and
7 source; and

8 (7) offer to users periodic electronic notification
9 of database updates relating to users' topics of inter-
10 est.

11 (d) OUTREACH.—Not later than the first date the
12 database is made publicly available and periodically there-
13 after, the Secretary of Health and Human Services shall
14 publicize the availability, features, and uses of the data-
15 base under this section to the stakeholders described in
16 subsection (e).

17 (e) CONSULTATION.—For purposes of developing the
18 database under this section and maintaining and updating
19 such database, the Secretary of Health and Human Serv-
20 ices shall convene and consult with an advisory committee
21 composed of relevant stakeholders, including—

22 (1) Federal Medicaid administrators and State
23 agencies administering State plans under title XIX
24 of the Social Security Act pursuant to section
25 1902(a)(5) of such Act (42 U.S.C. 1396a(a)(5));

1 (2) providers of maternity and newborn care
2 from both academic and community-based settings,
3 including obstetrician-gynecologists, family physi-
4 cians, certified nurse midwives, certified midwives,
5 certified professional midwives, physician assistants,
6 perinatal nurses, pediatricians, and nurse practi-
7 tioners;

8 (3) maternal-fetal medicine specialists;

9 (4) neonatologists;

10 (5) childbearing individuals and advocates for
11 such individuals, including childbirth educators cer-
12 tified by a nationally accredited program, rep-
13 resenting communities that are diverse in terms of
14 race, ethnicity, indigenous status, and geographic
15 area;

16 (6) employers and purchasers;

17 (7) health facility and system leaders, including
18 both hospital and birth center facilities;

19 (8) journalists; and

20 (9) bibliographic informatics specialists.

21 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
22 authorized to be appropriated \$2,500,000 for each of the
23 fiscal years 2023 through 2025 for the purpose of devel-
24 oping the database and such sums as may be necessary
25 for each subsequent fiscal year for updating the database

1 and providing outreach and notification to users, as de-
2 scribed in this section.

3 **SEC. 5218. DEVELOPMENT OF INTERPROFESSIONAL MA-**
4 **TERNITY CARE EDUCATIONAL MODELS AND**
5 **TOOLS.**

6 (a) IN GENERAL.—Not later than 6 months after the
7 date of the enactment of this Act, the Secretary of Health
8 and Human Services, acting in conjunction with the Ad-
9 ministrator of Health Resources and Services Administra-
10 tion, shall convene, for a 1-year period, an Interprofes-
11 sional Maternity Provider Education Commission (re-
12 ferred to in this section as the “Commission”) to discuss
13 and make recommendations for—

14 (1) a consensus standard physiologic maternity
15 care curriculum that takes into account the core
16 competencies for basic midwifery practice such as
17 those developed by the American College of Nurse-
18 Midwives and the North American Registry of Mid-
19 wives, and the educational objectives for physicians
20 practicing in obstetrics and gynecology as deter-
21 mined by the Council on Resident Education in Ob-
22 stetrics and Gynecology;

23 (2) suggestions for multidisciplinary use of the
24 consensus physiologic curriculum;

1 (3) strategies to integrate and coordinate edu-
2 cation across maternity care disciplines, including
3 recommendations to increase medical and midwifery
4 student exposure to out-of-hospital birth;

5 (4) curriculum and strategies for continuing
6 education of practicing perinatal professionals who
7 have completed their undergraduate and graduate
8 education; and

9 (5) pilot demonstrations of interprofessional
10 educational models.

11 (b) PARTICIPANTS.—

12 (1) PROFESSIONS.—The Commission shall in-
13 clude maternity care educators, curriculum devel-
14 opers, service leaders, certification leaders, and ac-
15 creditation leaders from the various professions that
16 provide or support maternity care in the United
17 States. Such professions shall include obstetrician
18 gynecologists, certified nurse midwives or certified
19 midwives, family practice physicians, nurse practi-
20 tioners, physician assistants, certified professional
21 midwives, perinatal nurses, doulas, lactation per-
22 sonnel, and community health workers.

23 (2) CONSUMER ADVOCATES.—The Commission
24 shall also include representation from maternity care
25 consumer advocates.

1 (c) CURRICULUM.—The consensus standard physio-
2 logic maternity care curriculum described in subsection
3 (a)(1) shall—

4 (1) have a public health focus with a foundation
5 in health promotion and disease prevention;

6 (2) foster physiologic childbearing and person
7 and family centered care;

8 (3) reflect the extensive, growing research evi-
9 dence about—

10 (A) the innate abilities and processes of
11 the birthing person and the fetus or newborn
12 for labor, birth, postpartum transition,
13 breastfeeding, and attachment, when promoted,
14 supported, and protected; and

15 (B) the effects of factors that disturb and
16 disrupt these processes;

17 (4) integrate strategies to reduce maternal and
18 infant morbidity and mortality;

19 (5) incorporate recommendations to ensure re-
20 spectful, safe, and seamless consultation, referral,
21 transport, and transfer of care when necessary;

22 (6) include cultural sensitivity and strategies to
23 decrease inequities in maternity outcomes; and

24 (7) include implicit bias training.

1 (d) REPORT.—Not later than 6 months after the final
2 meeting of the Commission, the Secretary of Health and
3 Human Services shall—

4 (1) submit to Congress a report containing the
5 recommendations made by the Commission under
6 this section; and

7 (2) make such report publicly available.

8 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
9 authorized to be appropriated to carry out this section
10 \$1,000,000 for each of the fiscal years 2023 and 2024,
11 and such sums as are necessary for each of the fiscal years
12 2025 through 2027.

13 **SEC. 5219. DISSEMINATION OF THE QUALITY FAMILY PLAN-**
14 **NING GUIDELINES.**

15 (a) IN GENERAL.—Not later than 180 days after the
16 date of enactment of this Act, the Secretary of Health and
17 Human Services and the Director of the Centers for Dis-
18 ease Control and Prevention shall—

19 (1) develop a plan for outreach to publicly fund-
20 ed health care providers, including federally qualified
21 health centers (as defined in section 1861(aa)(4) of
22 the Social Security Act (42 U.S.C. 1395x(aa)(4)))
23 and branches of the Indian Health Service, about
24 the quality family planning guidelines referred to in
25 section 5304; and

1 (2) award grants to eligible entities to imple-
2 ment such guidelines for all patients seeking family
3 planning services.

4 (b) DEFINITION.—In this section, the term “eligible
5 entity” means a publicly funded health care provider that
6 serves persons of reproductive age.

7 **Subtitle D—Federal Agency**
8 **Coordination on Maternal Health**

9 **SEC. 5301. INTERAGENCY COORDINATING COMMITTEE ON**
10 **THE PROMOTION OF OPTIMAL MATERNITY**
11 **OUTCOMES.**

12 (a) IN GENERAL.—Part A of title II of the Public
13 Health Service Act (42 U.S.C. 202 et seq.) is amended
14 by adding at the end the following:

15 **“SEC. 229A. INTERAGENCY COORDINATING COMMITTEE ON**
16 **THE PROMOTION OF OPTIMAL MATERNITY**
17 **OUTCOMES.**

18 “(a) IN GENERAL.—The Secretary, acting through
19 the Deputy Assistant Secretary for Women’s Health under
20 section 229 and in collaboration with the Federal officials
21 specified in subsection (b), shall establish the Interagency
22 Coordinating Committee on the Promotion of Optimal Ma-
23 ternity Outcomes (referred to in this section as the
24 ‘ICCPOM’).

1 “(b) OTHER AGENCIES.—The officials specified in
2 this subsection are the Secretary of Labor, the Secretary
3 of Defense, the Secretary of Veterans Affairs, the Surgeon
4 General, the Director of the Centers for Disease Control
5 and Prevention, the Administrator of the Health Re-
6 sources and Services Administration, the Administrator of
7 the Centers for Medicare & Medicaid Services, the Direc-
8 tor of the Indian Health Service, the Administrator of the
9 Substance Abuse and Mental Health Services Administra-
10 tion, the Director of the National Institute of Child Health
11 and Human Development, the Director of the Agency for
12 Healthcare Research and Quality, the Assistant Secretary
13 for Children and Families, the Deputy Assistant Secretary
14 for Minority Health, the Director of the Office of Per-
15 sonnel Management, and such other Federal officials as
16 the Secretary of Health and Human Services determines
17 to be appropriate.

18 “(c) CHAIR.—The Deputy Assistant Secretary for
19 Women’s Health shall serve as the chair of the ICCPOM.

20 “(d) DUTIES.—The ICCPOM shall guide policy and
21 program development across the Federal Government with
22 respect to promotion of optimal maternity care, provided,
23 however, that nothing in this section shall be construed
24 as transferring regulatory or program authority from an
25 agency to the ICCPOM.

1 “(e) CONSULTATIONS.—The ICCPOM shall actively
2 seek the input of, and shall consult with, all appropriate
3 and interested stakeholders, including State health depart-
4 ments, public health research and interest groups, founda-
5 tions, childbearing individuals and their advocates, and
6 maternity care professional associations and organiza-
7 tions, reflecting racially, ethnically, demographically, and
8 geographically diverse communities.

9 “(f) ANNUAL REPORT.—

10 “(1) IN GENERAL.—The Secretary, on behalf of
11 the ICCPOM, shall annually submit to Congress a
12 report that summarizes—

13 “(A) all programs and policies of Federal
14 agencies (including the Medicare Program
15 under title XVIII of the Social Security Act and
16 the Medicaid program under title XIX of such
17 Act) designed to promote optimal maternity
18 care, focusing particularly on programs and
19 policies that support the adoption of evidence
20 based maternity care, as defined by timely, sci-
21 entifically sound systematic reviews;

22 “(B) all programs and policies of Federal
23 agencies (including the Medicare Program
24 under title XVIII of the Social Security Act and
25 the Medicaid program under title XIX of such

1 Act) designed to address the problems of mater-
2 nal mortality and morbidity, infant mortality,
3 prematurity, and low birth weight, including
4 such programs and policies designed to address
5 racial and ethnic inequities with respect to each
6 of such problems;

7 “(C) the extent of progress in reducing
8 maternal mortality and infant mortality, low
9 birth weight, and prematurity at State and na-
10 tional levels; and

11 “(D) such other information regarding op-
12 timal maternity care (such as quality and per-
13 formance measures) as the Secretary deter-
14 mines to be appropriate.

15 “(2) REDUCING INEQUITIES WITH RESPECT TO
16 INDIGENOUS STATUS.—The information specified in
17 paragraph (1)(C) shall be included in each such re-
18 port in a manner that disaggregates such informa-
19 tion by race, ethnicity, and indigenous status in
20 order to determine the extent of progress in reduc-
21 ing racial and ethnic inequities and inequities related
22 to indigenous status.

23 “(3) CERTAIN INFORMATION.—Each report
24 under paragraph (1) shall include information
25 (disaggregated by race, ethnicity, and indigenous

1 status, as applicable) on the following rates, trends,
2 and costs by State:

3 “(A) The rate and trend of primary cesar-
4 ean deliveries and repeat cesarean deliveries.

5 “(B) The rate and trend of vaginal births
6 after cesarean.

7 “(C) The rate and trend of vaginal breech
8 births.

9 “(D) The rate and trend of induction of
10 labor.

11 “(E) The rate and trend of freestanding
12 birth center births.

13 “(F) The rate and trend of planned and
14 unplanned home birth.

15 “(G) The rate and trends of attended
16 births by different types of maternity care pro-
17 viders, including by an obstetrician-gyne-
18 cologist, family practice physician, obstetrician-
19 gynecologist physician assistant, certified nurse-
20 midwife, certified midwife, and certified profes-
21 sional midwife.

22 “(H) The rate and trend of severe mater-
23 nal morbidity.

24 “(I) The rates and trends of prenatal and
25 postpartum anxiety and depression.

1 “(J) The rate and trend of pre-term birth.

2 “(K) The rate and trend of low birth
3 weight.

4 “(L) The cost of maternity care
5 disaggregated by place of birth and provider of
6 care, including—

7 “(i) uncomplicated vaginal birth;

8 “(ii) complicated vaginal birth;

9 “(iii) uncomplicated cesarean birth;

10 and

11 “(iv) complicated cesarean birth.

12 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
13 is authorized to be appropriated, in addition to amounts
14 authorized to be appropriated under section 229(e), to
15 carry out this section \$1,000,000 for each of the fiscal
16 years 2023 through 2027.”.

17 (b) CONFORMING AMENDMENTS.—

18 (1) INCLUSION AS DUTY OF HHS OFFICE ON
19 WOMEN’S HEALTH.—Section 229(b) of such Act (42
20 U.S.C. 237a(b)), as amended by section 5216, is
21 further amended by adding at the end the following
22 new paragraph:

23 “(9) establish the Interagency Coordinating
24 Committee on the Promotion of Optimal Maternity
25 Outcomes in accordance with section 229A; and”.

1 (2) TREATMENT OF BIENNIAL REPORTS.—Sec-
2 tion 229(d) of such Act (42 U.S.C. 237a(d)) is
3 amended by inserting “(other than under subsection
4 (b)(9))” after “under this section”.

5 **SEC. 5302. EXPANSION OF CDC PREVENTION RESEARCH**
6 **CENTERS PROGRAM TO INCLUDE CENTERS**
7 **ON OPTIMAL MATERNITY OUTCOMES.**

8 (a) IN GENERAL.—Not later than one year after the
9 date of the enactment of this Act, the Secretary of Health
10 and Human Services shall support the establishment of
11 additional Prevention Research Centers under the Preven-
12 tion Research Center Program administered by the Cen-
13 ters for Disease Control and Prevention. Such additional
14 centers shall each be known as a Center for Excellence
15 on Optimal Maternity Outcomes.

16 (b) RESEARCH.—Each Center for Excellence on Opti-
17 mal Maternity Outcomes shall—

18 (1) conduct at least one focused program of re-
19 search to improve maternity outcomes, including the
20 reduction of cesarean birth rates, early elective in-
21 ductions, prematurity rates, and low birth weight
22 rates within an underserved population that has a
23 disproportionately large burden of suboptimal mater-
24 nity outcomes, including maternal mortality and
25 morbidity, infant mortality, prematurity, or low

1 birth weight, which such program shall include de-
2 veloping performance and quality measures for ac-
3 countability;

4 (2) work with partners on special interest
5 projects, as specified by the Centers for Disease
6 Control and Prevention and other relevant agencies
7 within the Department of Health and Human Serv-
8 ices, and on projects funded by other sources; and

9 (3) involve a minimum of two distinct birth set-
10 ting models, such as—

11 (A) a hospital labor and delivery model
12 and freestanding birth center model; or

13 (B) a hospital labor and delivery model
14 and planned home birth model.

15 (c) INTERDISCIPLINARY PROVIDERS.—Each Center
16 for Excellence on Optimal Maternity Outcomes shall in-
17 clude the following interdisciplinary providers of maternity
18 care:

19 (1) Obstetrician-gynecologists.

20 (2) At least two of the following providers:

21 (A) Family practice physicians.

22 (B) Nurse practitioners.

23 (C) Physician assistants.

24 (D) Certified professional midwives, cer-
25 tified nurse-midwives, or certified midwives.

1 (d) SERVICES.—Research conducted by each Center
2 for Excellence on Optimal Maternity Outcomes shall in-
3 clude at least 2 (and preferably more) of the following sup-
4 portive provider services:

5 (1) Mental health.

6 (2) Doula labor support.

7 (3) Nutrition education.

8 (4) Childbirth education.

9 (5) Social work.

10 (6) Physical therapy or occupation therapy.

11 (7) Substance use disorder services.

12 (8) Home visiting.

13 (e) COORDINATION.—The programs of research at
14 each of the Centers of Excellence on Optimal Maternity
15 Outcomes shall complement and not replicate the work of
16 the other.

17 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
18 authorized to be appropriated to carry out this section
19 \$2,000,000 for each of the fiscal years 2023 through
20 2027.

1 **SEC. 5303. EXPANDING MODELS TO BE TESTED BY CENTER**
2 **FOR MEDICARE AND MEDICAID INNOVATION**
3 **TO EXPLICITLY INCLUDE MATERNITY CARE**
4 **AND CHILDREN'S HEALTH MODELS.**

Section 1115A(b)(2) of the Social Security Act (42 U.S.C. 1315a(b)(2)), as amended by section 5206(b), is amended—

(1) in subparagraph (B), by adding at the end
the following:

“(xxix) Promoting evidence-based models of care that have been associated with reductions in pregnancy-related and infant health inequities, including incorporating the use of and payment for doulas, particularly community-based doulas, and promoting support for people during pregnancy and for the one-year period after the last day of such person’s pregnancy, through evidence-based models of antepartum, birth, postpartum care, and two-generation birthing person and newborn care models, and supporting the risk-appropriate use of out-of-hospital birth models, including births at home and in freestanding birth centers. Such models shall be selected and evaluated based on

1 their impact on quality, equity, and devel-
2 opmental outcomes, notwithstanding any
3 other provision of this section.”;

4 (2) in subparagraph (C), by adding at the end
5 the following:

6 “(ix) Whether the model includes a
7 regular process for ensuring the provision
8 of culturally and linguistically appropriate
9 services.

10 “(x) Whether health care services and
11 supportive services included in the model
12 are tailored to community health and
13 health-related social needs and provided by
14 community-based and community-led pro-
15 viders.

16 “(xi) Whether the model is designed
17 to mitigate harmful effects of discrimina-
18 tion on the basis of race, sex, disability,
19 ethnicity, language, and age.”; and

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

21 “(D) MANDATORY HEALTH EQUITY MOD-
22 ELS TO BE TESTED.—The Secretary shall se-
23 lect—

24 “(i) Medicaid global and episode-based
25 payment models for culturally and linguis-

1 tically appropriate antepartum, labor and
2 delivery, and postpartum doula services, in-
3 cluding community-based doula services,
4 that are—

5 “(I) structured to provide pay-
6 ment to doulas as individuals, health
7 care entity staff, or members of a
8 doula group or collective, or through a
9 third-party administrator;

10 “(II) designed to reduce racial
11 and intersecting health inequities;

12 “(III) designed to provide doulas
13 providing support with an equitable
14 and sustainable reimbursement rate;

15 “(IV) designed to reduce barriers
16 to workforce entry for culturally and
17 linguistically competent and racially
18 congruent doulas to provide services
19 to Medicaid enrollees ; and

20 “(V) designed with input from
21 community-based doulas, maternal
22 health advocates, reproductive justice
23 advocates, and Medicaid beneficiaries;

24 “(ii) a Medicaid episode-based pay-
25 ment model for pregnancy-related services,

1 including health care services and sup-
2 portive services to address health-related
3 socials needs, during the prenatal,
4 intrapartum, and postpartum periods, to
5 improve health outcomes and reduce racial
6 health inequities, and to be designed with
7 input from maternity care providers, ma-
8 ternal health advocates, reproductive jus-
9 tice advocates, and Medicaid beneficiaries;

10 “(iii) a Medicaid alternative payment
11 model for a pregnancy-related health home
12 to improve health outcomes during and for
13 one year after pregnancy and during the
14 newborn period, and to reduce racial
15 health inequities, designed with input from
16 maternity care providers, maternal health
17 advocates, reproductive justice advocates,
18 and Medicaid beneficiaries;

19 “(iv) a Medicaid perinatal health
20 worker service delivery model for culturally
21 and linguistically appropriate and respect-
22 ful health care and supportive services that
23 are tailored to community health and
24 health-related social needs, designed to im-
25 prove health outcomes and mitigate harm-

1 ful effects of racism and other forms of
2 discrimination, and provided by commu-
3 nity-based and community-led providers;
4 and

5 “(v) one or more models exclusively
6 focused on early intervention and preven-
7 tion for children enrolled in a State plan
8 (or waiver of such plan) under title XIX or
9 a State child health plan under title XXI
10 using evidence-based interventions includ-
11 ing parenting support programs, home-vis-
12 iting services, and dyadic therapy treat-
13 ment for children and adolescents at-risk.
14 Such models shall be selected and evaluated
15 based on their impact on quality, equity, and
16 developmental outcomes, notwithstanding any
17 other provision of this section.”.

18 **SEC. 5304. INTERAGENCY UPDATE TO THE QUALITY FAMILY**
19 **PLANNING GUIDELINES.**

20 (a) IN GENERAL.—Not later than six months after
21 the date of enactment of this Act, the Director of the Cen-
22 ters for Disease Control and Prevention and the Office
23 of Population Affairs shall review and expand the 2014
24 Quality Family Planning Guidelines to address—

25 (1) health inequities; and

1 (2) the importance of patient-directed contra-
2 ceptive decision making.

3 (b) CONSULTATION.—In carrying out subsection (a),
4 the Director of the Centers for Disease Control and Pre-
5 vention and the Office of Population Affairs shall convene
6 a meeting, and solicit the views of, stakeholders including
7 experts on health inequities, experts on reproductive coer-
8 cion, representatives of provider organizations, patient ad-
9 vocates, reproductive justice organizations, organizations
10 that represent racial and ethnic minority communities, or-
11 ganizations that represent people with disabilities, organi-
12 zations that represent LGBTQ persons, and organizations
13 that represent people with limited English proficiency.

14 **Subtitle E—Reproductive and**
15 **Sexual Health**

16 **SEC. 5401. FINDINGS; SENSE OF CONGRESS ON URGENT**
17 **BARRIERS TO ABORTION ACCESS AND VITAL**
18 **SOLUTIONS.**

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

20 (1) Affordable, comprehensive health insurance
21 that includes coverage for a full range of pregnancy-
22 related care, including abortion, is critical to the
23 health of every person regardless of actual or per-
24 ceived race, color, national origin, immigration sta-
25 tus, sex (including sexual orientation, gender iden-

1 tity, pregnancy, childbirth, a medical condition relat-
2 ing to pregnancy or childbirth, or sex stereotyping),
3 age, or disability status.

4 (2) Abortion services are essential to health
5 care and access to those services is central to peo-
6 ple's ability to participate equally in the economic
7 and social life of the United States. Abortion access
8 allows people who are pregnant to make their own
9 decisions about their pregnancies, their families, and
10 their lives.

11 (3) Reproductive justice seeks to address re-
12 strictions on reproductive health, including abortion,
13 that perpetuate systems of oppression, lack of bodily
14 autonomy, White supremacy, and anti-Black racism.
15 The violent legacy of these systems of oppression has
16 manifested in policies including enslavement, rape,
17 and experimentation on Black people, forced steri-
18 lizations, medical experimentation on low-income
19 people's reproductive systems, and the forcible re-
20 moval of Indigenous children. Access to equitable re-
21 productive health care, including abortion services,
22 has always been deficient in the United States for
23 Black, Indigenous, and other People of Color
24 (BIPOC) and their families. Transgender, non-
25 binary, and gender expansive individuals, and spe-

1 cifically those who are Black, disabled, and at the
2 intersections of multiple forms of oppression, also
3 experience inequitable access to abortion services due
4 to systemic violence. Centering abortion rights and
5 access as a “women’s health” issue restricts access
6 to those with reproductive needs who do not identify
7 as cisgender women. In order to work towards repro-
8 ductive justice for all communities, transgender,
9 nonbinary, and gender expansive individuals must be
10 centered in conversations of abortion access. Improv-
11 ing abortion access for this community requires a
12 gender-neutral approach to abortion care, rights,
13 and justice policy.

14 (4) The legacy of restrictions on reproductive
15 health, rights, and justice is not a dated vestige of
16 a dark history. Access to abortion services is ob-
17 structed across the United States in various ways,
18 including blockades of health care facilities and asso-
19 ciated violence, prohibitions of, and restrictions on,
20 insurance coverage, parental involvement laws (noti-
21 fication and consent), restrictions that shame and
22 stigmatize people seeking abortion services, and
23 medically unnecessary regulations that neither con-
24 fer any health benefit nor further the safety of abor-
25 tion services, but which harm people by delaying,

1 complicating access to, and reducing the availability
2 of, abortion services. As of December 2, 2021, 19
3 States have enacted 106 restrictions, including 12
4 new abortion bans, making 2021 the year with the
5 highest number of restrictions passed since *Roe v.*
6 *Wade* was decided in 1973. Additionally, 21 States
7 are poised to immediately ban or significantly re-
8 strict access to abortion services if the Supreme
9 Court chooses to overturn or weaken *Roe v. Wade*.
10 These unprecedented attacks on abortion rights and
11 access fall especially heavily on people with low in-
12 comes, BIPOC, immigrants, young people, people
13 with disabilities, those living in rural and other
14 medically underserved areas, and transgender, non-
15 binary, and gender expansive individuals.

16 (5) Since 1976, the Federal Government has
17 withheld funds for abortion coverage in most cir-
18 cumstances through the Hyde amendment and simi-
19 lar coverage restrictions, affecting individuals of re-
20 productive age in the United States who are insured
21 through the Medicaid program, as well as individuals
22 who receive insurance or care through other Federal
23 health plans and programs. Of women aged 15 to 44
24 enrolled in Medicaid in 2017, 55 percent lived in the
25 35 States and the District of Columbia that do not

1 cover abortion, except in limited circumstances. This
2 amounts to roughly 7,300,000 women of reproduc-
3 tive age, including 3,100,000 women living below the
4 Federal poverty level. Women of color are dispropor-
5 tionately likely to be insured by the Medicaid pro-
6 gram, and nationwide, 32 percent of Black women
7 and 27 percent of Hispanic women aged 15 to 44
8 were enrolled in Medicaid in 2017, compared with
9 16 percent of White women.

10 (6) Abortion-specific restrictions are even more
11 compounded by the ongoing criminalization of people
12 who are pregnant, including those who are incarcer-
13 ated, living with HIV, or with substance use dis-
14 orders. These communities already experience health
15 inequities due to social, political, and environmental
16 inequities, and restrictions on abortion services exac-
17 erbate these harms. Removing medically unjustified
18 restrictions on abortion services would constitute one
19 important step on the path toward realizing repro-
20 ductive justice by ensuring that the full range of re-
21 productive health care is accessible to all who need
22 it.

23 (7) Abortion-specific restrictions are a tool of
24 gender oppression, as they target health care serv-
25 ices that are used primarily by individuals with re-

1 productive needs. These paternalistic restrictions
2 rely on and reinforce harmful stereotypes about gen-
3 der roles, people's decision making, and people's
4 need for protection instead of support, undermining
5 their ability to control their own lives and wellbeing.
6 These restrictions harm the basic autonomy, dignity,
7 and equality of individuals with reproductive health
8 needs, and their ability to participate in the social
9 and economic life of the Nation.

10 (8) Many abortion-specific restrictions do not
11 confer any health or safety benefits on the patient.
12 Instead, these restrictions have the purpose and ef-
13 fect of unduly burdening people's personal and pri-
14 vate medical decisions to end their pregnancies by
15 making access to abortion services more difficult,
16 invasive, and costly, often forcing people to travel
17 significant distances and make multiple unnecessary
18 visits to the provider, and in some cases, foreclosing
19 the option altogether.

20 (9) Congress has used its authority in the past
21 to protect access to abortion services and health care
22 providers' ability to provide abortion services. In the
23 early 1990s, protests and blockades at health care
24 facilities where abortion services were provided, and
25 associated violence, increased dramatically and

1 reached crisis level, requiring congressional action.
2 Congress passed the Freedom of Access to Clinic
3 Entrances Act (Public Law 103–259; 108 Stat. 694)
4 to address that situation and protect physical access
5 to abortion services.

6 (10) Congressional action is necessary to put an
7 end to harmful restrictions, to federally protect ac-
8 cess to abortion services for everyone regardless of
9 where they live, and to protect the ability of health
10 care providers to provide these services in a safe and
11 accessible manner.

12 (11) The Equal Access to Abortion Coverage in
13 Health Insurance Act of 2021 or the EACH Act of
14 2021 (H.R. 2234, S. 1021) introduced in the 117th
15 Congress, would reverse the Hyde amendment and
16 related abortion coverage restrictions. It would cre-
17 ate an enforceable statutory right for people who re-
18 ceive health coverage or care through enumerated
19 Federal programs (including Medicaid, the Chil-
20 dren’s Health Insurance Program, Medicare, and the
21 Indian Health Service, among others) and plans (in-
22 cluding government-sponsored health insurance due
23 to a current or former employment relationship) to
24 receive abortion coverage. It would require the Fed-
25 eral Government to facilitate abortion access for in-

1 dividuals eligible to receive health care in Federal fa-
2 cilities or in facilitates with which it contracts to
3 provide health care, such as immigration detention
4 centers. It also prohibits the Federal Government
5 from prohibiting, restricting, or otherwise inhibiting
6 State or local governments or private health insur-
7 ance issuers from providing abortion coverage.

8 (12) The Women’s Health Protection Act of
9 2021 (H.R. 3755, S. 1975) introduced in the 117th
10 Congress, would establish an enforceable statutory
11 right for health care providers to provide, and abor-
12 tion patients to receive, abortions free from medi-
13 cally unnecessary restrictions, limitations, and bans
14 that delay, and at times, completely obstruct, access
15 to abortion.

16 (b) SENSE OF CONGRESS.—It is the sense of Con-
17 gress that eliminating the Hyde amendment, enacting the
18 Equal Access to Abortion Coverage in Health Insurance
19 Act of 2021, and enacting the Women’s Health Protection
20 Act of 2021, are critical to—

21 (1) promoting equitable abortion access, includ-
22 ing coverage, for all who seek care;

23 (2) creating enforceable rights to receive, and
24 receive coverage for, such care;

1 (3) advancing equitable access to comprehensive
2 health coverage, which cannot be achieved without
3 abortion coverage; and

4 (4) alleviating urgent racial, gender, and other
5 inequities in health and health care and cor-
6 responding reproductive injustices.

7 **SEC. 5402. EMERGENCY CONTRACEPTION EDUCATION AND**
8 **INFORMATION PROGRAMS.**

9 (a) EMERGENCY CONTRACEPTION PUBLIC EDU-
10 CATION PROGRAM.—

11 (1) IN GENERAL.—The Secretary, acting
12 through the Director of the Centers for Disease
13 Control and Prevention, shall develop and dissemi-
14 nate to the public medically accurate and complete
15 information on emergency contraceptives.

16 (2) DISSEMINATION.—The Secretary may dis-
17 seminate medically accurate and complete informa-
18 tion under paragraph (1) directly or through ar-
19 rangements with nonprofit organizations, community
20 health workers, including promotores, consumer
21 groups, institutions of higher education, clinics, the
22 media, and Federal, State, and local agencies.

23 (3) INFORMATION.—The information dissemi-
24 nated under paragraph (1) shall—

1 (A) include, at a minimum, a description
2 of emergency contraceptives and an explanation
3 of the use, safety, efficacy, affordability, and
4 availability, including over-the-counter access,
5 of such contraceptives and options for access to
6 such contraceptives without cost-sharing
7 through insurance and other programs; and

8 (B) be pilot tested for consumer com-
9 prehension, cultural and linguistic appropriate-
10 ness, and acceptance of the messages across
11 geographically, racially, ethnically, and linguis-
12 tically diverse populations.

13 (b) EMERGENCY CONTRACEPTION INFORMATION
14 PROGRAM FOR HEALTH CARE PROVIDERS.—

15 (1) IN GENERAL.—The Secretary, acting
16 through the Administrator of the Health Resources
17 and Services Administration and in consultation
18 with major medical and public health organizations,
19 shall develop and disseminate to health care pro-
20 viders, including pharmacists, information on emer-
21 gency contraceptives.

22 (2) INFORMATION.—The information dissemi-
23 nated under paragraph (1) shall include, at a min-
24 imum—

1 (A) information describing the use, safety,
2 efficacy, and availability of emergency contra-
3 ceptives, and options for access without cost-
4 sharing through insurance and other programs;

5 (B) a recommendation regarding the use of
6 such contraceptives; and

7 (C) information explaining how to obtain
8 copies of the information developed under sub-
9 section (a) for distribution to the patients of
10 the providers.

11 (c) DEFINITIONS.—In this section:

12 (1) HEALTH CARE PROVIDER.—The term
13 “health care provider” means an individual who is li-
14 censed or certified under State law to provide health
15 care services and who is operating within the scope
16 of such license. Such term shall include a phar-
17 macist.

18 (2) INSTITUTION OF HIGHER EDUCATION.—The
19 term “institution of higher education” has the same
20 meaning given such term in section 101(a) of the
21 Higher Education Act of 1965 (20 U.S.C. 1001(a)).

22 (3) SECRETARY.—The term “Secretary” means
23 the Secretary of Health and Human Services.

24 (d) AUTHORIZATION OF APPROPRIATIONS.—There
25 are authorized to be appropriated to carry out this section

1 such sums as may be necessary for each of the fiscal years
2 2023 through 2027.

3 **SEC. 5403. ACCESS TO BIRTH CONTROL DUTIES OF PHAR-**
4 **MACIES TO ENSURE PROVISION OF FDA-AP-**
5 **PROVED CONTRACEPTION.**

6 Part B of title II of the Public Health Service Act
7 (42 U.S.C. 238 et seq.) is amended by adding at the end
8 the following:

9 **“SEC. 249. DUTIES OF PHARMACIES TO ENSURE PROVISION**
10 **OF FDA-APPROVED CONTRACEPTION.**

11 “(a) IN GENERAL.—Subject to subsection (c), a
12 pharmacy that receives Food and Drug Administration-
13 approved drugs or devices in interstate commerce shall
14 maintain compliance with the following:

15 “(1) If a customer requests a contraceptive or
16 a medication related to a contraceptive, including
17 emergency contraception, that is in stock, the phar-
18 macy shall ensure that the contraceptive is provided
19 to the customer without delay.

20 “(2) If a customer requests a contraceptive or
21 a medication related to a contraceptive that is not
22 in stock and the pharmacy in the normal course of
23 business stocks contraception, the pharmacy shall
24 immediately inform the customer that the contracep-

1 tive is not in stock and without delay offer the cus-
2 tomer the following options:

3 “(A) If the customer prefers to obtain the
4 contraceptive or a medication related to a con-
5 traceptive through a referral or transfer, the
6 pharmacy shall—

7 “(i) locate a pharmacy of the cus-
8 tomer’s choice or the closest pharmacy
9 confirmed to have the contraceptive or a
10 medication related to a contraceptive in
11 stock; and

12 “(ii) refer the customer or transfer
13 the prescription to that pharmacy.

14 “(B) If the customer prefers for the phar-
15 macy to order the contraceptive or a medication
16 related to a contraceptive, the pharmacy shall
17 obtain the contraceptive or medication under
18 the pharmacy’s standard procedure for expe-
19 dited ordering of medication and notify the cus-
20 tomer when the contraceptive or medication ar-
21 rives.

22 “(3) The pharmacy shall ensure that—

23 “(A) the pharmacy does not operate an en-
24 vironment in which customers are intimidated,
25 threatened, or harassed in the delivery of serv-

1 ices relating to a request for contraception or a
2 medication related to a contraceptive;

3 “(B) the pharmacy’s employees do not
4 interfere with or obstruct the delivery of serv-
5 ices relating to a request for contraception or a
6 medication related to a contraceptive;

7 “(C) the pharmacy’s employees do not in-
8 tentionally misrepresent or deceive customers
9 about the availability of a contraceptive or a
10 medication related to a contraceptive, or the
11 mechanism of action of such contraceptive or
12 medication;

13 “(D) the pharmacy’s employees do not
14 breach medical confidentiality with respect to a
15 request for a contraceptive or a medication re-
16 lated to a contraceptive or threaten to breach
17 such confidentiality; or

18 “(E) the pharmacy’s employees do not
19 refuse to return a valid, lawful prescription for
20 a contraceptive or a medication related to a
21 contraceptive upon customer request.

22 “(b) CONTRACEPTIVES NOT ORDINARILY
23 STOCKED.—Nothing in subsection (a)(2) shall be con-
24 strued to require any pharmacy to comply with such sub-
25 section if the pharmacy does not ordinarily stock contra-

1 ceptives or a medication related to a contraceptive in the
2 normal course of business.

3 “(c) REFUSALS PURSUANT TO STANDARD PHAR-
4 MACY PRACTICE.—This section does not prohibit a phar-
5 macy from refusing to provide a contraceptive or a medi-
6 cation related to a contraceptive to a customer in accord-
7 ance with any of the following:

8 “(1) If it is unlawful to dispense the contracep-
9 tive or a medication related to a contraceptive to the
10 customer without a valid, lawful prescription and no
11 such prescription is presented.

12 “(2) If the customer is unable to pay for the
13 contraceptive or the medication related to a contra-
14 ceptive.

15 “(3) If the employee of the pharmacy refuses to
16 provide the contraceptive or a medication related to
17 a contraceptive on the basis of a professional clinical
18 judgment.

19 “(d) RELATION TO OTHER LAW.—

20 “(1) RULE OF CONSTRUCTION.—Nothing in
21 this section shall be construed to invalidate or limit
22 rights, remedies, procedures, or legal standards
23 under title VII of the Civil Rights Act of 1964.

24 “(2) CERTAIN CLAIMS.—The Religious Free-
25 dom Restoration Act of 1993 shall not provide a

1 basis for a claim concerning, or a defense to a claim
2 under, this section, or provide a basis for challenging
3 the application or enforcement of this section.

4 “(e) PREEMPTION.—This section does not preempt
5 any provision of State law or any professional obligation
6 made applicable by a State board or other entity respon-
7 sible for licensing or discipline of pharmacies or phar-
8 macists, to the extent that such State law or professional
9 obligation provides protections for customers that are
10 greater than the protections provided by this section.

11 “(f) ENFORCEMENT.—

12 “(1) CIVIL PENALTY.—A pharmacy that vio-
13 lates a requirement of subsection (a) is liable to the
14 United States for a civil penalty in an amount not
15 exceeding \$1,000 per day of violation, not to exceed
16 \$100,000 for all violations adjudicated in a single
17 proceeding.

18 “(2) PRIVATE CAUSE OF ACTION.—Any person
19 aggrieved as a result of a violation of a requirement
20 of subsection (a) may, in any court of competent ju-
21 risdiction, commence a civil action against the phar-
22 macy involved to obtain appropriate relief, including
23 actual and punitive damages, injunctive relief, and a
24 reasonable attorney’s fee and cost.

1 “(3) LIMITATIONS.—A civil action under para-
2 graph (1) or (2) may not be commenced against a
3 pharmacy after the expiration of the 5-year period
4 beginning on the date on which the pharmacy alleg-
5 edly engaged in the violation involved.

6 “(g) DEFINITIONS.—In this section:

7 “(1) CONTRACEPTION.—The term ‘contracep-
8 tion’ or ‘contraceptive’ means any drug or device ap-
9 proved by the Food and Drug Administration to pre-
10 vent pregnancy.

11 “(2) EMPLOYEE.—The term ‘employee’ means
12 a person hired, by contract or any other form of an
13 agreement, by a pharmacy.

14 “(3) MEDICATION RELATED TO A CONTRACEP-
15 TIVE.—The term ‘medication related to a contracep-
16 tive’ means any drug or device approved by the Food
17 and Drug Administration that a medical professional
18 determines necessary to use before or in conjunction
19 with a contraceptive.

20 “(4) PHARMACY.—The term ‘pharmacy’ means
21 an entity that—

22 “(A) is authorized by a State to engage in
23 the business of selling prescription drugs at re-
24 tail; and

25 “(B) employs one or more employees.

1 “(5) PRODUCT.—The term ‘product’ means a
2 Food and Drug Administration-approved drug or de-
3 vice.

4 “(6) PROFESSIONAL CLINICAL JUDGMENT.—
5 The term ‘professional clinical judgment’ means the
6 use of professional knowledge and skills to form a
7 clinical judgment, in accordance with prevailing
8 medical standards.

9 “(7) WITHOUT DELAY.—The term ‘without
10 delay’, with respect to a pharmacy providing, pro-
11 viding a referral for, or ordering contraception, or
12 transferring the prescription for contraception,
13 means within the usual and customary timeframe at
14 the pharmacy for providing, providing a referral for,
15 or ordering other products, or transferring the pre-
16 scription for other products, respectively.

17 “(h) EFFECTIVE DATE.—This section shall take ef-
18 fect on the 31st day after the date of the enactment of
19 this section, without regard to whether the Secretary has
20 issued any guidance or final rule regarding this section.”.

21 **SEC. 5404. REAL EDUCATION AND ACCESS FOR HEALTHY**
22 **YOUTH.**

23 (a) PURPOSE.—The purpose of this section is to pro-
24 vide young people with sex education and sexual health
25 services that—

1 (1) promote and uphold the rights of young
2 people to information and services that empower
3 them to make decisions about their bodies, health,
4 sexuality, families, and communities in all areas of
5 life;

6 (2) are evidence-informed, comprehensive in
7 scope, confidential, equitable, accessible, medically
8 accurate and complete, age and developmentally ap-
9 propriate, culturally responsive, and trauma-in-
10 formed and resilience-oriented;

11 (3) provide information about the prevention,
12 treatment, and care of pregnancy, sexually trans-
13 mitted infections, and interpersonal violence;

14 (4) provide information about the importance of
15 consent as a basis for healthy relationships and for
16 autonomy in health care;

17 (5) provide information on gender roles and
18 gender discrimination;

19 (6) provide information on the historical and
20 current condition in which education and health sys-
21 tems, policies, programs, services, and practices have
22 uniquely and adversely impacted Black, Indigenous,
23 Latinx, Asian, Asian American and Pacific Islander,
24 and other People of Color; and

1 (7) redress inequities in the delivery of sex edu-
2 cation and sexual health services to marginalized
3 young people.

4 (b) DEFINITIONS.—In this section:

5 (1) AGE AND DEVELOPMENTALLY APPRO-
6 PRIATE.—The term “age and developmentally appro-
7 priate” means topics, messages, and teaching meth-
8 ods suitable to particular ages, age groups, or devel-
9 opmental levels, based on cognitive, emotional, so-
10 cial, and behavioral capacity of most young people at
11 that age level.

12 (2) CHARACTERISTICS OF EFFECTIVE PRO-
13 GRAMS.—The term “characteristics of effective pro-
14 grams” means the aspects of evidence-informed pro-
15 grams, including development, content, and imple-
16 mentation of such programs, that—

17 (A) have been shown to be effective in
18 terms of increasing knowledge, clarifying values
19 and attitudes, increasing skills, and impacting
20 behavior; and

21 (B) are widely recognized by leading med-
22 ical and public health agencies to be effective in
23 changing sexual behaviors that lead to sexually
24 transmitted infections, unintended pregnancy,
25 and interpersonal violence among young people.

1 (3) CONSENT.—The term “consent” means af-
2 firmative, conscious, and voluntary agreement to en-
3 gage in interpersonal, physical, or sexual activity.

4 (4) CULTURALLY RESPONSIVE.—The term “cul-
5 turally responsive” means education and services
6 that—

7 (A) embrace and actively engage and ad-
8 just to young people and their various cultural
9 identities;

10 (B) recognize the ways in which many
11 marginalized young people face unique barriers
12 in our society that result in increased adverse
13 health outcomes and associated stereotypes; and

14 (C) may address the ways in which racism
15 has shaped national health care policy, the last-
16 ing historical trauma associated with reproduc-
17 tive health experiments and forced sterilizations
18 of Black, Latinx, and Indigenous communities,
19 or sexual stereotypes assigned to young People
20 of Color or LGBTQ+ people.

21 (5) EVIDENCE-INFORMED.—The term “evi-
22 dence-informed” means incorporates characteristics,
23 content, or skills that have been proven to be effec-
24 tive through evaluation in changing sexual behavior.

1 (6) GENDER EXPRESSION.—The term “gender
2 expression” means the expression of one’s gender,
3 such as through behavior, clothing, haircut, or voice,
4 and which may or may not conform to socially de-
5 fined behaviors and characteristics typically associ-
6 ated with being either masculine or feminine.

7 (7) GENDER IDENTITY.—The term “gender
8 identity” means the gender-related identity, appear-
9 ance, mannerisms, or other gender-related character-
10 istics of an individual, regardless of the individual’s
11 designated sex at birth.

12 (8) INCLUSIVE.—The term “inclusive” means
13 content and skills that ensure marginalized young
14 people are valued, respected, centered, and sup-
15 ported in sex education instruction and materials.

16 (9) INSTITUTION OF HIGHER EDUCATION.—The
17 term “institution of higher education” has the
18 meaning given the term in section 101 of the Higher
19 Education Act of 1965 (20 U.S.C. 1001).

20 (10) INTERPERSONAL VIOLENCE.—The term
21 “interpersonal violence” means abuse, assault, bul-
22 lying, dating violence, domestic violence, harassment,
23 intimate partner violence, or stalking.

24 (11) MARGINALIZED YOUNG PEOPLE.—The
25 term “marginalized young people” means young peo-

1 ple who are disadvantaged by underlying structural
2 barriers and social inequities, including young people
3 who are—

4 (A) Black, Indigenous, and other People of
5 Color;

6 (B) immigrants;

7 (C) in contact with the foster care system;

8 (D) in contact with the juvenile justice sys-
9 tem;

10 (E) experiencing homelessness;

11 (F) pregnant or parenting;

12 (G) lesbian, gay, bisexual, transgender, or
13 queer;

14 (H) living with HIV;

15 (I) living with disabilities;

16 (J) from families with low incomes; or

17 (K) living in rural areas.

18 (12) MEDICALLY ACCURATE AND COMPLETE.—

19 The term “medically accurate and complete” means
20 that—

21 (A) the information provided through the
22 education is verified or supported by the weight
23 of research conducted in compliance with ac-
24 cepted scientific methods and is published in
25 peer-reviewed journals, where applicable; or

1 (B) the education contains information
2 that leading professional organizations and
3 agencies with relevant expertise in the field rec-
4 ognize as accurate, objective, and complete.

5 (13) RESILIENCE.—The term “resilience”
6 means the ability to adapt to trauma and tragedy.

7 (14) SECRETARY.—The term “Secretary”
8 means the Secretary of Health and Human Services.

9 (15) SEX EDUCATION.—The term “sex edu-
10 cation” means high quality teaching and learning
11 that—

12 (A) is delivered, to the maximum extent
13 practicable, following the National Sexuality
14 Education Standards of the Future of Sex Edu-
15 cation Initiative;

16 (B) is about a broad variety of topics re-
17 lated to sex and sexuality, including—

18 (i) puberty and adolescent develop-
19 ment;

20 (ii) sexual and reproductive anatomy
21 and physiology;

22 (iii) sexual orientation, gender iden-
23 tity, and gender expression;

24 (iv) contraception, pregnancy, and re-
25 production;

- 1 (v) HIV and other STIs;
- 2 (vi) consent and healthy relationships;
- 3 and
- 4 (vii) interpersonal violence;
- 5 (C) explores values and beliefs about such
- 6 topics; and
- 7 (D) helps young people in gaining the
- 8 skills that are needed to navigate relationships
- 9 and manage one's own sexual health.

10 (16) SEXUAL DEVELOPMENT.—The term “sex-

11 ual development” means the lifelong process of phys-

12 ical, behavioral, cognitive, and emotional growth and

13 change as it relates to an individual's sexuality and

14 sexual maturation, including puberty, identity devel-

15 opment, socio-cultural influences, and sexual behav-

16 iors.

17 (17) SEXUAL HEALTH SERVICES.—The term

18 “sexual health services” includes—

- 19 (A) sexual health information, education,
- 20 and counseling;
- 21 (B) all methods of contraception approved
- 22 by the Food and Drug Administration;
- 23 (C) routine gynecological care, including
- 24 human papillomavirus (HPV) vaccines and can-
- 25 cer screenings;

1 (D) pre-exposure prophylaxis or post-expo-
2 sure prophylaxis;

3 (E) substance use and mental health serv-
4 ices;

5 (F) interpersonal violence survivor services;
6 and

7 (G) other prevention, care, or treatment
8 services.

9 (18) SEXUAL ORIENTATION.—The term “sexual
10 orientation” means an individual’s romantic, emo-
11 tional, or sexual attraction to other people.

12 (19) TRAUMA.—The term “trauma” means a
13 response to an event, series of events, or set of cir-
14 cumstances that is experienced or witnessed by an
15 individual or group of people as physically or emo-
16 tionally harmful or life-threatening with lasting ad-
17 verse effects on their functioning and mental, phys-
18 ical, social, emotional, or spiritual well-being.

19 (20) TRAUMA-INFORMED AND RESILIENCE-ORI-
20 ENTED.—The term “trauma-informed and resil-
21 ience-oriented” means an approach that realizes the
22 prevalence of trauma, recognizes the various ways
23 individuals, organizations, and communities may re-
24 spond to trauma differently, recognizes that resil-

1 ience can be built, and responds by putting this
2 knowledge into practice.

3 (21) YOUNG PEOPLE.—The term “young peo-
4 ple” means individuals who are ages 10 through 29
5 at the time of commencement of participation in a
6 project supported under this section.

7 (22) YOUTH-FRIENDLY SEXUAL HEALTH SERV-
8 ICES.—The term “youth-friendly sexual health serv-
9 ices” means sexual health services that are provided
10 in a confidential, equitable, and accessible manner
11 that makes it easy and comfortable for young people
12 to seek out and receive services.

13 (c) GRANTS FOR SEX EDUCATION AT ELEMENTARY
14 AND SECONDARY SCHOOLS AND YOUTH-SERVING ORGA-
15 NIZATIONS.—

16 (1) PROGRAM AUTHORIZED.—The Secretary, in
17 coordination with the Secretary of Education, shall
18 award grants, on a competitive basis, to eligible enti-
19 ties to enable such eligible entities to carry out
20 projects that provide young people with sex edu-
21 cation.

22 (2) DURATION.—Grants awarded under this
23 subsection shall be for a period of 5 years.

1 (3) ELIGIBLE ENTITY.—In this subsection, the
2 term “eligible entity” means a public or private enti-
3 ty that delivers health education to young people.

4 (4) APPLICATIONS.—An eligible entity desiring
5 a grant under this subsection shall submit an appli-
6 cation to the Secretary at such time, in such man-
7 ner, and containing such information as the Sec-
8 retary may require.

9 (5) PRIORITY.—In awarding grants under this
10 subsection, the Secretary shall give priority to eligi-
11 ble entities that are—

12 (A) State educational agencies or local
13 educational agencies; or

14 (B) Indian Tribes or Tribal organizations,
15 as defined in section 4 of the Indian Self-Deter-
16 mination and Education Assistance Act (25
17 U.S.C. 5304).

18 (6) USE OF FUNDS.—Each eligible entity that
19 receives a grant under this subsection shall use the
20 grant funds to carry out a project that provides
21 young people with sex education.

22 (d) GRANTS FOR SEX EDUCATION AT INSTITUTIONS
23 OF HIGHER EDUCATION.—

24 (1) PROGRAM AUTHORIZED.—The Secretary, in
25 coordination with the Secretary of Education, shall

1 award grants, on a competitive basis, to institutions
2 of higher education or consortia of such institutions
3 to enable such institutions to provide students with
4 age and developmentally appropriate sex education.

5 (2) DURATION.—Grants awarded under this
6 subsection shall be for a period of 5 years.

7 (3) APPLICATIONS.—An institution of higher
8 education or consortium of such institutions desiring
9 a grant under this subsection shall submit an appli-
10 cation to the Secretary at such time, in such man-
11 ner, and containing such information as the Sec-
12 retary may require.

13 (4) PRIORITY.—In awarding grants under this
14 subsection, the Secretary shall give priority to an in-
15 stitution of higher education that—

16 (A) has an enrollment of needy students,
17 as defined in section 318(b) of the Higher Edu-
18 cation Act of 1965 (20 U.S.C. 1059e(b));

19 (B) is a Hispanic-serving institution, as
20 defined in section 502(a) of such Act (20
21 U.S.C. 1101a(a));

22 (C) is a Tribal College or University, as
23 defined in section 316(b) of such Act (20
24 U.S.C. 1059e(b));

1 (D) is an Alaska Native-serving institution,
2 as defined in section 317(b) of such Act (20
3 U.S.C. 1059d(b));

4 (E) is a Native Hawaiian-serving institu-
5 tion, as defined in section 317(b) of such Act
6 (20 U.S.C. 1059d(b));

7 (F) is a Predominantly Black Institution,
8 as defined in section 318(b) of such Act (20
9 U.S.C. 1059e(b));

10 (G) is a Native American-serving, non-
11 tribal institution, as defined in section 319(b)
12 of such Act (20 U.S.C. 1059f(b));

13 (H) is an Asian American and Native
14 American Pacific Islander-serving institution, as
15 defined in section 320(b) of such Act (20
16 U.S.C. 1059g(b)); or

17 (I) is a minority institution, as defined in
18 section 365 of such Act (20 U.S.C. 1067k),
19 with an enrollment of needy students, as de-
20 fined in section 312 of such Act (20 U.S.C.
21 1058).

22 (5) USES OF FUNDS.—An institution of higher
23 education or consortium of such institutions receiv-
24 ing a grant under this subsection shall use grant
25 funds to develop and implement a project to inte-

1 grate sex education into the institution of higher
2 education in order to reach a large number of stu-
3 dents, by carrying out 1 or more of the following ac-
4 tivities:

5 (A) Adopting and incorporating age and
6 developmentally appropriate sex education into
7 student orientation, general education, or
8 courses.

9 (B) Developing or adopting and imple-
10 menting educational programming outside of
11 class that delivers age and developmentally ap-
12 propriate sex education to students.

13 (C) Developing or adopting and imple-
14 menting innovative technology-based approaches
15 to deliver age and developmentally appropriate
16 sex education to students.

17 (D) Developing or adopting and imple-
18 menting peer-led activities to generate discus-
19 sion, educate, and raise awareness among stu-
20 dents about age and developmentally appro-
21 priate sex education.

22 (E) Developing or adopting and imple-
23 menting policies and practices to link students
24 to sexual health services.

25 (e) GRANTS FOR EDUCATOR TRAINING.—

1 (1) PROGRAM AUTHORIZED.—The Secretary, in
2 coordination with the Secretary of Education, shall
3 award grants, on a competitive basis, to eligible enti-
4 ties to enable such eligible entities to carry out the
5 activities described in paragraph (5).

6 (2) DURATION.—Grants awarded under this
7 subsection shall be for a period of 5 years.

8 (3) ELIGIBLE ENTITY.—In this subsection, the
9 term “eligible entity” means—

10 (A) a State educational agency or local
11 educational agency;

12 (B) an Indian Tribe or Tribal organiza-
13 tion, as defined in section 4 of the Indian Self-
14 Determination and Education Assistance Act
15 (25 U.S.C. 5304);

16 (C) a State or local department of health;

17 (D) an educational service agency;

18 (E) a nonprofit institution of higher edu-
19 cation or a consortium of such institutions; or

20 (F) a national or statewide nonprofit orga-
21 nization or consortium of nonprofit organiza-
22 tions that has as its primary purpose the im-
23 provement of provision of sex education through
24 training and effective teaching of sex education.

1 (4) APPLICATION.—An eligible entity desiring a
2 grant under this subsection shall submit an applica-
3 tion to the Secretary at such time, in such manner,
4 and containing such information as the Secretary
5 may require.

6 (5) AUTHORIZED ACTIVITIES.—

7 (A) REQUIRED ACTIVITY.—Each eligible
8 entity receiving a grant under this subsection
9 shall use grant funds for professional develop-
10 ment and training of relevant teachers, health
11 educators, faculty, administrators, and staff, in
12 order to increase effective teaching of sex edu-
13 cation to young people.

14 (B) PERMISSIBLE ACTIVITIES.—Each eligi-
15 ble entity receiving a grant under this sub-
16 section may use grant funds to—

17 (i) provide training and support for
18 educators about the content, skills, and
19 professional disposition needed to imple-
20 ment sex education effectively;

21 (ii) develop and provide training and
22 support to educators on incorporating anti-
23 racist and gender inclusive policies and
24 practices in sex education;

1 (iii) support the dissemination of in-
2 formation on effective practices and re-
3 search findings concerning the teaching of
4 sex education;

5 (iv) support research on—

6 (I) effective sex education teach-
7 ing practices; and

8 (II) the development of assess-
9 ment instruments and strategies to
10 document—

11 (aa) young people's under-
12 standing of sex education; and

13 (bb) the effects of sex edu-
14 cation;

15 (v) convene conferences on sex edu-
16 cation, in order to effectively train edu-
17 cators in the provision of sex education;
18 and

19 (vi) develop and disseminate appro-
20 priate research-based materials to foster
21 sex education.

22 (C) SUBGRANTS.—Each eligible entity re-
23 ceiving a grant under this subsection may
24 award subgrants to nonprofit organizations that
25 possess a demonstrated record of providing

1 training to teachers, health educators, faculty,
2 administrators, and staff on sex education to—

3 (i) train educators in sex education;

4 (ii) support internet or distance learn-
5 ing related to sex education;

6 (iii) promote rigorous academic stand-
7 ards and assessment techniques to guide
8 and measure student performance in sex
9 education;

10 (iv) encourage replication of best
11 practices and model programs to promote
12 sex education;

13 (v) develop and disseminate effective,
14 research-based sex education learning ma-
15 terials; or

16 (vi) develop academic courses on the
17 pedagogy of sex education at institutions
18 of higher education.

19 (f) AUTHORIZATION OF GRANTS TO SUPPORT THE
20 DELIVERY OF SEXUAL HEALTH SERVICES TO
21 MARGINALIZED YOUNG PEOPLE.—

22 (1) PROGRAM AUTHORIZED.—The Secretary
23 shall award grants, on a competitive basis, to eligible
24 entities to enable such entities to provide youth-

1 friendly sexual health services to marginalized young
2 people.

3 (2) DURATION.—Grants awarded under this
4 subsection shall be for a period of 5 years.

5 (3) ELIGIBLE ENTITY.—In this subsection, the
6 term “eligible entity” means—

7 (A) a public or private youth-serving orga-
8 nization; or

9 (B) a covered entity, as defined in section
10 340B of the Public Health Service Act (42
11 U.S.C. 256b).

12 (4) APPLICATIONS.—An eligible entity desiring
13 a grant under this subsection shall submit an appli-
14 cation to the Secretary at such time, in such man-
15 ner, and containing such information as the Sec-
16 retary may require.

17 (5) USES OF FUNDS.—Each eligible entity that
18 receives a grant under this subsection may use the
19 grant funds to—

20 (A) develop and implement an evidence-in-
21 formed project to deliver sexual health services
22 to marginalized young people;

23 (B) establish, alter, or modify staff posi-
24 tions, service delivery policies and practices,
25 service delivery locations, service delivery envi-

1 ronments, service delivery schedules, or other
2 services components in order to increase youth-
3 friendly sexual health services to marginalized
4 young people;

5 (C) conduct outreach to marginalized
6 young people to invite them to participate in
7 the eligible entity's sexual health services and to
8 provide feedback to inform improvements in the
9 delivery of such services;

10 (D) establish and refine systems of referral
11 to connect marginalized young people to other
12 sexual health services and supportive services;

13 (E) establish partnerships and collabora-
14 tions with entities providing services to
15 marginalized young people to link such young
16 people to sexual health services, such as by de-
17 livering health services at locations where they
18 congregate, providing transportation to loca-
19 tions where sexual health services are provided,
20 or other linkages to services approaches;

21 (F) provide evidence-informed, comprehen-
22 sive in scope, confidential, equitable, accessible,
23 medically accurate and complete, age and devel-
24 opmentally appropriate, culturally responsive,
25 and trauma-informed and resilience-oriented

1 sexual health information to marginalized
2 young people in the languages and cultural con-
3 texts that are most appropriate for the
4 marginalized young people to be served by the
5 eligible entity;

6 (G) promote effective communication re-
7 garding sexual health among marginalized
8 young people; and

9 (H) provide training and support for eligi-
10 ble entity personnel and community members
11 who work with marginalized young people about
12 the content, skills, and professional disposition
13 needed to provide youth-friendly sex education
14 and youth-friendly sexual health services.

15 (g) REPORTING AND IMPACT EVALUATION.—

16 (1) GRANTEE REPORT TO SECRETARY.—For
17 each year an eligible entity receives grant funds
18 under subsection (c), (d), (e), or (f), the eligible enti-
19 ty shall submit to the Secretary a report that in-
20 cludes—

21 (A) the use of grant funds by the eligible
22 entity;

23 (B) how the use of grant funds has in-
24 creased the access of young people to sex edu-
25 cation or sexual health services; and

1 (C) such other information as the Sec-
2 retary may require.

3 (2) SECRETARY'S REPORT TO CONGRESS.—Not
4 later than 1 year after the date of the enactment of
5 this Act, and annually thereafter for a period of 5
6 years, the Secretary shall prepare and submit to
7 Congress a report on the activities funded under this
8 section. The Secretary's report to Congress shall in-
9 clude—

10 (A) a statement of how grants awarded by
11 the Secretary meet the purposes described in
12 subsection (a); and

13 (B) information about—

14 (i) the number of eligible entities that
15 are receiving grant funds under sub-
16 sections (c), (d), (e), and (f);

17 (ii) the specific activities supported by
18 grant funds awarded under subsections (c),
19 (d), (e), and (f);

20 (iii) the number of young people
21 served by projects funded under sub-
22 sections (c), (d), (e), and (f), in the aggre-
23 gate and disaggregated and cross-tabulated
24 by grant program, race and ethnicity, sex,
25 sexual orientation, gender identity, and

1 other characteristics determined by the
2 Secretary (except that such disaggregation
3 or cross-tabulation shall not be required in
4 a case in which the results would reveal
5 personally identifiable information about
6 an individual young person);

7 (iv) the number of teachers, health
8 educators, faculty, school administrators,
9 and staff trained under subsection (e); and

10 (v) the status of the evaluation re-
11 quired under paragraph (3).

12 (3) MULTI-YEAR EVALUATION.—

13 (A) IN GENERAL.—Not later than 6
14 months after the date of the enactment of this
15 Act, the Secretary shall enter into a contract
16 with a nonprofit organization with experience in
17 conducting impact evaluations to conduct a
18 multi-year evaluation on the impact of the
19 projects funded under subsections (c), (d), (e),
20 and (f) and to report to Congress and the Sec-
21 retary on the findings of such evaluation.

22 (B) EVALUATION.—The evaluation con-
23 ducted under this paragraph shall—

24 (i) be conducted in a manner con-
25 sistent with relevant, nationally recognized

1 professional and technical evaluation
2 standards;

3 (ii) use sound statistical methods and
4 techniques relating to the behavioral
5 sciences, including quasi-experimental de-
6 signs, inferential statistics, and other
7 methodologies and techniques that allow
8 for conclusions to be reached;

9 (iii) be carried out by an independent
10 organization that has not received a grant
11 under subsection (c), (d), (e), or (f); and

12 (iv) be designed to provide informa-
13 tion on output measures and outcome
14 measures to be determined by the Sec-
15 retary.

16 (C) REPORT.—Not later than 6 years after
17 the date of enactment of this Act, the organiza-
18 tion conducting the evaluation under this para-
19 graph shall prepare and submit to the appro-
20 priate committees of Congress and the Sec-
21 retary a report on such evaluation. Such report
22 shall be made publicly available, including on
23 the website of the Department of Health and
24 Human Services.

1 (h) NONDISCRIMINATION.—Activities funded under
2 this section shall not discriminate on the basis of actual
3 or perceived sex (including sexual orientation and gender
4 identity), age, parental status, race, color, ethnicity, na-
5 tional origin, disability, or religion. Nothing in this section
6 shall be construed to invalidate or limit rights, remedies,
7 procedures, or legal standards available under any other
8 Federal law or any law of a State or a political subdivision
9 of a State, including the Civil Rights Act of 1964 (42
10 U.S.C. 2000a et seq.), title IX of the Education Amend-
11 ments of 1972 (20 U.S.C. 1681 et seq.), section 504 of
12 the Rehabilitation Act of 1973 (29 U.S.C. 794), the Amer-
13 icans with Disabilities Act of 1990 (42 U.S.C. 12101 et
14 seq.), and section 1557 of the Patient Protection and Af-
15 fordable Care Act (42 U.S.C. 18116).

16 (i) LIMITATION.—No Federal funds provided under
17 this section may be used for sex education or sexual health
18 services that—

19 (1) withhold health-promoting or life-saving in-
20 formation about sexuality-related topics, including
21 HIV;

22 (2) are medically inaccurate or incomplete;

23 (3) promote gender or racial stereotypes or are
24 unresponsive to gender or racial inequities;

1 (4) fail to address the needs of sexually active
2 young people;

3 (5) fail to address the needs of pregnant or par-
4 enting young people;

5 (6) fail to address the needs of survivors of
6 interpersonal violence;

7 (7) fail to address the needs of young people of
8 all physical, developmental, or mental abilities;

9 (8) fail to be inclusive of individuals with vary-
10 ing gender identities, gender expressions, and sexual
11 orientations; or

12 (9) are inconsistent with the ethical imperatives
13 of medicine and public health.

14 (j) AMENDMENTS TO OTHER LAWS.—

15 (1) AMENDMENT TO THE PUBLIC HEALTH
16 SERVICE ACT.—Section 2500 of the Public Health
17 Service Act (42 U.S.C. 300ee) is amended by strik-
18 ing subsections (b) through (d) and inserting the fol-
19 lowing:

20 “(b) CONTENTS OF PROGRAMS.—All programs of
21 education and information receiving funds under this title
22 shall include information about the potential effects of in-
23 travenous substance use.”.

24 (2) AMENDMENTS TO THE ELEMENTARY AND
25 SECONDARY EDUCATION ACT OF 1965.—Section 8526

1 of the Elementary and Secondary Education Act of
2 1965 (20 U.S.C. 7906) is amended—

3 (A) by striking paragraphs (3), (5), and
4 (6);

5 (B) in paragraph (2), by inserting “or”
6 after the semicolon;

7 (C) by redesignating paragraph (4) as
8 paragraph (3); and

9 (D) in paragraph (3), as redesignated by
10 subparagraph (C), by striking the semicolon
11 and inserting a period.

12 (k) FUNDING.—

13 (1) AUTHORIZATION.—For the purpose of car-
14 rying out this section, there is authorized to be ap-
15 propriated \$100,000,000 for each of fiscal years
16 2022 through 2027. Amounts appropriated under
17 this paragraph shall remain available until expended.

18 (2) RESERVATIONS OF FUNDS.—

19 (A) IN GENERAL.—Of the amount author-
20 ized under paragraph (1), the Secretary shall
21 reserve—

22 (i) not more than 30 percent for the
23 purposes of awarding grants for sex edu-
24 cation at elementary and secondary schools

1 and youth-serving organizations under sub-
2 section (c);

3 (ii) not more than 10 percent for the
4 purpose of awarding grants for sex edu-
5 cation at institutions of higher education
6 under subsection (d);

7 (iii) not more than 15 percent for the
8 purpose of awarding grants for educator
9 training under subsection (e);

10 (iv) not more than 30 percent for the
11 purpose of awarding grants for sexual
12 health services for marginalized youth
13 under subsection (f); and

14 (v) not less than 5 percent for the
15 purpose of carrying out the reporting and
16 impact evaluation required under sub-
17 section (g).

18 (B) RESEARCH, TRAINING AND TECHNICAL
19 ASSISTANCE.—The Secretary shall reserve not
20 less than 10 percent of the amount authorized
21 under paragraph (1) for expenditures by the
22 Secretary to provide, directly or through a com-
23 petitive grant process, research, training, and
24 technical assistance, including dissemination of
25 research and information regarding effective

1 and promising practices, providing consultation
2 and resources, and developing resources and
3 materials to support the activities of recipients
4 of grants. In carrying out such functions, the
5 Secretary shall collaborate with a variety of en-
6 tities that have expertise in sex education and
7 sexual health services standards setting, design,
8 development, delivery, research, monitoring, and
9 evaluation.

10 (3) REPROGRAMMING OF ABSTINENCE ONLY
11 UNTIL MARRIAGE PROGRAM FUNDING.—The unobli-
12 gated balance of funds made available to carry out
13 section 510 of the Social Security Act (42 U.S.C.
14 710) (as in effect on the day before the date of en-
15 actment of this Act) are hereby transferred and shall
16 be used by the Secretary to carry out this section.
17 The amounts transferred and made available to
18 carry out this section shall remain available until ex-
19 pended.

20 (4) REPEAL OF ABSTINENCE ONLY UNTIL MAR-
21 RIAGE PROGRAM.—Section 510 of the Social Secu-
22 rity Act (42 U.S.C. 710 et seq.) is repealed.

23 **SEC. 5405. COMPASSIONATE ASSISTANCE FOR RAPE EMER-**
24 **GENCIES.**

25 (a) MEDICARE.—

1 (1) LIMITATION ON PAYMENT.—Section
2 1866(a)(1) of the Social Security Act (42 U.S.C.
3 1395cc(a)(1)) is amended—

4 (A) by moving the indentation of subpara-
5 graph (W) 2 ems to the left;

6 (B) in subparagraph (X)—

7 (i) by moving the indentation 2 ems
8 to the left; and

9 (ii) by striking “and” at the end;

10 (C) in subparagraph (Y), by striking the
11 period at the end and inserting “; and”; and

12 (D) by inserting after subparagraph (Y)
13 the following new subparagraph:

14 “(Z) in the case of a hospital or critical access
15 hospital, to adopt and enforce a policy to ensure
16 compliance with the requirements of subsection (l)
17 and to meet the requirements of such subsection.”.

18 (2) ASSISTANCE TO VICTIMS.—Section 1866 of
19 the Social Security Act (42 U.S.C. 1395cc) is
20 amended by adding at the end the following new
21 subsection:

22 “(l) COMPASSIONATE ASSISTANCE FOR RAPE EMER-
23 GENCIES.—

24 “(1) IN GENERAL.—For purposes of subsection
25 (a)(1)(Z), a hospital meets the requirements of this

1 subsection if the hospital provides each of the serv-
2 ices described in paragraph (2) to each individual,
3 whether or not eligible for benefits under this title
4 or under any other form of health insurance, who
5 comes to the hospital on or after January 1, 2022,
6 and—

7 “(A) who states to hospital personnel that
8 they are victims of sexual assault;

9 “(B) who is accompanied by an individual
10 who states to hospital personnel that the indi-
11 vidual is a victim of sexual assault; or

12 “(C) whom hospital personnel, during the
13 course of treatment and care for the individual,
14 have reason to believe is a victim of sexual as-
15 sault.

16 “(2) REQUIRED SERVICES DESCRIBED.—For
17 purposes of paragraph (1), the services described in
18 this subparagraph are the following:

19 “(A) Provision of medically and factually
20 accurate and unbiased written and oral infor-
21 mation about emergency contraception that—

22 “(i) is written in clear and concise
23 language;

24 “(ii) is readily comprehensible;

1 “(iii) includes an explanation that
2 emergency contraceptives—

3 “(I) have been approved by the
4 Food and Drug Administration for in-
5 dividuals and are a safe and effective
6 way to prevent pregnancy after unpro-
7 tected intercourse or contraceptive
8 failure if taken in a timely manner;

9 “(II) are more effective the soon-
10 er it is taken; and

11 “(III) do not cause an abortion
12 and cannot interrupt an established
13 pregnancy;

14 “(iv) meet such conditions regarding
15 the provision of such information in lan-
16 guages other than English as the Secretary
17 may establish; and

18 “(v) are provided without regard to
19 the ability of the individual or their family
20 to pay costs associated with the provision
21 of such information to the individual.

22 “(B) Immediate offer to provide emergency
23 contraception to the individual at the hospital
24 and, in the case that such individual accepts
25 such offer, immediate provision to such indi-

1 vidual of such contraception on the same day it
2 is requested without regard to the inability of
3 the individual or their family to pay costs asso-
4 ciated with the offer and provision of such con-
5 traception.

6 “(C) Development and implementation of a
7 written policy to ensure that an individual is
8 present at the hospital, or on-call, who—

9 “(i) has authority to dispense or pre-
10 scribe emergency contraception, independ-
11 ently, or under a protocol prepared by a
12 physician for the administration of emer-
13 gency contraception at the hospital to a
14 victim of sexual assault; and

15 “(ii) is trained to comply with the re-
16 quirements of this section.

17 “(D) Provision of medically and factually
18 accurate and unbiased written and oral infor-
19 mation and counseling about post-exposure pro-
20 phylaxis (PEP) protocol for the prevention of
21 HIV.

22 “(E) Immediate offer to begin PEP to the
23 individual at the hospital except in cases where
24 the medical professional’s best judgement is
25 that further evaluation is required or that such

1 a regimen will be substantially detrimental to
2 the health of such individual. Such provision
3 shall be offered regardless of the individual's
4 ability to pay. Hospitals shall be responsible for
5 ensuring adequate supply of PEP medications
6 to provide to patients.

7 “(3) HOSPITAL DEFINED.—For purposes of
8 this paragraph, the term ‘hospital’ includes a critical
9 access hospital, as defined in section
10 1861(mm)(1).”.

11 (b) LIMITATION ON PAYMENT UNDER MEDICAID.—
12 Section 1903(i) of the Social Security Act (42 U.S.C.
13 1396b(i)), as amended by section 4106(b)(2), is further
14 amended—

15 (1) in paragraph (27), by striking “or” after
16 the semicolon;

17 (2) in paragraph (28), by striking the period
18 and inserting “; or”; and

19 (3) by inserting after paragraph (28) the fol-
20 lowing new paragraph:

21 “(29) with respect to any amount expended for
22 care or services furnished under the plan by a hos-
23 pital on or after January 1, 2023, unless such hos-
24 pital meets the requirements specified in section
25 1866(l) for purposes of title XVIII.”.

1 **SEC. 5406. MENSTRUAL EQUITY FOR ALL ACT OF 2022.**

2 (a) SHORT TITLE.—This section may be cited as the
3 “Menstrual Equity for All Act of 2022”.

4 (b) MENSTRUAL PRODUCTS FOR STUDENTS AT ELE-
5 MENTARY AND SECONDARY SCHOOLS.—

6 (1) IN GENERAL.—Section 4108(5)(C) of the
7 Elementary and Secondary Education Act of 1965
8 (20 U.S.C. 7118(5)(C)) is amended—

9 (A) in clause (vi), by striking “or” after
10 the semicolon;

11 (B) in clause (vii), by inserting “or” after
12 the semicolon; and

13 (C) by adding at the end the following:

14 “(viii) provide free menstrual products
15 to students who use menstrual products;”.

16 (2) DEFINITIONS.—Section 4102 of the Ele-
17 mentary and Secondary Education Act of 1965 (20
18 U.S.C. 7112) is amended—

19 (A) by redesignating paragraphs (6)
20 through (8) as paragraphs (7) through (9), re-
21 spectively; and

22 (B) by inserting after paragraph (5) the
23 following:

24 “(6) MENSTRUAL PRODUCTS.—The term ‘men-
25 strual products’ means sanitary napkins and tam-

1 pons that conform to applicable industry stand-
2 ards.”.

3 (3) RULEMAKING.—Not later than 1 year after
4 the date of enactment of this section, the Secretary
5 of Education, in consultation with the Secretary of
6 Health and Human Services, shall promulgate rules
7 with respect to the definition of “menstrual prod-
8 ucts” in paragraph (6) of section 4102 of the Ele-
9 mentary and Secondary Education Act of 1965 (20
10 U.S.C. 7112), as amended by paragraph (2).

11 (c) MENSTRUAL PRODUCTS FOR STUDENTS AT IN-
12 STITUTIONS OF HIGHER EDUCATION.—

13 (1) PURPOSE.—The purpose of this section is
14 to alleviate—

15 (A) the barriers to academic success faced
16 by many college and graduate students due to
17 the inability of such students to afford to pur-
18 chase menstrual products; and

19 (B) the unique set of burdens that college
20 and graduate students experiencing period pov-
21 erty face that can be compounded by lack of ac-
22 cess to basic needs such as housing, food, trans-
23 portation, and access to physical and mental
24 health services.

(2) IN GENERAL.—The Secretary of Education shall establish a program to award grants, on a competitive basis, to at least 4 institutions of higher education, to—

5 (A) support programs that provide free
6 menstrual products to students; and

7 (B) report on best practices of such pro-
8 grams.

(3) APPLICATION.—To apply for a grant under this subsection, an institution of higher education shall submit to the Secretary an application in such form, at such time, and containing such information as the Secretary determines appropriate, including an assurance that such grant will be used to carry out the activities described in paragraph (5).

(4) COMMUNITY COLLEGES.—At least 50 per-
cent of the grants awarded under this subsection
shall be awarded to community colleges.

19 (5) GRANT USES.—A grant awarded under this
20 subsection may only be used to—

(A) carry out or expand activities that fund programs that support direct provision of free menstrual products to students in appropriate campus locations, including—

25 (i) campus restroom facilities;

1 (ii) wellness centers; and

2 (iii) on-campus residential buildings;

3 (B) report on best practices of such pro-
4 grams;

5 (C) conduct outreach to students to en-
6 courage participation in menstrual equity pro-
7 grams and services;

8 (D) help eligible students apply for and en-
9 roll in local, State, and Federal public assist-
10 ance programs; and

11 (E) coordinate and collaborate with gov-
12 ernment or community-based organizations to
13 carry out the activities described in subpara-
14 graphs (A) through (D).

15 (6) PRIORITY.—In awarding grants under this
16 subsection, the Secretary shall prioritize—

17 (A) institutions with Federal Pell Grant
18 enrollment that is at least 25 percent of the
19 total enrollment of such institution; and

20 (B) historically Black colleges and univer-
21 sities, Hispanic-serving institutions, Asian
22 American and Native American Pacific Is-
23 lander-serving institutions, and other minority
24 serving institutions.

1 (7) MENSTRUAL PRODUCT DEFINED.—In this
2 subsection, the term “menstrual product” means a
3 sanitary napkin or tampon that conforms to industry
4 standards.

5 (8) AUTHORIZATION OF APPROPRIATIONS.—
6 There are authorized to be appropriated, out of
7 funds appropriated for a fiscal year to the Fund for
8 the Improvement of Postsecondary Education under
9 section 741 of the Higher Education Act of 1965
10 (20 U.S.C. 1138), \$5,000,000 to carry out the grant
11 program under this subsection.

12 (d) MENSTRUAL PRODUCTS FOR INCARCERATED IN-
13 DIVIDUALS AND DETAINEES.—

14 (1) REQUIREMENT FOR STATES.—Not later
15 than 180 days after the date of enactment of this
16 section, and annually thereafter, the chief executive
17 officer of each State that receives a grant under sub-
18 part 1 of part E of title I of the Omnibus Crime
19 Control and Safe Streets Act of 1968 (34 U.S.C.
20 10151 et seq.) (commonly referred to as the “Ed-
21 ward Byrne Memorial Justice Assistance Grant Pro-
22 gram”) shall submit to the Attorney General a cer-
23 tification, in such form and containing such informa-
24 tion as the Attorney General may require, that—

1 (A) all incarcerated individuals and detain-
2 ees in the custody of that State, a political sub-
3 division thereof, or an agent of that State or a
4 political subdivision thereof have access to men-
5 strual products—

6 (i) on demand; and

7 (ii) at no cost to such individuals and
8 detainees; and

9 (B) no visitor is prohibited from visiting an
10 incarcerated individual due to the visitor's use
11 of menstrual products.

12 (2) REDUCTION IN GRANT FUNDING.—If the
13 chief executive officer of a State fails to submit a
14 certification required under paragraph (1) during a
15 fiscal year, the Attorney General shall reduce the
16 amount that the State would have otherwise received
17 under section 505 of title I of the Omnibus Crime
18 Control and Safe Streets Act of 1968 (34 U.S.C.
19 10156) by 20 percent for the following fiscal year.

20 (3) REALLOCATION.—Amounts not allocated to
21 a State under section 505 of title I of the Omnibus
22 Crime Control and Safe Streets Act of 1968 (34
23 U.S.C. 10156) for a fiscal year pursuant to para-
24 graph (2) shall be reallocated under such section to
25 States that submit such certifications.

1 (4) MENSTRUAL PRODUCTS.—For the purposes
2 of paragraph (1), the term “menstrual products”
3 means sanitary napkins and tampons that conform
4 to applicable industry standards.

5 (5) AVAILABILITY FOR FEDERAL PRISONERS.—
6 The Attorney General shall issue rules requiring,
7 and the Director of the Bureau of Prisons shall take
8 such actions as may be necessary to ensure—

9 (A) the distribution and accessibility (with-
10 out charge) of menstrual products to prisoners
11 in the custody of the Bureau of Prisons, includ-
12 ing any prisoner in a Federal penal or correc-
13 tional institution, any Federal prisoner in a
14 State penal or correctional institution, and any
15 Federal prisoner in a facility administered by a
16 private detention entity; and

17 (B) that each prisoner described in sub-
18 paragraph (A) who requires menstrual products
19 may receive them in sufficient quantity.

20 (6) AVAILABILITY FOR DETAINEES.—The Sec-
21 retary of Homeland Security shall take such actions
22 as may be necessary to ensure that menstrual prod-
23 ucts are distributed and made accessible to each
24 alien detained by the Secretary of Homeland Secu-

1 rity, including any alien in a facility administered by
2 a private detention entity, at no expense to the alien.

3 (e) MENSTRUAL PRODUCTS AVAILABILITY FOR
4 HOMELESS INDIVIDUALS UNDER EMERGENCY FOOD AND
5 SHELTER GRANT PROGRAM.—Section 316(a) of the
6 McKinney-Vento Homeless Assistance Act (42 U.S.C.
7 11346(a)) is amended—

8 (1) in paragraph (5), by striking “and” at the
9 end;

10 (2) in paragraph (6), by striking the period at
11 the end and inserting “; and”; and

12 (3) by adding at the end the following new
13 paragraph:

14 “(7) guidelines that ensure that amounts pro-
15 vided under the program to private nonprofit organi-
16 zations and local governments may be used to pro-
17 vide sanitary napkins and tampons that conform to
18 applicable industry standards.”.

19 (f) MENSTRUAL PRODUCTS COVERED BY MED-
20 ICAID.—

21 (1) IN GENERAL.—Section 1905 of the Social
22 Security Act (42 U.S.C. 1396d), as amended by sec-
23 tions 2007(d)(3) and 5201(a)(5)(G)(i), is amend-
24 ed—

25 (A) in subsection (a)—

1 (i) by redesignating paragraph (32) as
2 paragraph (33);

3 (ii) in paragraph (31), by striking
4 “and” after the semicolon; and

5 (iii) by inserting after paragraph (31)
6 the following new paragraph:

7 “(32) menstrual products (as defined in sub-
8 section (oo)); and”; and

9 (B) by adding at the end the following:

10 “(oo) MENSTRUAL PRODUCTS.—For purposes of
11 subsection (a)(32), the term ‘menstrual products’ means
12 sanitary napkins, tampons, liners, cups, and similar items
13 used by individuals with respect to menstruation and that
14 conform to industry standards.”.

15 (2) EFFECTIVE DATE.—

16 (A) IN GENERAL.—Subject to subpara-
17 graph (B), the amendments made by this sub-
18 section shall apply with respect to medical as-
19 sistance furnished during or after the first cal-
20 endar quarter beginning on or after the date
21 that is 1 year after the date of the enactment
22 of this section.

23 (B) EXCEPTION FOR STATE LEGISLA-
24 TION.—In the case of a State plan under title
25 XIX of the Social Security Act (42 U.S.C. 1396

1 et seq.) that the Secretary of Health and
2 Human Services determines requires State leg-
3 islation in order for the respective plan to meet
4 any requirement imposed by amendments made
5 by this section, the respective plan shall not be
6 regarded as failing to comply with the require-
7 ments of such title solely on the basis of its fail-
8 ure to meet such an additional requirement be-
9 fore the first day of the first calendar quarter
10 beginning after the close of the first regular
11 session of the State legislature that begins after
12 the date of the enactment of this section. For
13 purposes of the previous sentence, in the case
14 of a State that has a 2-year legislative session,
15 each year of the session shall be considered to
16 be a separate regular session of the State legis-
17 lature.

18 (g) MENSTRUAL PRODUCTS FOR EMPLOYEES.—Sec-
19 tion 6 of the Occupational Safety and Health Act of 1970
20 (29 U.S.C. 655) is amended by adding at the end the fol-
21 lowing:

22 “(h) The Secretary shall by rule promulgate a re-
23 quirement that each employer with not less than 100 em-
24 ployees provide menstrual products free of charge for em-
25 ployees of the employer. For purposes of the preceding

1 sentence, ‘menstrual products’ means sanitary napkins
2 and tampons that conform to applicable industry stand-
3 ards.’’.

4 (h) MENSTRUAL PRODUCTS IN FEDERAL BUILD-
5 INGS.—

6 (1) DEFINITIONS.—In this subsection:

7 (A) APPROPRIATE AUTHORITY.—The term
8 “appropriate authority” means the head of a
9 Federal agency, the Architect of the Capitol, or
10 any other official authority responsible for the
11 operation of a covered public building.

12 (B) COVERED PUBLIC BUILDING.—

13 (i) IN GENERAL.—The term “covered
14 public building” means a public building
15 (as defined in section 3301(a) of title 40,
16 United States Code) that is open to the
17 public and contains a public restroom.

18 (ii) INCLUSIONS.—The term “covered
19 public building” includes specified build-
20 ings and grounds (as defined in section
21 6301 of title 40, United States Code) and
22 the Capitol Buildings (as defined in section
23 5101 of that title).

1 (C) COVERED RESTROOM.—The term “cov-
2 ered restroom” means a public restroom in a
3 covered public building.

4 (D) MENSTRUAL PRODUCTS.—The term
5 “menstrual products” means sanitary napkins
6 and tampons that conform to applicable indus-
7 try standards.

8 (2) REQUIREMENT.—Each appropriate author-
9 ity shall ensure that menstrual products are stocked
10 in, and available free of charge in, each covered rest-
11 room in each covered public building under the juris-
12 diction of that authority.

13 **SEC. 5407. ADDITIONAL FOCUS AREA FOR THE OFFICE ON**
14 **WOMEN’S HEALTH.**

15 Section 229(b) of the Public Health Service Act (42
16 U.S.C. 237a(b)), as amended by sections 5216 and 5301,
17 is further amended by adding at the end the following:

18 “(10) facilitate policymakers, health system
19 leaders and providers, consumers, and other stake-
20 holders in understanding optimal maternity care and
21 support for the provision of such care, including the
22 priorities of—

23 “(A) protecting, promoting, and supporting
24 the innate capacities of childbearing individuals

1 and their newborns for childbirth,
2 breastfeeding, and attachment;

3 “(B) using obstetric interventions only
4 when such interventions are supported by
5 strong, high-quality evidence, and minimizing
6 overuse of maternity practices that have been
7 shown to have benefit in limited situations and
8 that can expose people, infants, or both to risk
9 of harm if used routinely and indiscriminately,
10 including continuous electronic fetal monitoring,
11 labor induction, epidural analgesia, primary ce-
12 sarean section, and routine repeat cesarean
13 birth;

14 “(C) reliably incorporating noninvasive,
15 evidence-based practices that have a docu-
16 mented correlation with considerable improve-
17 ment in outcomes with no detrimental side ef-
18 fects, such as smoking cessation programs in
19 pregnancy, maternal immunizations, and proven
20 models (including group prenatal care, mid-
21 wifery care, and doula support) that integrate
22 health assessment, education, and support into
23 a unified program and supporting evidence-
24 based breastfeeding promotion efforts with re-

1 spect for a breastfeeding individual’s personal
2 decision making;

3 “(D) a shared understanding of the quali-
4 fications of licensed providers of maternity care
5 and the best evidence about the safety, satisfac-
6 tion, outcomes, and costs of maternity care, and
7 appropriate deployment of such caregivers with-
8 in the maternity care workforce to address the
9 needs of childbearing individuals and newborns
10 and the growing shortage of maternity care-
11 givers;

12 “(E) a shared understanding of the results
13 of the best available research comparing hos-
14 pital, birth center, and planned home births, in-
15 cluding information about each setting’s safety,
16 satisfaction, outcomes, and costs;

17 “(F) a shared understanding of the impor-
18 tance for the safety and choices of birthing
19 families of an integrated maternity care system
20 with seamless processes for consultation, shared
21 care, transfer and transport across maternity
22 care settings, and providers when birthing peo-
23 ple and their newborns require a higher level of
24 care;

1 “(G) high-quality, evidence-based child-
2 birth education that—

3 “(i) promotes a healthy and safe ap-
4 proach to pregnancy, childbirth, and early
5 parenting;

6 “(ii) is taught by certified educators,
7 peer counselors, and health professionals;
8 and

9 “(iii) promotes informed decision
10 making by childbearing individuals; and

11 “(H) developing measures that enable a
12 more robust, balanced set of standardized ma-
13 ternity care measures, including performance
14 and quality measures.”.

15 **SEC. 5408. INCLUDING SERVICES FURNISHED BY CERTAIN**
16 **STUDENTS, INTERNS, AND RESIDENTS SU-**
17 **PERVISED BY CERTIFIED NURSE MIDWIVES**
18 **OR CERTIFIED MIDWIVES WITHIN INPATIENT**
19 **HOSPITAL SERVICES UNDER MEDICARE.**

20 (a) IN GENERAL.—Section 1861(b) of the Social Se-
21 curity Act (42 U.S.C. 1395x(b)) is amended—

22 (1) in paragraph (6), by striking “; or” at the
23 end and inserting “, or in the case of services in a
24 hospital or osteopathic hospital by a student midwife
25 or an intern or resident-in-training under a teaching

1 program previously described in this paragraph who
2 is in the field of obstetrics and gynecology, if such
3 student midwife, intern, or resident-in-training is su-
4 pervised by a certified nurse-midwife or certified
5 midwife to the extent permitted under applicable
6 State law and as may be authorized by the hos-
7 pital;”;

8 (2) in paragraph (7), by striking the period at
9 the end and inserting “; or”; and

10 (3) by adding at the end the following new
11 paragraph:

12 “(8) a certified nurse-midwife or certified mid-
13 wife where the hospital has a teaching program ap-
14 proved as specified in paragraph (6), if—

15 “(A) the hospital elects to receive any pay-
16 ment due under this title for reasonable costs of
17 such services; and

18 “(B) all certified nurse-midwives or cer-
19 tified midwives in such hospital agree not to bill
20 charges for professional services rendered in
21 such hospital to individuals covered under the
22 insurance program established by this title.”.

23 (b) **EFFECTIVE DATE.**—The amendments made by
24 subsection (a) shall apply to services furnished on or after
25 the date of the enactment of this Act.

1 **SEC. 5409. GRANTS TO PROFESSIONAL ORGANIZATIONS**
2 **AND MINORITY-SERVING INSTITUTIONS TO**
3 **INCREASE DIVERSITY IN MATERNAL, REPRO-**
4 **DUCTIVE, AND SEXUAL HEALTH PROFES-**
5 **SIONALS.**

6 (a) GRANTS TO HEALTH PROFESSIONAL ORGANIZA-
7 TIONS.—

8 (1) IN GENERAL.—The Secretary of Health and
9 Human Services, acting through the Administrator
10 of the Health Resources and Services Administra-
11 tion, shall carry out a grant program under which
12 the Secretary may make to eligible organizations—

13 (A) for fiscal year 2023, planning grants
14 described in paragraph (2); and

15 (B) for the subsequent 4-year period, im-
16 plementation grants described in paragraph (3).

17 (2) PLANNING GRANTS.—

18 (A) IN GENERAL.—Planning grants de-
19 scribed in this paragraph are grants for the fol-
20 lowing purposes:

21 (i) To collect data and identify any
22 workforce inequalities, with respect to a
23 health profession, at each of the following
24 areas along the health professional con-
25 tinuum:

1 (I) Pipeline availability, with re-
2 spect to students at the high school
3 and college or university levels consid-
4 ering, and working toward, entrance
5 in the profession, including barriers
6 triggered by criminal records.

7 (II) Entrance into the training
8 program for the profession.

9 (III) Graduation from such train-
10 ing program.

11 (IV) Entrance into practice, in-
12 cluding barriers triggered by criminal
13 records.

14 (V) Retention in practice for
15 more than a 5-year period.

16 (ii) To develop one or more strategies
17 to address the workforce inequalities with-
18 in the health profession, as identified
19 under (and in response to the findings pur-
20 suant to) clause (i).

21 (B) APPLICATION.—To be eligible to re-
22 ceive a grant under this paragraph, an eligible
23 health professional organization shall submit to
24 the Secretary an application in such form and

1 manner and containing such information as
2 specified by the Secretary.

3 (C) AMOUNT.—Each grant awarded under
4 this paragraph shall be for an amount not to
5 exceed \$300,000.

6 (D) REPORT.—Each recipient of a grant
7 under this paragraph shall submit to the Sec-
8 retary a report containing—

9 (i) information on the extent and dis-
10 tribution of workforce inequities identified
11 through the grant; and

12 (ii) reasonable objectives and strate-
13 gies developed to address such inequalities
14 within a 5-, 10-, and 25-year period.

15 (3) IMPLEMENTATION GRANTS.—

16 (A) IN GENERAL.—Implementation grants
17 described in this paragraph are grants to imple-
18 ment one or more of the strategies developed
19 pursuant to a planning grant awarded under
20 paragraph (2).

21 (B) APPLICATION.—To be eligible to re-
22 ceive a grant under this paragraph, an eligible
23 health professional organization shall submit to
24 the Secretary an application in such form and

1 manner as specified by the Secretary. Each
2 such application shall contain information on—

3 (i) the capability of the organization
4 to carry out a strategy described in sub-
5 paragraph (A);

6 (ii) the involvement of partners or
7 coalitions; and

8 (iii) the organization's plans for devel-
9 oping sustainability of the efforts after the
10 culmination of the grant cycle, and any
11 other information specified by the Sec-
12 retary.

13 (C) AMOUNT; DURATION.—Each grant
14 awarded under this paragraph shall be for an
15 amount not to exceed \$500,000 each year of
16 the grant. The term of a grant under this sub-
17 section shall not exceed 4 years.

18 (D) REPORTS.—For each of the first 3
19 years for which an eligible health professional
20 organization is awarded a grant under this
21 paragraph, the organization shall submit to the
22 Secretary of Health and Human Services a re-
23 port on the activities carried out by such orga-
24 nization through the grant during such year
25 and objectives for the subsequent year. For the

1 fourth year for which an eligible health profes-
2 sional organization is awarded a grant under
3 this paragraph, the organization shall submit to
4 the Secretary a report that includes an analysis
5 of all the activities carried out by the organiza-
6 tion through the grant and a detailed plan for
7 the continuation of the organization's outreach
8 efforts.

9 (4) ELIGIBLE HEALTH PROFESSIONAL ORGANI-
10 ZATION DEFINED.—For purposes of this subsection,
11 the term “eligible health professional organization”
12 means a professional organization representing ob-
13 stetrician-gynecologists, certified nurse midwives,
14 certified midwives, family practice physicians, nurse
15 practitioners whose scope of practice includes mater-
16 nity or sexual and reproductive health care, physi-
17 cian assistants whose scope of practice includes ob-
18 stetrical or sexual and reproductive health care, or
19 certified professional midwives, adolescent medicine
20 specialists, and pediatricians who provide sexual and
21 reproductive health care.

22 (b) GRANTS TO MINORITY-SERVING INSTITUTIONS.—

23 (1) IN GENERAL.—The Secretary of Health and
24 Human Services, acting through the Administrator
25 of the Health Resources and Services Administration

1 (referred to in this section as the “Secretary”), shall
2 carry out a grant program under which the Sec-
3 retary may make to eligible minority-serving institu-
4 tions—

5 (A) for fiscal years 2023 and 2024, plan-
6 ning grants described in paragraph (2); and

7 (B) for the subsequent ten-year period, im-
8 plementation grants described in paragraph (3).

9 (2) PLANNING GRANTS.—

10 (A) IN GENERAL.—Planning grants de-
11 scribed in this paragraph are grants for plans
12 relating to the following purposes:

13 (i) To develop or expand academic
14 programs to educate maternity care clini-
15 cians and maternity care support per-
16 sonnel, including—

17 (I) nurses with the intention of
18 providing maternity, newborn, or sex-
19 ual and reproductive health care;

20 (II) nurse-practitioners whose
21 scope of practice includes maternity,
22 newborn, or sexual and reproductive
23 health care; and

1 (III) maternity care support per-
2 sonnel, such as doulas and lactation
3 counselors.

4 (ii) To develop or expand academic
5 programs to educate obstetrician-gyne-
6 cologists.

7 (B) APPLICATION.—To be eligible to re-
8 ceive a grant under this paragraph, an eligible
9 minority-serving institution shall submit to the
10 Secretary an application in such form and man-
11 ner and containing such information as speci-
12 fied by the Secretary.

13 (C) AMOUNT.—Each grant awarded under
14 this paragraph shall be for an amount not to
15 exceed \$400,000 for each of two years.

16 (D) REPORT.—Each recipient of a grant
17 under this paragraph shall submit to the Sec-
18 retary an annual report describing the planned
19 development or expansion of educational pro-
20 grams, including—

21 (i) the types of clinical or support per-
22 sonnel and the degrees or certificates to be
23 conferred;

24 (ii) the associated curricula;

1 (iii) the faculty and their capabilities
2 and commitments, including any plans for
3 recruitment;

4 (iv) the anticipated number of stu-
5 dents to be enrolled and plans for their re-
6 cruitment and social, emotional, and finan-
7 cial support; and

8 (v) the objectives and strategies for
9 addressing inequities and preparing stu-
10 dents to provide high-quality culturally
11 congruent care.

12 (3) IMPLEMENTATION GRANTS.—

13 (A) IN GENERAL.—Implementation grants
14 described in this paragraph are grants to imple-
15 ment the strategies developed under paragraph
16 (2).

17 (B) APPLICATION.—To be eligible to re-
18 ceive a grant under this paragraph, an eligible
19 minority-serving institution shall submit to the
20 Secretary of Health and Human Services an
21 application in such form and manner as speci-
22 fied by the Secretary. Each such application
23 shall contain information on the capability of
24 the institution to carry out a strategy described
25 in paragraph (2), plans for sustainability of the

1 program after the culmination of the grant
2 cycle, and any other information specified by
3 the Secretary.

4 (C) AMOUNT.—Each grant under this
5 paragraph shall be for an amount not to exceed
6 \$1,000,000 each year during the 10-year period
7 of the grant.

8 (D) REPORTS.—

9 (i) INITIAL PERIOD.—For each of the
10 first 9 years for which an eligible minority-
11 serving institution is awarded a grant
12 under this paragraph, the institution shall
13 submit a report to the Secretary on the ac-
14 tivities carried out by such institution
15 through the grant during such year and
16 objectives for the subsequent year.

17 (ii) FINAL YEAR.—For the tenth year
18 for which an eligible minority-serving insti-
19 tution is awarded a grant under this para-
20 graph, the organization shall submit to the
21 Secretary a report that includes an anal-
22 ysis of all the activities carried out by the
23 institution through the grant and a de-
24 tailed plan for continuation of the edu-
25 cational program.

1 (4) ELIGIBLE MINORITY-SERVING INSTITUTIONS
2 DEFINED.—For the purposes of this subsection, the
3 term “minority-serving institution” means a histori-
4 cally Black college or university, Tribal college or
5 university, Latino-serving institution, Asian Amer-
6 ican and Pacific Islander serving institution, or
7 other minority-serving institution of higher edu-
8 cation.

9 (c) AUTHORIZATION OF APPROPRIATIONS.—There is
10 authorized to be appropriated to carry out—

11 (1) subsection (a), \$2,000,000 for fiscal year
12 2023 and \$3,000,000 for each of the fiscal years
13 2024 through 2027; and

14 (2) subsection (b), \$4,000,000 for each of fiscal
15 years 2023 and 2024 and \$10,000,000 for each of
16 fiscal years 2025 through 2034.

17 **Subtitle F—Children’s Health**

18 **SEC. 5501. CARING FOR KIDS ACT.**

19 (a) PERMANENT EXTENSION OF CHILDREN’S
20 HEALTH INSURANCE PROGRAM.—

21 (1) IN GENERAL.—Section 2104(a)(28) of the
22 Social Security Act (42 U.S.C. 1397dd(a)(28)) is
23 amended to read as follows:

1 “(28) for fiscal year 2027 and each subsequent
2 year, such sums as are necessary to fund allotments
3 to States under subsections (c) and (m).”.

4 (2) ALLOTMENTS.—

5 (A) IN GENERAL.—Section 2104(m) of the
6 Social Security Act (42 U.S.C. 1397dd(m)) is
7 amended—

8 (i) in paragraph (2)(B)(i), by striking
9 “,, 2023, and 2027” and inserting “and
10 2023”;

11 (ii) in paragraph (7)—

12 (I) in subparagraph (A), by strik-
13 ing “and ending with fiscal year
14 2027,”; and

15 (II) in the flush left matter at
16 the end, by striking “or fiscal year
17 2026” and inserting “fiscal year
18 2026, or a subsequent even-numbered
19 fiscal year”;

20 (iii) in paragraph (9)—

21 (I) by striking “(10), or (11)”
22 and inserting “or (10)”; and

23 (II) by striking “2023, or 2027,”
24 and inserting “or 2023”; and

25 (iv) by striking paragraph (11).

1 (B) CONFORMING AMENDMENT.—Section
2 50101(b)(2) of the Bipartisan Budget Act of
3 2018 (Public Law 115–123) is repealed.

4 (b) PERMANENT EXTENSIONS OF OTHER PROGRAMS
5 AND DEMONSTRATION PROJECTS.—

6 (1) PEDIATRIC QUALITY MEASURES PRO-
7 GRAM.—Section 1139A(i)(1) of the Social Security
8 Act (42 U.S.C. 1320b–9a(i)(1)) is amended—

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

11 (B) in subparagraph (D), by striking the
12 period at the end and insert a semicolon; and

13 (C) by adding at the end the following new
14 subparagraphs:

15 “(E) for fiscal year 2028, \$15,000,000 for
16 the purpose of carrying out this section (other
17 than subsections (e), (f), and (g)); and

18 “(F) for a subsequent fiscal year, the
19 amount appropriated under this paragraph for
20 the previous fiscal year, increased by the per-
21 centage increase in the consumer price index for
22 all urban consumers (all items; United States
23 city average) over such previous fiscal year, for
24 the purpose of carrying out this section (other
25 than subsections (e), (f), and (g)).”.

1 (2) EXPRESS LANE ELIGIBILITY OPTION.—Sec-
2 tion 1902(e)(13) of the Social Security Act (42
3 U.S.C. 1396a(e)(13)) is amended by striking sub-
4 paragraph (I).

5 (3) ASSURANCE OF AFFORDABILITY STANDARD
6 FOR CHILDREN AND FAMILIES.—

7 (A) IN GENERAL.—Section 2105(d)(3) of
8 the Social Security Act (42 U.S.C.
9 1397ee(d)(3)) is amended—

10 (i) in the paragraph heading, by strik-
11 ing “THROUGH SEPTEMBER 30, 2027”;
12 and

13 (ii) in subparagraph (A), in the mat-
14 ter preceding clause (i)—

15 (I) by striking “During the pe-
16 riod that begins on the date of enact-
17 ment of the Patient Protection and
18 Affordable Care Act and ends on Sep-
19 tember 30, 2027” and inserting “Be-
20 ginning on the date of the enactment
21 of the Patient Protection and Afford-
22 able Care Act”;

23 (II) by striking “During the pe-
24 riod that begins on October 1, 2019,
25 and ends on September 30, 2027”

1 and inserting “Beginning on October
2 1, 2019”; and

3 (III) by striking “The preceding
4 sentences shall not be construed as
5 preventing a State during any such
6 periods from” and inserting “The pre-
7 ceding sentences shall not be con-
8 strued as preventing a State from”.

9 (B) CONFORMING AMENDMENTS.—Section
10 1902(gg)(2) of the Social Security Act (42
11 U.S.C. 1396a(gg)(2)) is amended—

12 (i) in the paragraph heading, by strik-
13 ing “THROUGH SEPTEMBER 30, 2027”;
14 and

15 (ii) by striking “through September
16 30” and all that follows through “ends on
17 September 30, 2027” and inserting “(but
18 beginning on October 1, 2019,”.

19 (4) QUALIFYING STATES OPTION.—Section
20 2105(g)(4) of the Social Security Act (42 U.S.C.
21 1397ee(g)(4)) is amended—

22 (A) in the paragraph heading, by striking
23 “FOR FISCAL YEARS 2009 THROUGH 2027” and
24 inserting “AFTER FISCAL YEAR 2008”; and

1 (B) in subparagraph (A), by striking “for
2 any of fiscal years 2009 through 2027” and in-
3 serting “for any fiscal year after fiscal year
4 2008”.

5 (5) OUTREACH AND ENROLLMENT PROGRAM.—
6 Section 2113 of the Social Security Act (42 U.S.C.
7 1397mm) is amended—

8 (A) in subsection (a)—

9 (i) in paragraph (1), by striking “dur-
10 ing the period of fiscal years 2009 through
11 2027” and inserting “, beginning with fis-
12 cal year 2009,”;

13 (ii) in paragraph (2)—

14 (I) by striking “10 percent of
15 such amounts” and inserting “10 per-
16 cent of such amounts for the period or
17 the fiscal year for which such amounts
18 are appropriated”; and

19 (II) by striking “during such pe-
20 riod” and inserting “, during such pe-
21 riod or such fiscal year,”; and

22 (iii) in paragraph (3), by striking
23 “For the period of fiscal years 2024
24 through 2027, an amount equal to 10 per-
25 cent of such amounts” and inserting “Be-

1 ginning with fiscal year 2024, an amount
2 equal to 10 percent of such amounts for
3 the period or the fiscal year for which such
4 amounts are appropriated”; and

5 (B) in subsection (g)—

6 (i) by striking “2017,,” and inserting
7 “2017,”;

8 (ii) by striking “and \$48,000,000”
9 and inserting “\$48,000,000”; and

10 (iii) by inserting after “through
11 2027” the following: “, \$12,000,000 for
12 fiscal year 2028, and, for each fiscal year
13 after fiscal year 2028, the amount appro-
14 priated under this subsection for the pre-
15 vious fiscal year, increased by the percent-
16 age increase in the consumer price index
17 for all urban consumers (all items; United
18 States city average) over such previous fis-
19 cal year”.

20 (6) CHILD ENROLLMENT CONTINGENCY

21 FUND.—Section 2104(n) of the Social Security Act
22 (42 U.S.C. 1397dd(n)) is amended—

23 (A) in paragraph (2)—

24 (i) in subparagraph (A)(ii)—

1 (I) by striking “and 2024
2 through 2026” and inserting “begin-
3 ning with fiscal year 2024”; and

4 (II) by striking “2023, and
5 2027” and inserting “, and 2023”;
6 and

7 (ii) in subparagraph (B)—

8 (I) by striking “2024 through
9 2026” and inserting “beginning with
10 fiscal year 2024”; and

11 (II) by striking “2023, and
12 2027” and inserting “, and 2023”;
13 and

14 (B) in paragraph (3)(A)—

15 (i) by striking “fiscal years 2024
16 through 2026” and inserting “beginning
17 with fiscal year 2024”; and

18 (ii) by striking “2023, or 2027” and
19 inserting “, or 2023”.

20 **SEC. 5502. END DIAPER NEED ACT OF 2021.**

21 (a) TARGETED FUNDING FOR DIAPER ASSISTANCE
22 (INCLUDING DIAPERING SUPPLIES AND ADULT INCONTI-
23 NENCE MATERIALS AND SUPPLIES) THROUGH THE SO-
24 CIAL SERVICES BLOCK GRANT PROGRAM.—

1 (1) INCREASE IN FUNDING FOR SOCIAL SERV-
2 ICES BLOCK GRANT PROGRAM.—

3 (A) IN GENERAL.—The amount specified
4 in subsection (c) of section 2003 of the Social
5 Security Act (42 U.S.C. 1397b) for purposes of
6 subsections (a) and (b) of such section is
7 deemed to be \$1,900,000,000 for each of fiscal
8 years 2023 through 2026, of which, the amount
9 equal to \$200,000,000, reduced by the amounts
10 reserved under subparagraph (B)(ii) for each
11 such fiscal year, shall be obligated by States in
12 accordance with paragraph (2).

13 (B) APPROPRIATION.—

14 (i) IN GENERAL.—Out of any money
15 in the Treasury of the United States not
16 otherwise appropriated, there is appro-
17 priated \$200,000,000 for each of fiscal
18 years 2023 through 2026, to carry out this
19 subsection.

20 (ii) RESERVATIONS.—

21 (I) PURPOSES.—The Secretary
22 shall reserve, from the amount appro-
23 priated under clause (i) to carry out
24 this subsection—

1 (aa) for each of fiscal years
2 2023 through 2026, not more
3 than 2 percent of the amount ap-
4 propriated for the fiscal year for
5 purposes of entering into an
6 agreement with a national entity
7 described in clause (iii) to assist
8 in providing technical assistance
9 and training, to support effective
10 policy, practice, research, and
11 cross-system collaboration among
12 grantees and subgrantees, and to
13 assist in the administration of
14 the program described in this
15 subsection; and

16 (bb) for fiscal year 2023, an
17 amount, not to exceed
18 \$2,000,000, for purposes of con-
19 ducting an evaluation under
20 paragraph (4).

21 (II) NO STATE ENTITLEMENT TO
22 RESERVED FUNDS.—The State enti-
23 tlement under section 2002(a) of the
24 Social Security Act (42 U.S.C.

1 1397a(a)) shall not apply to the
2 amounts reserved under subclause (I).

3 (iii) NATIONAL ENTITY DESCRIBED.—

4 A national entity described in this clause is
5 a nonprofit organization described in sec-
6 tion 501(c)(3) of the Internal Revenue
7 Code of 1986 and exempt from taxation
8 under section 501(a) of such Code, that—

9 (I) has experience in more than 1
10 State in the area of—

11 (aa) community distribu-
12 tions of basic need services, in-
13 cluding experience collecting,
14 warehousing, and distributing
15 basic necessities such as diapers,
16 food, or menstrual products;

17 (bb) child care;

18 (cc) child development ac-
19 tivities in low-income commu-
20 nities; or

21 (dd) motherhood, father-
22 hood, or parent education efforts
23 serving low-income parents of
24 young children;

1 (II) demonstrates competency to
2 implement a project, provide fiscal ac-
3 countability, collect data, and prepare
4 reports and other necessary docu-
5 mentation; and

6 (III) demonstrates a willingness
7 to share information with researchers,
8 practitioners, and other interested
9 parties.

10 (2) RULES GOVERNING USE OF ADDITIONAL
11 FUNDS.—

12 (A) IN GENERAL.—Funds are used in ac-
13 cordance with this paragraph if—

14 (i) the State, in consultation with rel-
15 evant stakeholders, including agencies, pro-
16 fessional associations, and nonprofit orga-
17 nizations, distributes the funds to eligible
18 entities to—

19 (I) decrease the need for diapers
20 and diapering supplies and adult in-
21 continence materials and supplies in
22 low-income families and meet such
23 unmet needs of infants and toddlers,
24 medically complex children, and low-

1 income adults and adults with disabil-
2 ities in such families through—

3 (aa) the distribution of free
4 diapers and diapering supplies,
5 medically necessary diapers, and
6 adult incontinence materials and
7 supplies;

8 (bb) community outreach to
9 assist in participation in existing
10 diaper distribution programs or
11 programs that distribute medi-
12 cally necessary diapers or adult
13 incontinence materials and sup-
14 plies; or

15 (cc) improving access to dia-
16 pers and diapering supplies,
17 medically necessary diapers, and
18 adult incontinence materials and
19 supplies; and

20 (II) increase the ability of com-
21 munities and low-income families in
22 such communities to provide for the
23 need for diapers and diapering sup-
24 plies, medically necessary diapers, and
25 adult continence materials and sup-

1 plies, of infants and toddlers, medi-
2 cally complex children, and low-income
3 adults and adults with disabilities;

4 (ii) the funds are used subject to the
5 limitations in section 2005 of the Social
6 Security Act (42 U.S.C. 1397d);

7 (iii) the funds are used to supplement,
8 not supplant, State general revenue funds
9 provided for the purposes described in
10 clause (i); and

11 (iv) the funds are not used for costs
12 that are reimbursable by the Federal
13 Emergency Management Agency, under a
14 contract for insurance, or by self-insur-
15 ance.

16 (B) ALLOWABLE USES BY ELIGIBLE ENTI-
17 TIES.—An eligible entity receiving funds made
18 available under paragraph (1) shall use the
19 funds for any of the following:

20 (i) To pay for the purchase and dis-
21 tribution of diapers and diapering supplies,
22 medically necessary diapers, and funding
23 diaper (including medically necessary dia-
24 pers) distribution that serves low-income
25 families with—

1 (I) 1 or more children 3 years of
2 age or younger; or

3 (II) 1 or more medically complex
4 children.

5 (ii) To pay for the purchase and dis-
6 tribution of adult incontinence materials
7 and supplies and funding distribution of
8 such materials and supplies that serves
9 low-income families with 1 or more low-in-
10 come adults or adults with disabilities who
11 rely on adult incontinence materials and
12 supplies.

13 (iii) To integrate activities carried out
14 under clause (i) with other basic needs as-
15 sistance programs serving eligible children
16 and their families, including the following:

17 (I) Programs funded by the tem-
18 porary assistance for needy families
19 program under part A of title IV of
20 the Social Security Act (42 U.S.C.
21 601 et seq.), including the State
22 maintenance of effort provisions of
23 such program.

24 (II) Programs designed to sup-
25 port the health of eligible children,

1 such as the Children's Health Insur-
2 ance Program under title XXI of the
3 Social Security Act, the Medicaid pro-
4 gram under title XIX of such Act, or
5 State funded health care programs.

6 (III) Programs funded through
7 the special supplemental nutrition
8 program for women, infants, and chil-
9 dren under section 17 of the Child
10 Nutrition Act of 1966.

11 (IV) Programs that offer early
12 home visiting services, including the
13 maternal, infant, and early childhood
14 home visiting program (including the
15 Tribal home visiting program) under
16 section 511 of the Social Security Act
17 (42 U.S.C. 711).

18 (V) Programs to provide im-
19 proved and affordable access to child
20 care, including programs funded
21 through the Child Care and Develop-
22 ment Fund, the temporary assistance
23 for needy families program under part
24 A of title IV of the Social Security

1 Act (42 U.S.C. 601 et seq.), or a
2 State-funded program.

3 (C) AVAILABILITY OF FUNDS.—

4 (i) FUNDS DISTRIBUTED TO ELIGIBLE
5 ENTITIES.—Funds made available under
6 paragraph (1) that are distributed to an el-
7 igible entity by a State for a fiscal year
8 may be expended by the eligible entity only
9 in such fiscal year or the succeeding fiscal
10 year.

11 (ii) EVALUATION.—Funds reserved
12 under paragraph (1)(B)(ii)(I)(aa) to carry
13 out the evaluation under paragraph (4)
14 shall be available for expenditure during
15 the 3-year period that begins on the date
16 of enactment of this Act.

17 (D) NO EFFECT ON OTHER PROGRAMS.—

18 Any assistance or benefits received by a family
19 through funds made available under paragraph
20 (1) shall be disregarded for purposes of deter-
21 mining the family's eligibility for, or amount of,
22 benefits under any other Federal needs-based
23 programs.

24 (3) ANNUAL REPORTS.—A State shall include
25 in the annual report required under section 2006 of

1 the Social Security Act (42 U.S.C. 1397e) covering
2 each of fiscal years 2022 through 2025, information
3 detailing how eligible entities, including subgrantees,
4 used funds made available under paragraph (1) to
5 distribute diapers and diapering supplies and adult
6 incontinence materials and supplies to families in
7 need. Each such report shall include the following:

8 (A) The number and age of infants, tod-
9 dlers, medically complex children, and low-in-
10 come adults and adults with disabilities who re-
11 ceived assistance or benefits through such
12 funds.

13 (B) The number of families that have re-
14 ceived assistance or benefits through such
15 funds.

16 (C) The number of diapers, medically nec-
17 essary diapers, or adult incontinence materials
18 and supplies (such as adult diapers, briefs, pro-
19 tective underwear, pull-ons, pull-ups, liners,
20 shields, guards, pads, undergarments), and the
21 number of each type of diapering or adult in-
22 continence supply, distributed through the use
23 of such funds.

24 (D) The ZIP Code or ZIP Codes where the
25 eligible entity (or subgrantee) distributed dia-

1 pers and diapering supplies and adult inconti-
2 nence materials and supplies.

3 (E) The method or methods the eligible en-
4 tity (or subgrantee) uses to distribute diapers
5 and diapering supplies and, adult incontinence
6 materials and supplies.

7 (F) Such other information as the Sec-
8 retary may specify.

9 (4) EVALUATION.—The Secretary, in consulta-
10 tion with States, the national entity described in
11 paragraph (1)(B)(iii), and eligible entities receiving
12 funds made available under this subsection, shall—

13 (A) not later than 2 years after the date
14 of enactment of this Act—

15 (i) complete an evaluation of the effec-
16 tiveness of the assistance program carried
17 out pursuant to this subsection, such as
18 the effect of activities carried out under
19 this section on mitigating the health and
20 developmental risks of unmet diaper need
21 among infants, toddlers, medically complex
22 children, and other family members in low-
23 income families, including the risks of dia-
24 per dermatitis, urinary tract infections,

1 and parental and child depression and anx-
2 iety;

3 (ii) submit to the relevant congres-
4 sional committees a report on the results
5 of such evaluation; and

6 (iii) publish the results of the evalua-
7 tion on the internet website of the Depart-
8 ment of Health and Human Services;

9 (B) not later than 3 years after the date
10 of enactment of this Act, update the evaluation
11 required by subparagraph (A)(i); and

12 (C) not later than 90 days after completion
13 of the updated evaluation under subparagraph
14 (B)—

15 (i) submit to the relevant congres-
16 sional committees a report describing the
17 results of such updated evaluation; and

18 (ii) publish the results of such evalua-
19 tion on the internet website of the Depart-
20 ment of Health and Human Services.

21 (5) GUIDANCE.—Not later than 180 days after
22 enactment of this Act, the Secretary shall issue
23 guidance regarding how the provisions of this sub-
24 section should be carried out, including information

1 regarding eligible entities, allowable use of funds,
2 and reporting requirements.

3 (6) DEFINITIONS.—In this subsection:

4 (A) ADULT INCONTINENCE MATERIALS
5 AND SUPPLIES.—The term “adult incontinence
6 materials and supplies” means those supplies
7 that are used to assist low-income adults or
8 adults with disabilities and includes adult dia-
9 pers, briefs, protective underwear, pull-ons,
10 pull-ups, liners, shields, guards, pads, undergar-
11 ments, disposable wipes, over-the-counter adult
12 diaper rash cream products, intermittent cath-
13 eterization, indwelling catheters, condom cath-
14 eters, urinary drainage bags, external collection
15 devices, wearable urinals, and penile clamps.

16 (B) ADULTS WITH DISABILITIES.—The
17 term “adults with disabilities” means individ-
18 uals who—

19 (i) have attained age 18; and

20 (ii) have a disability (as such term is
21 defined, with respect to an individual, in
22 section 3 of the Americans with Disabil-
23 ities Act of 1990 (42 U.S.C. 12102)).

24 (C) DIAPER.—The term “diaper” means
25 an absorbent garment that—

1 (i) is washable or disposable that may
2 be worn by an infant or toddler who is not
3 toilet-trained; and

4 (ii) if disposable—

5 (I) does not use any latex or
6 common allergens; and

7 (II) meets or exceeds the quality
8 standards for diapers commercially
9 available through retail sale in the fol-
10 lowing categories:

11 (aa) Absorbency (with ac-
12 ceptable rates for first and sec-
13 ond wetting).

14 (bb) Waterproof outer cover.

15 (cc) Flexible leg openings.

16 (dd) Refastening closures.

17 (D) DIAPERING SUPPLIES.—The term
18 “diapering supplies” means items, including di-
19 aper wipes and diaper cream, necessary to en-
20 sure that—

21 (i) an eligible child using a diaper is
22 properly cleaned and protected from diaper
23 rash; or

24 (ii) a medically complex child who
25 uses a medically necessary diaper is prop-

1 erly cleaned and protected from diaper
2 rash.

3 (E) ELIGIBLE CHILD.—The term “eligible
4 child” means a child who—

5 (i) has not attained 4 years of age;

6 and

7 (ii) is a member of a low-income fam-
8 ily.

9 (F) ELIGIBLE ENTITIES.—The term “eligi-
10 ble entity” means a State or local governmental
11 entity, an Indian tribe or tribal organization (as
12 defined in section 4 of the Indian Self-Deter-
13 mination and Education Assistance Act), or a
14 nonprofit organization described in section
15 501(c)(3) of the Internal Revenue Code of 1986
16 and exempt from taxation under section 501(a)
17 of such Code that—

18 (i) has experience in the area of—

19 (I) community distributions of
20 basic need services, including experi-
21 ence collecting, warehousing, and dis-
22 tributing basic necessities such as dia-
23 pers, food, or menstrual products;

24 (II) child care;

1 (III) child development activities
2 in low-income communities; or

3 (IV) motherhood, fatherhood, or
4 parent education efforts serving low-
5 income parents of young children;

6 (ii) demonstrates competency to im-
7 plement a project, provide fiscal account-
8 ability, collect data, and prepare reports
9 and other necessary documentation; and

10 (iii) demonstrates a willingness to
11 share information with researchers, practi-
12 tioners, and other interested parties.

13 (G) FEDERAL POVERTY LINE.—The term
14 “Federal poverty line” means the Federal pov-
15 erty line as defined by the Office of Manage-
16 ment and Budget and revised annually in ac-
17 cordance with section 673(2) of the Omnibus
18 Budget Reconciliation Act of 1981 applicable to
19 a family of the size involved.

20 (H) LOW-INCOME.—The term “low-in-
21 come”, with respect to a family, means a family
22 whose self-certified income is not more than
23 200 percent of the Federal poverty line.

24 (I) MEDICALLY COMPLEX CHILD.—The
25 term “medically complex child” means an indi-

1 vidual who has attained age 3 and for whom a
2 licensed health care provider has provided a di-
3 agnosis of bowel or bladder incontinence, a
4 bowel or bladder condition that causes excess
5 urine or stool (such as short gut syndrome or
6 diabetes insipidus), or a severe skin condition
7 that causes skin erosions (such as epidermolysis
8 bullosa).

9 (J) MEDICALLY NECESSARY DIAPER.—The
10 term “medically necessary diaper” means an
11 absorbent garment that is—

12 (i) washable or disposable;

13 (ii) worn by a medically complex child
14 who has been diagnosed with bowel or
15 bladder incontinence, a bowel or bladder
16 condition that causes excess urine or stool
17 (such as short gut syndrome or diabetes
18 insipidus), or a severe skin condition that
19 causes skin erosions (such as epidermolysis
20 bullosa) and needs such garment to correct
21 or ameliorate such condition; and

22 (iii) if disposable—

23 (I) does not use any latex or
24 common allergens; and

1 (II) meets or exceeds the quality
2 standards for diapers commercially
3 available through retail sale in the fol-
4 lowing categories:

5 (aa) Absorbency (with ac-
6 ceptable rates for first and sec-
7 ond wetting).

8 (bb) Waterproof outer cover.

9 (cc) Flexible leg openings.

10 (dd) Refastening closures.

11 (7) EXEMPTION OF PROGRAM FROM SEQUES-
12 TRATION.—

13 (A) IN GENERAL.—Section 255(h) of the
14 Balanced Budget and Emergency Deficit Con-
15 trol Act of 1985 (2 U.S.C. 905(h)) is amended
16 by inserting after “Supplemental Security In-
17 come Program (28–0406–0–1–609).” the fol-
18 lowing:

19 “Targeted funding for States for diaper assist-
20 ance (including diapering supplies and adult inconti-
21 nence materials and supplies) through the Social
22 Services Block Grant Program.”.

23 (B) APPLICABILITY.—The amendment
24 made by this paragraph shall apply to any se-
25 questration order issued under the Balanced

1 Budget and Emergency Deficit Control Act of
2 1985 (2 U.S.C. 900 et seq.) on or after the
3 date of enactment of this Act.

4 (b) IMPROVING ACCESS TO DIAPERS FOR MEDICALLY
5 COMPLEX CHILDREN.—Section 1915(c) of the Social Se-
6 curity Act (42 U.S.C. 1396n(c)) is amended by adding at
7 the end the following new paragraph:

8 “(11)(A) In the case of any waiver under this sub-
9 section that provides medical assistance to a medically
10 complex child who has been diagnosed with bowel or blad-
11 der incontinence, a bowel or bladder condition that causes
12 excess urine or stool (such as short gut syndrome or diabe-
13 tes insipidus), or a severe skin condition that causes skin
14 erosions (such as epidermolysis bullosa), such medical as-
15 sistance shall include, for the duration of the waiver, the
16 provision of 200 medically necessary diapers per month
17 and diapering supplies. Such medical assistance may in-
18 clude the provision of medically necessary diapers in
19 amounts greater than 200 if a licensed health care pro-
20 vider (such as a physician, nurse practitioner, or physician
21 assistant) specifies that such greater amounts are nec-
22 essary for such medically complex child.

23 “(B) For purposes of this paragraph:

24 “(i) The term ‘medically complex child’ means
25 an individual who has attained age 3 and for whom

1 a licensed health care provider has provided a diag-
2 nosis of 1 or more significant chronic conditions.

3 “(ii) The term ‘medically necessary diaper’
4 means an absorbent garment that is—

5 “(I) washable or disposable;

6 “(II) worn by a medically complex child
7 who has been diagnosed with a condition de-
8 scribed in subparagraph (A) and needs such
9 garment to correct or ameliorate such condition;
10 and

11 “(III) if disposable—

12 “(aa) does not use any latex or com-
13 mon allergens; and

14 “(bb) meets or exceeds the quality
15 standards for diapers commercially avail-
16 able through retail sale in the following
17 categories:

18 “(AA) Absorbency (with accept-
19 able rates for first and second wet-
20 ting).

21 “(BB) Waterproof outer cover.

22 “(CC) Flexible leg openings.

23 “(DD) Refastening closures.

24 “(iii) The term ‘diapering supplies’ means
25 items, including diaper wipes and diaper creams,

1 necessary to ensure that a medically complex child
2 who has been diagnosed with a condition described
3 in subparagraph (A) and uses a medically necessary
4 diaper is properly cleaned and protected from diaper
5 rash.”.

6 (c) INCLUSION OF DIAPERS AND DIAPERING SUP-
7 PLIES AS QUALIFIED MEDICAL EXPENSES.—

8 (1) HEALTH SAVINGS ACCOUNTS.—Section
9 223(d)(2) of the Internal Revenue Code of 1986 is
10 amended—

11 (A) by inserting “, medically necessary dia-
12 pers, and diapering supplies” after “menstrual
13 care products” in the last sentence of subpara-
14 graph (A); and

15 (B) by adding at the end the following new
16 subparagraph:

17 “(E) MEDICALLY NECESSARY DIAPERS
18 AND DIAPERING SUPPLIES.—For purposes of
19 this paragraph—

20 “(i) MEDICALLY NECESSARY DIA-
21 PERS.—The term ‘medically necessary dia-
22 per’ means an absorbent garment which is
23 washable or disposable and which is worn
24 by an individual who has attained 3 years
25 of age because of medical necessity, such

1 as someone who has been diagnosed with
2 bowel or bladder incontinence, a bowel or
3 bladder condition that causes excess urine
4 or stool (such as short gut syndrome or di-
5 abetes insipidus), or a severe skin condi-
6 tion that causes skin erosions (such as
7 epidermolysis bullosa) and needs such gar-
8 ment to correct or ameliorate such condi-
9 tion, to serve a preventative medical pur-
10 pose, or to correct or ameliorate defects or
11 physical or mental illnesses or conditions
12 diagnosed by a licensed health care pro-
13 vider, and, if disposable—

14 “(I) does not use any latex or
15 common allergens; and

16 “(II) meets or exceeds the quality
17 standards for diapers commercially
18 available through retail sale in the fol-
19 lowing categories:

20 “(aa) Absorbency (with ac-
21 ceptable rates for first and sec-
22 ond wetting).

23 “(bb) Waterproof outer
24 cover.

25 “(cc) Flexible leg openings.

1 “(dd) Refastening closures.

2 “(ii) DIAPERING SUPPLIES.—The
3 term ‘diapering supplies’ means items, in-
4 cluding diaper wipes and diaper creams,
5 necessary to ensure that an individual
6 wearing medically necessary diapers is
7 properly cleaned and protected from diaper
8 rash.”.

9 (2) ARCHER MSAS.—The last sentence of sec-
10 tion 220(d)(2)(A) of such Code is amended by in-
11 serting “, medically necessary diapers (as defined in
12 section 223(d)(2)(E)), and diapering supplies (as de-
13 fined in section 223(d)(2)(E))” after “menstrual
14 care products (as defined in section 223(d)(2)(D))”.

15 (3) HEALTH FLEXIBLE SPENDING ARRANGE-
16 MENTS AND HEALTH REIMBURSEMENT ARRANGE-
17 MENTS.—Section 106(f) of such Code is amended—

18 (A) by inserting “, medically necessary dia-
19 pers (as defined in section 223(d)(2)(E)), and
20 diapering supplies (as defined in section
21 223(d)(2)(E))” after “menstrual care products
22 (as defined in section 223(d)(2)(D))”; and

23 (B) in the heading, by inserting “, MEDI-
24 CALLY NECESSARY DIAPERS, AND DIAPERING

1 SUPPLIES” after “MENSTRUAL CARE PROD-
2 UCTS”.

3 (4) EFFECTIVE DATES.—

4 (A) DISTRIBUTIONS FROM CERTAIN AC-
5 COUNTS.—The amendments made by para-
6 graphs (1) and (2) shall apply to amounts paid
7 after December 31, 2023.

8 (B) REIMBURSEMENTS.—The amendment
9 made by paragraph (3) shall apply to expenses
10 incurred after December 31, 2023.

11 **SEC. 5503. DECREASING THE RISK FACTORS FOR SUDDEN**
12 **UNEXPECTED INFANT DEATH AND SUDDEN**
13 **UNEXPLAINED DEATH IN CHILDHOOD.**

14 (a) ESTABLISHMENT.—The Secretary of Health and
15 Human Services, acting through the Administrator of the
16 Health Resources and Services Administration and in con-
17 sultation with the Director of the Centers for Disease Con-
18 trol and Prevention and the Director of the National Insti-
19 tutes of Health (in this section referred to as the “Sec-
20 retary”), shall establish and implement a culturally and
21 linguistically competent public health awareness and edu-
22 cation campaign to provide information that is focused on
23 decreasing the risk factors for sudden unexpected infant
24 death and sudden unexplained death in childhood, includ-
25 ing educating individuals about safe sleep environments,

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

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

8 (c) CONSULTATION.—In establishing and imple-
9 menting the campaign under subsection (a), the Secretary
10 shall consult with national organizations representing
11 health care providers, including nurses and physicians,
12 parents, child care providers, children’s advocacy and safe-
13 ty organizations, maternal and child health programs, nu-
14 trition professionals focusing on people, infants, and chil-
15 dren, and other individuals and groups determined nec-
16 essary by the Secretary for such establishment and imple-
17 mentation.

18 (d) GRANTS.—

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

1 viders, public health agencies, and community orga-
2 nizations.

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

8 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
9 authorized to be appropriated to carry out this section
10 such sums as may be necessary for each of fiscal years
11 2023 through 2027.

12 **Subtitle G—Nutrition for Women,**
13 **Children, Families**

14 **SEC. 5601. CLOSING THE MEAL GAP.**

15 (a) ELIMINATION OF TIME LIMIT.—

16 (1) IN GENERAL.—Section 6 of the Food and
17 Nutrition Act of 2008 (7 U.S.C. 2015) is amend-
18 ed—

19 (A) by striking subsection (o); and

20 (B) by redesignating subsections (p)
21 through (s) as subsections (o) through (r), re-
22 spectively.

23 (2) ADDITIONAL ALLOCATIONS FOR STATES
24 THAT ENSURE AVAILABILITY OF WORK OPPORTUNI-

1 TIES.—Section 16(h) of the Food and Nutrition Act
2 of 2008 (7 U.S.C. 2025(h)) is amended—

3 (A) in paragraph (1)—

4 (i) in subparagraph (C)(iv)(I)—

5 (I) by striking “(F)(viii)” each
6 place it appears and inserting
7 “(E)(viii)”;

8 (II) by striking “(F)(vii)(I)” each
9 place it appears and inserting
10 “(E)(vii)(I)”;

11 (III) in item (bb)(BB), by strik-
12 ing “(F)(vii)(II)” and inserting
13 “(E)(vii)(II)”;

14 (IV) in item (cc), by striking
15 “(F)(vii)” and inserting “(E)(vii)”;

16 (ii) by striking subparagraph (E); and

17 (iii) by redesignating subparagraph
18 (F) as subparagraph (E);

19 (B) in paragraphs (3) and (4), by striking
20 “(1)(F)” each place it appears and inserting
21 “(1)(E)”;

22 (C) in paragraph (5)(C)—

23 (i) in clause (ii), by adding “and” at
24 the end;

- 1 (ii) in clause (iii), by striking “; and”
2 and inserting a period; and
3 (iii) by striking clause (iv).

4 (3) CONFORMING AMENDMENTS.—

5 (A) Section 5 of the Food and Nutrition
6 Act of 2008 (7 U.S.C. 2014) is amended—

- 7 (i) in subsection (a), in the second
8 sentence, by striking “(r)” and inserting
9 “(q)”; and

- 10 (ii) in subsection (g)(3), in the first
11 sentence, by striking “16(h)(1)(F)” and
12 inserting “16(h)(1)(E)”.

13 (B) Section 6(d)(4) of the Food and Nutri-
14 tion Act of 2008 (7 U.S.C. 2015(d)(4)) is
15 amended—

- 16 (i) in subparagraph
17 (B)(ii)(I)(bb)(DD), by striking “or sub-
18 section (o)”; and

- 19 (ii) in subparagraph (N), by striking
20 “or subsection (o)” each place it appears.

21 (C) Section 7 of the Food and Nutrition
22 Act of 2008 (7 U.S.C. 2016) is amended—

- 23 (i) in subsection (a), by striking “Ex-
24 cept as provided in subsection (i), EBT”
25 and inserting “EBT”;

1 (ii) in subsection (f)(3)—

2 (I) by striking subparagraph (B);

3 and

4 (II) by redesignating subpara-
5 graph (C) as subparagraph (B);

6 (iii) in subsection (h)—

7 (I) in paragraph (13)(B), by
8 striking “subsection (j)(1)(H)” and
9 inserting “subsection (i)(1)”; and

10 (II) in paragraph
11 (14)(B)(ii)(III), by striking “section
12 7(f)(2)(B)” and inserting “subsection
13 (f)(2)(B)”;

14 (iv) by striking subsection (i); and

15 (v) by redesignating subsections (j)
16 and (k) as subsections (i) and (j), respec-
17 tively.

18 (D) Section 16(h)(1) of the Food and Nu-
19 trition Act of 2008 (7 U.S.C. 2025(h)) is
20 amended—

21 (i) in subparagraph (B), in the matter
22 preceding clause (i), by striking “that—”
23 and all that follows through the period at
24 the end of clause (ii) and inserting “that

1 is determined and adjusted by the Sec-
2 retary.”; and

3 (ii) in clause (ii)(III)(ee)(AA) of sub-
4 paragraph (E) (as redesignated by para-
5 graph (2)(A)(iii)), by striking “, individ-
6 uals subject to the requirements under sec-
7 tion 6(o),”.

8 (E) Section 17(b)(1)(B)(iv) of the Food
9 and Nutrition Act of 2008 (7 U.S.C.
10 2026(b)(1)(B)(iv)) is amended—

11 (i) in subclause (V), by adding “or”
12 at the end after the semicolon;

13 (ii) in subclause (VI), by striking “;
14 or” and inserting a period; and

15 (iii) by striking subclause (VII).

16 (F) Section 51(d)(8)(A)(ii) of the Internal
17 Revenue Code of 1986 is amended—

18 (i) in subclause (I), by striking “, or”
19 at the end and inserting a period;

20 (ii) in the matter preceding subclause
21 (I), by striking “family—” and all that fol-
22 lows through “receiving” in subclause (I)
23 and inserting “family receiving”; and

24 (iii) by striking subclause (II).

1 (G) Section 103(a)(2) of the Workforce In-
2 novation and Opportunity Act (29 U.S.C. 3113)
3 is amended—

4 (i) by striking subparagraph (D); and
5 (ii) by redesignating subparagraphs
6 (E) through (K) as subparagraphs (D)
7 through (J), respectively.

8 (H) Section 121(b)(2)(B) of the Workforce
9 Innovation and Opportunity Act (29 U.S.C.
10 3151) is amended—

11 (i) by striking clause (iv); and
12 (ii) by redesignating clauses (v)
13 through (vii) as clauses (iv) through (vi),
14 respectively.

15 (4) Section 703(c)(1) of division N of the Con-
16 solidated Appropriations Act, 2021 (7 U.S.C. 2016
17 note; Public Law 116–260), is amended by striking
18 “section 7(k)(14) of the Food and Nutrition Act of
19 2008” and inserting “section 7(j)(4) of the Food
20 and Nutrition Act of 2008 (7 U.S.C. 2016(j)(4))”.

21 (b) PARTICIPATION OF PUERTO RICO, AMERICAN
22 SAMOA, AND THE NORTHERN MARIANA ISLANDS IN SUP-
23 PLEMENTAL NUTRITION ASSISTANCE PROGRAM.—

24 (1) DEFINITIONS.—

1 (A) STATE.—Section 3(r) of the Food and
2 Nutrition Act of 2008 (7 U.S.C. 2012(r)) is
3 amended by inserting “the Commonwealth of
4 Puerto Rico, American Samoa, the Common-
5 wealth of the Northern Mariana Islands,” after
6 “Guam,”.

7 (B) THRIFTY FOOD PLAN.—Section
8 3(u)(3) of the Food and Nutrition Act of 2008
9 (7 U.S.C. 2012(u)(3)) is amended by inserting
10 “the Commonwealth of Puerto Rico, American
11 Samoa, the Commonwealth of the Northern
12 Mariana Islands,” after “Guam,”.

13 (2) ELIGIBLE HOUSEHOLDS.—Section 5 of the
14 Food and Nutrition Act of 2008 (7 U.S.C. 2014) (as
15 amended by section 4003(g)(1)(A)(iv)) is amended—

16 (A) in subsection (c), in the undesignated
17 matter at the end, by striking “States or
18 Guam” and inserting “States, Guam, the Com-
19 monwealth of Puerto Rico, American Samoa, or
20 the Commonwealth of the Northern Mariana Is-
21 lands”;

22 (B) in subsection (e)(1)(B)—

23 (i) in the subparagraph heading, by
24 striking “GUAM” and inserting “GUAM,
25 THE COMMONWEALTH OF THE NORTHERN

1 MARIANA ISLANDS, AND AMERICAN
2 SAMOA”;

3 (ii) in clause (i), in the matter pre-
4 ceding subclause (I), by inserting “, the
5 Commonwealth of the Northern Mariana
6 Islands, and American Samoa” after
7 “Guam”; and

8 (iii) in clause (ii), in the matter pre-
9 ceding subclause (I), by inserting “, the
10 Commonwealth of the Northern Mariana
11 Islands, and American Samoa” after
12 “Guam”; and

13 (C) by adding at the end the following:

14 “(n) PUERTO RICO, AMERICAN SAMOA, AND THE
15 NORTHERN MARIANA ISLANDS.—Notwithstanding any
16 other provision of this Act, including the requirements
17 under this section, the Commonwealth of Puerto Rico,
18 American Samoa, and the Commonwealth of the Northern
19 Mariana Islands shall each establish their own standards
20 of eligibility for participation by households in the supple-
21 mental nutrition assistance program.”.

22 (3) EFFECTIVE DATE.—

23 (A) IN GENERAL.—The amendments made
24 by paragraphs (1) and (2) shall be effective
25 with respect to the Commonwealth of Puerto

1 Rico, American Samoa, and the Commonwealth
2 of the Northern Mariana Islands, as applicable,
3 on the date described in subparagraph (B) if
4 the Secretary of Agriculture submits to Con-
5 gress a certification under subsection (f)(2)(B)
6 of section 19 of the Food and Nutrition Act of
7 2008 (7 U.S.C. 2028).

8 (B) DATE DESCRIBED.—The date referred
9 to in subparagraph (A) is, with respect to the
10 Commonwealth of Puerto Rico, American
11 Samoa, and the Commonwealth of the Northern
12 Mariana Islands, the date established by the
13 Commonwealth of Puerto Rico, American
14 Samoa, or the Commonwealth of the Northern
15 Mariana Islands, respectively, in the applicable
16 plan of operation submitted to the Secretary of
17 Agriculture under subsection (f)(1) of section
18 19 of the Food and Nutrition Act of 2008 (7
19 U.S.C. 2028).

20 (c) TRANSITION OF PUERTO RICO, AMERICAN
21 SAMOA, AND THE NORTHERN MARIANA ISLANDS TO SUP-
22 PLEMENTAL NUTRITION ASSISTANCE PROGRAM.—Section
23 19 of the Food and Nutrition Act of 2008 (7 U.S.C. 2028)
24 is amended—

25 (1) in subsection (a)(1)—

1 (A) in subparagraph (A), by striking
2 “and” at the end;

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

5 (C) by adding at the end the following:

6 “(C) the Commonwealth of the Northern
7 Mariana Islands.”; and

8 (2) by adding at the end the following:

9 “(f) TRANSITION OF PUERTO RICO, AMERICAN
10 SAMOA, AND THE NORTHERN MARIANA ISLANDS TO SUP-
11 PLEMENTAL NUTRITION ASSISTANCE PROGRAM.—

12 “(1) REQUEST FOR PARTICIPATION.—A govern-
13 mental entity may submit to the Secretary a request
14 to participate in the supplemental nutrition assist-
15 ance program, which shall include a plan of oper-
16 ation described in section 11(d), which shall include
17 the date on which the governmental entity intends to
18 begin participation in the program.

19 “(2) CERTIFICATION BY SECRETARY.—

20 “(A) IN GENERAL.—The Secretary shall
21 certify a governmental entity that submits a re-
22 quest under paragraph (1) as qualified to par-
23 ticipate in the supplemental nutrition assistance
24 program if the Secretary—

1 “(i) approves the plan of operation
2 submitted with the request, in accordance
3 with this subsection; and

4 “(ii) approves the applications de-
5 scribed in paragraph (4) in accordance
6 with that paragraph.

7 “(B) SUBMISSION OF CERTIFICATION TO
8 CONGRESS.—The Secretary shall submit each
9 certification under subparagraph (A) to Con-
10 gress.

11 “(3) DETERMINATION OF PLAN OF OPER-
12 ATION.—

13 “(A) APPROVAL.—The Secretary shall ap-
14 prove a plan of operation submitted with a re-
15 quest under paragraph (1) if the plan satisfies
16 the requirements under this Act for a plan of
17 operation.

18 “(B) DISAPPROVAL.—If the Secretary does
19 not approve a plan of operation submitted with
20 a request under paragraph (1), the Secretary
21 shall provide to the governmental entity a state-
22 ment that describes each requirement under
23 this Act that is not satisfied by the plan.

24 “(4) APPROVAL OF RETAIL FOOD STORES.—

1 “(A) SOLICITATION OF APPLICATIONS.—If
2 the Secretary approves a plan of operation
3 under paragraph (3)(A) for a governmental en-
4 tity, the Secretary shall accept applications
5 from retail food stores located in that govern-
6 mental entity to be authorized under section 9
7 to participate in the supplemental nutrition as-
8 sistance program.

9 “(B) DETERMINATION.—The Secretary
10 shall authorize a retail food store applying to
11 participate in the supplemental nutrition assist-
12 ance program under subparagraph (A) if the
13 application satisfies the requirements under this
14 Act for authorization of a retail food store.

15 “(5) PUERTO RICO.—In the case of a request
16 under paragraph (1) by the Commonwealth of Puer-
17 to Rico, notwithstanding subsection (g), the Sec-
18 retary shall allow the Commonwealth of Puerto Rico
19 to continue to carry out under the supplemental nu-
20 trition assistance program the Family Market Pro-
21 gram established pursuant to this section.

22 “(6) AUTHORIZATION OF APPROPRIATIONS.—
23 There are authorized to be appropriated to the Sec-
24 retary to carry out this subsection such sums as are

1 necessary for fiscal year 2023, to remain available
2 until expended.

3 “(g) TERMINATION OF EFFECTIVENESS.—

4 “(1) IN GENERAL.—Subsections (a) through (e)
5 shall cease to be effective with respect to the Com-
6 monwealth of Puerto Rico, American Samoa, and
7 the Commonwealth of the Northern Mariana Is-
8 lands, as applicable, on the date described in para-
9 graph (2) if the Secretary submits to Congress a
10 certification under subsection (f)(2)(B) for that gov-
11 ernmental entity.

12 “(2) DATE DESCRIBED.—The date referred to
13 in paragraph (1) is, with respect to the Common-
14 wealth of Puerto Rico, American Samoa, and the
15 Commonwealth of the Northern Mariana Islands,
16 the date established by the Commonwealth of Puerto
17 Rico, American Samoa, or the Commonwealth of the
18 Northern Mariana Islands, respectively, in the appli-
19 cable plan of operation submitted to the Secretary
20 under subsection (f)(1).”.

21 **SEC. 5602. REPEAL OF DENIAL OF SUPPLEMENTAL NUTRI-**
22 **TION ASSISTANCE PROGRAM BENEFITS.**

23 Section 115 of the Personal Responsibility and Work
24 Opportunity Reconciliation Act of 1996 (21 U.S.C. 862a)
25 is amended—

1 (1) in subsection (a)—

2 (A) by striking paragraph (2);

3 (B) in paragraph (1), by striking “, or”

4 and inserting a period; and

5 (C) in the matter preceding paragraph (1),

6 by striking “for—” and all that follows through

7 “assistance” in paragraph (1) and inserting

8 “for assistance”;

9 (2) in subsection (b)—

10 (A) by striking paragraph (2);

11 (B) in paragraph (1), by striking the para-

12 graph designation and heading and all that fol-

13 lows through “The amount” and inserting “The

14 amount”; and

15 (3) in subsection (e)—

16 (A) by striking paragraph (2);

17 (B) in paragraph (1), by striking “, and”

18 and inserting a period; and

19 (C) in the matter preceding paragraph (1),

20 by striking “it—” and all that follows through

21 “in section 419(5)” in paragraph (1) and in-

22 serting “the term in section 419(5)”.

1 **Subtitle H—Universal School Meals**
2 **Program**

3 **SEC. 5701. SHORT TITLE.**

4 This subtitle may be cited as the “Universal School
5 Meals Program Act of 2022”.

6 **SEC. 5702. EFFECTIVE DATE.**

7 Unless otherwise provided, this subtitle, and the
8 amendments made by this subtitle, shall take effect 1 year
9 after the date of enactment of this Act.

10 **SEC. 5703. FREE SCHOOL BREAKFAST PROGRAM.**

11 (a) IN GENERAL.—Section 4(a) of the Child Nutri-
12 tion Act of 1966 (42 U.S.C. 1773(a)) is amended, in the
13 first sentence—

14 (1) by striking “is hereby” and inserting “are”;
15 and

16 (2) by inserting “to provide free breakfast to all
17 children enrolled at those schools” before “in accord-
18 ance”.

19 (b) APPORTIONMENT TO STATES.—Section 4(b) of
20 the Child Nutrition Act of 1966 (42 U.S.C. 1773(b)) is
21 amended—

22 (1) in paragraph (1)—

23 (A) in subparagraph (A)(i), by striking
24 subclause (II) and inserting the following:

1 “(II) the national average pay-
2 ment for free breakfasts, as specified
3 in subparagraph (B).”;

4 (B) by striking subparagraph (B) and in-
5 serting the following:

6 “(B) PAYMENT AMOUNTS.—

7 “(i) IN GENERAL.—The national aver-
8 age payment for each free breakfast shall
9 be \$2.72, adjusted annually for inflation in
10 accordance with clause (ii) and rounded in
11 accordance with clause (iii).

12 “(ii) INFLATION ADJUSTMENT.—

13 “(I) IN GENERAL.—The annual
14 inflation adjustment under clause (i)
15 shall reflect changes in the cost of op-
16 erating the free breakfast program
17 under this section, as indicated by the
18 change in the Consumer Price Index
19 for food away from home for all urban
20 consumers.

21 “(II) BASIS.—Each inflation an-
22 nual adjustment under clause (i) shall
23 reflect the changes in the Consumer
24 Price Index for food away from home

1 for the most recent 12-month period
2 for which that data is available.

3 “(iii) ROUNDING.—On July 1, 2022,
4 and annually thereafter, the national aver-
5 age payment rate for free breakfast shall
6 be—

7 “(I) adjusted to the nearest
8 lower-cent increment; and

9 “(II) based on the unrounded
10 amounts for the preceding 12-month
11 period.”;

12 (C) by striking subparagraphs (C) and
13 (E); and

14 (D) by redesignating subparagraph (D) as
15 subparagraph (C);

16 (2) by striking paragraphs (2) and (3);

17 (3) by redesignating paragraphs (4) and (5) as
18 paragraphs (2) and (3), respectively; and

19 (4) in paragraph (3) (as so redesignated), by
20 striking “paragraph (3) or (4)” and inserting “para-
21 graph (2)”.

22 (c) STATE DISBURSEMENT TO SCHOOLS.—Section 4
23 of the Child Nutrition Act of 1966 (42 U.S.C. 1773) is
24 amended by striking subsection (c) and inserting the fol-
25 lowing:

1 “(c) STATE DISBURSEMENT TO SCHOOLS.—Funds
2 apportioned and paid to any State for the purpose of this
3 section shall be disbursed by the State educational agency
4 to schools selected by the State educational agency to as-
5 sist those schools in operating a breakfast program.”.

6 (d) NO COLLECTION OF DEBT.—

7 (1) IN GENERAL.—Notwithstanding any other
8 provision of the Child Nutrition Act of 1966 (42
9 U.S.C. 1771 et seq.) or any other provision of law,
10 effective beginning on the date of enactment of this
11 Act, as a condition of participation in the breakfast
12 program under section 4 of that Act (42 U.S.C.
13 1773), a school—

14 (A) shall not collect any debt owed to the
15 school for unpaid meal charges; and

16 (B) shall continue to accrue debt for un-
17 paid meal charges—

18 (i) for the purpose of receiving reim-
19 bursement under section 5715; and

20 (ii) until the effective date specified in
21 section 5702.

22 (2) CHILD NUTRITION ACT OF 1966.—

23 (A) IN GENERAL.—Section 4 of the Child
24 Nutrition Act of 1966 (42 U.S.C. 1773) is

1 amended by striking subsection (d) and insert-
2 ing the following:

3 “(d) NO COLLECTION OF DEBT.—A school partici-
4 pating in the free breakfast program under this section
5 shall not collect any debt owed to the school for unpaid
6 meal charges.”.

7 (B) CONFORMING AMENDMENT.—Section
8 23(a) of the Child Nutrition Act of 1966 (42
9 U.S.C. 1793(a)) is amended by striking “school
10 in severe need, as described in section 4(d)(1)”
11 and inserting the following: “school—

12 “(1) that has a free breakfast program under
13 section 4 or seeks to initiate a free breakfast pro-
14 gram under that section; and

15 “(2) of which not less than 40 percent of the
16 students are identified students (as defined in para-
17 graph (8) of section 1113(a) of the Elementary and
18 Secondary Education Act of 1965 (20 U.S.C.
19 6313(a)))”.

20 (e) NUTRITIONAL AND OTHER PROGRAM REQUIRE-
21 MENTS.—Section 4(e) of the Child Nutrition Act of 1966
22 (42 U.S.C. 1773(e)) is amended—

23 (1) in paragraph (1)(A), in the second sentence,
24 by striking “free or” and all that follows through
25 the period at the end and inserting “free to all chil-

1 dren enrolled at a school participating in the school
2 breakfast program.”; and

3 (2) in paragraph (2), in the second sentence, by
4 striking “the full charge to the student for a break-
5 fast meeting the requirements of this section or”.

6 (f) PROHIBITION ON BREAKFAST SHAMING, MEAL
7 DENIAL.—

8 (1) IN GENERAL.—Effective beginning on the
9 date of enactment of this Act, a school or school
10 food authority—

11 (A) shall not—

12 (i) physically segregate or otherwise
13 discriminate against any child participating
14 in the breakfast program under section 4
15 of the Child Nutrition Act of 1966 (42
16 U.S.C. 1773); or

17 (ii) overtly identify a child described
18 in clause (i) by a special token or ticket,
19 an announced or published list of names,
20 or any other means; and

21 (B) shall provide the program meal to any
22 child eligible under the program.

23 (2) CHILD NUTRITION ACT OF 1966.—Section 4
24 of the Child Nutrition Act of 1966 (42 U.S.C. 1773)
25 is amended by adding at the end the following:

1 “(f) PROHIBITION ON BREAKFAST SHAMING.—A
2 school or school food authority shall not—

3 “(1) physically segregate or otherwise discrimi-
4 nate against any child participating in the free
5 breakfast program under this section; or

6 “(2) overtly identify a child described in para-
7 graph (1) by a special token or ticket, an announced
8 or published list of names, or any other means.”.

9 (g) DEPARTMENT OF DEFENSE OVERSEAS DEPEND-
10 ENTS’ SCHOOLS.—Section 20(b) of the Child Nutrition
11 Act of 1966 (42 U.S.C. 1789(b)) is amended—

12 (1) by striking “and reduced-price”; and

13 (2) by striking “and shall” and all that follows
14 through “section”.

15 (h) CONFORMING AMENDMENTS.—The Child Nutri-
16 tion Act of 1966 (42 U.S.C. 1771 et seq.) is amended—

17 (1) by striking “or reduced price” each place it
18 appears;

19 (2) by striking “and reduced price” each place
20 it appears; and

21 (3) by striking “a reduced price” each place it
22 appears.

23 **SEC. 5704. APPORTIONMENT TO STATES.**

24 Section 4(b) of the Richard B. Russell National
25 School Lunch Act (42 U.S.C. 1753(b)) is amended—

1 (1) by striking paragraph (2) and inserting the
2 following:

3 “(2) PAYMENT AMOUNTS.—

4 “(A) IN GENERAL.—The national average
5 payment for each free lunch shall be \$3.81, ad-
6 justed annually for inflation in accordance with
7 subparagraph (C) and rounded in accordance
8 with subparagraph (D).

9 “(B) ADDITIONAL PAYMENT FOR LOCAL
10 FOOD.—

11 “(i) DEFINITION OF LOCALLY-
12 SOURCED FARM PRODUCT.—In this sub-
13 paragraph, the term ‘locally-sourced farm
14 product’ means a farm product that—

15 “(I) is marketed to consumers—

16 “(aa) directly; or

17 “(bb) through intermediated
18 channels (such as food hubs and
19 cooperatives); and

20 “(II) with respect to the school
21 food authority purchasing the farm
22 product, is produced and distrib-
23 uted—

1 “(aa) in the State in which
2 the school food authority is lo-
3 cated; or

4 “(bb) not more than 250
5 miles from the location of the
6 school food authority.

7 “(ii) ADDITIONAL PAYMENT ELIGI-
8 BILITY.—During a school year, a school
9 food authority shall receive an additional
10 payment described in clause (iii) if the
11 State certifies that the school food author-
12 ity served meals (including breakfasts,
13 lunches, suppers, and supplements) during
14 the last school year of which not less than
15 25 percent were made with locally-sourced
16 farm products.

17 “(iii) PAYMENT AMOUNT.—

18 “(I) IN GENERAL.—The addi-
19 tional payment amount under this
20 subparagraph shall be—

21 “(aa) \$0.30 for each free
22 lunch and supper;

23 “(bb) \$0.21 for each free
24 breakfast; and

1 “(cc) \$0.08 for each free
2 supplement.

3 “(II) ADJUSTMENTS.—Each ad-
4 ditional payment amount under sub-
5 clause (I) shall be adjusted annually
6 in accordance with subparagraph (C)
7 and rounded in accordance with sub-
8 paragraph (D).

9 “(iv) DISBURSEMENT.—The State
10 agency shall disburse funds made available
11 under this clause to school food authorities
12 eligible to receive additional reimburse-
13 ment.

14 “(C) INFLATION ADJUSTMENT.—

15 “(i) IN GENERAL.—The annual infla-
16 tion adjustment under subparagraphs (A)
17 and (B)(iii) shall reflect changes in the
18 cost of operating the free lunch program
19 under this Act, as indicated by the change
20 in the Consumer Price Index for food away
21 from home for all urban consumers.

22 “(ii) BASIS.—Each annual inflation
23 adjustment under subparagraphs (A) and
24 (B)(iii) shall reflect the changes in the
25 Consumer Price Index for food away from

1 home for the most recent 12-month period
2 for which that data is available.

3 “(D) ROUNDING.—On July 1, 2022, and
4 annually thereafter, the national average pay-
5 ment rate for free lunch and the additional pay-
6 ment amount for free breakfast, lunch, supper,
7 and supplement under subparagraph (B) shall
8 be—

9 “(i) adjusted to the nearest lower-cent
10 increment; and

11 “(ii) based on the unrounded amounts
12 for the preceding 12-month period.”; and

13 (2) by striking paragraph (3).

14 **SEC. 5705. NUTRITIONAL AND OTHER PROGRAM REQUIRE-**
15 **MENTS.**

16 (a) ELIMINATION OF FREE LUNCH ELIGIBILITY RE-
17 QUIREMENTS.—

18 (1) IN GENERAL.—Section 9 of the Richard B.
19 Russell National School Lunch Act (42 U.S.C.
20 1758) is amended by striking subsection (b) and in-
21 serting the following:

22 “(b) ELIGIBILITY.—All children enrolled in a school
23 that participates in the school lunch program under this
24 Act shall be eligible to receive free lunch under this Act.”.

25 (2) CONFORMING AMENDMENTS.—

1 (A) Section 9 of the Richard B. Russell
2 National School Lunch Act (42 U.S.C. 1758) is
3 amended—

4 (i) in subsection (c), in the third sen-
5 tence, by striking “or at a reduced cost”;
6 and

7 (ii) in subsection (e), by striking “, re-
8 duced price,”.

9 (B) Section 18 of the Richard B. Russell
10 National School Lunch Act (42 U.S.C. 1769) is
11 amended—

12 (i) by striking subsection (j); and

13 (ii) by redesignating subsection (k) as
14 subsection (j).

15 (C) Section 28(b)(4) of the Richard B.
16 Russell National School Lunch Act (42 U.S.C.
17 1769i(b)(4)) is amended—

18 (i) by striking subparagraph (B); and

19 (ii) in subparagraph (A), by striking
20 the subparagraph designation and heading
21 and all that follows through “the Sec-
22 retary” and inserting “The Secretary”.

23 (D) Section 17 of the Child Nutrition Act
24 of 1966 (42 U.S.C. 1786) is amended—

25 (i) in subsection (d)(2)(A)—

1 (I) by striking clause (i); and

2 (II) by redesignating clauses (ii)

3 and (iii) as clauses (i) and (ii), respec-

4 tively; and

5 (ii) in subsection (f)(17), by striking

6 “Notwithstanding subsection (d)(2)(A)(i),

7 not later” and inserting “Not later”.

8 (E) Section 1902(a) of the Social Security

9 Act (42 U.S.C. 1396a(a)) is amended by strik-

10 ing paragraph (7) and inserting the following:

11 “(7) provide safeguards which restrict the use

12 or disclosure of information concerning applicants

13 and recipients to purposes directly connected with

14 the administration of the plan;”.

15 (F) Section 1154(a)(2)(A)(i) of title 10,

16 United States Code, is amended by striking “in

17 accordance with section 9(b)(1) of the Richard

18 B. Russell National School Lunch Act (42

19 U.S.C. 1758(b)(1)”.

20 (G) Section 4301 of the Food, Conserva-

21 tion, and Energy Act of 2008 (42 U.S.C.

22 1758a) is repealed.

23 (b) NO COLLECTION OF DEBT.—

24 (1) IN GENERAL.—Notwithstanding any other

25 provision of the Richard B. Russell National School

1 Lunch Act (42 U.S.C. 1751 et seq.) or any other
2 provision of law, effective beginning on the date of
3 enactment of this Act, as a condition of participation
4 in the school lunch program under that Act, a
5 school—

6 (A) shall not collect any debt owed to the
7 school for unpaid meal charges; and

8 (B) shall continue to accrue debt for un-
9 paid meal charges—

10 (i) for the purpose of receiving reim-
11 bursement under section 5715; and

12 (ii) until the effective date specified in
13 section 5702.

14 (2) NATIONAL SCHOOL LUNCH ACT.—Section 9
15 of the Richard B. Russell National School Lunch
16 Act (42 U.S.C. 1758) is amended by striking sub-
17 section (d) and inserting the following:

18 “(d) NO COLLECTION OF DEBT.—A school partici-
19 pating in the school lunch program under this Act shall
20 not collect any debt owed to the school for unpaid meal
21 charges.”.

22 **SEC. 5706. SPECIAL ASSISTANCE PROGRAM.**

23 (a) IN GENERAL.—Section 11 of the Richard B. Rus-
24 sell National School Lunch Act (42 U.S.C. 1759a) is re-
25 pealed.

1 (b) CONFORMING AMENDMENTS.—

2 (1) Section 6 of the Richard B. Russell Na-
3 tional School Lunch Act (42 U.S.C. 1755) is amend-
4 ed—

5 (A) in subsection (a)(2), by striking “sec-
6 tions 11 and 13” and inserting “section 13”;
7 and

8 (B) in subsection (e)(1), in the matter pre-
9 ceding subparagraph (A), by striking “section
10 4, this section, and section 11” and inserting
11 “this section and section 4”.

12 (2) Section 7(d) of the Richard B. Russell Na-
13 tional School Lunch Act (42 U.S.C. 1756(d)) is
14 amended by striking “or 11”.

15 (3) Section 8(g) of the Richard B. Russell Na-
16 tional School Lunch Act (42 U.S.C. 1757(g)) is
17 amended by striking “and under section 11 of this
18 Act”.

19 (4) Section 12(f) of the Richard B. Russell Na-
20 tional School Lunch Act (42 U.S.C. 1760(f)) is
21 amended by striking “11,”.

22 (5) Section 7(a) of the Child Nutrition Act of
23 1966 (42 U.S.C. 1766(a)) is amended—

24 (A) in paragraph (1)(A), by striking “4,
25 11, and 17” and inserting “4 and 17”; and

1 (B) in paragraph (2)(A), by striking “sec-
2 tions 4 and 11” and inserting “section 4”.

3 **SEC. 5707. PRICE FOR A PAID LUNCH.**

4 Section 12 of the Richard B. Russell National School
5 Lunch Act (42 U.S.C. 1760) is amended—

6 (1) by striking subsection (p); and

7 (2) by redesignating subsections (q) and (r) as
8 subsections (p) and (q), respectively.

9 **SEC. 5708. SUMMER FOOD SERVICE PROGRAM FOR CHIL-**
10 **DREN.**

11 Section 13 of the Richard B. Russell National School
12 Lunch Act (42 U.S.C. 1761) is amended—

13 (1) in subsection (a)—

14 (A) in paragraph (2), by adding at the end
15 the following:

16 “(C) **WAIVER.**—If the Secretary deter-
17 mines that a program requirement under this
18 section limits the access of children to meals
19 served under this section, the Secretary may
20 waive that program requirement.

21 “(D) **ELIGIBILITY.**—All children shall be
22 eligible to participate in the program under this
23 section.”; and

24 (B) in paragraph (5), by striking “only
25 for” and all that follows through the period at

1 the end and inserting “for meals served to all
2 children.”;

3 (2) in subsection (b)(2), by striking “may only
4 serve” and all that follows through “migrant chil-
5 dren”;

6 (3) by striking subsection (c) and inserting the
7 following:

8 “(c) PAYMENTS.—

9 “(1) IN GENERAL.—Payments shall be made to
10 service institutions for meals served—

11 “(A) during the months of May through
12 September;

13 “(B) during school vacation at any time
14 during an academic school year;

15 “(C) during a teacher in-service day; and

16 “(D) on days that school is closed during
17 the months of October through April due to a
18 natural disaster, building repair, court order, or
19 similar cause, as determined by the Secretary.

20 “(2) LIMITATION ON PAYMENTS.—A service in-
21 stitution shall receive payments under this section
22 for not more than 3 meals and 1 supplement per
23 child per day.”; and

24 (4) in subsection (f)(3), by striking “, except
25 that” and all that follows through “section”.

1 **SEC. 5709. SUMMER ELECTRONIC BENEFIT TRANSFER FOR**
2 **CHILDREN PROGRAM.**

3 Section 13(a) of the Richard B. Russell National
4 School Lunch Act (42 U.S.C. 1761(a)) is amended by add-
5 ing at the end the following:

6 “(13) SUMMER ELECTRONIC BENEFIT TRANS-
7 FER FOR CHILDREN PROGRAM.—

8 “(A) DEFINITIONS.—In this paragraph:

9 “(i) EBT CARD.—The term ‘EBT
10 card’ means an electronic benefit transfer
11 card.

12 “(ii) ELIGIBLE HOUSEHOLD.—The
13 term ‘eligible household’ means a house-
14 hold with—

15 “(I) an income that does not ex-
16 ceed 200 percent of the poverty line
17 (as defined in section 673 of the Com-
18 munity Services Block Grant Act (42
19 U.S.C. 9902)); and

20 “(II) 1 or more children.

21 “(iii) PROGRAM.—The term ‘Program’
22 means the Summer Electronic Benefit
23 Transfer for Children Program established
24 under subparagraph (B).

25 “(B) ESTABLISHMENT.—The Secretary
26 shall establish a national program, to be known

1 as the ‘Summer Electronic Benefit Transfer for
2 Children Program’, under which the Secretary
3 shall issue EBT cards to eligible households to
4 provide food assistance during the summer
5 months.

6 “(C) EBT AMOUNT.—

7 “(i) IN GENERAL.—The value of an
8 EBT card provided under the Program to
9 an eligible household shall be \$60 per
10 month per child (adjusted for inflation).

11 “(ii) ANNUAL LIMITATION.—No eligi-
12 ble household shall receive benefits under
13 the Program for more than 3 months in a
14 calendar year.

15 “(D) ADMINISTRATION.—

16 “(i) IN GENERAL.—Except as pro-
17 vided under this paragraph, the Program
18 shall be based on the summer electronic
19 benefit transfer for children demonstration
20 program carried out pursuant to section
21 749(g) of the Agriculture, Rural Develop-
22 ment, Food and Drug Administration, and
23 Related Agencies Appropriations Act, 2010
24 (Public Law 111–80; 123 Stat. 2132).

25 “(ii) SNAP OR WIC.—

1 “(I) IN GENERAL.—Subject to
2 subclause (II), a State shall admin-
3 ister the Program through the supple-
4 mental nutrition assistance program
5 established under the Food and Nutri-
6 tion Act of 2008 (7 U.S.C. 2011 et
7 seq.).

8 “(II) WIC OPTION.—If a State
9 has participated in the demonstration
10 program described in clause (i) before
11 the effective date specified in section
12 5702 of the Universal School Meals
13 Program Act of 2022, the State may
14 elect to administer the Program
15 through the special supplemental nu-
16 trition program for women, infants,
17 and children established by section 17
18 of the Child Nutrition Act of 1966
19 (42 U.S.C. 1786).

20 “(E) AUTHORIZATION OF APPROPRIA-
21 TIONS.—There are authorized to be appro-
22 priated to the Secretary to carry out this para-
23 graph such sums as are necessary for fiscal
24 year 2022 and each fiscal year thereafter.”.

1 **SEC. 5710. CHILD AND ADULT CARE FOOD PROGRAM.**

2 Section 17 of the Richard B. Russell National School
3 Lunch Act (42 U.S.C. 1766) is amended—

4 (1) in subsection (a)(2), by striking subpara-
5 graph (B) and inserting the following:

6 “(B) any other private organization pro-
7 viding nonresidential child care or day care out-
8 side school hours for school children;”;

9 (2) by striking subsection (c) and inserting the
10 following:

11 “(c) FREE MEALS.—Notwithstanding any other pro-
12 vision of law—

13 “(1) all meals and supplements served under
14 the program authorized under this section shall be
15 provided for free to participants of the program; and

16 “(2) an institution that serves those meals and
17 supplements shall be reimbursed—

18 “(A) in the case of breakfast, at the rate
19 established for free breakfast under section
20 4(b)(1)(B)(i) of the Child Nutrition Act of
21 1966 (42 U.S.C. 1773(b)(1)(B)(i));

22 “(B) in the case of lunch, at the rate es-
23 tablished for free lunch under section
24 4(b)(2)(A); and

1 “(C) in the case of a supplemental meal,
2 \$0.96, adjusted for inflation in accordance with
3 section 4(b)(2)(C).”;

4 (3) in subsection (f)—

5 (A) in paragraph (2), by striking subpara-
6 graph (B) and inserting the following:

7 “(B) LIMITATION TO REIMBURSEMENTS.—

8 An institution may claim reimbursement under
9 this paragraph for not more than 3 meals and
10 1 supplement per day per child.”;

11 (B) by striking paragraph (3); and

12 (C) by redesignating paragraph (4) as
13 paragraph (3); and

14 (4) in subsection (r)—

15 (A) in the subsection heading, by striking
16 “PROGRAM FOR AT-RISK SCHOOL CHILDREN”
17 and inserting “AFTERSCHOOL MEAL AND
18 SNACK PROGRAM”;

19 (B) by striking “at-risk school” each place
20 it appears and inserting “eligible”;

21 (C) in paragraph (1)—

22 (i) in the paragraph heading, by strik-
23 ing “AT-RISK SCHOOL” and inserting “ELI-
24 GIBLE”; and

1 (ii) in subparagraph (B), by striking
2 “operated” and all that follows through
3 the period at the end and inserting a pe-
4 riod; and

5 (D) in paragraph (4)(A), by striking “only
6 for” and all that follows through the period at
7 the end and inserting the following: “for—

8 “(i) not more than 1 meal and 1 sup-
9 plement per child per day served on a reg-
10 ular school day; and

11 “(ii) not more than 3 meals and 1
12 supplement per child per day served on
13 any day other than a regular school day.”.

14 **SEC. 5711. MEALS AND SUPPLEMENTS FOR CHILDREN IN**
15 **AFTERSCHOOL CARE.**

16 Section 17A of the Richard B. Russell National
17 School Lunch Act (42 U.S.C. 1766a) is amended—

18 (1) in the section heading, by striking “**MEAL**
19 **SUPPLEMENTS**” and inserting “**MEALS AND SUP-**
20 **PLEMENTS**”;

21 (2) in subsection (a)(1), by striking “meal sup-
22 plements” and inserting “free meals and supple-
23 ments”;

24 (3) in subsection (b), by inserting “meals and”
25 before “supplements”; and

1 (4) by striking subsection (c) and inserting the
2 following:

3 “(c) REIMBURSEMENT.—

4 “(1) IN GENERAL.—

5 “(A) MEALS.—A free meal provided under
6 this section to a child shall be reimbursed at a
7 rate of \$3.81, adjusted annually for inflation in
8 accordance with paragraph (3)(A) and rounded
9 in accordance with paragraph (3)(B).

10 “(B) SUPPLEMENTS.—A free supplement
11 provided under this section to a child shall be
12 reimbursed at the rate at which free supple-
13 ments are reimbursed under section
14 17(c)(2)(C).

15 “(2) LIMITATION TO REIMBURSEMENTS.—An
16 institution may claim reimbursement under this sec-
17 tion for not more than 1 meal and 1 supplement per
18 day per child served on a regular school day.

19 “(3) INFLATION; ROUNDING.—

20 “(A) INFLATION ADJUSTMENT.—

21 “(i) IN GENERAL.—The annual infla-
22 tion adjustment under paragraph (1)(A)
23 shall reflect changes in the cost of oper-
24 ating the program under this section, as
25 indicated by the change in the Consumer

1 Price Index for food away from home for
2 all urban consumers.

3 “(ii) BASIS.—Each inflation annual
4 adjustment under paragraph (1)(A) shall
5 reflect the changes in the Consumer Price
6 Index for food away from home for the
7 most recent 12-month period for which
8 that data is available.

9 “(B) ROUNDING.—On July 1, 2022, and
10 annually thereafter, the reimbursement rate for
11 a free meal under this section shall be—

12 “(i) adjusted to the nearest lower-cent
13 increment; and

14 “(ii) based on the unrounded amounts
15 for the preceding 12-month period.”.

16 **SEC. 5712. ACCESS TO LOCAL FOODS: FARM TO SCHOOL**
17 **PROGRAM.**

18 Section 18(g)(5) of the Richard B. Russell National
19 School Lunch Act (42 U.S.C. 1769(g)(5)) is amended by
20 striking subparagraph (B) and inserting the following:

21 “(B) serve a high proportion of identified
22 students (as defined in paragraph (8) of section
23 1113(a) of the Elementary and Secondary Edu-
24 cation Act of 1965 (20 U.S.C. 6313(a)));”.

1 **SEC. 5713. FRESH FRUIT AND VEGETABLE PROGRAM.**

2 Section 19(d) of the Richard B. Russell National
3 School Lunch Act (42 U.S.C. 1769a(d)) is amended—

4 (1) in paragraph (1)—

5 (A) in the matter preceding subparagraph
6 (A), by striking “paragraph (2) of this sub-
7 section and”;

8 (B) in subparagraph (A), in the matter
9 preceding clause (i), by striking “school—” and
10 all that follows through “submits” in clause (ii)
11 and inserting “school that submits”;

12 (C) in subparagraph (B), by striking
13 “schools” and all that follows through “Act”
14 and inserting “high-need schools (as defined in
15 section 2211(b) of the Elementary and Sec-
16 ondary Education Act of 1965 (20 U.S.C.
17 6631(b)))”; and

18 (D) in subparagraph (D)—

19 (i) by striking clause (i); and

20 (ii) by redesignating clauses (ii)
21 through (iv) as clauses (i) through (iii), re-
22 spectively; and

23 (2) by striking paragraphs (2) and (3) and in-
24 serting the following:

25 “(2) OUTREACH TO HIGH-NEED SCHOOLS.—

26 Prior to making decisions regarding school participa-

1 tion in the program, a State agency shall inform
2 high-need schools (as defined in section 2211(b) of
3 the Elementary and Secondary Education Act of
4 1965 (20 U.S.C. 6631(b))), including Tribal schools,
5 of the eligibility of the schools for the program.”.

6 **SEC. 5714. TRAINING, TECHNICAL ASSISTANCE, AND FOOD**
7 **SERVICE MANAGEMENT INSTITUTE.**

8 Section 21(a)(1)(B) of the Richard B. Russell Na-
9 tional School Lunch Act (42 U.S.C. 1769b–1(a)(1)(B)) is
10 amended in the matter preceding clause (i) by striking
11 “certified to receive free or reduced price meals” and in-
12 serting “who are identified students (as defined in para-
13 graph (8) of section 1113(a) of the Elementary and Sec-
14 ondary Education Act of 1965 (20 U.S.C. 6313(a))”.

15 **SEC. 5715. REIMBURSEMENT OF SCHOOL MEAL DELIN-**
16 **QUENT DEBT PROGRAM.**

17 (a) DEFINITIONS.—In this section:

18 (1) DELINQUENT DEBT.—The term “delinquent
19 debt” means the debt owed by a parent or guardian
20 of a child to a school—

21 (A) as of the effective date specified in sec-
22 tion 5702; and

23 (B) for meals served by the school under—

1 (i) the school breakfast program
2 under section 4 of the Child Nutrition Act
3 of 1966 (42 U.S.C. 1773);

4 (ii) the school lunch program estab-
5 lished under the Richard B. Russell Na-
6 tional School Lunch Act (42 U.S.C. 1751
7 et seq.); or

8 (iii) both of the programs described in
9 clauses (i) and (ii).

10 (2) PROGRAM.—The term “program” means
11 the program established under subsection (b)(1).

12 (3) SECRETARY.—The term “Secretary” means
13 the Secretary of Agriculture.

14 (b) REIMBURSEMENT PROGRAM.—

15 (1) ESTABLISHMENT.—Not later than 60 days
16 after the effective date specified in section 5702, the
17 Secretary shall establish a program under which the
18 Secretary shall reimburse each school participating
19 in a program described in clause (i) or (ii) of sub-
20 section (a)(1)(B) for all delinquent debt.

21 (2) FORM FOR REIMBURSEMENT.—To carry out
22 the program, the Secretary shall design and dis-
23 tribute a form to State agencies to collect data on
24 all delinquent debt in applicable schools in the State,
25 grouped by school food authority.

1 (3) COMPLETION DATE.—The Secretary shall
2 provide all reimbursements under the program not
3 later than 180 days after the effective date specified
4 in section 5702.

5 (c) REPORT.—Not later than 2 years after the effec-
6 tive date specified in section 5702, the Comptroller Gen-
7 eral of the United States shall submit to Congress and
8 make publicly available a report that describes the suc-
9 cesses and challenges of the program.

10 **SEC. 5716. CONFORMING AMENDMENTS.**

11 The Richard B. Russell National School Lunch Act
12 (42 U.S.C. 1751 et seq.) is amended—

13 (1) by striking “or reduced price” each place it
14 appears;

15 (2) by striking “or a reduced price” each place
16 it appears;

17 (3) by striking “and reduced price” each place
18 it appears; and

19 (4) by striking “a reduced price” each place it
20 appears.

21 **SEC. 5717. MEASURE OF POVERTY.**

22 Section 1113(a) of the Elementary and Secondary
23 Education Act of 1965 (20 U.S.C. 6313(a)) is amended—

24 (1) in paragraph (5)(A), by striking “the num-
25 ber of children eligible for a free or reduced price

1 lunch under the Richard B. Russell National School
2 Lunch Act (42 U.S.C. 1751 et seq.)” and inserting
3 “the number of identified students”; and

4 (2) by adding at the end the following:

5 “(8) IDENTIFIED STUDENTS DEFINED.—

6 “(A) IN GENERAL.—In this subsection, the
7 term ‘identified students’ means the number of
8 students—

9 “(i) who are—

10 “(I) homeless children and
11 youths, as defined under section
12 725(2) of the McKinney-Vento Home-
13 less Assistance Act (42 U.S.C.
14 11434a(2));

15 “(II) runaway and homeless
16 youth served by programs established
17 under the Runaway and Homeless
18 Youth Act (34 U.S.C. 11201 et seq.);

19 “(III) migratory children, as de-
20 fined under section 1309; or

21 “(IV) foster children;

22 “(ii) who are eligible for and receiving
23 medical assistance under the program of
24 medical assistance established under title

1 XIX of the Social Security Act (42 U.S.C.
2 1396 et seq.); or

3 “(iii) who participate (or who are part
4 of a household that participates) in at least
5 one of the following:

6 “(I) The supplemental nutrition
7 assistance program established under
8 the Food and Nutrition Act of 2008
9 (7 U.S.C. 2011 et seq.).

10 “(II) A State program funded
11 under the program of block grants to
12 States for temporary assistance for
13 needy families established under part
14 A of title IV of the Social Security
15 Act (42 U.S.C. 601 et seq.).

16 “(III) The food distribution pro-
17 gram on Indian reservations estab-
18 lished under section 4(b) of the Food
19 and Nutrition Act of 2008 (7 U.S.C.
20 2013(b)).

21 “(IV) A Head Start program au-
22 thorized under the Head Start Act
23 (42 U.S.C. 9831 et seq.) or a com-
24 parable State-funded Head Start or
25 pre-kindergarten program.

1 “(B) MULTIPLIER.—In determining the
2 number of identified students under subpara-
3 graph (A), the local educational agency shall
4 multiply the number determined under such
5 subparagraph by 1.6.”.

6 **SEC. 5718. SUPPLEMENTAL NUTRITION ASSISTANCE PRO-**
7 **GRAM.**

8 (a) AGREEMENT FOR DIRECT CERTIFICATION.—

9 (1) IN GENERAL.—Section 11 of the Food and
10 Nutrition Act of 2008 (7 U.S.C. 2020) is amend-
11 ed—

12 (A) by striking subsection (u); and

13 (B) by redesignating subsections (v)
14 through (x) as subsections (u) through (w), re-
15 spectively.

16 (2) CONFORMING AMENDMENTS.—Section 11(e)
17 of the Food and Nutrition Act of 2008 (7 U.S.C.
18 2020(e)) is amended—

19 (A) in paragraph (8)(F), by striking “or
20 subsection (u)”;

21 (B) in paragraph (26)(B), by striking
22 “(x)” and inserting “(w)”.

23 (b) NUTRITION EDUCATION AND OBESITY PREVEN-
24 TION GRANT PROGRAM.—Section 28(a) of the Food and

1 Nutrition Act of 2008 (7 U.S.C. 2036a(a)) is amended
2 by striking paragraph (1) and inserting the following:

3 “(1) an individual eligible for benefits under
4 this Act;”.

5 **SEC. 5719. HIGHER EDUCATION ACT OF 1965.**

6 (a) **TEACHER QUALITY ENHANCEMENT.**—Subpara-
7 graph (A) of section 200(11) of the Higher Education Act
8 of 1965 (20 U.S.C. 1021(11)) is amended to read as fol-
9 lows:

10 “(A) **IN GENERAL.**—The term ‘high-need
11 school’ means a school that is in the highest
12 quartile of schools in a ranking of all schools
13 served by a local educational agency, ranked in
14 descending order by percentage of students
15 from low-income families enrolled in such
16 schools, as determined by the local educational
17 agency based on one of the following measures
18 of poverty:

19 “(i) The percentage of students aged
20 5 through 17 in poverty counted in the
21 most recent census data approved by the
22 Secretary.

23 “(ii) The percentage of students in
24 families receiving assistance under the
25 State program funded under the program

1 of block grants to States for temporary as-
2 sistance for needy families established
3 under part A of title IV of the Social Secu-
4 rity Act (42 U.S.C. 601 et seq.).

5 “(iii) The percentage of students eligi-
6 ble to receive medical assistance under the
7 program of medical assistance established
8 under title XIX of the Social Security Act
9 (42 U.S.C. 1396 et seq.).

10 “(iv) A composite of two or more of
11 the measures described in clauses (i)
12 through (iii).”.

13 (b) GEAR UP.—Subparagraph (A) of section
14 404B(d)(1) of the Higher Education Act of 1965 (20
15 U.S.C. 1070a–22(d)(1)) is amended to read as follows:

16 “(A) provide services under this chapter to
17 at least one grade level of students, beginning
18 not later than 7th grade, in a participating
19 school—

20 “(i) that has a 7th grade; and

21 “(ii) in which—

22 “(I) at least 50 percent of the
23 students enrolled are identified stu-
24 dents (as described in clause (i), (ii),
25 or (iii) of section 1113(a)(8)(A) of the

1 Elementary and Secondary Education
2 Act of 1965); or

3 “(II) if an eligible entity deter-
4 mines that it would promote the effec-
5 tiveness of a program, an entire grade
6 level of students, beginning not later
7 than the 7th grade, reside in public
8 housing, as defined in section 3(b)(1)
9 of the United States Housing Act of
10 1937 (42 U.S.C. 1437a(b)(1)).”.

11 (c) SIMPLIFIED NEEDS TEST.—Section 479(d)(2) of
12 the Higher Education Act of 1965 (20 U.S.C.
13 1087ss(d)(2)) is amended—

14 (1) by striking subparagraph (C); and
15 (2) by redesignating subparagraphs (D)
16 through (F) as subparagraphs (C) through (E), re-
17 spectively.

18 (d) EARLY FEDERAL PELL GRANT COMMITMENT
19 DEMONSTRATION PROGRAM.—Section 894(b) of the
20 Higher Education Act of 1965 (20 U.S.C. 1161y(b)) is
21 amended—

22 (1) in paragraph (1)(B), by striking “qualify
23 for a free or reduced price school lunch under the
24 Richard B. Russell National School Lunch Act (42
25 U.S.C. 1751 et seq.) or the Child Nutrition Act of

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1 1966 (42 U.S.C. 1771 et seq.)” and inserting “are
2 identified students (as described in clause (i), (ii), or
3 (iii) of section 1113(a)(8)(A) of the Elementary and
4 Secondary Education Act of 1965)”;

5 (2) in paragraph (5), by striking “eligible for a
6 free or reduced price school lunch under the Richard
7 B. Russell National School Lunch Act (42 U.S.C.
8 1751 et seq.) or the Child Nutrition Act of 1966 (42
9 U.S.C. 1771 et seq.)” and inserting “identified stu-
10 dents (as described in clause (i), (ii), or (iii) of sec-
11 tion 1113(a)(8)(A) of the Elementary and Sec-
12 ondary Education Act of 1965)”.

13 **SEC. 5720. ELEMENTARY AND SECONDARY EDUCATION ACT**
14 **OF 1965.**

15 (a) LITERACY EDUCATION FOR ALL.—Section
16 2221(b)(3)(B) of the Elementary and Secondary Edu-
17 cation Act of 1965 (20 U.S.C. 6641(b)(3)(B)) is amend-
18 ed—

19 (1) by striking clause (i); and

20 (2) by redesignating clauses (ii) and (iii) as
21 clauses (i) and (ii), respectively.

22 (b) GRANTS FOR EDUCATION INNOVATION AND RE-
23 SEARCH.—Section 4611(d)(2) of the Elementary and Sec-
24 ondary Education Act of 1965 (20 U.S.C. 7261(d)(2)) is
25 amended—

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1 (1) by striking subparagraph (B); and
2 (2) by redesignating subparagraphs (C) and
3 (D) as subparagraphs (B) and (C), respectively.

4 (c) ELIGIBILITY FOR HEAVILY IMPACTED LOCAL
5 EDUCATIONAL AGENCIES.—Item (bb) of section
6 7003(b)(2)(B)(i)(III) of the Elementary and Secondary
7 Education Act of 1965 (20 U.S.C. 7703(b)(2)(B)(i)(III))
8 is amended to read as follows:

9 “(bb) has an enrollment of
10 children described in subsection
11 (a)(1) that constitutes a percent-
12 age of the total student enroll-
13 ment of the agency that is not
14 less than 30 percent; or”.

15 **SEC. 5721. AMERICA COMPETES ACT.**

16 Section 6122(3) of the America COMPETES Act (20
17 U.S.C. 9832(3)) is amended by striking “data on children
18 eligible for free or reduced-price lunches under the Rich-
19 ard B. Russell National School Lunch Act,”.

20 **SEC. 5722. WORKFORCE INNOVATION AND OPPORTUNITY**
21 **ACT.**

22 Section 3(36)(A) of the Workforce Innovation and
23 Opportunity Act (29 U.S.C. 3102(36)(A)) is amended—
24 (1) by striking clause (iv); and

1 (2) by redesignating clauses (v) and (vi) as
2 clauses (iv) and (v), respectively.

3 **SEC. 5723. NATIONAL SCIENCE FOUNDATION AUTHORIZA-**
4 **TION ACT OF 2002.**

5 Section 4(8) of the National Science Foundation Au-
6 thorization Act of 2002 (42 U.S.C. 1862n note) is amend-
7 ed—

8 (1) by striking subparagraph (A); and
9 (2) by redesignating subparagraphs (B) and
10 (C) as subparagraphs (A) and (B), respectively.

11 **SEC. 5724. CHILD CARE AND DEVELOPMENT BLOCK GRANT.**

12 Section 6580(b) of the Child Care and Development
13 Block Grant Act of 1990 (42 U.S.C. 9858m(b)) is amend-
14 ed—

15 (1) in paragraph (1)(B), by striking “school
16 lunch factor” and inserting “identified students fac-
17 tor”; and

18 (2) by striking paragraph (3) and inserting the
19 following:

20 “(3) IDENTIFIED STUDENTS FACTOR.—The
21 term ‘identified students factor’ means the ratio of
22 the number of children who are identified students
23 (as determined under paragraph (8) of section
24 1113(a) of the Elementary and Secondary Edu-
25 cation Act of 1965 (20 U.S.C. 6313(a))) in the

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1 State to the number of such children in all the
2 States as determined annually by the Secretary of
3 Education.”.

4 **SEC. 5725. CHILDREN’S HEALTH ACT OF 2000.**

5 Section 1404(b) of the Children’s Health Act of 2000
6 (42 U.S.C. 9859c(b)) is amended—

7 (1) in paragraph (1)(B), by striking “school
8 lunch factor” and inserting “identified students fac-
9 tor”; and

10 (2) by amending paragraph (3) to read as fol-
11 lows:

12 “(3) IDENTIFIED STUDENTS FACTOR.—In this
13 subsection, the term ‘identified students factor’
14 means the ratio of the number of children who are
15 identified students (as determined under paragraph
16 (8) of section 1113(a) of the Elementary and Sec-
17 ondary Education Act of 1965 (20 U.S.C. 6313(a)))
18 in the State to the number of such children in all
19 the States as determined annually by the Secretary
20 of Education.”.

21 **SEC. 5726. JUVENILE JUSTICE AND DELINQUENCY PREVEN-**
22 **TION.**

23 Section 252(i) of the Juvenile Justice and Delin-
24 quency Prevention Act of 1974 (34 U.S.C. 11162(i)) is
25 amended to read as follows:

1 “(i) FREE SCHOOL LUNCHES FOR INCARCERATED
2 JUVENILES.—

3 “(1) ELIGIBLE JUVENILE DETENTION CENTER
4 DEFINED.—In this subsection, the term ‘eligible ju-
5 venile detention center’ does not include any private,
6 for-profit detention center.

7 “(2) ELIGIBILITY FOR FREE LUNCH.—A juve-
8 nile who is incarcerated in an eligible juvenile deten-
9 tion center is eligible to receive free lunch under the
10 Richard B. Russell National School Lunch Act (42
11 U.S.C. 1751 et seq.).

12 “(3) GUIDANCE.—Not later than 1 year after
13 the date of enactment of the Universal School Meals
14 Program Act of 2022, the Attorney General, in con-
15 sultation with the Secretary of Agriculture, shall
16 provide guidance to States relating to the options for
17 school food authorities in the States to apply for re-
18 imbursement for free lunches under the Richard B.
19 Russell National School Lunch Act (42 U.S.C. 1751
20 et seq.) for juveniles who are incarcerated.”.

Subtitle I—Elder Care

2 SEC. 5801. EXPENSES FOR HOUSEHOLD AND ELDER CARE **3 SERVICES NECESSARY FOR GAINFUL EM-** **4 PLOYMENT.**

5 (a) IN GENERAL.—Subpart A of part IV of sub-
6 chapter A of chapter 1 of the Internal Revenue Code of
7 1986 is amended by inserting after section 25D the fol-
8 lowing new section:

9 “SEC. 25E. EXPENSES FOR HOUSEHOLD AND ELDER CARE **10 SERVICES NECESSARY FOR GAINFUL EM-** **11 PLOYMENT.**

12 “(a) ALLOWANCE OF CREDIT.—

13 “(1) IN GENERAL.—In the case of an individual
14 for which there are one or more qualifying individ-
15 uals (as defined in subsection (b)(1)) with respect to
16 such individual, there shall be allowed as a credit
17 against the tax imposed by this chapter for the tax-
18 able year an amount equal to the applicable percent-
19 age of the employment-related expenses (as defined
20 in subsection (b)(3)) paid by such individual during
21 the taxable year.

22 “(2) APPLICABLE PERCENTAGE DEFINED.—For
23 purposes of paragraph (1), the term ‘applicable per-
24 centage’ means 35 percent reduced (but not below
25 20 percent) by 1 percentage point for each \$2,000

1 (or fraction thereof) by which the taxpayer's ad-
2 justed gross income for the taxable year exceeds
3 \$15,000.

4 “(b) DEFINITIONS OF QUALIFYING INDIVIDUAL AND
5 EMPLOYMENT-RELATED EXPENSES.—For purposes of
6 this section—

7 “(1) QUALIFYING INDIVIDUAL.—The term
8 ‘qualifying individual’ means an individual who—

9 “(A) has attained age 50, and

10 “(B) satisfies the requirements of any of
11 the following clauses:

12 “(i) An individual who bears a rela-
13 tionship to the taxpayer described in sub-
14 paragraph (C) or (D) of section 152(d)(2)
15 (relating to fathers, mothers, and ances-
16 tors).

17 “(ii) An individual who would be a de-
18 pendent of the taxpayer (as defined in sec-
19 tion 152, determined without regard to
20 subsections (b)(1) and (b)(2)) as a quali-
21 fying relative described in section
22 152(d)(1) if—

23 “(I) in lieu of the requirements
24 under subparagraphs (B) and (C) of

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1 such section, with respect to such in-
2 dividual—

3 “(aa) the taxpayer has pro-
4 vided over one-half of the individ-
5 ual’s support for the calendar
6 year in which such taxable year
7 begins and each of the preceding
8 4 taxable years, and

9 “(bb) the individual’s modi-
10 fied adjusted gross income for
11 the calendar year in which such
12 taxable year begins is less than
13 the exemption amount (as de-
14 fined in section 151(d)),

15 “(II) the individual is physically
16 or mentally incapable of caring for
17 himself or herself, and

18 “(III) the individual has the
19 same principal place of abode as the
20 taxpayer for more than one-half of
21 such taxable year.

22 “(iii) The spouse of the taxpayer, if
23 such spouse is physically or mentally in-
24 capable of caring for himself or herself.

1 “(2) MODIFIED ADJUSTED GROSS INCOME.—

2 The term ‘modified adjusted gross income’ means
3 adjusted gross income determined without regard to
4 section 86.

5 “(3) EMPLOYMENT-RELATED EXPENSES.—

6 “(A) IN GENERAL.—The term ‘employ-
7 ment-related expenses’ means amounts paid for
8 the following expenses, but only if such ex-
9 penses are incurred to enable the taxpayer to be
10 gainfully employed for any period for which
11 there are one or more qualifying individuals
12 with respect to the taxpayer:

13 “(i) Expenses for household services
14 with respect to the qualifying individual.

15 “(ii) Expenses for the care of a quali-
16 fying individual, including expenses for res-
17 pite care and hospice care.

18 “(B) EXCEPTION.—The term ‘employ-
19 ment-related expenses’ shall not include services
20 provided outside the taxpayer’s household un-
21 less such expenses are incurred for the care
22 of—

23 “(i) a qualifying individual described
24 in paragraph (1)(A), or

1 “(ii) a qualifying individual (not de-
2 scribed in paragraph (1)(A)) who regularly
3 spends at least 8 hours each day in the
4 taxpayer’s household.

5 “(C) DEPENDENT CARE CENTERS.—The
6 term ‘employment-related expenses’ shall not
7 include services provided outside the taxpayer’s
8 household by a dependent care center (as de-
9 fined in subparagraph (D)) unless—

10 “(i) such center complies with all ap-
11 plicable laws and regulations of the State
12 and local government in which such center
13 is located, and

14 “(ii) the requirements of subpara-
15 graph (B) are met.

16 “(D) DEPENDENT CARE CENTER DE-
17 FINED.—For purposes of this paragraph, the
18 term ‘dependent care center’ means any facility
19 which—

20 “(i) provides care for more than 6 in-
21 dividuals (other than individuals who re-
22 side at the facility), and

23 “(ii) receives a fee, payment, or grant
24 for providing services for any of the indi-

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1 viduals (regardless of whether such facility
2 is operated for profit).

3 “(c) DOLLAR LIMIT ON AMOUNT CREDITABLE.—The
4 amount of the employment-related expenses incurred dur-
5 ing any taxable year which may be taken into account
6 under subsection (a) shall not exceed—

7 “(1) if there is 1 qualifying individual with re-
8 spect to the taxpayer for such taxable year, \$3,000,
9 or

10 “(2) if there are 2 or more qualifying individ-
11 uals with respect to the taxpayer for such taxable
12 year, \$6,000.

13 The amount determined under this subsection shall be re-
14 duced by the aggregate amount excludable from gross in-
15 come under section 129 for the taxable year.

16 “(d) EARNED INCOME LIMITATION.—The amount of
17 the employment-related expenses incurred during any tax-
18 able year which may be taken into account under sub-
19 section (a) shall not exceed—

20 “(1) in the case of an individual who is not
21 married at the close of such year, such individual’s
22 earned income for such year, or

23 “(2) in the case of an individual who is married
24 at the close of such year, the lesser of such individ-

1 ual's earned income or the earned income of his
2 spouse for such year.

3 “(e) SPECIAL RULES.—For purposes of this sec-
4 tion—

5 “(1) PLACE OF ABODE.—An individual shall
6 not be treated as having the same principal place of
7 abode of the taxpayer if at any time during the tax-
8 able year of the taxpayer the relationship between
9 the individual and the taxpayer is in violation of
10 local law.

11 “(2) MARRIED COUPLES MUST FILE JOINT RE-
12 TURN.—In the case of an individual who is married
13 as of the close of the taxable year, the credit shall
14 be allowed under subsection (a) only if a joint return
15 is filed for the taxable year under section 6013.

16 “(3) MARITAL STATUS.—An individual legally
17 separated from his or her spouse under a decree of
18 divorce or of separate maintenance shall not be con-
19 sidered as married.

20 “(4) CERTAIN MARRIED INDIVIDUALS LIVING
21 APART.—In the case of an individual who is married
22 and does not file a joint return for the taxable year,
23 if—

24 “(A) such individual—

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1 “(i) maintains as his or her home a
2 household which constitutes for more than
3 one-half of the taxable year the principal
4 place of abode of a qualifying individual,

5 “(ii) furnishes over half of the cost of
6 maintaining such household during the
7 taxable year, and

8 “(B) during the last 6 months of such tax-
9 able year, such individual’s spouse is not a
10 member of such household,

11 such individual shall not be considered as married.

12 “(5) PAYMENTS TO RELATED INDIVIDUALS.—
13 No credit shall be allowed under subsection (a) for
14 any amount paid by the taxpayer to an individual—

15 “(A) with respect to whom, for the taxable
16 year, a deduction under section 151(c) (relating
17 to deduction for personal exemptions for de-
18 pendents) is allowable either to the taxpayer or
19 the taxpayer’s spouse, or

20 “(B) who—

21 “(i) is a child of the taxpayer (within
22 the meaning of section 152(f)(1)), and

23 “(ii) has not attained the age of 19 at
24 the close of the taxable year.

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1 For purposes of this paragraph, the term ‘taxable
2 year’ means the taxable year of the taxpayer in
3 which the service (as described in clause (i) of sub-
4 section (b)(3)(A)) is performed or the care (as de-
5 scribed in clause (ii) of such subsection) is provided.

6 “(6) IDENTIFYING INFORMATION REQUIRED
7 WITH RESPECT TO SERVICE PROVIDER.—No credit
8 shall be allowed under subsection (a) for any amount
9 paid to any person unless—

10 “(A) the name, address, and taxpayer
11 identification number of such person are in-
12 cluded on the return of tax for the taxable year
13 in which the credit under this section is being
14 claimed, or

15 “(B) if such person is an organization de-
16 scribed in section 501(c)(3) and exempt from
17 tax under section 501(a), the name and address
18 of such person are included on the return of tax
19 for the taxable year in which the credit under
20 this section is being claimed.

21 In the case of a failure to provide the information
22 required under the preceding sentence, the preceding
23 sentence shall not apply if it is shown that the tax-
24 payer exercised due diligence in attempting to pro-
25 vide the information so required.

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1 “(7) IDENTIFYING INFORMATION REQUIRED
2 WITH RESPECT TO QUALIFYING INDIVIDUALS.—No
3 credit shall be allowed under this section with re-
4 spect to any qualifying individual unless the TIN of
5 such individual is included on the return of tax for
6 the taxable year in which the credit under this sec-
7 tion is being claimed.

8 “(f) REGULATIONS.—The Secretary shall prescribe
9 such regulations as may be necessary to carry out the pur-
10 poses of this section.”.

11 (b) CLERICAL AMENDMENT.—The table of sections
12 for subpart A of part IV of subchapter A of chapter 1
13 of the Internal Revenue Code of 1986 is amended by in-
14 serting after the item relating to section 25D the following
15 new item:

 “Sec. 25E. Expenses for household and elder care services necessary for gainful
 employment.”.

16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to taxable years beginning after
18 the date of the enactment of this Act.

1 **Subtitle J—Miscellaneous**
2 **Provisions**

3 **SEC. 5901. CLARIFICATION SUPPORTING PERMISSIBLE USE**
4 **OF FUNDS FOR STILLBIRTH PREVENTION AC-**
5 **TIVITIES.**

6 Section 501(a) of the Social Security Act (42 U.S.C.
7 701(a)) is amended—

8 (1) in paragraph (1)(B), by inserting “to re-
9 duce the incidence of stillbirth,” after “among chil-
10 dren,”; and

11 (2) in paragraph (2), by inserting after “follow-
12 up services” the following: “, and for evidence-based
13 programs and activities and outcome research to re-
14 duce the incidence of stillbirth (including tracking
15 and awareness of fetal movements, improvement of
16 birth timing for pregnancies with risk factors, initia-
17 tives that encourage safe sleeping positions during
18 pregnancy, screening and surveillance for fetal
19 growth restriction, efforts to achieve smoking ces-
20 sation during pregnancy, community-based programs
21 that provide home visits or other types of support,
22 and any other research or evidence-based program-
23 ming to prevent stillbirths)”.

1 **TITLE VI—MENTAL HEALTH AND**
2 **SUBSTANCE USE DISORDERS**

3 **SEC. 6001. MENTAL HEALTH FINDINGS.**

4 Congress finds the following:

5 (1) Despite the existence of effective treat-
6 ments, inequities lie in the availability, accessibility,
7 and quality of mental health services for racial and
8 ethnic minorities and people with disabilities.

9 (2) These inequities have powerful significance
10 for minority groups and for society as a whole.

11 (3) Racial and ethnic minorities bear a greater
12 burden from unmet mental health needs and thus
13 suffer a greater loss to their overall health and pro-
14 ductivity.

15 (4) Improving community conditions and one's
16 home environment, paired with high-quality, acces-
17 sible, and culturally and linguistically tailored men-
18 tal health services, can reduce the likelihood, fre-
19 quency, and intensity of challenges to one's mental
20 health.

21 (5) The presence of strong social connections
22 and trust, opportunities to experience and share cul-
23 tural identity, safe gathering places, and economic
24 opportunity are community factors that benefit men-
25 tal health.

1 (6) The social, physical, economic, and other
2 conditions, otherwise known as social determinants
3 of health, in communities can have tremendous in-
4 fluence on daily stressors that shape mental health
5 outcomes.

6 (7) Significant barriers include the cost of and
7 access to quality care, societal stigma, mental health
8 workforce shortages, the fragmented organization of
9 services and needed social supports, and the history
10 of racism and discrimination in the mental health
11 system.

12 (8) People with severe and persistent mental ill-
13 ness who are racial or ethnic minorities often have
14 co-occurring health and mental health conditions
15 and experience direct inequities in access to nec-
16 essary supports, resources, and services which, with-
17 out proper accommodations and support, further
18 stigmatize them and limit their participation in soci-
19 ety.

20 (9) African-American, Latinx, Asian American,
21 Pacific Islander, Native, Middle Eastern and North
22 African (MENA), and other people of color commu-
23 nities are more likely to experience systemic dis-
24 crimination by health care and social service pro-

1 viders and may be reluctant to seek mental health
2 care and other health interventions.

3 (10) Mental health conditions and substance
4 abuse disorders retain considerable stigma in many
5 communities of color and seeking treatment is not
6 always encouraged.

7 (11) Addressing mental health stigma and in-
8 creasing access to culturally and linguistically appro-
9 priate treatments and supports in communities will
10 help to increase utilization of mental health services
11 for people who have functional difficulties because of
12 mental health challenges.

13 (12) There is a link between a mental health di-
14 agnosis and the likelihood of an individual commit-
15 ting suicide.

16 (13) A comprehensive public health approach to
17 behavioral health is one that fosters and finances
18 protective factors in racial and ethnic communities
19 that support mental health.

20 (14) Approaches to mental health and trauma
21 must keep in mind the historical and present day
22 and cultural trauma that impacts many communities
23 of color, including trauma and loss caused by ad-
24 verse weather events and structural violence.

1 (15) Culturally and linguistically appropriate
2 treatments and supports must keep approaches of
3 individual communities to mental health in mind, in-
4 cluding by considering—

5 (A) approaches to cultural healing prac-
6 tices; and

7 (B) the diverse mental health professionals
8 needed for such practices, such as peer support
9 specialists.

10 (16) Approaches to mental health and address-
11 ing trauma must keep in mind the concept of
12 intersectionality of individuals; that individuals may
13 experience many inequities that shape the way they
14 process and experience everyday life.

15 **SEC. 6002. SENSE OF CONGRESS.**

16 It is the sense of the Congress that it is imperative
17 that a comprehensive public health approach to addressing
18 trauma and mental health care be focused on care delivery
19 that is culturally and linguistically appropriate.

**Subtitle A—Access to Care and
Funding Streams**

SEC. 6011. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES, MENTAL HEALTH COUNSELOR SERVICES, SUBSTANCE ABUSE COUNSELOR SERVICES, AND PEER SUPPORT SPECIALIST SERVICES UNDER PART B OF THE MEDICARE PROGRAM.

(a) COVERAGE OF SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 4251(c)(1), is amended—

(A) in subparagraph (HH), by striking “and” at the end;

(B) in subparagraph (II), by adding “and” at the end; and

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

“(JJ) marriage and family therapist services (as defined in subsection (ooo)(1)), mental health counselor services (as defined in subsection (ooo)(3)), substance abuse counselor services (as defined in subsection (ooo)(5)), and peer support specialist services (as defined in subsection (ooo)(7));”.

1 (2) DEFINITIONS.—Section 1861 of the Social
2 Security Act (42 U.S.C. 1395x), as amended by sec-
3 tions 2007(b), 4221(a), and 4251(c)(2), is amended
4 by adding at the end the following new subsection:
5 “Marriage and Family Therapist Services; Marriage and
6 Family Therapist; Mental Health Counselor Serv-
7 ices; Mental Health Counselor; Substance Abuse
8 Counselor Services; Substance Abuse Counselor;
9 Peer Support Specialist Services; Peer Support Spe-
10 cialist

11 “(ooo)(1) The term ‘marriage and family therapist
12 services’ means services performed by a marriage and
13 family therapist (as defined in paragraph (2)) for the diag-
14 nosis and treatment of mental illnesses, which the mar-
15 riage and family therapist is legally authorized to perform
16 under State law (or the State regulatory mechanism pro-
17 vided by State law) of the State in which such services
18 are performed, as would otherwise be covered if furnished
19 by a physician or as an incident to a physician’s profes-
20 sional service, but only if no facility or other provider
21 charges or is paid any amounts with respect to the fur-
22 nishing of such services.

23 “(2) The term ‘marriage and family therapist’ means
24 an individual who—

1 “(A) possesses a master’s or doctoral degree
2 that qualifies for licensure or certification as a mar-
3 riage and family therapist pursuant to State law, in-
4 cluding but not limited to, clinical social workers and
5 occupational therapists;

6 “(B) after obtaining such degree has performed
7 at least 2 years of clinical supervised experience in
8 marriage and family therapy; and

9 “(C) in the case of an individual performing
10 services in a State that provides for licensure or cer-
11 tification of marriage and family therapists, is li-
12 censed or certified as a marriage and family thera-
13 pist in such State.

14 “(3) The term ‘mental health counselor services’
15 means services performed by a mental health counselor (as
16 defined in paragraph (4)) for the diagnosis and treatment
17 of mental health conditions and disabilities that the men-
18 tal health counselor is legally authorized to perform under
19 State law (or the State regulatory mechanism provided by
20 the State law) of the State in which such services are per-
21 formed, as would otherwise be covered if furnished by a
22 physician or as incident to a physician’s professional serv-
23 ice, but only if no facility or other provider charges or is
24 paid any amounts with respect to the furnishing of such
25 services.

1 “(4) The term ‘mental health counselor’ means an
2 individual who—

3 “(A) possesses a master’s or doctor’s degree in
4 mental health counseling or a related field, including
5 clinical social workers and occupational therapists;

6 “(B) after obtaining such a degree has per-
7 formed at least 2 years of supervised mental health
8 counselor practice; and

9 “(C) in the case of an individual performing
10 services in a State that provides for licensure or cer-
11 tification of mental health counselors or professional
12 counselors, is licensed or certified as a mental health
13 counselor or professional counselor in such State.

14 “(5) The term ‘substance abuse counselor services’
15 means services performed by a substance abuse counselor
16 (as defined in paragraph (6)) for the diagnosis and treat-
17 ment of substance abuse and addiction that the substance
18 abuse counselor is legally authorized to perform under
19 State law (or the State regulatory mechanism provided by
20 the State law) of the State in which such services are per-
21 formed, as would otherwise be covered if furnished by a
22 physician or as incident to a physician’s professional serv-
23 ice, but only if no facility or other provider charges or is
24 paid any amounts with respect to the furnishing of such
25 services.

1 “(6) The term ‘substance abuse counselor’ means an
2 individual who—

3 “(A) has performed at least 2 years of super-
4 vised substance abuse counselor practice;

5 “(B) in the case of an individual performing
6 services in a State that provides for licensure or cer-
7 tification of substance abuse counselors or profes-
8 sional counselors, is licensed or certified as a sub-
9 stance abuse counselor or professional counselor in
10 such State; or

11 “(C) is a drug and alcohol counselor as defined
12 in section 40.281 of title 49, Code of Federal Regu-
13 lations.

14 “(7) The term ‘peer support specialist services’
15 means services performed by a peer support specialist (as
16 defined in paragraph (8)) for the well-being of individuals
17 needing mental health support that the peer support spe-
18 cialist is legally authorized to perform under State law (or
19 the State regulatory mechanism provided by the State
20 law) of the State in which such services are performed,
21 as would otherwise be covered if furnished by a physician
22 or as incident to a physician’s professional service, but
23 only if no facility or other provider charges or is paid any
24 amounts with respect to the furnishing of such services.

1 “(8) The term ‘peer support specialist’ means an in-
2 dividual who—

3 “(A) is an individual living in recovery with
4 mental illness, addiction, or systems involvement;

5 “(B) has skills learned in formal training;

6 “(C) uses assets-based framing in speaking
7 about mental health, recovery, and well-being; and

8 “(D) delivers services in behavioral health set-
9 tings to promote mind-body recovery and resil-
10 iency.”.

11 (3) PROVISION FOR PAYMENT UNDER PART
12 B.—Section 1832(a)(2)(B) of the Social Security
13 Act (42 U.S.C. 1395k(a)(2)(B)) is amended—

14 (A) by striking “and” at the end of clause
15 (iv); and

16 (B) by adding at the end the following new
17 clause:

18 “(v) marriage and family therapist
19 services, mental health counselor services,
20 substance abuse counselor services, and
21 peer support specialist services; and”.

22 (4) AMOUNT OF PAYMENT.—Section 1833(a)(1)
23 of the Social Security Act (42 U.S.C. 1395l(a)(1)),
24 as amended by section 4251(c)(3), is amended—

25 (A) by striking “and” before “(EE)”; and

1 (B) by inserting before the semicolon at
2 the end the following: “, and (FF) with respect
3 to marriage and family therapist services, men-
4 tal health counselor services, substance abuse
5 counselor services, and peer support specialist
6 services under section 1861(s)(2)(JJ), the
7 amounts paid shall be 80 percent of the lesser
8 of the actual charge for the services or 75 per-
9 cent of the amount determined for payment of
10 a psychologist under subparagraph (L)”.

11 (5) EXCLUSION OF MARRIAGE AND FAMILY
12 THERAPIST SERVICES, MENTAL HEALTH COUNSELOR
13 SERVICES, AND PEER SUPPORT SPECIALIST SERV-
14 ICES FROM SKILLED NURSING FACILITY PROSPEC-
15 TIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii)
16 of the Social Security Act (42 U.S.C.
17 1395yy(e)(2)(A)(ii)) is amended by inserting “mar-
18 riage and family therapist services (as defined in
19 section 1861(nnn)(1)), mental health counselor serv-
20 ices (as defined in section 1861(nnn)(3)), and peer
21 support specialist services (as defined in section
22 1861(nnn)(7)),” after “qualified psychologist serv-
23 ices,”.

24 (6) INCLUSION OF MARRIAGE AND FAMILY
25 THERAPISTS, MENTAL HEALTH COUNSELORS, AND

1 SUBSTANCE ABUSE COUNSELORS AS PRACTITIONERS
2 FOR ASSIGNMENT OF CLAIMS.—Section
3 1842(b)(18)(C) of the Social Security Act (42
4 U.S.C. 1395u(b)(18)(C)) is amended by adding at
5 the end the following new clauses:

6 “(vii) A marriage and family therapist (as de-
7 fined in section 1861(nnn)(2)).

8 “(viii) A mental health counselor (as defined in
9 section 1861(nnn)(4)).

10 “(ix) A substance abuse counselor (as defined
11 in section 1861(nnn)(6)).

12 “(x) A peer support specialist (as defined in
13 section 1861(nnn)(8)).”.

14 (b) COVERAGE OF CERTAIN MENTAL HEALTH SERV-
15 ICES PROVIDED IN CERTAIN SETTINGS.—

16 (1) RURAL HEALTH CLINICS AND FEDERALLY
17 QUALIFIED HEALTH CENTERS.—Section
18 1861(aa)(1)(B) of the Social Security Act (42
19 U.S.C. 1395x(aa)(1)(B)) is amended by striking “or
20 by a clinical social worker (as defined in subsection
21 (hh)(1)),” and inserting “, by a clinical social worker
22 (as defined in subsection (hh)(1)), by a marriage
23 and family therapist (as defined in subsection
24 (nnn)(2)), or by a mental health counselor (as de-
25 fined in subsection (nnn)(4)), or by a substance

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1 abuse counselor (as defined in section 1861
2 (nnn)(6)), or by a peer support specialist (as defined
3 in section 1861(nnn)(8)).”.

4 (2) HOSPICE PROGRAMS.—Section
5 1861(dd)(2)(B)(i)(III) of the Social Security Act (42
6 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by in-
7 serting “or one marriage and family therapist (as
8 defined in subsection (nnn)(2))” after “social work-
9 er”.

10 (c) AUTHORIZATION OF MARRIAGE AND FAMILY
11 THERAPISTS TO DEVELOP DISCHARGE PLANS FOR
12 POSTHOSPITAL SERVICES.—Section 1861(ee)(2)(G) of
13 the Social Security Act (42 U.S.C. 1395x(ee)(2)(G)) is
14 amended by inserting “marriage and family therapist (as
15 defined in subsection (nnn)(2)),” after “social worker,”.

16 (d) EFFECTIVE DATE.—The amendments made by
17 this section shall apply with respect to services furnished
18 on or after January 1, 2023.

19 **SEC. 6012. REAUTHORIZATION OF MINORITY FELLOWSHIP**
20 **PROGRAM.**

21 Section 597(c) of the Public Health Service Act (42
22 U.S.C. 297ll(c)) is amended by striking “\$12,669,000 for
23 each of fiscal years 2018 through 2022” and inserting
24 “\$25,000,000 for each of fiscal years 2023 through
25 2027”.

1 **SEC. 6013. ADDITIONAL FUNDS FOR NATIONAL INSTITUTES**
2 **OF HEALTH.**

3 (a) IN GENERAL.—In addition to amounts otherwise
4 authorized to be appropriated to the National Institutes
5 of Health, there is authorized to be appropriated to such
6 Institutes \$100,000,000 for each of fiscal years 2023
7 through 2027 to build relations with communities and con-
8 duct or support clinical research, including clinical re-
9 search on racial or ethnic disparities in physical and men-
10 tal health.

11 (b) DEFINITION.—In this section, the term “clinical
12 research” has the meaning given to such term in section
13 409 of the Public Health Service Act (42 U.S.C. 284d).

14 **SEC. 6014. ADDITIONAL FUNDS FOR NATIONAL INSTITUTE**
15 **ON MINORITY HEALTH AND HEALTH DISPARI-**
16 **TIES.**

17 In addition to amounts otherwise authorized to be ap-
18 propriated to the National Institute on Minority Health
19 and Health Disparities, there is authorized to be appro-
20 priated to such Institute \$650,000,000 for each of fiscal
21 years 2023 through 2027.

1 **SEC. 6015. GRANTS FOR INCREASING RACIAL AND ETHNIC**
2 **MINORITY ACCESS TO HIGH-QUALITY TRAU-**
3 **MA SUPPORT SERVICES AND MENTAL**
4 **HEALTH CARE.**

5 (a) IN GENERAL.—The Secretary of Health and
6 Human Services (in this section referred to as the “Sec-
7 retary”), acting through the Assistant Secretary for Men-
8 tal Health and Substance Use, shall award grants to eligi-
9 ble entities to establish or expand programs for the pur-
10 pose of increasing racial and ethnic minority access to
11 high-quality trauma support services and mental health
12 care.

13 (b) ELIGIBLE ENTITIES.—To seek a grant under this
14 section, an entity shall be a community-based program or
15 organization that—

16 (1) provides culturally and linguistically appro-
17 priate programs and resources that are aligned with
18 evidence-based practices for trauma-informed care;
19 and

20 (2) has demonstrated expertise in serving com-
21 munities of color or can partner with a program that
22 has such demonstrated expertise.

23 (c) USE OF FUNDS.—As a condition on receipt of a
24 grant under this section, a grantee shall agree to use the
25 grant to increase racial and ethnic minority access to high-

1 quality trauma support services and mental health care,
2 such as by—

3 (1) establishing and maintaining community-
4 based programs providing evidence-based services in
5 trauma-informed care and culturally specific services
6 and other resources;

7 (2) developing innovative, culturally-specific
8 strategies and projects to enhance access to trauma-
9 informed care and resources for racial and ethnic
10 minorities who face obstacles to using more tradi-
11 tional services and resources (such as obstacles in
12 geographic access to providers, insurance coverage,
13 and access to audio and video technologies);

14 (3) working with State and local governments
15 and social service agencies to develop and enhance
16 effective strategies to provide culturally-specific serv-
17 ices to racial and ethnic minorities;

18 (4) increasing communities' capacity to provide
19 culturally-specific resources and support for commu-
20 nities of color;

21 (5) working in cooperation with the community
22 to develop education and prevention strategies high-
23 lighting culturally-specific issues and resources re-
24 garding racial and ethnic minorities;

1 (6) providing culturally-specific programs for
2 racial and ethnic minorities exposed to law enforce-
3 ment violence; and

4 (7) examining the dynamics of culture and its
5 impact on victimization and healing.

6 (d) PRIORITY.—In awarding grants under this sec-
7 tion, the Secretary shall give priority to eligible entities
8 proposing to serve communities that have faced high rates
9 of community trauma, including from exposure to law en-
10 forcement violence, intergenerational poverty, civil unrest,
11 discrimination, or oppression.

12 (e) GRANT PERIOD.—The period of a grant under
13 this section shall be 4 years.

14 (f) EVALUATION.—Not later than 6 months after the
15 end of the period of all grants under this section, the Sec-
16 retary shall—

17 (1) conduct an evaluation of the programs
18 funded by a grant under this section;

19 (2) include in such evaluation an assessment of
20 the outcomes of each such program; and

21 (3) submit a report on the results of such eval-
22 uation to the Congress.

23 (g) AUTHORIZATION OF APPROPRIATIONS.—To carry
24 out this section, there is authorized to be appropriated
25 \$20,000,000 for each of fiscal years 2023 through 2027.

1 **SEC. 6016. GRANTS FOR UNARMED 9-1-1 RESPONSE PRO-**
2 **GRAMS.**

3 Part D of title V of the Public Health Service Act,
4 as amended by sections 6022, 6023, and 6052, is further
5 amended by adding at the end the following new section:

6 **“SEC. 556. GRANTS FOR UNARMED 9-1-1 RESPONSE PRO-**
7 **GRAMS.**

8 “(a) IN GENERAL.—The Secretary, acting through
9 the Assistant Secretary for Mental Health and Substance
10 Use, may award grants to States, territories, political sub-
11 divisions of States and territories, Tribal governments,
12 and consortia of Tribal governments to establish an un-
13 armed 9-1-1 response program under which nonviolent 9-
14 1-1 calls are referred to unarmed professional service pro-
15 viders for response, instead of to a law enforcement agen-
16 cy.

17 “(b) PROGRAM REQUIREMENTS.—An unarmed 9-1-
18 1 response program funded under this section shall—

19 “(1) dispatch unarmed professional service pro-
20 viders in groups of two or more in a timely manner;

21 “(2) be capable of providing screening, assess-
22 ment, de-escalation, trauma-informed culturally and
23 linguistically appropriate services, referrals to treat-
24 ment providers, and transportation to immediately
25 necessary treatment;

1 “(3) when necessary, coordinate with health or
2 social services;

3 “(4) not be subject to oversight of State or local
4 law enforcement agencies; and

5 “(5) clearly outline the scope of calls that must
6 or may be referred to the unarmed 9-1-1 response
7 program.

8 “(c) USES OF FUNDS.—A grant under this section
9 may be used for—

10 “(1) hiring unarmed professional service pro-
11 viders and 9-1-1 dispatchers;

12 “(2) training unarmed professional service pro-
13 viders to respond to 9-1-1 calls by identifying, un-
14 derstanding, and responding to signs of mental ill-
15 nesses, developmental or intellectual disabilities, and
16 substance use disorders, including by means of—

17 “(A) de-escalation;

18 “(B) crisis intervention; and

19 “(C) connecting individuals to local social
20 service providers, health care providers, commu-
21 nity-based organizations, and the full range of
22 other available providers and resources, with a
23 focus on culturally and linguistically appro-
24 priate service providers;

1 “(3) updating 9-1-1 response systems to enable
2 triage between nonviolent 9-1-1 calls and those that
3 require a response from law enforcement;

4 “(4) training 9-1-1 dispatchers on call diver-
5 sion;

6 “(5) building the capacity—

7 “(A) to coordinate with local social service
8 providers, health care providers, suicide hotline
9 operators, and community-based organizations;
10 and

11 “(B) to provide multilingual and culturally
12 and linguistically appropriate services; and

13 “(6) collecting data for reports to the Sec-
14 retary.

15 “(d) APPLICATION.—An applicant seeking a grant
16 under this section shall submit to the Secretary an appli-
17 cation at such time, in such manner, and containing such
18 information as the Secretary may reasonably require, in-
19 cluding the applicant’s plan to train 9-1-1 dispatchers to
20 determine when a call should be diverted to the unarmed
21 9-1-1 response program.

22 “(e) REPORTS TO SECRETARY.—A recipient of a
23 grant under this section shall submit to the Secretary, on
24 a biannual basis, a report on the following:

1 “(1) The number of calls placed to 9-1-1 that
2 were diverted to the grantee’s unarmed 9-1-1 re-
3 sponse program.

4 “(2) Demographic information on the individ-
5 uals served by the grantee’s unarmed 9-1-1 response
6 program, disaggregated by race, ethnicity, age, sex,
7 sexual orientation, gender identity, and location.

8 “(3) The effects of the grantee’s unarmed 9-1-
9 1 response program on emergency room visits, hos-
10 pitalizations, use of ambulances, and involvement of
11 law enforcement in mental health or substance use
12 disorder crises.

13 “(4) An assessment of the types of events and
14 crises to which the grantee’s unarmed 9-1-1 re-
15 sponse program responded and the services provided,
16 including—

17 “(A) the number of individuals to whom
18 services were provided who were involuntarily
19 committed for treatment;

20 “(B) the number of individuals successfully
21 transferred to an alternative destination;

22 “(C) the time between notification by a 9-
23 1-1 dispatcher and arrival at the scene by a
24 provider; and

25 “(D) the time spent by providers at scene.

1 “(5) A cost analysis of the grantee’s unarmed
2 9-1-1 response program.

3 “(6) An assessment of data sharing limitations
4 or problems associated with adherence to—

5 “(A) Federal regulations (concerning the
6 privacy of individually identifiable health infor-
7 mation) promulgated under section 264(c) of
8 the Health Insurance Portability and Account-
9 ability Act of 1996; and

10 “(B) part 2 of title 42, Code of Federal
11 Regulations.

12 “(f) REPORTS TO CONGRESS.—The Secretary shall
13 submit to the Congress, on a biannual basis, a report on
14 the program under this section, including a summary of
15 the reports submitted by grantees pursuant to subsection
16 (e).

17 “(g) GRANT AMOUNT.—The Secretary may make
18 grants to applicants that do not meet all of the criteria
19 under subsection (b), but applicants that do not meet all
20 such criteria may not receive the full grant amount.

21 “(h) DEFINITIONS.—In this section:

22 “(1) The term ‘alternative destination’—

23 “(A) means any service- or care-providing
24 site other than a hospital emergency depart-
25 ment or jail; and

1 “(B) includes a clinic, primary care office,
2 crisis center, and community care center.

3 “(2) The term ‘nonviolent 9-1-1 call’ means a
4 9-1-1 call that—

5 “(A) relates to mental health, homeless-
6 ness, addiction problems, social services, tru-
7 ancy, intellectual and developmental disabilities,
8 or public intoxication; and

9 “(B) does not involve obvious violent be-
10 havior.

11 “(3) The term ‘unarmed professional service
12 provider’ means a professional (which may include a
13 nurse, social worker, emergency medical technician,
14 counselor, community health worker, trauma-in-
15 formed personnel, social service provider, or peer
16 support specialist) who—

17 “(A) is trained to deal with mental health
18 or substance abuse crises or intellectual and de-
19 velopmental disabilities; and

20 “(B) does not carry a firearm.”.

1 **Subtitle B—Interprofessional Care**

2 **SEC. 6021. HEALTH PROFESSIONS COMPETENCIES TO AD-**
3 **DRESS RACIAL AND ETHNIC MENTAL HEALTH**
4 **INEQUITIES.**

5 (a) IN GENERAL.—The Secretary of Health and
6 Human Services, acting through the Assistant Secretary
7 for Mental Health and Substance Use, shall award grants
8 to qualified national organizations for the purposes of—

9 (1) developing, and disseminating to health pro-
10 fessional educational programs, culturally and lin-
11 guistically appropriate curricula or core com-
12 petencies addressing mental health inequities among
13 racial and ethnic minority groups for use in the
14 training of students in the professions of social
15 work, psychology, psychiatry, marriage and family
16 therapy, mental health counseling, peer support, and
17 substance abuse counseling; and

18 (2) certifying community health workers and
19 peer wellness specialists with respect to such cur-
20 ricula and core competencies and integrating and ex-
21 panding the use of such workers and specialists into
22 health care and community-based settings to address
23 mental health inequities among racial and ethnic mi-
24 nority groups.

1 (b) CURRICULA; CORE COMPETENCIES.—Organiza-
2 tions receiving funds under subsection (a) may use the
3 funds to engage in the following activities related to the
4 development and dissemination of curricula or core com-
5 petencies described in subsection (a)(1):

6 (1) Formation of committees or working groups
7 comprised of experts from accredited health profes-
8 sions schools to identify core competencies relating
9 to mental health inequities among racial and ethnic
10 minority groups.

11 (2) Planning of workshops in collaboration with
12 community-based organizations and communities of
13 color in national fora to directly facilitate public
14 input, including input from communities of color
15 with lived experience, into the educational needs as-
16 sociated with mental health inequities among racial
17 and ethnic minority groups.

18 (3) Dissemination and promotion of the use of
19 curricula or core competencies in undergraduate and
20 graduate health professions training programs na-
21 tionwide.

22 (4) Establishing external stakeholder advisory
23 boards to provide meaningful input into policy and
24 program development and best practices to reduce
25 mental health inequities among racial and ethnic

1 groups, including participation and leadership from
2 communities of color with lived experience of the im-
3 pacts of mental health inequities.

4 (c) DEFINITIONS.—In this section:

5 (1) QUALIFIED NATIONAL ORGANIZATION.—The
6 term “qualified national organization” means a na-
7 tional organization that focuses on the education of
8 students in programs of social work, occupational
9 therapy, psychology, psychiatry, substance use coun-
10 seling, and marriage and family therapy.

11 (2) RACIAL AND ETHNIC MINORITY GROUP.—
12 The term “racial and ethnic minority group” has the
13 meaning given to such term in section 1707(g) of
14 the Public Health Service Act (42 U.S.C. 300u-
15 6(g)), as amended by title I of this Act.

16 (d) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated to carry out this section
18 such sums as may be necessary for each of fiscal years
19 2023 through 2027.

20 **SEC. 6022. INTERPROFESSIONAL HEALTH CARE TEAMS FOR**
21 **BEHAVIORAL HEALTH CARE.**

22 Part D of title V of the Public Health Service Act
23 (42 U.S.C. 290dd et seq.) is amended by adding at the
24 end the following:

1 **“SEC. 553. INTERPROFESSIONAL HEALTH CARE TEAMS FOR**
2 **PROVISION OF BEHAVIORAL HEALTH CARE**
3 **IN PRIMARY CARE SETTINGS.**

4 “(a) GRANTS.—The Secretary, acting through the
5 Assistant Secretary, shall award grants to eligible entities
6 for the purpose of establishing interprofessional health
7 care teams that provide behavioral health care.

8 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
9 a grant under this section, an entity shall be a Federally
10 qualified health center (as defined in section 1861(aa) of
11 the Social Security Act), rural health clinic, women’s
12 health clinic, or behavioral health program (including any
13 such program operated by a community-based organiza-
14 tion) serving a high proportion of individuals from racial
15 and ethnic minority groups (as defined in section
16 1707(g)).

17 “(c) LOAN FORGIVENESS.—To encourage qualified
18 and diverse allied health professionals to enter the mental
19 health field, an eligible entity receiving a grant under this
20 section shall agree to use not less than \$10,000 of the
21 grant funds on a loan forgiveness program for practi-
22 tioners who commit to working in the mental health field
23 for a period of 2 years.

24 “(d) SCIENTIFICALLY AND CULTURALLY BASED.—
25 Integrated health care funded through this section shall
26 be scientifically and culturally based, taking into consider-

1 ation the results of the most recent peer-reviewed research
2 available, including information on language accessibility,
3 cultural humility, diversity of practitioners, and consider-
4 ation of social determinants of health.

5 “(e) AUTHORIZATION OF APPROPRIATIONS.—To
6 carry out this section, there is authorized to be appro-
7 priated \$20,000,000 for each of fiscal years 2023 through
8 2027.”.

9 **SEC. 6023. INTEGRATED HEALTH CARE DEMONSTRATION**
10 **PROGRAM.**

11 Part D of title V of the Public Health Service Act
12 (42 U.S.C. 290dd et seq.), as amended by sections 6022
13 and 6052, is further amended by adding at the end the
14 following:

15 **“SEC. 555. INTERPROFESSIONAL HEALTH CARE TEAMS FOR**
16 **PROVISION OF BEHAVIORAL HEALTH CARE**
17 **IN PRIMARY CARE SETTINGS.**

18 “(a) GRANTS.—The Secretary shall award grants to
19 eligible entities for the purpose of establishing interprofes-
20 sional health care teams that provide behavioral health
21 care.

22 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
23 a grant under this section, an entity shall be a Federally
24 qualified health center (as defined in section 1861(aa) of
25 the Social Security Act), rural health clinic, or behavioral

1 health program, serving a high proportion of individuals
2 from racial and ethnic minority groups (as defined in sec-
3 tion 1707(g)).

4 “(c) SCIENTIFICALLY BASED.—Integrated health
5 care funded through this section shall be scientifically
6 based, taking into consideration the results of the most
7 recent peer-reviewed research available.

8 “(d) AUTHORIZATION OF APPROPRIATIONS.—To
9 carry out this section, there is authorized to be appro-
10 priated \$20,000,000 for each of the first 5 fiscal years
11 following the date of enactment of the Health Equity and
12 Accountability Act.”.

13 **Subtitle C—Workforce** 14 **Development**

15 **SEC. 6031. BUILDING AN EFFECTIVE WORKFORCE IN MEN-** 16 **TAL HEALTH.**

17 (a) IN GENERAL.—The Secretary of Health and
18 Human Services, in coordination with the Assistant Sec-
19 retary for Mental Health and Substance Use, the Adminis-
20 trator of the Health Resources and Services Administra-
21 tion, the Secretary of Labor, and advocacy and behavioral
22 and mental health organizations serving vulnerable popu-
23 lations, including youth and young adults, people with low
24 incomes, and people of color, shall—

1 (1) develop, strengthen, and implement strate-
2 gies to bolster career pathways for diverse mental
3 health professionals;

4 (2) identify the breadth of settings where men-
5 tal health care and behavioral health care can take
6 place; and

7 (3) identify current mental health professional
8 workforce shortages, inclusive of shortages of diverse
9 mental health professionals.

10 (b) CONTENTS.—Strategies under subsection (a)
11 shall include—

12 (1) the variety of settings where mental health
13 professionals are needed, including community-based
14 organizations, women’s centers, shelters, organiza-
15 tions focused on youth development, workforce agen-
16 cies, job placement and development centers, emer-
17 gency rooms, the special supplemental nutrition pro-
18 gram for women, infants, and children under section
19 17 of the Child Nutrition Act of 1966 (42 U.S.C.
20 1786), food banks, legal aid, and benefit issuers as
21 defined in section 3 of the Food and Nutrition Act
22 of 2008 (7 U.S.C. 2012);

23 (2) defining career pathways in mental and be-
24 havioral health, to help diverse communities under-

1 stand the variety of careers in mental and behavioral
2 health that are available;

3 (3) building career pathways in mental and be-
4 havioral health as part of the curriculum at the
5 postsecondary education level;

6 (4) providing accessible training and certifi-
7 cation pathways for diverse lay health workers such
8 as community health workers and other peer support
9 specialists to ensure that careers pay a living wage;

10 (5) creating incentives for students in the fields
11 of occupational therapy, social work, psychology,
12 medicine, and nursing to learn more about mental
13 health, and to include a mental health rotation, with
14 a particular focus in racially and ethnically diverse
15 communities, as a part of the health professional
16 curricula;

17 (6) including training and education for teach-
18 ers about the basics of section 504 of the Rehabilita-
19 tion Act of 1973 (29 U.S.C. 794) and individualized
20 education programs (as defined in section 614(d) of
21 the Individuals with Disabilities Education Act (20
22 U.S.C. 1414(d)));

23 (7) researching, developing, and implementing
24 programs for mental and behavioral health profes-
25 sionals to prevent burnout; and

1 (8) finding better and increased avenues to en-
2 sure equity by providing better loan forgiveness pro-
3 grams, including a focus area within the National
4 Health Service Corps focused on community trauma.

5 (c) USE OF FUNDS.—Programs and activities funded
6 under this section shall be consistent with subsection
7 (a)(1) and shall include the following:

8 (1) Subgrants to entities serving youth and
9 young adults which demonstrate a need for an in-
10 creased mental health workforce, using strategies
11 mentioned in subsection (a)(1).

12 (2) Funding towards the Health Resources and
13 Services Administration’s Behavioral Health Work-
14 force Education and Training Program.

15 (3) Funding towards the development and im-
16 plementation of a National Health Service Corps
17 program focused on community trauma.

18 (d) AUTHORIZATION OF APPROPRIATIONS.—There
19 are authorized to be appropriated to carry out this section,
20 \$50,000,000 for each of fiscal years 2023 through 2033.

21 **SEC. 6032. PILOT PROGRAM TO INCREASE LANGUAGE AC-**
22 **CESS AT FEDERALLY QUALIFIED HEALTH**
23 **CENTERS.**

24 (a) LOAN REPAYMENTS TO QUALIFIED HEALTH
25 CARE PROFESSIONALS.—

1 (1) IN GENERAL.—For the purpose of increas-
2 ing language access to mental health services, the
3 Secretary shall carry out a demonstration project
4 under which—

5 (A) the Secretary matches qualified mental
6 health professionals with Federally qualified
7 health centers;

8 (B) the qualified mental health profes-
9 sionals each agree to a period of obligated serv-
10 ice at a Federally qualified health center with
11 which they are so matched; and

12 (C) the Secretary agrees to make loan re-
13 payments under section 338B of the Public
14 Health Service Act (42 U.S.C. 2541–1) on be-
15 half of such qualified mental health profes-
16 sionals.

17 (2) PREFERENCE.—In matching qualified men-
18 tal health professionals with Federally qualified
19 health centers under paragraph (1), the Secretary
20 shall give preference to placement at Federally quali-
21 fied health centers at which at least 20 percent of
22 the patients are best served in a language other than
23 English, as indicated by data in the Uniform Data
24 System (or any successor database).

1 (3) ENHANCED COMPENSATION.—For each
2 year of obligated service that a qualified mental
3 health professional contracts to serve under para-
4 graph (1) at a Federally qualified health center at
5 which at least 20 percent of the patients are best
6 served in a language other than English, as indi-
7 cated by data in the Uniform Data System (or any
8 successor database), the Secretary may pay the
9 higher of—

10 (A) \$10,000 above the maximum amount
11 otherwise applicable under section
12 338B(g)(2)(A) of the Public Health Service Act
13 (42 U.S.C. 254l–1(g)(2)(A)); or

14 (B) if the qualified health professional is
15 fluent in a language other than English that is
16 needed by such Federally qualified health cen-
17 ter, \$15,000 above such maximum amount.

18 (4) ACHIEVING FLUENCY.—A qualified mental
19 health professional eligible to receive the enhanced
20 pay amount specified in paragraph (3)(A) at the be-
21 ginning of the professional’s period of obligated serv-
22 ice may transition to being eligible to receive the en-
23 hanced higher pay amount specified in paragraph
24 (3)(B) if the professional is determined by the Fed-
25 erally qualified health center at which the profes-

1 sional serves to have achieved fluency in a language
2 other than English needed by that health center.

3 (b) GRANTS TO HEALTH CENTERS.—

4 (1) IN GENERAL.—The Secretary shall carry
5 out a demonstration program consisting of awarding
6 grants under section 330 of the Public Health Serv-
7 ice Act (42 U.S.C. 254b) to Federally qualified
8 health centers to recruit, hire, employ, and supervise
9 qualified mental health professionals who are fluent
10 in a language other than English to provide mental
11 health services in such other language.

12 (2) PREFERENCE.—In selecting grant recipi-
13 ents under paragraph (1), the Secretary shall give
14 preference to Federally qualified health centers at
15 which at least 20 percent of the patients are best
16 served in a language other than English, as indi-
17 cated by data in the Uniform Data System (or any
18 successor database).

19 (3) MARKETING.—A Federally qualified health
20 center receiving a grant under this subsection shall
21 use a portion of the grant funds to disseminate in-
22 formation about, and otherwise market, the mental
23 health services supported through the grant.

24 (c) REPORTS.—

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1 (1) INITIAL REPORT.—Not later than 6 months
2 after awarding loan repayment agreements under
3 subsection (a) and grants under subsection (b), the
4 Secretary shall submit to the Committees on Appro-
5 priations of the House of Representatives and the
6 Senate, and to other appropriate congressional com-
7 mittees, a report on the implementation of the pro-
8 grams under this section. Such report shall in-
9 clude—

10 (A) the languages spoken by the qualified
11 mental health professionals receiving loan re-
12 payments pursuant to subsection (a) or re-
13 cruited pursuant to a grant under subsection
14 (b);

15 (B) the Federally qualified health centers
16 at which such professionals were placed;

17 (C) how many Federally qualified health
18 centers received funding through the grant pro-
19 gram under subsection (b);

20 (D) an analysis, conducted in consultation
21 with the Federally qualified health centers re-
22 ceiving grants under section (b), of the effec-
23 tiveness of such grants at increasing language
24 access to mental health services; and

1 (E) best practices, developed in consulta-
2 tion with Federally qualified health centers re-
3 ceiving grants under section (b), for the recruit-
4 ment and retention of mental health profes-
5 sionals at Federally qualified health centers.

6 (2) FINAL REPORT.—Not later than the end of
7 fiscal year 2027, the Secretary shall submit to the
8 Committees on Appropriations of the House of Rep-
9 resentatives and the Senate, and to other appro-
10 priate congressional committees, a final report on
11 the implementation of the programs under this sec-
12 tion, including the information, analysis, and best
13 practices listed in subparagraphs (A) through (E) of
14 paragraph (1).

15 (d) DEFINITIONS.—In this section:

16 (1) The term “Federally qualified health cen-
17 ter” has the meaning given the term in section
18 1861(aa) of the Social Security Act (42 U.S.C.
19 1395x(aa)).

20 (2) The term “qualified mental health profes-
21 sional” means—

22 (A) physicians, allopathic physicians, osteo-
23 pathic physicians, nurse practitioners, and phy-
24 sician assistants with a specialty in mental
25 health and psychiatry;

- 1 (B) health service psychologists;
- 2 (C) licensed clinical social workers;
- 3 (D) psychiatric nurse specialists;
- 4 (E) marriage and family therapists;
- 5 (F) licensed professional counselors;
- 6 (G) substance use disorder counselors;
- 7 (H) occupational therapists; and
- 8 (I) other individuals who—

9 (i) have not yet been licensed or cer-
10 tified to serve as a professional listed in
11 any of subparagraphs (A) through (H);
12 and

13 (ii) will serve at the Federally quali-
14 fied health center under the supervision of
15 a licensed individual or certified profes-
16 sional so listed.

17 (3) The term “Secretary” means the Secretary
18 of Health and Human Services.

19 (e) AUTHORIZATION OF APPROPRIATIONS.—

20 (1) IN GENERAL.—To carry out this section,
21 there is authorized to be appropriated \$75,000,000
22 for each of fiscal years 2023 through 2027.

23 (2) SUPPLEMENT NOT SUPPLANT.—Amounts
24 made available to carry out this section shall be in
25 addition to amounts otherwise available to provide

1 mental health services at Federally qualified health
2 centers pursuant to sections 338B and 330 of the
3 Public Health Service Act (42 U.S.C. 254l–1, 254b).

4 **SEC. 6033. HEALTH PROFESSIONS COMPETENCIES TO AD-**
5 **DRESS RACIAL AND ETHNIC MINORITY MEN-**
6 **TAL HEALTH DISPARITIES.**

7 (a) IN GENERAL.—The Secretary of Health and
8 Human Services may award grants to qualified national
9 organizations for the purposes of—

10 (1) developing, and disseminating to health pro-
11 fessional educational programs, best practices or
12 core competencies addressing mental health dispari-
13 ties among racial and ethnic minority groups for use
14 in the training of students in the professions of so-
15 cial work, psychology, psychiatry, marriage and fam-
16 ily therapy, mental health counseling, and substance
17 abuse counseling; and

18 (2) certifying community health workers and
19 peer wellness specialists with respect to such best
20 practices and core competencies and integrating and
21 expanding the use of such workers and specialists
22 into health care to address mental health disparities
23 among racial and ethnic minority groups.

24 (b) BEST PRACTICES; CORE COMPETENCIES.—Orga-
25 nizations receiving funds under subsection (a) may use the

1 funds to engage in the following activities related to the
2 development and dissemination of best practices or core
3 competencies described in subsection (a)(1):

4 (1) Formation of committees or working groups
5 comprised of experts from accredited health profes-
6 sions schools to identify best practices and core com-
7 petencies relating to mental health disparities among
8 racial and ethnic minority groups.

9 (2) Planning of workshops at the national level
10 to allow for public input into the educational needs
11 associated with mental health disparities among ra-
12 cial and ethnic minority groups.

13 (3) Dissemination and promotion of the use of
14 best practices or core competencies for culturally
15 and linguistically appropriate mental health services
16 in undergraduate and graduate health professions
17 training programs nationwide.

18 (4) Establishing external stakeholder advisory
19 boards to provide meaningful input into policy and
20 program development and best practices to reduce
21 mental health disparities among racial and ethnic
22 minority groups.

23 (c) DEFINITIONS.—In this section:

24 (1) QUALIFIED NATIONAL ORGANIZATION.—The
25 term “qualified national organization” means a na-

1 tional organization that focuses on the education of
2 students in one or more of the professions of social
3 work, psychology, psychiatry, marriage and family
4 therapy, mental health counseling, and substance
5 misuse counseling.

6 (2) RACIAL AND ETHNIC MINORITY GROUP.—
7 The term “racial and ethnic minority group” has the
8 meaning given to such term in section 1707(g) of
9 the Public Health Service Act (42 U.S.C. 300u–
10 6(g)).

11 **Subtitle D—Children’s Mental** 12 **Health**

13 **SEC. 6041. PEDIATRIC BEHAVIORAL HEALTH CARE.**

14 Subpart V of part D of title III of the Public Health
15 Service Act (42 U.S.C. 256 et seq.) is amended by adding
16 at the end the following:

17 **“SEC. 340A-1. GRANTS TO SUPPORT PEDIATRIC BEHAV-** 18 **IORAL HEALTH CARE INTEGRATION AND CO-** 19 **ORDINATION.**

20 “(a) IN GENERAL.—The Secretary, acting through
21 the Administrator of the Health Resources and Services
22 Administration, shall award grants to eligible entities for
23 the purpose of supporting pediatric behavioral health care
24 integration and coordination within communities to meet
25 local community needs.

1 “(b) ELIGIBLE ENTITIES.—Entities eligible for
2 grants under subsection (a) include—

3 “(1) pediatricians;

4 “(2) children’s hospitals;

5 “(3) pediatric behavioral health providers with
6 the capacity to organize and implement activities
7 working with community organizations and pro-
8 viders; and

9 “(4) other entities as determined appropriate by
10 the Secretary.

11 “(c) PRIORITIZATION.—In awarding grants under
12 subsection (a), the Secretary shall prioritize applicants
13 that demonstrate the highest needs at the local level along
14 the care continuum for strengthening children’s behavioral
15 health crisis care and access.

16 “(d) USE OF FUNDS.—Activities that may be funded
17 through a grant under subsection (a) include—

18 “(1) the recruitment and retention of commu-
19 nity health workers or navigators to coordinate fam-
20 ily access to pediatric mental, emotional, and behav-
21 ioral health services;

22 “(2) training the pediatric mental, emotional,
23 and behavioral health care workforce, relevant stake-
24 holders, and community members;

1 “(3) expanding evidence-based, integrated mod-
2 els of care for pediatric mental, emotional, and be-
3 havioral health services;

4 “(4) pediatric practice integration for the provi-
5 sion of pediatric mental, emotional, and behavioral
6 health services;

7 “(5) addressing surge capacity for pediatric
8 mental, emotional, and behavioral health needs;

9 “(6) providing pediatric mental, emotional, and
10 behavioral health services to children as delivered by
11 behavioral, emotional, and mental health profes-
12 sionals utilizing telehealth services;

13 “(7) establishing or maintaining initiatives to
14 decompress emergency departments, including par-
15 tial hospitalization, step down residency programs,
16 and intensive outpatient programs;

17 “(8) supporting, enhancing, or expanding pedi-
18 atric mental, emotional, and behavioral health pre-
19 ventive and crisis intervention services;

20 “(9) establishing or maintaining pediatric men-
21 tal, emotional, and behavioral health urgent care;

22 “(10) establishing or maintaining community-
23 based initiatives, such as school-based partnerships;
24 and

1 “(11) addressing other access and coordination
2 gaps to mental, emotional, and behavioral health
3 services in the community for children.

4 “(e) FUNDING.—To carry out this section, there is
5 hereby appropriated, out of amounts in the Treasury not
6 otherwise obligated, \$500,000,000 for each of fiscal years
7 2023 through 2027.

8 **“SEC. 340A-2. PEDIATRIC BEHAVIORAL HEALTH WORK-**
9 **FORCE TRAINING PROGRAM.**

10 “(a) IN GENERAL.—The Secretary, acting through
11 the Administrator of the Health Resources and Services
12 Administration, shall award grants to eligible entities for
13 the purpose of supporting evidence-based pediatric behav-
14 ioral health workforce training.

15 “(b) ELIGIBLE ENTITIES.—Entities eligible for
16 grants under subsection (a) include—

17 “(1) children’s hospitals; and

18 “(2) other pediatric health care providers as de-
19 termined appropriate by the Secretary.

20 “(c) USE OF FUNDS.—The training that may be sup-
21 ported through a grant under subsection (a) includes ex-
22 panded training in pediatric behavioral health for physi-
23 cians and nonphysician practitioners, including the fol-
24 lowing practitioner types:

25 “(1) Child and adolescent psychiatrists.

1 “(2) Psychiatric nurses.

2 “(3) Psychologists.

3 “(4) Advanced practice nurses.

4 “(5) Family therapists.

5 “(6) Social workers.

6 “(7) Mental health counselors.

7 “(8) Other practitioner types as determined ap-
8 propriate by the Secretary.

9 “(d) FUNDING.—To carry out this section, there is
10 hereby appropriated, out of amounts in the Treasury not
11 otherwise obligated, \$100,000,000 for each of fiscal years
12 2023 through 2027.”.

13 **SEC. 6042. MENTAL HEALTH IN SCHOOLS.**

14 (a) PURPOSE.— It is the purpose of this section to—

15 (1) revise, increase funding for, and expand the
16 scope of the Project AWARE State Educational
17 Agency Grant Program carried out by the Secretary
18 of Health and Human Services, in order to provide
19 access to more comprehensive school-based mental
20 health services and supports;

21 (2) provide for comprehensive staff development
22 for school and community service personnel working
23 in the school;

24 (3) provide for comprehensive training to im-
25 prove health and academic outcomes for children

1 with, or who have a high likelihood of developing,
2 mental health conditions, for parents or guardians,
3 siblings, and other family members of such children,
4 and for concerned members of the community;

5 (4) provide for comprehensive, universal, evi-
6 dence-based screening to identify children and ado-
7 lescents with potential mental health conditions or
8 unmet emotional health needs;

9 (5) recognize best practices for the delivery of
10 mental health care in school-based settings, includ-
11 ing school-based health centers;

12 (6) provide for comprehensive training for par-
13 ents or guardians, siblings, other family members,
14 and concerned members of the community on behalf
15 of children and adolescents experiencing mental
16 health trauma, disorders, cooccurring conditions, or
17 disabilities; and

18 (7) establish formal working relationships
19 among health, human service, and educational enti-
20 ties that support the mental and emotional health of
21 children and adolescents in the school setting or that
22 have a child or youth focus.

23 (b) TECHNICAL AMENDMENTS.—The second part G
24 (relating to services provided through religious organiza-

1 tions) of title V of the Public Health Service Act (42
2 U.S.C. 290kk et seq.) is amended—

3 (1) by redesignating such part as part J; and

4 (2) by redesignating sections 581 through 584
5 as sections 596 through 596C, respectively.

6 (c) SCHOOL-BASED MENTAL HEALTH AND CHIL-
7 DREN AND VIOLENCE.—Section 581 of the Public Health
8 Service Act (42 U.S.C. 290hh) (relating to children and
9 violence) is amended to read as follows:

10 **“SEC. 581. SCHOOL-BASED MENTAL HEALTH; CHILDREN**
11 **AND ADOLESCENTS.**

12 “(a) IN GENERAL.—The Secretary, in consultation
13 with the Secretary of Education, shall, through grants,
14 contracts, or cooperative agreements awarded to eligible
15 entities described in subsection (b), provide comprehensive
16 school-based mental health services and supports to assist
17 children in local communities and schools (including
18 schools funded by the Bureau of Indian Education) deal-
19 ing with traumatic experiences, grief, bereavement, risk of
20 suicide, and the risk of experiencing community or inter-
21 personal violence, such as abuse or neglect. All services
22 and supports provided under such a grant, contract, or
23 cooperative agreement shall—

24 “(1) be developmentally, linguistically, and cul-
25 turally appropriate;

1 “(2) be trauma-informed; and

2 “(3) incorporate positive behavioral interven-
3 tions and supports.

4 “(b) ACTIVITIES.—Grants, contracts, or cooperative
5 agreements awarded under subsection (a), shall, as appro-
6 priate, be used for—

7 “(1) implementation of school and community-
8 based mental health programs that—

9 “(A) build awareness of individual trauma
10 and the intergenerational continuum of impacts
11 of trauma on populations;

12 “(B) train appropriate staff to identify,
13 and screen for, signs of trauma exposure, men-
14 tal health and cooccurring conditions, or risk of
15 suicide; and

16 “(C) incorporate positive behavioral inter-
17 ventions, family engagement, student treatment,
18 and multigenerational supports to foster the
19 health and development of children, prevent
20 mental health disorders, and ameliorate the im-
21 pact of trauma;

22 “(2) technical assistance to local communities
23 with respect to the development of programs de-
24 scribed in paragraph (1);

1 “(3) facilitating diverse community partnerships
2 among families, students, educational agencies, men-
3 tal health and substance use disorder service sys-
4 tems, family-based mental health service systems,
5 child welfare agencies, health care providers (includ-
6 ing primary care physicians, mental health profes-
7 sionals, and other professionals who specialize in
8 children’s mental health such as child and adolescent
9 psychiatrists), institutions of higher education, faith-
10 based programs, trauma networks, and other com-
11 munity-based systems to address child and adoles-
12 cent trauma, as well as unmet mental health needs;
13 and

14 “(4) establishing and promoting best practices
15 that are either evidence-based or culturally-based for
16 children and adolescents to share their experiences
17 of individual and community trauma, including their
18 exposure to community and domestic violence, with
19 trusted adults.

20 “(c) REQUIREMENTS.—

21 “(1) IN GENERAL.—To be eligible for a grant,
22 contract, or cooperative agreement under subsection
23 (a), an entity shall be a partnership that includes—

24 “(A) a State educational agency, as de-
25 fined in section 8101 of the Elementary and

1 Secondary Education Act of 1965, in coordina-
2 tion with one or more local educational agen-
3 cies, as defined in section 8101 of the Elemen-
4 tary and Secondary Education Act of 1965, or
5 a consortium of any entities described in sub-
6 paragraph (B), (C), (D), or (E) of section
7 8101(30) of such Act; and

8 “(B) at least 1 community-based mental
9 health provider, including a public or private
10 mental health entity, health care entity, family-
11 based mental health entity, trauma network, or
12 other community-based entity, as determined by
13 the Secretary (and which may include addi-
14 tional entities such as a human services agency,
15 child welfare agency, an institution of higher
16 education, or another entity, as determined by
17 the Secretary).

18 “(2) COMPLIANCE WITH HIPAA.—Any patient
19 records developed by covered entities through activi-
20 ties under the grant shall meet the regulations pro-
21 mulgated under section 264(c) of the Health Insur-
22 ance Portability and Accountability Act of 1996.

23 “(3) COMPLIANCE WITH FERPA.—Section 444
24 of the General Education Provisions Act (commonly
25 known as the ‘Family Educational Rights and Pri-

1 vacy Act of 1974') shall apply to any entity that is
2 a member of the partnership in the same manner
3 that such section applies to an educational agency or
4 institution (as that term is defined in such section).

5 “(d) GEOGRAPHICAL DISTRIBUTION.—The Secretary
6 shall ensure that grants, contracts, or cooperative agree-
7 ments under subsection (a) will be distributed equitably
8 among the regions of the country and among urban and
9 rural areas.

10 “(e) DURATION OF AWARDS.—With respect to a
11 grant, contract, or cooperative agreement under sub-
12 section (a), the period during which payments under such
13 an award will be made to the recipient shall be 5 years,
14 with options for renewal.

15 “(f) EVALUATION AND MEASURES OF OUTCOMES.—

16 “(1) DEVELOPMENT OF PROCESS.—The Assist-
17 ant Secretary shall develop a fiscally appropriate
18 process for evaluating activities carried out under
19 this section. Such process shall include—

20 “(A) the development of guidelines for the
21 submission of program data by grant, contract,
22 or cooperative agreement recipients;

23 “(B) the development of measures of out-
24 comes (in accordance with paragraph (2)) to be

1 applied by such recipients in evaluating pro-
2 grams carried out under this section; and

3 “(C) the submission of annual reports by
4 such recipients concerning the effectiveness of
5 programs carried out under this section.

6 “(2) MEASURES OF OUTCOMES.—The Assistant
7 Secretary shall develop measures of outcomes to be
8 applied by recipients of assistance under this section
9 to evaluate the effectiveness of programs carried out
10 under this section, including outcomes related to the
11 student, family, and local educational systems sup-
12 ported by this section.

13 “(3) SUBMISSION OF ANNUAL DATA.—An eligi-
14 ble entity described in subsection (c) that receives a
15 grant, contract, or cooperative agreement under this
16 section shall annually submit to the Assistant Sec-
17 retary a report that includes data to evaluate the
18 success of the program carried out by the entity
19 based on whether such program is achieving the pur-
20 poses of the program. Such reports shall utilize the
21 measures of outcomes under paragraph (2) in a rea-
22 sonable manner to demonstrate the progress of the
23 program in achieving such purposes.

24 “(4) EVALUATION BY ASSISTANT SECRETARY.—
25 Based on the data submitted under paragraph (3),

1 the Assistant Secretary shall annually submit to
2 Congress a report concerning the results and effec-
3 tiveness of the programs carried out with assistance
4 received under this section.

5 “(5) LIMITATION.—An eligible entity shall use
6 not more than 20 percent of amounts received under
7 a grant under this section to carry out evaluation
8 activities under this subsection.

9 “(g) INFORMATION AND EDUCATION.—The Sec-
10 retary shall disseminate best practices based on findings
11 made pursuant to this section.

12 “(h) AMOUNT OF GRANTS AND AUTHORIZATION OF
13 APPROPRIATIONS.—

14 “(1) AMOUNT OF GRANTS.—A grant under this
15 section shall be in an amount that is not more than
16 \$2,000,000 for each of the first 5 fiscal years fol-
17 lowing the date of enactment of this section. The
18 Secretary shall determine the amount of each such
19 grant based on the population of children up to age
20 21 of the area to be served under the grant.

21 “(2) AUTHORIZATION OF APPROPRIATIONS.—
22 There is authorized to be appropriated to carry out
23 this section, \$130,000,000 for each of fiscal years
24 2023 through 2026.”.

1 (d) CONFORMING AMENDMENT.—Part G of title V
2 of the Public Health Service Act (42 U.S.C. 290hh et
3 seq.), as amended by this section, is further amended, in
4 the part heading by striking “**PROJECTS FOR CHIL-**
5 **DREN AND VIOLENCE**” and inserting the following:
6 “**SCHOOL-BASED MENTAL HEALTH**”.

7 (e) SCHOOL-BASED MENTAL HEALTH SERVICES.—

8 (1) IN GENERAL.—The Secretary of Education
9 shall award grants to State educational agencies to
10 support services provided by school-based mental
11 health services providers at schools receiving funds
12 under part A of title I of the Elementary and Sec-
13 ondary Education Act of 1965 (20 U.S.C. 6311 et
14 seq.).

15 (2) USE OF FUNDS.—Grants under this sub-
16 section shall be used to help meet the recommended
17 ratios of—

18 (A) 250 students per school counselor;

19 (B) 500 students per school psychologist;

20 and

21 (C) 250 students per school social worker.

22 (3) CONDITION.—The Secretary shall ensure
23 that funds made available under this subsection are
24 used to provide services that are developmentally,
25 linguistically, and culturally appropriate, are trau-

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1 ma-informed, and incorporate positive behavioral
2 interventions and supports.

3 (4) DEFINITIONS.—For purposes of this sub-
4 section:

5 (A) The term “school-based mental health
6 services provider” has the meaning given such
7 term in section 4102 of the Elementary and
8 Secondary Education Act of 1965 (20 U.S.C.
9 7112).

10 (B) The term “State educational agency”
11 has the meaning given such term in section
12 8101 of the Elementary and Secondary Edu-
13 cation Act of 1965 (20 U.S.C. 7801).

14 **SEC. 6043. ADDITIONAL SUPPORT FOR YOUTH AND YOUNG**
15 **ADULT MENTAL HEALTH SERVICE PROVI-**
16 **SION.**

17 Section 1903 of the Social Security Act (42 U.S.C.
18 1396b) is amended by adding at the end the following new
19 subsection:

20 “(cc) YOUTH AND YOUNG ADULT INTERVENTION
21 SERVICES.—

22 “(1) IN GENERAL.—Notwithstanding section
23 1902(a)(1) (relating to Statewideness), section
24 1902(a)(10)(B) (relating to comparability), section
25 1902(a)(23)(A) (relating to freedom of choice of

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1 providers), or section 1902(a)(27) (relating to pro-
2 vider agreements), a State may, during the 5-year
3 period beginning on the first day of the fiscal year
4 quarter that begins on or after January 1, 2024,
5 provide medical assistance for qualifying youth and
6 young adult mental health and substance use inter-
7 vention services (as defined in paragraph (2)(C))
8 under a State plan amendment or waiver approved
9 under section 1115 or 1915(c).

10 “(2) DEFINITIONS.—For the purposes of this
11 subsection:

12 “(A) PRIORITY SERVICE.—The term ‘pri-
13 ority service’ means any of the following if vol-
14 untarily received and provided in a manner that
15 maintains the privacy and confidentiality of pa-
16 tient information consistent with Federal and
17 State requirements:

18 “(i) Community based mobile crisis
19 intervention services, as defined in section
20 1947.

21 “(ii) Telehealth.

22 “(iii) Youth peer support.

23 “(iv) Screening for adverse childhood
24 experiences.

25 “(v) Trauma responsive care.

1 “(vi) Other priority services for youth,
2 as defined by the Secretary.

3 “(B) QUALIFIED MENTAL HEALTH PRO-
4 VIDERS.—The term ‘qualified mental health
5 providers’ means a behavioral health care pro-
6 fessional who is capable of conducting an as-
7 sessment of the individual, in accordance with
8 the professional’s permitted scope of practice
9 under State law, and other professionals or
10 paraprofessionals with appropriate expertise in
11 youth and young adult behavioral health or
12 mental health, including social workers, peer
13 support specialists, recovery coaches, commu-
14 nity health workers, mental health clinicians,
15 and others, as designated by the State and ap-
16 proved by the Secretary.

17 “(C) QUALIFYING YOUTH AND YOUNG
18 ADULT MENTAL HEALTH AND SUBSTANCE USE
19 INTERVENTION SERVICES DEFINED.—The term
20 ‘qualifying youth and young adult mental health
21 and substance use intervention services’ means,
22 with respect to a State, items and services for
23 which medical assistance is available under the
24 State plan under this title or a waiver of such
25 plan, that are—

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1 “(i) furnished to an individual 16 to
2 25 years of age who is—

3 “(I) experiencing a mental health
4 or substance use disorder crisis;

5 “(II) subject to the juvenile or
6 adult justice system as defined in sec-
7 tion 3102 of title 29, United States
8 Code;

9 “(III)(aa) experiencing homeless-
10 ness (as defined in section 41403(6)
11 of the Violence Against Women Act of
12 1994 (42 U.S.C. 14043e–2(6)));

13 “(bb) a homeless child or youth
14 (as defined in section 725(2) of the
15 McKinney-Vento Homeless Assistance
16 Act (42 U.S.C. 11434a(2)));

17 “(cc) a runaway, in foster care,
18 or has aged out of the foster care sys-
19 tem;

20 “(dd) a child eligible for assist-
21 ance under section 477 of the Social
22 Security Act (42 U.S.C. 677); or

23 “(ee) in an out-of-home place-
24 ment;

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1 “(IV) pregnant or parenting as
2 defined in section 3102 of title 29,
3 United States Code;

4 “(V) a youth who is an individual
5 with a disability as defined in section
6 3102 of title 29, United States Code;

7 “(VI) a low income youth requir-
8 ing additional assistance to enter or
9 complete an educational program or
10 to secure or hold employment as de-
11 fined in section 3102 of title 29,
12 United States Code; or

13 “(VII) living in a community that
14 has faced acute or long-term exposure
15 to substantial discrimination, histor-
16 ical oppression, intergenerational pov-
17 erty, civil unrest, or a high rate of vio-
18 lence or drug overdose deaths;

19 “(ii) furnished by qualified mental
20 health providers; and

21 “(iii) a priority service.

22 “(D) TELEHEALTH.—The term ‘telehealth’
23 means use of electronic information and tele-
24 communications technologies, including voice
25 only audio, text, remote patient monitoring, and

1 mHealth via applications, to support clinical
2 mental health care, patient and professional
3 health-related education, public health, and
4 health administration.

5 “(3) PAYMENTS.—Notwithstanding section
6 1905(b), beginning January 1, 2024, during each of
7 the first 20 fiscal quarters that a State meets the
8 requirements described in paragraph (4), the Fed-
9 eral medical assistance percentage applicable to
10 amounts expended by the State for medical assist-
11 ance for qualifying youth and young adult mental
12 health and substance use intervention services fur-
13 nished during such quarter shall be equal to 100
14 percent.

15 “(4) REQUIREMENTS.—The requirements de-
16 scribed in this paragraph are the following:

17 “(A) The State demonstrates, to the satis-
18 faction of the Secretary—

19 “(i) that it will be able to support the
20 provision of qualifying youth and young
21 adult mental health and substance use
22 intervention services that meet the condi-
23 tions specified in paragraphs (1) and (2));
24 and

1 “(ii) how it will support coordination
2 between qualified mental health providers
3 and substance use teams and community
4 partners, including health care providers,
5 to enable the provision of services, needed
6 referrals, and other activities identified by
7 the Secretary.

8 “(B) The State provides assurances satis-
9 factory to the Secretary that—

10 “(i) any additional Federal funds re-
11 ceived by the State for qualifying youth
12 and young adult mental health and sub-
13 stance use intervention services provided
14 under this subsection that are attributable
15 to the increased Federal medical assistance
16 percentage under paragraph (3)(A) will be
17 used to supplement, and not supplant, the
18 level of State funds expended for such
19 services for fiscal year 2024;

20 “(ii) if the State made qualifying
21 youth and young adult mental health and
22 substance use intervention services avail-
23 able in a region of the State in fiscal year
24 2023 the State will continue to make such
25 services available in such region under this

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1 subsection at the same level that the State
2 made such services available in such fiscal
3 year; and

4 “(iii) the State will conduct the eval-
5 uation and assessment, and submit the re-
6 port required under paragraph (5).

7 “(5) STATE EVALUATION AND REPORT.—

8 “(A) STATE EVALUATION.—Not later than
9 4 fiscal quarters after a State begins providing
10 qualifying youth and young adult mental health
11 and substance use intervention services in ac-
12 cordance with this subsection, the State shall
13 enter into a contract with an independent entity
14 or organization to conduct an evaluation for the
15 purposes of—

16 “(i) determining the effect of the pro-
17 vision of such services on—

18 “(I) emergency room visits;

19 “(II) use of ambulatory services;

20 “(III) hospitalizations;

21 “(IV) the involvement of law en-
22 forcement in mental health or sub-
23 stance use disorder crisis events; and

24 “(V) the diversion of individuals
25 from jails or similar settings; and

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1 “(ii) assessing—

2 “(I) the types of services pro-
3 vided to individuals;

4 “(II) the types of events re-
5 sponded to;

6 “(III) cost savings or cost-effec-
7 tiveness attributable to such services;

8 “(IV) the experiences of individ-
9 uals who receive qualifying youth and
10 young adult mental health and sub-
11 stance use intervention services;

12 “(V) the successful connection of
13 individuals with follow-up services;
14 and

15 “(VI) other relevant outcomes
16 identified by the Secretary.

17 “(B) COMPARISON TO HISTORICAL MEAS-
18 URES.—The contract described in subparagraph
19 (A) shall specify that the evaluation is based on
20 a comparison of the historical measures of
21 State performance with respect to the outcomes
22 specified under such subparagraph to the
23 State’s performance with respect to such out-
24 comes during the period beginning with the
25 first quarter in which the State begins pro-

1 viding qualifying youth and young adult mental
2 health and substance use intervention services
3 in accordance with this subsection.

4 “(C) REPORT.—Not later than 2 years
5 after a State begins to provide qualifying youth
6 and young adult mental health and substance
7 use intervention services in accordance with this
8 subsection, the State shall submit a report to
9 the Secretary on the following:

10 “(i) The results of the evaluation car-
11 ried out under subparagraph (A).

12 “(ii) The number of individuals who
13 received qualifying youth and young adult
14 mental health and substance use interven-
15 tion services.

16 “(iii) Demographic information re-
17 garding such individuals when available,
18 including the race and ethnicity, age, sex,
19 sexual orientation, gender identity, and ge-
20 ographic location of such individuals.

21 “(iv) The processes and models devel-
22 oped by the State to provide qualifying
23 youth and young adult mental health and
24 substance use intervention services under
25 such the State plan or waiver, including

1 the processes developed to provide referrals
2 for, or coordination with, follow-up care
3 and services.

4 “(v) Lessons learned regarding the
5 provision of such services.

6 “(D) PUBLIC AVAILABILITY.—The State
7 shall make the report required under subpara-
8 graph (C) publicly available, including on the
9 website of the appropriate State agency, upon
10 submission of such report to the Secretary.

11 “(6) BEST PRACTICES REPORT.—

12 “(A) IN GENERAL.—Not later than 3 years
13 after the first State begins to provide qualifying
14 youth and young adult mental health and sub-
15 stance use intervention services in accordance
16 with this subsection, the Secretary shall submit
17 a report to Congress that—

18 “(i) identifies the States that elected
19 to provide services in accordance with this
20 subsection;

21 “(ii) summarizes the information re-
22 ported by such States under paragraph
23 (5)(C); and

24 “(iii) identifies best practices for the
25 effective delivery of youth and young adult

1 mental health and substance use interven-
2 tion services.

3 “(B) PUBLIC AVAILABILITY.—The report
4 required under subparagraph (A) shall be made
5 publicly available, including on the website of
6 the Department of Health and Human Services,
7 upon submission to Congress.

8 “(7) NONDISCRIMINATION.—

9 “(A) FEDERALLY FUNDED ACTIVITIES.—

10 (i) For the purpose of applying the prohibitions
11 against discrimination on the basis of age under
12 the Age Discrimination Act of 1975 (42 U.S.C.
13 6101 et seq.), on the basis of handicap under
14 section 504 of the Rehabilitation Act of 1973
15 (29 U.S.C. 794), on the basis of sex under title
16 IX of the Education Amendments of 1972 (20
17 U.S.C. 1681 et seq.), or on the basis of race,
18 color, or national origin under title VI of the
19 Civil Rights Act of 1964 (42 U.S.C. 2000d et
20 seq.), programs and activities funded in whole
21 or in part with funds made available under this
22 subchapter are considered to be programs and
23 activities receiving Federal financial assistance.

24 “(ii) No person shall on the ground of sex
25 or religion be excluded from participation in, be

1 denied the benefits of, or be subjected to dis-
2 crimination under, any program or activity
3 funded in whole or in part with funds made
4 available under this title.

5 “(B) COMPLIANCE.—Whenever the Sec-
6 retary finds that a State, or an entity that has
7 received a payment from an allotment to a
8 State under section 702(c) of this title, has
9 failed to comply with a provision of law referred
10 to in subsection (a)(1), with subsection (a)(2),
11 or with an applicable regulation (including one
12 prescribed to carry out subsection (a)(2)), he
13 shall notify the chief executive officer of the
14 State and shall request him to secure compli-
15 ance. If within a reasonable period of time, not
16 to exceed 60 days, the chief executive officer
17 fails or refuses to secure compliance, the Sec-
18 retary may—

19 “(i) refer the matter to the Attorney
20 General with a recommendation that an
21 appropriate civil action be instituted;

22 “(ii) exercise the powers and functions
23 provided by title VI of the Civil Rights Act
24 of 1964 (42 U.S.C. 2000d et seq.), the
25 Age Discrimination Act of 1975 (42

1 U.S.C. 6101 et seq.), or section 504 of the
2 Rehabilitation Act of 1973 (29 U.S.C.
3 794), as may be applicable; or

4 “(iii) take such other action as may
5 be provided by law.

6 “(C) AUTHORITY OF ATTORNEY GENERAL;
7 CIVIL ACTIONS.—When a matter is referred to
8 the Attorney General pursuant to subsection
9 (b)(1), or whenever he has reason to believe
10 that the entity is engaged in a pattern or prac-
11 tice in violation of a provision of law referred
12 to in subsection (a)(1) or in violation of sub-
13 section (a)(2), the Attorney General may bring
14 a civil action in any appropriate district court
15 of the United States for such relief as may be
16 appropriate, including injunctive relief.”.

17 **SEC. 6044. EARLY INTERVENTION AND PREVENTION PRO-**
18 **GRAMS FOR TRANSITION-AGE YOUTH.**

19 (a) IN GENERAL.—Section 1912(b)(1) of the Public
20 Health Service Act (42 U.S.C. 300x–1(b)(1)) is amend-
21 ed—

22 (1) by redesignating subparagraph (E) as sub-
23 paragraph (F); and

24 (2) by inserting after subparagraph (D) the fol-
25 lowing:

1 “(E) EARLY INTERVENTION AND PREVEN-
2 TION PROGRAMS FOR TRANSITION-AGE
3 YOUTH.—The plan shall describe the State’s
4 plans to carry out demonstration grants or con-
5 tracts for early intervention and prevention pro-
6 grams for transition-age youth of 16 to 25
7 years of age who meet one or more of the cri-
8 teria specified in section 129(a)(1)(B) of the
9 Workforce Innovation and Opportunity Act to
10 be considered out-of-school youth.”.

11 (b) SET-ASIDE.—Section 1920 of the Public Health
12 Service Act (42 U.S.C. 300x–9) is amended by adding at
13 the end the following:

14 “(d) EARLY INTERVENTION AND PREVENTION PRO-
15 GRAMS FOR TRANSITION-AGE YOUTH.—

16 “(1) IN GENERAL.—Except as provided in para-
17 graph (2), a State shall expend at least 15 percent
18 of the amount of the allotment of the State pursuant
19 to a funding agreement under section 1911 for each
20 fiscal year to support programs described in section
21 1912(b)(1)(E).

22 “(2) STATE FLEXIBILITY.—In lieu of expending
23 15 percent of the amount of the allotment for a fis-
24 cal year as required by paragraph (1), a State may
25 elect to expend not less than 30 percent of such

1 amount to support such programs by the end of two
2 consecutive fiscal years.”.

3 **SEC. 6045. STRATEGIES TO INCREASE ACCESS TO TELE-**
4 **HEALTH UNDER MEDICAID AND CHILDREN’S**
5 **HEALTH INSURANCE PROGRAM.**

6 (a) GUIDANCE.—Not later than 1 year after the date
7 of the enactment of this Act, the Secretary of Health and
8 Human Services shall issue and disseminate guidance to
9 States to clarify strategies to overcome existing barriers
10 and increase access to telehealth under the Medicaid pro-
11 gram under title XIX of the Social Security Act (42
12 U.S.C. 1396 et seq.) and the Children’s Health Insurance
13 Program under title XXI of such Act (42 U.S.C. 1397aa
14 et seq.). Such guidance shall include technical assistance
15 and best practices regarding—

- 16 (1) telehealth delivery of covered services;
- 17 (2) recommended voluntary billing codes, modi-
18 fiers, and place-of-service designations for telehealth
19 and other virtual health care services;
- 20 (3) the simplification or alignment (including
21 through reciprocity) of provider licensing,
22 credentialing, and enrollment protocols with respect
23 to telehealth across States, State Medicaid plans
24 under such title XIX, and Medicaid managed care

1 organizations, including during national public
2 health emergencies;

3 (4) existing strategies States can use to inte-
4 grate telehealth and other virtual health care serv-
5 ices into value-based health care models; and

6 (5) examples of States that have used waivers
7 under the Medicaid program to test expanded access
8 to telehealth, including during the emergency period
9 described in section 1135(g)(1)(B) of the Social Se-
10 curity Act (42 U.S.C. 1320b–5(g)(1)(B)).

11 (b) STUDIES.—

12 (1) TELEHEALTH IMPACT ON HEALTH CARE
13 ACCESS.—Not later than 1 year after the date of the
14 enactment of this Act, the Medicaid and CHIP Pay-
15 ment and Access Commission shall conduct a study,
16 with respect to a minimum of 10 States across geo-
17 graphic regions of the United States, and submit to
18 Congress a report, on the impact of telehealth on
19 health care access, utilization, cost, and outcomes,
20 broken down by race, ethnicity, sex, age, disability
21 status, and zip code. Such report shall—

22 (A) evaluate cost, access, utilization, out-
23 comes, and patient experience data from across
24 the health care field, including States, Medicaid
25 managed care organizations, provider organiza-

1 tions, and other organizations that provide or
2 pay for telehealth under the Medicaid program
3 and Children’s Health Insurance Program;

4 (B) identify barriers and potential solu-
5 tions to provider entry and participation in tele-
6 health that States are experiencing, as well as
7 barriers to providing telehealth across State
8 lines, including during times of public health
9 crisis or public health emergency;

10 (C) determine the frequency at which out-
11 of-State telehealth is provided to patients en-
12 rolled in the Medicaid program and the poten-
13 tial impact on access to telehealth if State Med-
14 icaid policies were more aligned; and

15 (D) identify and evaluate opportunities for
16 more alignment among such policies to promote
17 access to telehealth across all States, State
18 Medicaid plans under title XIX of the Social
19 Security Act (42 U.S.C. 1396 et seq.), State
20 child health plans under title XXI of such Act
21 (42 U.S.C. 1397aa et seq.), and Medicaid man-
22 aged care organizations, including the potential
23 for regional compacts or reciprocity agreements.

24 (2) FEDERAL AGENCY TELEHEALTH COLLABO-
25 RATION.—Not later than 1 year after the date of the

1 enactment of this Act, the Comptroller General of
2 the United States shall conduct a study and submit
3 to Congress a report evaluating collaboration be-
4 tween Federal agencies with respect to telehealth
5 services furnished under the Medicaid or CHIP pro-
6 gram to individuals under the age of 18, including
7 such services furnished to such individuals in early
8 care and education settings. Such report shall in-
9 clude recommendations on—

10 (A) opportunities for Federal agencies to
11 improve collaboration with respect to such tele-
12 health services; and

13 (B) opportunities for collaboration between
14 Federal agencies to expand telehealth access to
15 such individuals enrolled under the Medicaid or
16 CHIP program, including in early care and
17 education settings.

18 **SEC. 6046. YOUTH AND YOUNG ADULT MENTAL HEALTH**
19 **PROMOTION, PREVENTION, INTERVENTION,**
20 **AND TREATMENT.**

21 Title III of the Public Health Service Act is amended
22 by inserting after section 399Z–3, as added by section
23 5001, the following:

1 **“SEC. 399Z–4. YOUTH AND YOUNG ADULT MENTAL HEALTH**
2 **PROMOTION, PREVENTION, INTERVENTION,**
3 **AND TREATMENT.**

4 “(a) GRANTS.—The Secretary shall—

5 “(1) award grants to eligible entities to develop,
6 maintain, or enhance youth and young adult mental
7 health promotion, prevention, intervention, and
8 treatment programs, including—

9 “(A) programs for youth and young adults
10 who may be likely to develop, are showing early
11 signs of, or have been diagnosed with a mental
12 health condition, including a serious emotional
13 disturbance; and

14 “(B) infrastructure and organization
15 change at a State, tribal, or territorial level to
16 improve cross-system collaboration, service ca-
17 pacity, and expertise related to youth and
18 young adults; and

19 “(2) ensure that programs funded through
20 grants under this section use community-driven, evi-
21 dence-informed, or evidence-based models, practices,
22 and methods that are, as appropriate, culturally and
23 linguistically appropriate, and can be replicated in
24 other appropriate settings.

25 “(b) ELIGIBLE TRANSITION AGE YOUTH AND ENTI-
26 TIES.—In this section:

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1 “(1) ELIGIBLE ENTITY.—The term ‘eligible en-
2 tity’ means—

3 “(A) a local educational agency;

4 “(B) a State educational agency;

5 “(C) an institution of higher education (or
6 consortia of such institutions), which may in-
7 clude a recovery program at an institution of
8 higher education;

9 “(D) a local board, or a one-stop operator,
10 as defined in section 3 of the Workforce Inno-
11 vation and Opportunity Act;

12 “(E) a nonprofit organization with appro-
13 priate expertise in providing services or pro-
14 grams for children, adolescents, or young
15 adults, excluding a school;

16 “(F) a State, political subdivision of a
17 State, Indian tribe, or tribal organization; or

18 “(G) a high school or dormitory serving
19 high school students that receives funding from
20 the Bureau of Indian Education.

21 “(2) ELIGIBLE TRANSITION AGE YOUTH.—The
22 term ‘eligible transition age youth’ means a youth or
23 young adult from age 16 to not more than 25 years
24 of age who is—

1 “(A) an out-of-school youth as defined in
2 section 129(a)(1)(B) of the Workforce Innova-
3 tion and Opportunity Act;

4 “(B) a homeless individual (as defined in
5 section 41403(6) of the Violence Against
6 Women Act of 1994), a homeless child or youth
7 (as defined in section 725(2) of the McKinney-
8 Vento Homeless Assistance Act) a runaway, in
9 foster care or has aged out of the foster care
10 system, a child eligible for assistance under sec-
11 tion 477 of the Social Security Act, or in an
12 out-of-home placement;

13 “(C) an individual who is pregnant or par-
14 enting, as referred to in section 129(a)(1)(B) of
15 the Workforce Innovation and Opportunity Act;

16 “(D) a youth who is an individual with a
17 disability, as referred to in section 129(a)(1)(B)
18 of the Workforce Innovation and Opportunity
19 Act;

20 “(E) a low-income individual who requires
21 additional assistance to enter or complete an
22 educational program or to secure or hold em-
23 ployment, as referred to in section 129(a)(1)(B)
24 of the Workforce Innovation and Opportunity
25 Act; or

1 “(F) living in a community that has faced
2 acute or long-term exposure to substantial dis-
3 crimination, historical oppression, intergenera-
4 tional poverty, civil unrest, a high rate of vio-
5 lence, or drug overdose deaths.

6 “(c) APPLICATION.—An eligible entity seeking a
7 grant under subsection (a) shall submit to the Secretary
8 an application at such time, in such manner, and con-
9 taining such information as the Secretary may require.

10 “(d) USE OF FUNDS FOR MENTAL HEALTH PRO-
11 MOTION, PREVENTION, INTERVENTION AND TREATMENT
12 PROGRAMS.—An eligible entity may use amounts awarded
13 under a grant under subsection (a)(1) to carry out the
14 following:

15 “(1) Creation, implementation, and expansion
16 of services and supports that are culturally and lin-
17 guistically appropriate and youth-guided, involve and
18 include family and community members (including
19 business leaders and faith-based organizations), and
20 provide for continuity of care between child- and
21 adult-serving systems to ensure seamless transition.

22 “(2) Infrastructure and organization change at
23 a State, Tribal, or territorial level to improve cross-
24 system collaboration, service capacity, and expertise
25 related to youth and young adults with, or at-risk of,

1 mental health conditions and substance use dis-
2 orders as they transition into adult roles and respon-
3 sibilities.

4 “(3) Public awareness and cross-system pro-
5 vider training for individuals employed at institu-
6 tions of higher education and community colleges,
7 behavioral health providers, individuals working in
8 the criminal justice system, primary care providers,
9 vocational service providers, and child welfare work-
10 ers.

11 “(e) MATCHING FUNDS.—The Secretary may not
12 award a grant under this section to an eligible entity un-
13 less the eligible entity agrees, with respect to the costs to
14 be incurred by the eligible entity in carrying out the activi-
15 ties described in subsection (d), to make available non-
16 Federal contributions (in cash or in kind) toward such
17 costs in an amount that is not less than 10 percent of
18 the total amount of Federal funds provided in the grant.

19 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
20 carry out this section, there are authorized to be appro-
21 priated \$25,000,000 for each of fiscal years 2024 through
22 2033.”.

1 **SEC. 6047. STUDY ON THE EFFECTS OF SMARTPHONE AND**
2 **SOCIAL MEDIA USE ON ADOLESCENTS.**

3 (a) IN GENERAL.—Not later than 1 year after the
4 date of enactment of this Act, the Secretary of Health and
5 Human Services shall conduct or support research on—

6 (1) smartphone and social media use by adoles-
7 cents; and

8 (2) the effects of such use on—

9 (A) emotional, behavioral, and physical
10 health and development; and

11 (B) disparities in minority and under-
12 served populations.

13 (b) REPORT.—Not later than 5 years after the date
14 of the enactment of this Act, the Secretary shall submit
15 to the Congress, and make publicly available, a report on
16 the findings of research described in this section.

17 **Subtitle E—Community Based Care**

18 **SEC. 6051. MENTAL HEALTH AT THE BORDER.**

19 (a) SHORT TITLE.—This section may be cited as the
20 “Immigrants’ Mental Health Act of 2022”.

21 (b) DEFINITIONS.—In this section:

22 (1) FORWARD OPERATING BASE.—The term
23 “forward operating base” means a permanent facil-
24 ity—

1 (A) established by U.S. Customs and Bor-
2 der Protection in forward or remote locations;
3 and

4 (B) designated as such by U.S. Customs
5 and Border Protection.

6 (2) The term “U.S. Customs and Border Pro-
7 tection facility” means any of the following facilities
8 that typically detain migrants on behalf of U.S. Cus-
9 toms and Border Protection:

10 (A) U.S. Border Patrol stations.

11 (B) Ports of entry.

12 (C) Checkpoints.

13 (D) Forward operating bases.

14 (E) Secondary inspection areas.

15 (F) Short-term custody facilities.

16 (c) TRAINING FOR CERTAIN CBP PERSONNEL IN
17 MENTAL HEALTH ISSUES.—

18 (1) TRAINING TO IDENTIFY RISK FACTORS AND
19 WARNING SIGNS IN IMMIGRANTS AND REFUGEES.—

20 (A) IN GENERAL.—The Commissioner of
21 U.S. Customs and Border Protection, in con-
22 sultation with the Assistant Secretary for Men-
23 tal Health and Substance Use, the Adminis-
24 trator of the Health Resources and Services Ad-
25 ministration, and nongovernmental experts in

1 the delivery of health care in humanitarian cri-
2 ses and in the delivery of health care to chil-
3 dren, shall develop and implement a training
4 curriculum for U.S. Customs and Border Pro-
5 tection agents and officers to enable such
6 agents and officers to identify the risk factors
7 and warning signs in immigrants and refugees
8 of mental health issues relating to trauma.

9 (B) REQUIREMENTS.—The training cur-
10 riculum required under subparagraph (A)
11 shall—

12 (i) be offered to all U.S. Customs and
13 Border Protection agents and officers
14 working at U.S. Customs and Border Pro-
15 tection facilities;

16 (ii) provide for crisis intervention
17 using a trauma-informed approach; and

18 (iii) provide for mental health
19 screenings for immigrants and refugees ar-
20 riving at the border in their preferred lan-
21 guage or with appropriate language assist-
22 ance.

23 (2) TRAINING TO ADDRESS MENTAL HEALTH
24 AND WELLNESS OF CBP AGENTS AND OFFICERS.—

1 (A) IN GENERAL.—The Commissioner of
2 U.S. Customs and Border Protection, in con-
3 sultation with the Assistant Secretary for Men-
4 tal Health and Substance Use, the Adminis-
5 trator of the Health Resources and Services Ad-
6 ministration, and nongovernmental experts in
7 the delivery of mental health care, shall develop
8 and implement a training curriculum for U.S.
9 Customs and Border Protection agents and offi-
10 cers assigned to U.S. Customs and Border Pro-
11 tection facilities to address the mental health
12 and wellness of individuals working at such fa-
13 cilities.

14 (B) REQUIREMENT.—The training cur-
15 riculum described in subparagraph (A) shall be
16 designed to help the agents and officers de-
17 scribed in such subparagraph—

- 18 (i) to better manage their own stress
19 and the stress of their coworkers; and
20 (ii) to be more aware of the psycho-
21 logical pressures experienced during their
22 jobs.

23 (3) ANNUAL REVIEW OF TRAINING.—Beginning
24 in fiscal year 2023, the Assistant Secretary for Men-
25 tal Health and Substance Use shall—

1 (A) conduct an annual review of the train-
2 ing required under paragraphs (1) and (2); and

3 (B) submit the results of each such review,
4 including any recommendations for improve-
5 ment of such training, to—

6 (i) the Commissioner of U.S. Customs
7 and Border Protection;

8 (ii) the Committee on Appropriations
9 of the Senate;

10 (iii) the Committee on Health, Edu-
11 cation, Labor, and Pensions of the Senate;

12 (iv) the Committee on Homeland Se-
13 curity and Governmental Affairs of the
14 Senate;

15 (v) the Committee on the Judiciary of
16 the Senate;

17 (vi) the Committee on Appropriations
18 of the House of Representatives;

19 (vii) the Committee on Energy and
20 Commerce of the House of Representa-
21 tives;

22 (viii) the Committee on Homeland Se-
23 curity of the House of Representatives;
24 and

1 (ix) the Committee on the Judiciary
2 of the House of Representatives.

3 (4) AUTHORIZATION OF APPROPRIATIONS.—

4 There is authorized to be appropriated—

5 (A) \$50,000 for fiscal year 2023 to develop
6 the training curriculum required under para-
7 graphs (1) and (2); and

8 (B) for each of the fiscal years 2024
9 through 2028—

10 (i) \$20,000 to provide the training re-
11 quired under paragraphs (1) and (2); and

12 (ii) such sums as may be necessary to
13 conduct the annual review of training pur-
14 suant to paragraph (3).

15 (d) STAFFING BORDER FACILITIES AND DETENTION
16 CENTERS.—

17 (1) IN GENERAL.—The Commissioner of U.S.
18 Customs and Border Protection shall assign at least
19 1 qualified mental or behavioral health expert to
20 each U.S. Customs and Border Protection facility to
21 adequately evaluate the mental health needs of im-
22 migrants, refugees, border patrol agents, and staff.

23 (2) QUALIFICATIONS.—Each mental or behav-
24 ioral health expert assigned pursuant to paragraph
25 (1)—

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1 (A) shall be bilingual;

2 (B) shall be well-versed in culturally and
3 linguistically appropriate and trauma-informed
4 interventions; and

5 (C) shall have particular expertise in child
6 or adolescent mental health or family mental
7 health.

8 (3) AUTHORIZATION OF APPROPRIATIONS.—

9 There is authorized to be appropriated \$3,000,000
10 for each of the fiscal years 2023 through 2027 to
11 carry out this subsection.

12 (e) CONFIDENTIALITY OF DEPARTMENT OF HEALTH
13 AND HUMAN SERVICES MENTAL HEALTH INFORMATION
14 FOR ASYLUM DETERMINATIONS, IMMIGRATION HEAR-
15 INGS, OR DEPORTATION PROCEEDINGS.—The officers,
16 employees, and agents of the Department of Health and
17 Human Services, including the Office of Refugee Resettle-
18 ment, may not share with the Department of Homeland
19 Security, and the officers, employees, and agents of the
20 Department of Homeland Security may not request or re-
21 ceive from the Department of Health and Human Serv-
22 ices, for the purposes of an asylum determination, immi-
23 gration hearing, or deportation proceeding, any informa-
24 tion or record that—

25 (1) concerns the mental health of an alien; and

1 (2) was obtained or produced by a mental or
2 behavioral health professional while the alien was in
3 a shelter or otherwise in the custody of the Federal
4 Government.

5 **SEC. 6052. ASIAN AMERICAN, AFRICAN AMERICAN, NATIVE**
6 **HAWAIIAN, PACIFIC ISLANDER, INDIGENOUS,**
7 **MIDDLE EASTERN AND NORTH AFRICAN, AND**
8 **HISPANIC AND LATINO BEHAVIORAL AND**
9 **MENTAL HEALTH OUTREACH AND EDU-**
10 **CATION STRATEGY.**

11 Part D of title V of the Public Health Service Act
12 (42 U.S.C. 290dd et seq.), as amended by section 6022,
13 is further amended by adding at the end the following new
14 section:

15 **“SEC. 554. BEHAVIORAL AND MENTAL HEALTH OUTREACH**
16 **AND EDUCATION STRATEGY.**

17 “(a) IN GENERAL.—The Secretary, acting through
18 the Assistant Secretary for Mental Health and Substance
19 Use, shall, in coordination with advocacy and behavioral
20 and mental health organizations serving populations of
21 Asian American, African American, Native Hawaiian, Pa-
22 cific Islander, Indigenous, Middle Eastern and North Afri-
23 can (in this section referred to as ‘MENA’), and Hispanic
24 and Latino/a/x individuals or communities, develop and
25 implement an outreach and education strategy to promote

1 behavioral and mental health, emphasize that behavioral
2 and mental health conditions are treatable and that rea-
3 sonable accommodations under section 504 of the Reha-
4 bilitation Act of 1973 and titles II and III of the Ameri-
5 cans with Disabilities Act of 1990 are necessary and may
6 help, as well as reduce stigma associated with mental
7 health conditions and substance abuse among the Asian
8 American, African American, Native Hawaiian, Pacific Is-
9 lander, Indigenous, MENA, and Hispanic and Latino/a/
10 x populations. Such strategy shall—

11 “(1) be designed to—

12 “(A) meet the diverse cultural and lan-
13 guage needs of the various Asian American, Af-
14 rican American, Indigenous, MENA, Native
15 Hawaiian, Pacific Islander, and Hispanic and
16 Latino/a/x populations; and

17 “(B) ensure that approaches recommended
18 in the strategy are developmentally (with re-
19 spect to the beneficiary’s relative age and expe-
20 rience) and age appropriate, as well as cog-
21 nitively accessible to persons with cognitive dis-
22 abilities;

23 “(2) increase awareness of symptoms of mental
24 illnesses common among such populations, taking
25 into account differences within subgroups (such as

1 gender, gender identity, age, sexual orientation, dis-
2 ability, and ethnicity) of such populations;

3 “(3) provide information on evidence-based, cul-
4 turally and linguistically appropriate and adapted
5 interventions and treatments;

6 “(4) ensure full participation of, and engage,
7 both consumers and community members rep-
8 resenting the communities of focus in the develop-
9 ment and implementation of materials; and

10 “(5) seek to broaden the perspective among
11 both individuals in such communities and stake-
12 holders serving such communities to use a com-
13 prehensive public health approach to promoting be-
14 havioral and mental health that addresses a holistic
15 view of health by focusing on the intersection be-
16 tween behavioral and physical health.

17 “(b) REPORTS.—Beginning not later than 1 year
18 after the date of the enactment of this section and annu-
19 ally thereafter, the Secretary, acting through the Assistant
20 Secretary, shall submit to the Congress, and make publicly
21 available, a report on the extent to which the strategy de-
22 veloped and implemented under subsection (a) increased
23 behavioral and mental health outcomes associated with
24 mental health conditions and substance abuse among
25 Asian American, African American, Native Hawaiian, Pa-

1 cific Islander, Indigenous, MENA, and Hispanic and
2 Latino/a/x populations.

3 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
4 is authorized to be appropriated to carry out this section
5 \$10,000,000 for each of fiscal years 2024 through 2028.”.

6 **Subtitle F—Reports**

7 **SEC. 6061. ADDRESSING RACIAL AND ETHNIC MENTAL** 8 **HEALTH INEQUITIES RESEARCH GAPS.**

9 (a) IN GENERAL.—Not later than 6 months after the
10 date of the enactment of this Act—

11 (1) the Director of the National Institute on
12 Minority Health and Health Disparities shall enter
13 into an arrangement with the National Academy of
14 Sciences to carry out the activities under subsection
15 (b); or

16 (2) if the National Academy of Sciences de-
17 clines to enter into such an arrangement, the Direc-
18 tor of the National Institute on Minority Health and
19 Health Disparities, in cooperation with the Agency
20 for Healthcare Research and Quality, shall carry out
21 the activities under subsection (b).

22 (b) ACTIVITIES.—The applicable entity under sub-
23 section (a) shall—

24 (1) conduct a study with respect to mental
25 health inequities in racial and ethnic minority

1 groups (as defined in section 1707(g) of the Public
2 Health Service Act (42 U.S.C. 300u–6(g)), as
3 amended by title I of this Act); and

4 (2) submit to the Congress a report on the re-
5 sults of such study, including—

6 (A) a compilation of information on the dy-
7 namics of mental health outcomes in such racial
8 and ethnic minority groups;

9 (B) the degree and impacts of the co-oc-
10 currence of mental conditions with other dis-
11 abilities in such racial and ethnic groups, in-
12 cluding physical disabilities, mental disabilities,
13 substance use disorders, severe and persistent
14 mental illness, and mental disorders or mental
15 health conditions which co-occur with one an-
16 other;

17 (C) a compilation of information on the
18 impact of community violence, community trau-
19 ma, adverse childhood experiences, weather ex-
20 tremes worsened by climate change (such as
21 heat waves, flooding, hurricanes, and wildfires),
22 substance use, and other psychological traumas,
23 on mental disorders in such racial and ethnic
24 minority groups, stratified by household income
25 level;

1 (D) a compilation of information on the
2 impact of the intersectionality of transgender
3 individuals, gender nonbinary individuals, sex-
4 ual orientation, and age in racial and ethnic mi-
5 nority groups; and

6 (E) a description of how protective factors
7 contrast and compare among different commu-
8 nities of color, identifying cultural strengths.

9 **SEC. 6062. RESEARCH ON ADVERSE HEALTH EFFECTS AS-**
10 **SOCIATED WITH INTERACTIONS WITH LAW**
11 **ENFORCEMENT.**

12 (a) IN GENERAL.—The Secretary of Health and
13 Human Services (in this section referred to as the “Sec-
14 retary”), acting through the Director of the Office of Mi-
15 nority Health of the Centers for Disease Control and Pre-
16 vention (established pursuant to section 1707A of the
17 Public Health Service Act (42 U.S.C. 300u–6a)), shall
18 conduct research on the adverse health effects associated
19 with interactions with law enforcement.

20 (b) EFFECTS AMONG RACIAL AND ETHNIC MINORI-
21 TIES.—The research under subsection (a) shall include re-
22 search on—

23 (1) the health consequences, both individual
24 and community-wide, of trauma related to violence

1 committed by law enforcement among racial and
2 ethnic minorities; and

3 (2) the disproportionate burden of morbidity
4 and mortality associated with such trauma.

5 (c) REPORT.—Not later than 1 year after the date
6 of enactment of this Act, the Secretary shall—

7 (1) complete the research under this section;
8 and

9 (2) submit to the Congress a report on the find-
10 ings, conclusions, and recommendations resulting
11 from such research.

12 **SEC. 6063. GEOACCESS STUDY.**

13 The Assistant Secretary for Mental Health and Sub-
14 stance Use shall—

15 (1) conduct a study to—

16 (A) determine which geographic areas of
17 the United States have shortages of racially and
18 ethnically diverse mental health providers, as
19 well as mental health providers trained to work
20 with racially and ethnically diverse clients and
21 clients with multiple mental health, cognitive,
22 and developmental disabilities; and

23 (B) assess the preparedness of mental
24 health providers to deliver culturally and lin-

1 guistically appropriate, affordable, and acces-
2 sible services; and

3 (2) submit a report to Congress on the results
4 of such study.

5 SEC. 6064. COOCCURRING CONDITIONS.

(a) GAO REPORT.—Not later than two years after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on barriers to care for persons with cooccurring conditions and access to care in the United States. Such report shall include the information and recommendations described in subsection (b).

13 (b) CONTENT OF REPORT.—The report under sub-
14 section (a) shall include—

(1) an assessment of current barriers to behavioral health and substance use disorder treatment for low-income, uninsured, and Medicaid-enrolled adults, and recommendations for addressing such barriers, particularly for women and diverse racial and ethnic groups;

21 (2) an assessment of—

(A) how many adults have a behavioral health condition and options for adults to receive behavioral health and substance use disorder treatment in nonexpansion States;

1 (B) Medicaid expansion States who provide
2 behavioral health coverage for newly eligible en-
3 rollees;

4 (C) how enrollment in coverage affects
5 treatment availability; and

6 (D) the impacts of COVID–19 to receiving
7 and accessing treatment for behavioral health,
8 substance use disorders, and diverse racial and
9 ethnic groups, and recommendations for ad-
10 dressing such barriers;

11 (3) an assessment of current barriers, inclusive
12 of social determinants of health and cultural bar-
13 riers, that prevent adults from receiving behavioral
14 health and substance use disorder treatment, and
15 recommendations for addressing such barriers, par-
16 ticularly for low-income women and adults from ra-
17 cial and ethnic groups;

18 (4) an assessment of disparities in access to ad-
19 diction counselors and mental or behavioral health
20 care providers acting in accordance with State law,
21 stratified by race, ethnicity, gender identity, geo-
22 graphic location, and insurance type, and rec-
23 ommendations to promote greater access equity; and

24 (5) recommendations to promote greater equity
25 in access to care for behavioral services and sub-

1 stance use disorders, particularly for low-income
2 women and adults from diverse racial and ethnic
3 groups.

4 **SEC. 6065. TECHNICAL CORRECTION.**

5 Title V of the Public Health Service Act (42 U.S.C.
6 290aa et seq.) is amended—

7 (1) by redesignating the second section 550 (42
8 U.S.C. 290ee–10) (relating to Sobriety Treatment
9 And Recovery Teams) as section 552A; and

10 (2) by moving such section, as so redesignated,
11 so as to appear after section 552 (42 U.S.C. 290ee–
12 7).

13 **Subtitle G—Miscellaneous**
14 **Provisions**

15 **SEC. 6071. CHILDREN’S MENTAL HEALTH INFRASTRUC-**
16 **TURE ACT.**

17 Part D of title III of the Public Health Service Act
18 (42 U.S.C. 254b et seq.) is amended by inserting after
19 subpart V, as amended by section 6041, the following new
20 subpart:

21 **“Subpart VI—Increasing Investment in Pediatric**
22 **Behavioral Health Services**

23 **“SEC. 340AA–1. GRANTS TO CHILDREN’S HOSPITALS.**

24 “(a) IN GENERAL.—The Secretary, acting through
25 the Administrator of the Health Resources and Services

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1 Administration, shall make grants to eligible entities for
2 the purpose of improving their ability to provide pediatric
3 behavioral health services, including by—

4 “(1) constructing or modernizing sites of care
5 for pediatric behavioral health services;

6 “(2) expanding capacity to provide pediatric be-
7 havioral health services, including enhancements to
8 digital infrastructure, telehealth capabilities, or other
9 improvements to patient care infrastructure; and

10 “(3) supporting the reallocation of existing re-
11 sources to accommodate pediatric behavioral health
12 patients, including by—

13 “(A) converting or adding a sufficient
14 number of beds to establish or increase the hos-
15 pital’s inventory of licensed and operational,
16 short-term psychiatric and substance use inpa-
17 tient beds; and

18 “(B) ensuring compliance with safety
19 standards.

20 “(b) ELIGIBILITY.—To be eligible to seek a grant
21 under this section, an entity shall be a hospital that pre-
22 dominantly treats individuals under the age of 21, includ-
23 ing any hospital that receives funds under section 340E.

24 “(c) FUNDING.—To carry out this section, there is
25 hereby appropriated, out of amounts in the Treasury not

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1 otherwise obligated, \$2,000,000,000 for each of fiscal
2 years 2022 through 2026.”.

3 **SEC. 6072. MENTAL HEALTH FOR LATINOS.**

4 Part D of title V of the Public Health Service Act
5 (42 U.S.C. 290dd et seq.), as amended by sections 6022,
6 6023, 6052, and 6016, is further amended by adding at
7 the end the following new section:

8 **“SEC. 557. BEHAVIORAL AND MENTAL HEALTH OUTREACH**
9 **AND EDUCATION STRATEGY.**

10 “(a) IN GENERAL.—The Secretary, acting through
11 the Assistant Secretary, shall, in coordination with advo-
12 cacy and behavioral and mental health organizations serv-
13 ing populations of Hispanic and Latino individuals or
14 communities, develop and implement an outreach and edu-
15 cation strategy to promote behavioral and mental health
16 and reduce stigma associated with mental health condi-
17 tions and substance abuse among the Hispanic and Latino
18 populations. Such strategy shall—

19 “(1) be designed to—

20 “(A) meet the diverse cultural and lan-
21 guage needs of the various Hispanic and Latino
22 populations; and

23 “(B) be developmentally and age-appro-
24 priate;

1 “(2) increase awareness of symptoms of mental
2 illnesses common among such populations, taking
3 into account differences within subgroups, such as
4 gender, gender identity, age, sexual orientation, or
5 ethnicity, of such populations;

6 “(3) provide information on evidence-based, cul-
7 turally and linguistically appropriate and adapted
8 interventions and treatments;

9 “(4) ensure full participation of, and engage,
10 both consumers and community members in the de-
11 velopment and implementation of materials;

12 “(5) seek to broaden the perspective among
13 both individuals in these communities and stake-
14 holders serving these communities to use a com-
15 prehensive public health approach to promoting be-
16 havioral health that addresses a holistic view of
17 health by focusing on the intersection between be-
18 havioral and physical health; and

19 “(6) address the impact of the SARS-CoV-2
20 pandemic on the mental and behavioral health of the
21 Hispanic and Latino populations.

22 “(b) REPORTS.—Beginning not later than 1 year
23 after the date of the enactment of this section and annu-
24 ally thereafter, the Secretary, acting through the Assistant
25 Secretary, shall submit to Congress, and make publicly

1 available, a report on the extent to which the strategy de-
2 veloped and implemented under subsection (a) improved
3 behavioral and mental health outcomes associated with
4 mental health conditions and substance abuse among His-
5 panic and Latino populations.

6 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
7 is authorized to be appropriated to carry out this section
8 \$1,000,000 for each of fiscal years 2023 through 2025.”.

9 **SEC. 6073. STRENGTHENING MENTAL HEALTH SUPPORTS**
10 **FOR BIPOC COMMUNITIES.**

11 (a) IN GENERAL.—Section 1942(a) of the Public
12 Health Service Act (42 U.S.C. 300x–52(a)) is amended—

13 (1) in paragraph (1), by striking “and” at the
14 end;

15 (2) by redesignating paragraph (2) as para-
16 graph (5); and

17 (3) by inserting after paragraph (1) the fol-
18 lowing:

19 “(2) services provided by the State to adults
20 with a serious mental illness and children with a se-
21 rious emotional disturbance who are members of ra-
22 cial and ethnic minority groups, including—

23 “(A) the extent to which such services are
24 provided to such adults and children; and

1 “(B) the outcomes experienced by such
2 adults and children as a result of the provision
3 of such services, including with respect to—

4 “(i) diversions from hospitalization
5 and criminal justice system involvement;

6 “(ii) treatment for first episode psy-
7 chosis or undefined psychosis;

8 “(iii) reductions in suicide and in-
9 creased utilization of appropriate treat-
10 ments and interventions for suicidal idea-
11 tion;

12 “(iv) response through crisis services,
13 including mobile crisis services;

14 “(v) treatment of individuals who are
15 experiencing homelessness or housing inse-
16 curity and individuals residing in rural
17 communities; and

18 “(vi) increased patient family and
19 caregiver engagement and education on se-
20 rious mental illness to reduce social stigma
21 and promote healthy social support for pa-
22 tients;

23 “(3) any outreach by the State to, and the hir-
24 ing of, providers of mental health services from mul-
25 tiple disciplines (such as a psychologist, psychiatrist,

1 peer support provider, or social worker) who are
2 members of racial and ethnic minority groups;

3 “(4) any outreach by the State to providers
4 from multiple disciplines of mental health services—

5 “(A) to provide training on culturally ef-
6 fective, culturally affirming, and linguistically
7 competent services; and

8 “(B) to increase awareness of community-
9 defined practices by practitioners of racial and
10 ethnic minority groups; and”.

11 (b) APPLICABILITY.—The amendments made by sub-
12 section (a) shall apply with respect to funding agreements
13 entered into under section 1911 or 1921 of the Public
14 Health Service Act (42 U.S.C. 300x; 42 U.S.C. 300x–21)
15 on or after the date of the enactment of this Act.

16 **SEC. 6074. STRONG SUPPORT FOR CHILDREN.**

17 (a) DATA ANALYSIS AND STRATEGY IMPLEMENTA-
18 TION TO PREVENT AND MITIGATE CHILDHOOD TRAU-
19 MA.—Title XXXI of the Public Health Service Act (42
20 U.S.C. 300kk) is amended by adding at the end the fol-
21 lowing:

1 **“SEC. 3102. DATA ANALYSIS AND STRATEGY IMPLEMENTA-**
2 **TION TO PREVENT AND MITIGATE CHILD-**
3 **HOOD TRAUMA.**

4 “(a) IN GENERAL.—The Secretary shall establish a
5 program—

6 “(1) to support the development and implemen-
7 tation of programs that use data analysis methods
8 to identify and facilitate strategies for early inter-
9 vention and prevention, in order to prevent and miti-
10 gate childhood trauma and support communities and
11 families, including—

12 “(A) improving connections through care
13 coordination;

14 “(B) aligning community initiatives in tar-
15 geted areas of need; and

16 “(C) expanding community capacity
17 through cross-sector collaboration; and

18 “(2) to evaluate the effectiveness of these pro-
19 grams in improving outcomes for children.

20 “(b) GRANTS.—The Secretary shall award grants to
21 up to 5 eligible entities to carry out the activities described
22 in subsection (a).

23 “(c) USE OF FUNDS.—A grant for activities under
24 this section shall be used to support the development and
25 implementation of programs that use data analysis meth-
26 ods to identify and facilitate strategies for early interven-

1 tion and prevention, in order to prevent and mitigate
2 childhood trauma and support communities and families,
3 including as follows:

4 “(1) Utilize data analysis methods to—

5 “(A) identify specific geographic areas,
6 such as census tracts, with a high prevalence of
7 adverse childhood experiences and significant
8 risk factors for poor outcomes for children
9 (such as increased risk of experiencing adverse
10 childhood experiences), including areas with
11 high rates of—

12 “(i) poor public health outcomes in-
13 cluding illness, disease, suicide, and mor-
14 tality;

15 “(ii) exclusionary discipline practices,
16 including suspensions, expulsions, and re-
17 ferrals to law enforcement, as well as low
18 graduation rates;

19 “(iii) substance use disorders;

20 “(iv) poverty;

21 “(v) foster system involvement or re-
22 ferrals;

23 “(vi) housing instability and homeless-
24 ness;

25 “(vii) food insecurity;

1 “(viii) inequity, including disparities
2 in income, wealth, employment, educational
3 attainment, health care access, and public
4 health outcomes, along lines of race, sex,
5 sexuality and gender identity, ethnicity, or
6 nationality;

7 “(ix) incarceration rates; or

8 “(x) other indicators of adversity as
9 defined by the Secretary; and

10 “(B) identify strategies to improve out-
11 comes for children aged 0 through 17 that build
12 on strengths in communities that could be fur-
13 ther supported, including—

14 “(i) existing support networks for
15 families; and

16 “(ii) enhanced connections to commu-
17 nity-based organizations.

18 “(2) Implement strategies identified pursuant
19 to paragraph (1)(B) to facilitate outreach and in-
20 volvement of children and their caregivers in Fed-
21 eral, State, or local programs that provide repar-
22 ative, gender-responsive, culturally specific, and
23 trauma-informed prevention services, and for which
24 children and their caregivers are eligible, including—

25 “(A) home visiting programs;

1 “(B) training and education on parenting
2 skills;

3 “(C) substance use disorder prevention and
4 treatment that is voluntary and noncoercive;

5 “(D) mental health supports and care that
6 is voluntary and noncoercive;

7 “(E) family and intimate partner violence
8 prevention services;

9 “(F) child advocacy center programming;

10 “(G) economic and nutrition support serv-
11 ices;

12 “(H) housing support services, including
13 emergency and temporary shelter for those ex-
14 perencing homelessness and housing insecurity,
15 as well as stable, long-term housing;

16 “(I) voluntary, noncoercive, gender-respon-
17 sive, and culturally specific mental health sup-
18 ports in school and early childhood education
19 center-based settings;

20 “(J) wraparound programs for
21 transitioning youth and youth currently in the
22 foster system;

23 “(K) programming to support the health
24 and well-being of lesbian, gay, bisexual,

1 transgender, and intersex children and their
2 families; and

3 “(L) family resource center services.

4 “(d) SPECIAL RULES.—

5 “(1) PRIMARY PAYER RESTRICTION.—The Sec-
6 retary may not award a grant under this section to
7 an eligible entity for a service if the service to be
8 provided is available pursuant to the State plan ap-
9 proved under title XIX of the Social Security Act for
10 the State in which the program funded by the grant
11 is being conducted unless the State and all eligible
12 subdivisions involved—

13 “(A) will enter into agreements with public
14 or nonprofit private entities under which the
15 entities will provide the service; and

16 “(B) demonstrate that the State and all el-
17 igible subdivisions will ensure that the entities
18 providing the service—

19 “(i) will seek payment for each such
20 service rendered in accordance with the
21 usual payment schedule under the State
22 plan; and

23 “(ii) the entities have entered into a
24 participation agreement and are qualified
25 to receive payments under such plan.

1 “(2) IMPLEMENTATION.—An eligible entity that
2 receives a grant under this section may use—

3 “(A) not more than 25 percent of the
4 amounts made available through the grant for
5 the first 24 months of the grant period to uti-
6 lize data analysis methods to—

7 “(i) identify specific geographic areas
8 where care coordination, prevention and
9 early intervention, and facilitation services
10 will be provided; and

11 “(ii) identify support and intervention
12 services to improve outcomes for children
13 located in a geographic area identified
14 under subsection (c)(1)(A); and

15 “(B) not more than 10 percent of the
16 grant in each subsequent year to continue data
17 analysis activities.

18 “(3) ADMINISTRATION.—An eligible entity that
19 receives a grant under this section may not use more
20 than 5 percent of amounts received through the
21 grant for administration, reporting, and program
22 oversight functions, including the development of
23 systems to improve data collection and data sharing
24 for the purposes of improving services and the provi-
25 sion of care.

1 “(4) PRIORITY.—

2 “(A) IN GENERAL.—In awarding grants
3 under this section, the Secretary shall give pri-
4 ority, to the extent practical, to eligible entities
5 that use community-based system dynamic
6 modeling as the primary data analysis method.

7 “(B) SYSTEM DYNAMIC MODELING DE-
8 FINED.—The term ‘system dynamic modeling’
9 means a method of data analysis and predictive
10 modeling that includes—

11 “(i) utilization of community-based
12 participatory research methods for involv-
13 ing community in the process of under-
14 standing and changing systems and evalu-
15 ating outcomes of grants;

16 “(ii) consideration of a multitude of
17 environmental risk factors and ascertain-
18 ment of the significance of contributing
19 community risk factors for purposes of
20 identifying strategies to reduce adverse
21 child outcomes, including—

22 “(I) maltreatment cases;

23 “(II) involvement with the juve-
24 nile criminal legal system or foster
25 system;

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1 “(III) exclusionary school dis-
2 cipline; or

3 “(IV) exposure to violence; and

4 “(iii) identification of cross-sector re-
5 sponses involving reparative, trauma-in-
6 formed, culturally specific, gender-respon-
7 sive, and community-based organizations
8 to reduce adverse child outcomes.

9 “(5) SUBGRANT.—

10 “(A) IN GENERAL.—An eligible entity that
11 receives a grant under this section shall use at
12 least 25 percent of the total amount of the
13 grant to make subgrants to organizations that
14 aid in implementing the strategy identified
15 under subsection (c)(1)(B) for preventing and
16 mitigating childhood trauma and supporting
17 communities and families.

18 “(B) ELIGIBILITY.—To be eligible to re-
19 ceive a subgrant under this paragraph, an orga-
20 nization shall prepare and submit to the eligible
21 entity an application in such form, and con-
22 taining such information, as the eligible entity
23 may require, including evidence that the—

24 “(i) needs of the population to be
25 served are urgent and are not met by the

1 services currently available in the geo-
2 graphic area; and

3 “(ii) organization has the capacity to
4 provide the services listed in subsection
5 (c)(2).

6 “(C) SUPPLEMENT NOT SUPPLANT.—
7 Subgrant funds received pursuant to this para-
8 graph by an organization shall be used to sup-
9 plement and not supplant State or local funds
10 provided to the partnership organization for
11 services listed in subsection (c)(2).

12 “(e) APPLICATION.—To be eligible to receive a grant
13 under this section, an eligible entity shall submit to the
14 Secretary an application in such form, and containing
15 such information, as the Secretary may require, to include
16 the following:

17 “(1) A demonstration that—

18 “(A) the applicant utilizes trauma-in-
19 formed, culturally specific, and gender-respon-
20 sive practices, including a demonstration of the
21 extent to which the applicant has trained staff
22 in these practices;

23 “(B) the applicant has the capacity to ad-
24 minister the grant, including conducting all re-
25 quired data analysis activities; and

1 “(C) services will be provided to children
2 and families in an accessible, culturally rel-
3 evant, and linguistically specific manner con-
4 sistent with local needs.

5 “(2) A preliminary analysis of how the appli-
6 cant will use the grant to—

7 “(A) identify the geographic area or areas
8 to be served using data analysis methods;

9 “(B) utilize data analysis methods to iden-
10 tify strategies to improve outcomes for children
11 in the geographic area;

12 “(C) facilitate strategies identified through
13 care coordination efforts; and

14 “(D) track data for evaluation of out-
15 comes.

16 “(3) A detailed project plan for the use of the
17 grant that includes anticipated technical assistance
18 needs.

19 “(4) Additional funding sources, including State
20 and local funds, supporting the prevention and miti-
21 gation of adverse childhood experiences.

22 “(f) GRANT AMOUNT.—The amount of a grant under
23 this section shall not exceed \$9,500,000.

24 “(g) PERIOD OF A GRANT.—The period of a grant
25 under this section shall not exceed 7 years.

1 “(h) SERVICE PROVISION WITHOUT REGARD TO
2 ABILITY TO PAY.—As a condition on receipt of a grant
3 under this section, an eligible entity shall agree that any
4 assistance provided to an individual through the grant will
5 be provided without regard to—

6 “(1) the ability of the individual to pay for such
7 services;

8 “(2) the current or past health condition of the
9 individual to be served;

10 “(3) the immigration status of the individual to
11 be served;

12 “(4) the sexual orientation and gender identity
13 of the individual to be served; and

14 “(5) any prior involvement of the individual in
15 the criminal legal system.

16 “(i) PROHIBITIONS.—In addition to any other prohi-
17 bitions determined by the Secretary, an eligible entity may
18 not use a grant under this section to—

19 “(1) use data analysis methods to inform indi-
20 vidual case decisions, including child removal or
21 placement decisions, or to target services at certain
22 individuals or families;

23 “(2) require any individual or family to partici-
24 pate in any service or program as a condition of re-

1 ceipt of a benefit to which the individual or family
2 is otherwise eligible;

3 “(3) increase the presence or funding of law en-
4 forcement surveillance, involvement, or activity in
5 implementing the strategies identified under sub-
6 section (c)(1)(B); or

7 “(4) enable the practice of conversion therapy.

8 “(j) EVALUATION.—

9 “(1) DATA MODEL EVALUATION.—Not later
10 than 36 months after the date of enactment of this
11 section, the Assistant Secretary for Planning and
12 Evaluation of the Department of Health and Human
13 Services, in coordination with the grantees receiving
14 a grant under this section, shall complete an evalua-
15 tion of the effectiveness of the data model accuracy
16 of the grant program under this section to address
17 each of the following:

18 “(A) Determining the effectiveness of the
19 grantees’ use of data analysis methods to iden-
20 tify geographic areas pursuant to subsection
21 (c)(1).

22 “(B) Examining the grantees’ development
23 and utilization of data analysis methods.

1 “(C) Examining the grantees’ ability to ef-
2 fectively utilize data analysis methods in future
3 prevention work.

4 “(D) Establishing a method for rigorously
5 evaluating the activities of grantees and com-
6 paring the reduction of child and family expo-
7 sure to adverse experiences in other commu-
8 nities with similar demographics.

9 “(E) Examining the grantees’ utilization of
10 community-based system dynamics modeling
11 methods and other community engagement
12 methods.

13 “(2) PROGRAM EVALUATION.—Not later than 6
14 years after the date of enactment of this section, the
15 Assistant Secretary for Planning and Evaluation of
16 the Department of Health and Human Services, in
17 coordination with eligible entities receiving grants
18 under this section, shall complete an evaluation of
19 the effectiveness of the grant program under this
20 section.

21 “(3) DATA COLLECTION.—

22 “(A) IN GENERAL.—The Assistant Sec-
23 retary for Planning and Evaluation of the De-
24 partment of Health and Human Services and
25 each eligible entity receiving a grant under this

1 section shall collect any relevant data necessary
2 to complete the evaluations required by para-
3 graphs (1) and (2) to include—

4 “(i) the activities funded by the grant
5 under this section, including development
6 and implementation data analysis methods;

7 “(ii) the number of children and of
8 families receiving coordination and facilita-
9 tion of care and services; and

10 “(iii) the effect of activities supported
11 by the grant under this section on the local
12 area serviced by the program, including
13 such effects on—

14 “(I) children and adolescents’
15 health and well-being;

16 “(II) the number of children who
17 enter into or depart from foster serv-
18 ices; and

19 “(III) homelessness and housing
20 insecurity.

21 “(B) STUDY.—

22 “(i) IN GENERAL.—Not later than 7
23 years after the date of enactment of this
24 section, the Assistant Secretary for Plan-

ning and Evaluation of the Department of
Health and Human Services shall—

“(I) complete a study on the re-
sults of the grant program under this
section using the community-based
participatory action research method,
which focuses on social, structural,
and physical environmental inequities
through active involvement of commu-
nity members, clients, organizational
representatives, and researchers in all
aspects of the research process; and

“(II) submit a report on the re-
sults of the study to the Congress.

“(ii) PARTNERS.—In conducting the
study under clause (i), the Assistant Sec-
retary for Planning and Evaluation of the
Department of Health and Human Serv-
ices shall ensure that partners and persons
that have participated in the grant pro-
gram under this section on every level, es-
pecially those such partners or persons re-
ceiving services and support through the
program, have an opportunity to contribute

1 their expertise to evaluating the strategy
2 and outcomes.

3 “(k) REPORT.—Not later than three months after the
4 completion of the evaluation required by subsection (j)(2),
5 the Assistant Secretary for Planning and Evaluation of
6 the Department of Health and Human Services shall sub-
7 mit to Congress and make available to the public on the
8 internet website of the Department of Health and Human
9 Services a report based upon the evaluation under sub-
10 section (j)(2), to include—

11 “(1) the impact of the program under this sec-
12 tion on homelessness and housing insecurity, sub-
13 stance use disorder and drug deaths, incarceration,
14 foster system involvement, and other child and fam-
15 ily outcomes as identified by the Assistant Secretary
16 for Planning and Evaluation of the Department of
17 Health and Human Services;

18 “(2) an analysis of which elements of the pro-
19 gram should be replicated and scaled by govern-
20 mental or non-governmental entities; and

21 “(3) such recommendations for legislation and
22 administrative action as the Secretary determines
23 appropriate.

24 “(l) DEFINITION.—In this section:

1 “(1) The term ‘adverse childhood experience’
2 means a potentially traumatic experience that occurs
3 in childhood and can have a tremendous impact on
4 the child’s lifelong health and opportunity outcomes,
5 such as any of the following:

6 “(A) Abuse, such as any of the following:

7 “(i) Emotional and psychological
8 abuse.

9 “(ii) Physical abuse.

10 “(iii) Sexual abuse.

11 “(B) Household challenges such as any of
12 the following:

13 “(i) A household member is treated
14 violently.

15 “(ii) A household member has a sub-
16 stance use disorder.

17 “(iii) A household member has a men-
18 tal health condition.

19 “(iv) Parental separation or divorce.

20 “(v) A household member is incarcer-
21 ated, is placed in immigrant detention, or
22 has been deported.

23 “(vi) A household member has a life-
24 threatening illness such as COVID-19.

25 “(C) Neglect.

1 “(D) Living in—

2 “(i) impoverished communities that
3 lack access to human services;

4 “(ii) areas of high unemployment
5 neighborhoods; or

6 “(iii) communities experiencing de
7 facto segregation.

8 “(E) Experiencing food insecurity and
9 poor nutrition.

10 “(F) Witnessing violence.

11 “(G) Involvement with the foster system.

12 “(H) Experiencing discrimination.

13 “(I) Dealing with historical and ongoing
14 traumas due to systemic and interpersonal rac-
15 ism.

16 “(J) Dealing with historical and ongoing
17 traumas regarding systemic and interpersonal
18 sexism, homophobia, biphobia, and transphobia.

19 “(K) Dealing with the threat of deporta-
20 tion or detention as a result of immigration sta-
21 tus.

22 “(L) The impacts of multigenerational pov-
23 erty resulting from limited educational and eco-
24 nomic opportunities.

1 “(M) Living through natural disasters
2 such as earthquakes, forest fires, floods, or hur-
3 ricanes.

4 “(2) The term ‘eligible entity’ means a State or
5 local health department.

6 “(3) The term ‘practice of conversion ther-
7 apy’—

8 “(A) means any practice or treatment by
9 any person that seeks to change another indi-
10 vidual’s sexual orientation or gender identity,
11 including efforts to change behaviors or gender
12 expressions, or to eliminate or reduce sexual or
13 romantic attractions or feelings toward individ-
14 uals of the same gender, if such person receives
15 monetary compensation in exchange for any
16 such practice or treatment; and

17 “(B) does not include any practice or
18 treatment that does not seek to change sexual
19 orientation or gender identity and—

20 “(i) provides assistance to an indi-
21 vidual undergoing a gender transition; or

22 “(ii) provides acceptance, support,
23 and understanding of a client or facilita-
24 tion of a client’s coping, social support,
25 and identity exploration and development.

1 “(m) AUTHORIZATION OF APPROPRIATIONS.—There
2 is authorized to be appropriated to carry out this section
3 for the period of fiscal years 2023 through 2030—

4 “(1) to carry out subsection (a)(1) through the
5 award of grants under subsection (b)—

6 “(A) \$47,500,000 for grants; and

7 “(B) such sums as may be necessary for
8 the administrative costs of carrying out such
9 subsection; and

10 “(2) \$7,500,000 to carry out the evaluation
11 under subsection (a)(2).”.

12 (b) CARE COORDINATION GRANTS.—Part E of title
13 XII of the Public Health Service Act (42 U.S.C. 300d–
14 51 et seq.) is amended by adding at the end the following
15 new section:

16 **“SEC. 1255. CARE COORDINATION GRANTS.**

17 “(a) IN GENERAL.—The Secretary shall award
18 grants to eligible entities to establish or expand trauma-
19 informed care coordination services to support—

20 “(1) children aged 0 through 5 at risk of ad-
21 verse childhood experiences; and

22 “(2) their caregivers, including prenatal people
23 of any age.

24 “(b) NUMBER OF GRANTS.—Subject to the avail-
25 ability of appropriations, the Secretary shall award not

1 fewer than 9 and not more than 40 grants under this sec-
2 tion.

3 “(c) AMOUNT OF GRANTS.—Subject to the avail-
4 ability of appropriations, the amount of a grant under this
5 section for a fiscal year shall be—

6 “(1) not less than \$250,000; and

7 “(2) not more than \$1,000,000.

8 “(d) ELIGIBLE ENTITIES.—To be eligible to receive
9 a grant under this section, an entity shall be a local gov-
10 ernment or Indian Tribe, acting through the public health
11 department thereof if such government or Tribe has a
12 public health department.

13 “(e) PRIORITY.—

14 “(1) IN GENERAL.—In awarding grants under
15 this section, the Secretary shall give priority to eligi-
16 ble entities proposing to serve communities with a
17 high need for trauma-informed care coordination
18 services, as demonstrated by indicators such as—

19 “(A) pregnant people who face barriers to
20 prenatal care;

21 “(B) mortality or morbidity of people giv-
22 ing birth or infants;

23 “(C) caretakers and parents who are living
24 with a mental health condition or substance use
25 disorder;

1 “(D) a high prevalence of community vio-
2 lence, including domestic violence, as dem-
3 onstrated by instances of homicide and public
4 health statistics, including treatment of injury
5 or trauma;

6 “(E) high proportions of low-income chil-
7 dren;

8 “(F) a high prevalence of child fatalities or
9 near fatalities related to child abuse and ne-
10 glect;

11 “(G) significant disparities in health out-
12 comes for people giving birth and infants;

13 “(H) a high rate of exclusionary discipline
14 and referrals to law enforcement; and

15 “(I) a high rate of homelessness and hous-
16 ing instability.

17 “(2) DATA FROM TRIBAL AREAS.—The Sec-
18 retary, acting through the Director of the Indian
19 Health Service, shall consult with Indian Tribes to
20 establish criteria to measure indicators of need, for
21 purposes of paragraph (1), with respect to Tribal
22 areas.

23 “(f) USE OF FUNDS.—

24 “(1) REQUIRED USES.—

1 “(A) IN GENERAL.—A grant received
2 under this section shall be used to establish or
3 expand gender-responsive, culturally specific,
4 trauma-informed care coordination services, in-
5 cluding by instituting and conducting risk and
6 needs assessments including—

7 “(i) using strengths-based approaches
8 focused on protective factors for children
9 and their caregivers, including prenatal
10 people of any age; and

11 “(ii) inputting screening results into a
12 centralized intake system to promote a sin-
13 gle point of access system across providers
14 and services.

15 “(B) TRAINING.—A grant received under
16 this section shall be used to ensure that individ-
17 uals employed through the grant funds, in
18 whole or in part, have received sufficient and
19 up-to-date training on trauma-informed care
20 and strategies that are reparative, culturally
21 sensitive, gender-responsive, and healing-cen-
22 tered.

23 “(2) PERMISSIBLE USES.—A grant received
24 under this section may be used for any of the fol-
25 lowing:

1 “(A) Employing care coordinators, case
2 managers, community health workers, certified
3 infant mental health specialists, and outreach
4 and engagement specialists to work with chil-
5 dren and their caregivers, including prenatal in-
6 dividuals, to prevent and respond to adverse
7 childhood experiences by connecting clients with
8 culturally specific, trauma-informed care treat-
9 ment services, including economic, social, food,
10 and housing supports.

11 “(B) Providing training described in para-
12 graph (1)(B) to community health providers
13 and community partners.

14 “(C) Expanding, enhancing, modifying,
15 and connecting the existing network of commu-
16 nity programs and services to achieve a more
17 comprehensive and coordinated system of care
18 approach, including—

19 “(i) developing local infrastructure to
20 bolster and shape community support sys-
21 tems and map and build access to services
22 in a coordinated and comprehensive way;
23 and

24 “(ii) creating infrastructure to con-
25 duct outreach to children and families, in-

1 cluding those experiencing homelessness
2 and housing instability, so they acquire ac-
3 cess to the services and supports they need
4 and the benefits to which they are entitled.

5 “(D) Compiling information on resources
6 (including any referral services) available
7 through community-based organizations and
8 local, State, and Federal agencies, such as—

9 “(i) programs addressing social deter-
10 minants of health, including—

11 “(I) emergency, temporary, and
12 long-term housing;

13 “(II) programs that offer free or
14 affordable and nutritious food;

15 “(III) vocational and workforce
16 development; and

17 “(IV) transportation supports;

18 “(ii) home visiting programs for new
19 parents and their infants;

20 “(iii) workforce development programs
21 to support caregivers in skill building;

22 “(iv) trauma-responsive, parenting
23 skills-building programs;

24 “(v) the continuum of substance use
25 prevention, intervention, and treatment

1 programs and mental health support pro-
2 grams, including programs with trauma-in-
3 formed, gender-responsive, and culturally
4 specific counseling; and

5 “(vi) childcare support and early
6 childhood education, including Head Start
7 and Early Head Start programs.

8 “(E) Subject to subsection (g)(1), estab-
9 lishing or updating a database that compiles
10 data used to track the effectiveness of the care
11 coordination services funded through the grant.

12 “(F) Developing and implementing referral
13 partnership agreements with community-based
14 organizations, parent organizations, substance
15 use disorder treatment providers and facilities,
16 housing and shelter providers, health care pro-
17 viders, mental health care providers, and Fed-
18 eral and State offices and programs that imple-
19 ment practices to support children ages 0
20 through 5 who are at risk of adverse childhood
21 experiences and their caregivers, including pre-
22 natal people. Such practices shall include—

23 “(i) a bilateral ‘warm handoff’ system
24 whereby a grantee understands the needs
25 of the children and their families, and fam-

1 ilies are involved in addressing these needs;
2 and

3 “(ii) an active service connection
4 whereby the children and families are each
5 actively connected with a resource in a
6 well-coordinated way that ensures avail-
7 ability and direct contact.

8 “(G) Supporting cross-system planning
9 and collaboration among employees who may
10 work in emergency medical services, health care
11 services, public health, early childhood edu-
12 cation, and substance use disorder treatment
13 and recovery support.

14 “(H) Providing or subsidizing services to
15 address barriers that children, prenatal individ-
16 uals, and caregivers face to utilizing community
17 resources and services, such as by providing or
18 subsidizing transportation or childcare costs as
19 applicable and within reasonable amounts.

20 “(I) Creating or expanding infrastructure
21 and investing in technology, including the provi-
22 sion of communications technology and internet
23 service to children and their caregivers, to en-
24 able increased telemedicine capabilities to reach
25 participants.

1 “(3) INDIAN TRIBES.—In the case of an eligible
2 entity that is an Indian Tribe, the Secretary may
3 waive such provisions of this subsection as the Sec-
4 retary determines appropriate.

5 “(4) PROHIBITIONS.—In addition to any other
6 prohibitions determined by the Secretary, an eligible
7 entity may not use a grant under this section to—

8 “(A) use data analysis methods to inform
9 individual case decisions, including child re-
10 moval or placement decisions, or to target serv-
11 ices at certain individuals or families;

12 “(B) require any individual or family to
13 participate in any service or program as a con-
14 dition of receipt of a benefit to which the indi-
15 vidual or family is otherwise eligible; or

16 “(C) increase the presence or funding of
17 law enforcement surveillance, involvement, or
18 activity in connection with trauma-informed
19 care coordination services supported pursuant
20 to this section.

21 “(g) REQUIREMENTS.—As a condition on receipt of
22 a grant under this section, an eligible entity shall agree
23 to each of the following funding conditions:

24 “(1) RESTRICTION OF FUNDING ALLOCATION.—

25 The eligible entity will not use more than 30 percent

1 of the funds made available to the entity through the
2 grant (for the total grant period) to establish or up-
3 date a database pursuant to subsection (f)(2)(E).

4 “(2) ACCESSIBLE SETTING.—

5 “(A) IN GENERAL.—The eligible entity will
6 ensure that all care coordination services pro-
7 vided through the grant are provided in a set-
8 ting that is accessible, including through mobile
9 settings, to—

10 “(i) low-income or no-income individ-
11 uals, including individuals experiencing
12 homelessness or housing instability; and

13 “(ii) individuals in rural areas.

14 “(B) COMMUNITY OUTREACH.—In com-
15 plying with subparagraph (A), the eligible entity
16 will ensure that at least 50 percent of the care
17 coordination services provided through the
18 grant occur in community settings that are con-
19 venient to the children and caregivers who are
20 being served, such as homes, schools, and shel-
21 ters, whether for initial outreach or as part of
22 long-term care.

23 “(3) SUPPLEMENT NOT SUPPLANT.—The grant
24 will be used to supplement not supplant other Fed-

1 eral, State, or local funds available for care coordi-
2 nation services.

3 “(4) CONFIDENTIALITY.—The eligible entity
4 will maintain the confidentiality of individuals receiv-
5 ing services through the grant in a manner con-
6 sistent with applicable law.

7 “(5) PARTNERING; RISK STRATIFICATION.—In
8 providing care coordination services through the
9 grant, the eligible entity will—

10 “(A) partner with community-based orga-
11 nizations with experience serving child popu-
12 lations prenatally through age 5;

13 “(B) coordinate with the local agency re-
14 sponsible for administering the State plan ap-
15 proved under title XIX of the Social Security
16 Act; and

17 “(C) employ risk stratification to develop
18 different effective models of care for different
19 populations based on their needs.

20 “(h) APPLICATION.—

21 “(1) IN GENERAL.—To seek a grant under this
22 section, an eligible entity shall submit an application
23 to the Secretary at such time, in such manner, and
24 containing such information, as the Secretary may
25 require.

1 “(2) CONTENTS.—An application under para-
2 graph (1) shall, at a minimum, contain each of the
3 following:

4 “(A) Goals to be achieved through the
5 grant, including the activities that will be un-
6 dertaken to achieve those goals.

7 “(B) The number of individuals likely to
8 be served through the grant, including demo-
9 graphic data on the populations to be served.

10 “(C) Existing programs and services that
11 can be used to significantly increase the propor-
12 tion of children and families who receive needed
13 supports and services.

14 “(D) A plan for expanding, coordinating,
15 or modifying the existing network of programs
16 and services to meet the needs of children and
17 families for preventing and mitigating the trau-
18 matic impact of adverse childhood experiences.

19 “(E) A demonstration of the ability of the
20 eligible entity to reach the individuals to be
21 served, including by partnering with local stake-
22 holders.

23 “(F) An indication of how the personnel
24 involved are reflective of the communities to be
25 served.

1 “(G) A list of stakeholders with whom the
2 entity plans to partner or consult.

3 “(i) REPORTING BY GRANTEES.—Not later than 4
4 years after the date of enactment of this section, an eligi-
5 ble entity receiving a grant under this section shall submit
6 to the Secretary a report on the activities funded through
7 the grant. Such report shall include, at a minimum, a de-
8 scription of—

9 “(1) the number of individuals served through
10 activities funded through the grant, including demo-
11 graphics as applicable;

12 “(2) the number of referrals made through the
13 grant and the rate of such referrals successfully
14 linked or closed;

15 “(3) a qualitative analysis or number of collabo-
16 rative partnerships with other organizations in car-
17 rying out the activities funded through the grant;

18 “(4) the number of services provided to individ-
19 uals through the grant;

20 “(5) aggregated and de-identified outcomes ex-
21 perienced by individuals served through the grant
22 such as—

23 “(A) the rate of successful service connec-
24 tions;

1 “(B) any increases in development of pro-
2 tective factors for children;

3 “(C) any increase in development of pro-
4 tective factors for the caregivers;

5 “(D) any mitigation of the negative out-
6 comes associated with adverse childhood experi-
7 ences or decreased likelihood of children experi-
8 encing an adverse childhood experience as evi-
9 denced by—

10 “(i) decreased presence of law en-
11 forcement or other punitive State surveil-
12 lance in the community;

13 “(ii) a parent completing substance
14 use treatment;

15 “(iii) a parent receiving voluntary
16 treatment for mental health-related condi-
17 tions;

18 “(iv) a family entering into or main-
19 taining a stable housing situation;

20 “(v) a family achieving or maintaining
21 economic security;

22 “(vi) a parent achieving or maintain-
23 ing job stability; or

24 “(vii) a child meeting developmental
25 markers for school readiness; and

1 “(E) reports of satisfaction with the co-
2 ordination of care by people served; and

3 “(6) any other information required by the Sec-
4 retary.

5 “(j) CONVENING PARTICIPANTS FOR SHARING LES-
6 SONS LEARNED.—After the period of all grants awarded
7 under this section has concluded, the Assistant Secretary
8 for Planning and Evaluation of the Department of Health
9 and Human Services shall provide an in-person or online
10 opportunity for persons participating in the programs
11 funded through this section to share with each other—

12 “(1) lessons learned;

13 “(2) challenges experienced; and

14 “(3) ideas for next steps and solutions.

15 “(k) COMPILING FINDINGS AND CONCLUSIONS.—
16 After providing the opportunity required by subsection (j),
17 the Secretary shall—

18 “(1) compile the findings and conclusions of
19 grantees under this section on the provision of care
20 coordination services described in subsection (a);

21 “(2) submit a report on such findings and con-
22 clusions to the appropriate congressional commit-
23 tees; and

24 “(3) make such report publicly available.

25 “(l) DEFINITIONS.—In this section:

“(1) ADVERSE CHILDHOOD EXPERIENCE.—The term ‘adverse childhood experience’ means a potentially traumatic experience that occurs in childhood and can have a tremendous impact on the child’s lifelong health and opportunity outcomes, such as any of the following:

7 “(A) Abuse, such as any of the following:

8 “(i) Emotional and psychological
9 abuse.

10 “(ii) Physical abuse.

11 “(iii) Sexual abuse.

12 “(B) Household challenges such as any of
13 the following:

14 “(i) A household member is treated
15 violently.

16 “(ii) A household member has a sub-
17 stance use disorder.

18 “(iii) A household member has a men-
19 tal health condition.

20 “(iv) Parental separation or divorce.

21 “(v) A household member is incarcerated,
22 ated, is placed in immigrant detention, or
23 has been deported.

24 “(vi) A household member has a life-
25 threatening illness such as COVID-19.

1 “(C) Neglect.

2 “(D) Living in—

3 “(i) impoverished communities that
4 lack access to human services;

5 “(ii) areas of high unemployment
6 neighborhoods; or

7 “(iii) communities experiencing de
8 facto segregation.

9 “(E) Experiencing food insecurity and
10 poor nutrition.

11 “(F) Witnessing violence.

12 “(G) Involvement with the foster system.

13 “(H) Experiencing discrimination.

14 “(I) Dealing with historical and ongoing
15 traumas due to systemic and interpersonal rac-
16 ism.

17 “(J) Dealing with historical and ongoing
18 traumas regarding systemic and interpersonal
19 sexism, homophobia, biphobia, and transphobia.

20 “(K) Dealing with the threat of deporta-
21 tion or detention as a result of immigration sta-
22 tus.

23 “(L) The impacts of multigenerational pov-
24 erty resulting from limited educational and eco-
25 nomic opportunities.

1 “(M) Living through natural disasters
2 such as earthquakes, forest fires, floods, or hur-
3 ricanes.

4 “(2) CARE COORDINATION.—The term ‘care co-
5 ordination’ means an active, ongoing process that—

6 “(A) assists children ages 0 through 5 at
7 risk of, or who have experienced, an adverse
8 childhood experience, and their caregivers, in-
9 cluding prenatal people of any age, to identify,
10 access, and use community resources and serv-
11 ices;

12 “(B) is client-centered and comprehensive
13 of the services a child or caregiver may need;

14 “(C) ensures a closed loop referral by ob-
15 taining feedback from the families served; and

16 “(D) works across systems and services to
17 promote collaboration to effectively meet the
18 needs of community members.

19 “(3) INDIAN TRIBE.—The term ‘Indian Tribe’
20 has the meaning given such term in section 4 of the
21 Indian Self-Determination and Education Assistance
22 Act.

23 “(4) PROTECTIVE FACTORS.—The term ‘protec-
24 tive factors’ refers to any supportive element in a
25 child or caretaker’s life that helps the child or care-

1 taker to withstand trauma such as a stable school
2 environment or supportive peer relationships.

3 “(m) AUTHORIZATION OF APPROPRIATIONS.—

4 “(1) IN GENERAL.—To carry out this section,
5 there is authorized to be appropriated \$15,000,000
6 for each of the 5 fiscal years following the fiscal year
7 in which this section is enacted.

8 “(2) GRANTS TO INDIAN TRIBES.—Of the
9 amount made available to carry out this section for
10 a fiscal year, the Secretary shall use not less than
11 10 percent of such amount for grants to eligible en-
12 tities that are Indian Tribes.

13 “(3) ADMINISTRATIVE EXPENSES.—Of the
14 amount made available to carry out this section for
15 a fiscal year, the Secretary may use not more than
16 15 percent of such amount for administrative ex-
17 penses, including the expenses of the Assistant Sec-
18 retary for Planning and Evaluation of the Depart-
19 ment of Health and Human Services for compiling
20 and reporting information.

21 “(4) TECHNICAL ASSISTANCE.—Of the amount
22 made available to carry out this section for a fiscal
23 year, the Secretary may reserve up to 5 percent of
24 such amount to provide technical assistance to eligi-

1 ble entities in preparing and submitting applications
2 under this section.”.

3 **SEC. 6075. IMPROVING ACCESS TO MENTAL HEALTH.**

4 (a) ACCESS TO CLINICAL SOCIAL WORKERS.—Sec-
5 tion 1833(a)(1)(F)(ii) of the Social Security Act (42
6 U.S.C. 1395l(a)(1)(F)(ii)) is amended by striking “75
7 percent of the amount determined for payment of a psy-
8 chologist under clause (L)” and inserting “85 percent of
9 the fee schedule amount provided under section 1848”.

10 (b) ACCESS TO CLINICAL SOCIAL WORKER SERVICES
11 PROVIDED TO RESIDENTS OF SKILLED NURSING FACILI-
12 TIES.—

13 (1) IN GENERAL.—Section 1888(e)(2)(A)(ii) of
14 the Social Security Act (42 U.S.C.
15 1395yy(e)(2)(A)(ii)), as amended by section
16 6011(a)(5), is amended by inserting “clinical social
17 worker services,” after “peer support specialist serv-
18 ices (as defined in section 1861(nnn)(7)),”.

19 (2) CONFORMING AMENDMENT.—Section
20 1861(hh)(2) of the Social Security Act (42 U.S.C.
21 1395x(hh)(2)) is amended by striking “and other
22 than services furnished to an inpatient of a skilled
23 nursing facility which the facility is required to pro-
24 vide as a requirement for participation”.

1 (c) ACCESS TO THE COMPLETE SET OF CLINICAL SO-
2 CIAL WORKER SERVICES.—Section 1861(hh)(2) of the So-
3 cial Security Act (42 U.S.C. 1395x(hh)(2)) is further
4 amended by striking “for the diagnosis and treatment of
5 mental illnesses (other than services” and inserting “(in-
6 cluding services for the diagnosis and treatment of mental
7 illnesses or services for health and behavior assessment
8 and intervention (identified as of January 1, 2022, by
9 HCPCS codes 96150 through 96161 (and any succeeding
10 codes)), but not including services”.

11 (d) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to items and services furnished on
13 or after January 1, 2023.

14 **SEC. 6076. MENTAL HEALTH IN SCHOOLS EXCELLENCE**
15 **PROGRAM.**

16 (a) PROGRAM TO ESTABLISH PUBLIC-PRIVATE CON-
17 TRIBUTIONS TO INCREASE THE AVAILABLE WORKFORCE
18 OF SCHOOL-BASED MENTAL HEALTH SERVICE PRO-
19 VIDERS.—

20 (1) PROGRAM AUTHORIZED.—The Secretary
21 shall carry out a program under which eligible grad-
22 uate institutions may enter into an agreement with
23 the Secretary to cover a portion of the cost of at-
24 tendance of a participating student, which contribu-

1 tions shall be matched by equivalent contributions
2 towards such cost of attendance by the Secretary.

3 (2) DESIGNATION OF PROGRAM.—The program
4 under this subsection shall be known as the “Mental
5 Health in Schools Excellence Program”.

6 (3) AGREEMENTS.—The Secretary shall enter
7 into an agreement with each eligible graduate insti-
8 tution seeking to participate in the program under
9 this section. Each agreement shall specify the fol-
10 lowing:

11 (A) The manner (whether by direct grant,
12 scholarship, or otherwise) in which the eligible
13 graduate institution will contribute to the cost
14 of attendance of a participating student.

15 (B) The maximum amount of the contribu-
16 tion to be made by the eligible graduate institu-
17 tion with respect to any particular participating
18 student in any given academic year.

19 (C) The maximum number of individuals
20 for whom the eligible graduate institution will
21 make contributions in any given academic year.

22 (D) That the eligible graduate institution,
23 in selecting participating students to receive as-
24 sistance under the program, shall prioritize the

1 participating students described in paragraph
2 (4)(B).

3 (E) Such other matters as the Secretary
4 and the eligible graduate institution determine
5 appropriate.

6 (4) OUTREACH.—The Secretary shall—

7 (A) make publicly available and periodi-
8 cally update on the internet website of the De-
9 partment of Education a list of the eligible
10 graduate institutions participating in the pro-
11 gram under this subsection that shall specify,
12 for each such graduate institution, appropriate
13 information on the agreement between the Sec-
14 retary and such college or university under
15 paragraph (3); and

16 (B) conduct outreach about the program
17 under this section to participating students
18 who, as undergraduates—

19 (i) received a Federal Pell Grant
20 under section 401 of the Higher Education
21 Act of 1965 (20 U.S.C. 1070a); or

22 (ii) attended an institution listed in
23 section 371(a) of the Higher Education
24 Act of 1965 (20 U.S.C. 1067q(a)).

1 (5) MATCHING CONTRIBUTIONS.—The Sec-
2 retary may provide a contribution of up to 50 per-
3 cent of the cost of attendance of a participating stu-
4 dent if the eligible graduate institution at which
5 such student is enrolled enters into an agreement
6 under paragraph (3) with the Secretary to match
7 such contribution.

8 (b) DEFINITIONS.—In this section:

9 (1) COST OF ATTENDANCE.—The term “cost of
10 attendance” has the meaning given the term in sec-
11 tion 472 of the Higher Education Act of 1965 (20
12 U.S.C. 1087ll).

13 (2) ELIGIBLE GRADUATE INSTITUTION.—The
14 term “eligible graduate institution” means an insti-
15 tution of higher education in that offers a program
16 of study that leads to a graduate degree—

17 (A) in school psychology that is accredited
18 or approved by the National Association of
19 School Psychologists’ Program Accreditation
20 Board or the Commission on Accreditation of
21 the American Psychological Association and
22 that prepares students in such program for the
23 State licensing or certification examination in
24 school psychology at the specialist level;

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1 (B) in an accredited school counseling pro-
2 gram that prepares students in such program
3 for the State licensing or certification examina-
4 tion in school counseling;

5 (C) in school social work that is accredited
6 by the Council on Social Work Education and
7 that prepares students in such program for the
8 State licensing or certification examination in
9 school social work;

10 (D) in another school-based mental health
11 field that prepares students in such program
12 for the State licensing or certification examina-
13 tion in such field, if applicable; or

14 (E) in any combination of study described
15 in subparagraphs (A) through (D).

16 (3) INSTITUTION OF HIGHER EDUCATION.—The
17 term “institution of higher education” has the
18 meaning given such term in section 101 of the High-
19 er Education Act of 1965 (20 U.S.C. 1001), but ex-
20 cludes any institution of higher education described
21 in section 102(a)(1)(C) of such Act.

22 (4) PARTICIPATING STUDENT.—The term “par-
23 ticipating student” means an individual who is en-
24 rolled in a graduate degree program in a school-

1 based mental health field at a participating eligible
2 graduate institution.

3 (5) SCHOOL-BASED MENTAL HEALTH FIELD.—

4 The term “school-based mental health field” means
5 each of the following fields:

6 (A) School counseling.

7 (B) School social work.

8 (C) School psychology.

9 (D) Any other field of study that leads to
10 employment as a school-based mental health
11 services provider, as determined by the Sec-
12 retary.

13 (6) SCHOOL-BASED MENTAL HEALTH SERVICES
14 PROVIDER.—The term “school-based mental health
15 services provider” has the meaning given the term in
16 section 4102 of the Elementary and Secondary Edu-
17 cation Act of 1965 (20 U.S.C. 7112).

18 (7) SECRETARY.—The term “Secretary” means
19 the Secretary of Education.

20 **SEC. 6077. SCHOOL SOCIAL WORKERS IMPROVING STU-**
21 **DENT SUCCESS.**

22 (a) SCHOOL SOCIAL WORKER GRANTS.—

23 (1) PURPOSES.—The purpose of this section is
24 to assist States and local educational agencies in hir-
25 ing additional school social workers in order to in-

1 crease access to mental health and other student
2 support services to students in elementary and sec-
3 ondary schools in the United States to the minimum
4 ratios recommended by the National Association of
5 Social Workers, the School Social Work Association
6 of America, and the American Council for School
7 Social Work of one school social worker for every
8 250 students, and one school social worker for every
9 50 students when a social worker is providing serv-
10 ices to students with intensive needs.

11 (2) ESEA AMENDMENT.—Subpart 4 of part F
12 of title IV of the Elementary and Secondary Edu-
13 cation Act of 1965 (20 U.S.C. 7271 et seq.) is
14 amended by adding at the end the following new sec-
15 tion:

16 **“SEC. 4645. GRANTS FOR SCHOOL SOCIAL WORKERS.**

17 “(a) GRANTS AUTHORIZED.—

18 “(1) IN GENERAL.—From the amounts appro-
19 priated under subsection (g), the Secretary shall
20 award grants to high-need local educational agencies
21 to enable such agencies to retain school social work-
22 ers employed by such agencies or to hire additional
23 school social workers.

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1 “(2) DURATION.—A grant awarded under this
2 section shall be awarded for a period not to exceed
3 4 years.

4 “(3) SUPPLEMENT, NOT SUPPLANT.—Funds
5 made available under this section shall be used to
6 supplement, and not to supplant, other Federal,
7 State, or local funds used for hiring and retaining
8 school social workers.

9 “(b) APPLICATION.—

10 “(1) IN GENERAL.—To be eligible to receive a
11 grant under this section, a high-need local edu-
12 cational agency shall submit to the Secretary an ap-
13 plication at such time, in such manner, and con-
14 taining such information as the Secretary may re-
15 quire.

16 “(2) CONTENTS.—An application submitted
17 under paragraph (1) shall include an assurance that
18 each school social worker who receives assistance
19 under the grant will provide the services described in
20 subsection (d), and a description of the specific serv-
21 ices to be provided by such social worker.

22 “(c) USE OF FUNDS.—A high-need local educational
23 agency receiving a grant under this section—

24 “(1) shall use the grant—

1 “(A) to achieve a ratio of not less than 1
2 school social worker for every 250 students
3 served by the agency, by—

4 “(i) retaining school social workers
5 employed by such agency; or

6 “(ii)(I) employing additional school
7 social workers; or

8 “(II) hiring contractors to serve as
9 school social workers only in a case in
10 which—

11 “(aa) the local educational agen-
12 cy demonstrates to the Secretary that
13 the agency—

14 “(AA) has not been able to
15 employ a sufficient number of
16 school social workers under sub-
17 clause (I) to achieve such ratio
18 despite strong and continuing ef-
19 forts to recruit and employ school
20 social workers; and

21 “(BB) hiring contractors is
22 the only viable option to ensure
23 students have adequate access to
24 school social work services; and

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1 “(bb) each such contractor meets
2 the requirements of subparagraphs
3 (A) and (B) of subsection (h)(2); and

4 “(B) to ensure that each school social
5 worker who receives assistance under such
6 grant provides the services described in sub-
7 section (d); and

8 “(2) may use the grant to reimburse school so-
9 cial workers who receive assistance under such grant
10 for—

11 “(A) in the case of a school served by the
12 agency in which the majority of students are
13 higher risk students, to hire or retain additional
14 school social workers in accordance with clauses
15 (i) and (ii) of paragraph (1)(A) to achieve a
16 ratio of not less than 1 school social worker for
17 every 50 students;

18 “(B) travel expenses incurred during home
19 visits and other school-related trips;

20 “(C) any additional expenses incurred by
21 such social workers in rendering any service de-
22 scribed in subsection (d); and

23 “(D) the cost of clinical social work super-
24 vision for such social workers.

1 “(d) RESPONSIBILITIES OF A SCHOOL SOCIAL WORK-
2 ER.—A school social worker who receives assistance under
3 a grant under this section shall provide the following serv-
4 ices:

5 “(1) Identifying high-need students in each
6 school that the social worker serves, and targeting
7 services provided at the school to such students.

8 “(2) Providing students in each school that the
9 school social worker serves, social work services to
10 promote school engagement and improve academic
11 outcomes, including—

12 “(A) counseling and crisis intervention;

13 “(B) trauma-informed services;

14 “(C) evidence-based educational, behav-
15 ioral, and mental health services (such as imple-
16 menting multi-tiered programs and practices,
17 monitoring progress, and evaluating service ef-
18 fectiveness);

19 “(D) addressing the social and emotional
20 learning needs of students;

21 “(E) promoting a school climate and cul-
22 ture conducive to student learning and teaching
23 excellence (such as promoting effective school
24 policies and administrative procedures, enhanc-
25 ing the professional capacity of school per-

1 sonnel, and facilitating engagement between
2 student, family, school, and community);

3 “(F) providing access to school-based and
4 community based resources (such as promoting
5 a continuum of services, mobilizing resources
6 and promoting assets, providing leadership,
7 interdisciplinary collaboration, systems coordi-
8 nation, and professional consultation, and con-
9 necting students and families to resource sys-
10 tems);

11 “(G) working with students, families,
12 schools, and communities to address barriers to
13 educational attainment (such as homelessness
14 and housing insecurity, lack of transportation,
15 food insecurity, equity, social justice issues, ac-
16 cess to quality education, and school, family,
17 and community risk factors);

18 “(H) providing assistance to schools and
19 teachers to design social-emotional, educational,
20 behavioral, and mental health interventions;

21 “(I) case management activities to coordi-
22 nate the delivery of and access to the appro-
23 priate social work services to the highest-need
24 students;

1 “(J) home visits to meet the family of stu-
2 dents in need of social work services in the
3 home environment;

4 “(K) supervising or coordinating district
5 level school social work services; and

6 “(L) other services the Secretary deter-
7 mines, in partnership with students, educators,
8 and community member voices, are necessary to
9 be carried out by such a social worker.

10 “(e) GRANT RENEWAL.—

11 “(1) IN GENERAL.—A grant awarded under
12 this section may be renewed for additional periods
13 with the same duration as the original grant period.

14 “(2) CONTINUING ELIGIBILITY APPLICATION.—

15 To be eligible for a renewal under this section a
16 high-need local educational agency shall submit to
17 the Secretary, for each renewal, a report on the
18 progress of such agency in retaining and hiring
19 school social workers to achieve the ratio of not less
20 than 1 school social worker for every 250 students
21 served by the agency, and shall include—

22 “(A) a description of the staffing expan-
23 sion of school social workers funded through the
24 original grant received under this section; and

1 “(B) a description of the work conducted
2 by such social workers for higher risk students.

3 “(f) TECHNICAL ASSISTANCE.—

4 “(1) IN GENERAL.—The Secretary shall provide
5 technical assistance to high-need local educational
6 agencies, including such agencies that do not have
7 adequate staff, in applying for grants under this sec-
8 tion.

9 “(2) EXTENSION OF APPLICATION PERIOD.—

10 The Secretary shall extend any application period
11 for a grant under this section for any high-need local
12 educational agency that—

13 “(A) submits to the Secretary a written
14 notification of the intent to apply for a grant
15 under this section before requesting technical
16 assistance under paragraph (1); and

17 “(B) after submitting the notification
18 under subparagraph (A), requests such tech-
19 nical assistance.

20 “(g) AUTHORIZATION FOR APPROPRIATIONS.—There
21 is authorized to be appropriated to carry out this section,
22 \$100,000,000 for each of fiscal years 2023 through 2027.

23 “(h) DEFINITIONS.—In this section:

24 “(1) HIGH-NEED LOCAL EDUCATIONAL AGEN-
25 CY.—The term ‘high-need local educational agency’

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1 has the meaning given the term in section 200 of the
2 Higher Education Act of 1965 (20 U.S.C. 1021).

3 “(2) SCHOOL SOCIAL WORKER.—The term
4 ‘school social worker’ means an individual who—

5 “(A) has a graduate degree in social work
6 from a social work program that is accredited
7 by the Council on Social Work Education; and

8 “(B) meets all other State and local
9 credentialing requirements for practicing as a
10 social worker in an elementary school or sec-
11 ondary school.”.

12 (b) NATIONAL TECHNICAL ASSISTANCE CENTER FOR
13 SCHOOL SOCIAL WORK.—

14 (1) IN GENERAL.—The Secretary of Education
15 shall establish an evaluation, documentation, dis-
16 semination, and technical assistance resource center
17 to provide appropriate information, training, and
18 technical assistance to States, political subdivisions
19 of States, federally recognized Indian Tribes, Tribal
20 organizations, institutions of higher education, State
21 and local educational agencies, and individual stu-
22 dents and educators with respect to hiring and re-
23 taining school social workers at elementary schools
24 and secondary schools served by local educational
25 agencies.

1 (2) RESPONSIBILITIES OF THE CENTER.—The
2 center established under paragraph (1) shall conduct
3 activities for the purpose of—

4 (A) developing and continuing statewide or
5 Tribal strategies for improving the effectiveness
6 of the school social work workforce;

7 (B) studying the costs and effectiveness of
8 school social work programs at institutions of
9 higher education to identify areas of improve-
10 ment and provide information on relevant issues
11 of importance to State, Tribal, and national
12 policymakers;

13 (C) working with Federal agencies and
14 other State, Tribal, and national stakeholders
15 to collect, evaluate, and disseminate data re-
16 garding school social work ratios, outcomes and
17 best practices of school-based mental health
18 services, and impact of expanding the number
19 of school social workers within elementary
20 schools and secondary schools; and

21 (D) establishing partnerships among na-
22 tional, State, Tribal, and local governments,
23 and local educational agencies, institutions of
24 higher education, non-profit organizations, and

1 State and national trade associations for the
2 purposes of—

- 3 (i) data collection and dissemination;
4 (ii) establishing a school social work
5 workforce development program;
6 (iii) documenting the success of school
7 social work methods on a national level;
8 and
9 (iv) conducting other activities deter-
10 mined appropriate by the Secretary.

11 (3) DEFINITIONS.—In this subsection:

12 (A) ESEA TERMS.—Except as otherwise
13 provided, any term used in this subsection that
14 is defined in section 8101 of the Elementary
15 and Secondary Education Act of 1965 (20
16 U.S.C. 7801) shall have the meaning given that
17 term in such section.

18 (B) SCHOOL SOCIAL WORKER.—The term
19 “school social worker” has the meaning given
20 the term in section 4645(h) of the Elementary
21 and Secondary Education Act of 1965, as
22 added by subsection (a).

1 **SEC. 6078. OPIOID GRANTS TO SUPPORT CAREGIVERS, KIN-**
2 **SHIP CARE FAMILIES, AND KINSHIP CARE-**
3 **GIVERS.**

4 (a) OPIOID GRANTS.—Section 1003(b)(2) of the 21st
5 Century Cures Act (42 U.S.C. 290ee–3 note) is amend-
6 ed—

7 (1) by redesignating subparagraph (E) as sub-
8 paragraph (F); and

9 (2) by inserting after subparagraph (D) the fol-
10 lowing:

11 “(E) Supporting opioid abuse prevention
12 and treatment services within a State provided
13 by State and local agencies for children and
14 caregivers, kinship care families, and kinship
15 caregivers through—

16 “(i) workforce recruitment and train-
17 ing;

18 “(ii) health care services (including
19 such services described in subparagraph
20 (D)); and

21 “(iii) foster and adoptive parent re-
22 cruitment and training.”.

23 (b) DEFINITIONS.—Section 1003 of the 21st Century
24 Cures Act (42 U.S.C. 290ee–3 note) is amended—

25 (1) by redesignating subsections (h), (i), and (j)
26 as subsections (i), (j), and (k), respectively; and

1 (2) by inserting after subsection (g) the fol-
2 lowing:

3 “(h) DEFINITIONS.—In this section:

4 “(1) The term ‘kinship care family’ means a
5 family with a kinship caregiver.

6 “(2) The term ‘kinship caregiver’ means a rel-
7 ative of a child by blood, marriage, or adoption,
8 who—

9 “(A) lives with the child;

10 “(B) is the primary caregiver of the child
11 because the biological or adoptive parent of the
12 child is unable or unwilling to serve as the pri-
13 mary caregiver of the child; and

14 “(C) has a legal relationship to the child or
15 is raising the child informally.”.

16 (c) AUTHORIZATION OF APPROPRIATIONS.—Section
17 1003(i) of the 21st Century Cures Act (42 U.S.C. 290ee–
18 3 note), as redesignated, is amended by inserting “, and
19 \$255,000,000 for each of fiscal years 2022 through 2026”
20 after “2021”.

21 (d) SET ASIDE.—Section 1003(j) of the 21st Century
22 Cures Act (42 U.S.C. 290ee–3 note), as redesignated, is
23 amended—

24 (1) by striking “, and up to” and inserting “,
25 up to”; and

1 (2) by inserting before the period at the end “,
2 and 1 percent of such amount for such fiscal year
3 shall be made available to carry out subsection
4 (b)(2)(E)”.

5 **TITLE VII—ADDRESSING HIGH**
6 **IMPACT MINORITY DISEASES**

7 **Subtitle A—Cancer**

8 **SEC. 7001. LUNG CANCER MORTALITY REDUCTION.**

9 (a) FINDINGS.—Congress makes the following find-
10 ings:

11 (1) Lung cancer is the leading cause of cancer
12 death for both men and women, accounting for 25
13 percent of all cancer deaths.

14 (2) Since the National Cancer Act of 1971
15 (Public Law 92–218; 85 Stat. 778), coordinated and
16 comprehensive research has raised the 5-year sur-
17 vival rates for breast cancer to 90 percent, for pros-
18 tate cancer to 99 percent, and for colon cancer to
19 64 percent.

20 (3) The 5-year survival rate for lung cancer is
21 still only 18 percent, and a similar coordinated and
22 comprehensive research effort is required to achieve
23 increases in lung cancer survivability rates.

24 (4) Sixty percent of lung cancer cases are now
25 diagnosed in nonsmokers or former smokers.

1 (5) Two-thirds of nonsmokers diagnosed with
2 lung cancer are women.

3 (6) Certain minority populations, such as Afri-
4 can-American males, have disproportionately high
5 rates of lung cancer incidence and mortality, despite
6 their smoking rate being similar to other racial
7 groups.

8 (7) Members of the Baby Boomer Generation
9 are entering their 60s, the most common age at
10 which people develop lung cancer.

11 (8) Tobacco addiction and exposure to other
12 lung cancer carcinogens such as Agent Orange and
13 other herbicides and battlefield emissions are serious
14 problems among military personnel and war vet-
15 erans.

16 (9) Significant and rapid improvements in lung
17 cancer mortality can be expected through greater
18 use and access to lung cancer screening tests for at-
19 risk individuals.

20 (10) Recent research has shown that screening
21 with low-dose computed tomography scan reduced
22 lung cancer death mortality by 20 percent for those
23 with a high risk of lung cancer through early detec-
24 tion. The Centers for Medicare & Medicaid Services

1 supports annual lung cancer screening for high-risk
2 patients with low-dose computed tomography.

3 (11) Additional strategies are necessary to fur-
4 ther enhance the existing tests and therapies avail-
5 able to diagnose and treat lung cancer in the future.

6 (12) The August 2001 Report of the Lung
7 Cancer Progress Review Group of the National Can-
8 cer Institute stated that funding for lung cancer re-
9 search was “far below the levels characterized for
10 other common malignancies and far out of propor-
11 tion to its massive health impact”.

12 (13) The Report of the Lung Cancer Progress
13 Review Group identified as its “highest priority” the
14 creation of integrated, multidisciplinary, multi-insti-
15 tutional research consortia organized around the
16 problem of lung cancer rather than around specific
17 research disciplines.

18 (14) The United States must enhance its re-
19 sponse to the issues raised in the Report of the
20 Lung Cancer Progress Review Group, and this can
21 be accomplished through the establishment of a co-
22 ordinated effort designed to reduce the lung cancer
23 mortality rate by 50 percent by 2023 and targeted
24 funding to support this coordinated effort.

1 (b) SENSE OF CONGRESS CONCERNING INVESTMENT
2 IN LUNG CANCER RESEARCH.—It is the sense of the Con-
3 gress that—

4 (1) lung cancer mortality reduction should be
5 made a national public health priority; and

6 (2) a comprehensive mortality reduction pro-
7 gram coordinated by the Secretary of Health and
8 Human Services is justified and necessary to ade-
9 quately address and reduce lung cancer mortality.

10 (c) LUNG CANCER MORTALITY REDUCTION PRO-
11 GRAM.—

12 (1) IN GENERAL.—Subpart 1 of part C of title
13 IV of the Public Health Service Act (42 U.S.C. 285
14 et seq.) is amended by adding at the end the fol-
15 lowing:

16 **“SEC. 417H. LUNG CANCER MORTALITY REDUCTION PRO-**
17 **GRAM.**

18 “(a) IN GENERAL.—Not later than 6 months after
19 the date of the enactment of the Health Equity and Ac-
20 countability Act of 2022, the Secretary, in consultation
21 with the Secretary of Defense, the Secretary of Veterans
22 Affairs, the Director of the National Institutes of Health,
23 the Director of the Centers for Disease Control and Pre-
24 vention, the Commissioner of Food and Drugs, the Admin-
25 istrator of the Centers for Medicare & Medicaid Services,

1 the Director of the National Institute on Minority Health
2 and Health Disparities, the Administrator of the Environ-
3 mental Protection Agency, and other members of the
4 Lung Cancer Advisory Board established under section
5 7001 of the Health Equity and Accountability Act of
6 2022, shall implement a comprehensive program, to be
7 known as the Lung Cancer Mortality Reduction Program,
8 to achieve a reduction of at least 25 percent in the mor-
9 tality rate of lung cancer by 2027.

10 “(b) REQUIREMENTS.—The Program shall include at
11 least the following:

12 “(1) With respect to the National Institutes of
13 Health—

14 “(A) a strategic review and prioritization
15 by the National Cancer Institute of research
16 grants to achieve the goal specified in sub-
17 section (a);

18 “(B) the provision of funds to enable the
19 Airway Biology and Disease Branch of the Na-
20 tional Heart, Lung, and Blood Institute to ex-
21 pand its research programs to include pre-
22 dispositions to lung cancer, the interrelationship
23 between lung cancer and other pulmonary and
24 cardiac disease, and the diagnosis and treat-
25 ment of such diseases;

1 “(C) the provision of funds to enable the
2 National Institute of Biomedical Imaging and
3 Bioengineering to expedite the development of
4 computer-assisted diagnostic, surgical, treat-
5 ment, and drug-testing innovations to reduce
6 lung cancer mortality, such as through expan-
7 sion of the Institute’s Quantum Grant Program
8 and Image-Guided Interventions program; and

9 “(D) the provision of funds to enable the
10 National Institute of Environmental Health
11 Sciences to implement research programs rel-
12 ative to the lung cancer incidence.

13 “(2) With respect to the Food and Drug Ad-
14 ministration—

15 “(A) activities under section 529B of the
16 Federal Food, Drug, and Cosmetic Act; and

17 “(B) activities under section 561 of the
18 Federal Food, Drug, and Cosmetic Act to ex-
19 pand access to investigational drugs and devices
20 for the diagnosis, monitoring, or treatment of
21 lung cancer.

22 “(3) With respect to the Centers for Disease
23 Control and Prevention, the establishment of an
24 early disease research and management program
25 under section 1511.

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

6 “(5) The promotion (including education) of
7 lung cancer screening within minority and rural pop-
8 ulations and the study of the effectiveness of efforts
9 to increase such screening.

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

17 “(7) The cooperation and coordination of all to-
18 bacco control and cessation programs within agen-
19 cies of the Department of Health and Human Serv-
20 ices to achieve the goals of the Lung Cancer Mor-
21 tality Reduction Program under this section with
22 particular emphasis on the coordination of drug and
23 other cessation treatments with early detection pro-
24 tocols.”.

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

5 **“SEC. 529B. DRUGS RELATING TO LUNG CANCER.**

6 “(a) IN GENERAL.—The provisions of this sub-
7 chapter shall apply to a drug described in subsection (b)
8 to the same extent and in the same manner as such provi-
9 sions apply to a drug for a rare disease or condition (as
10 defined in section 526).

11 “(b) QUALIFIED DRUGS.—A drug described in this
12 subsection is—

13 “(1) a chemoprevention drug for precancerous
14 conditions of the lung;

15 “(2) a drug for targeted therapeutic treat-
16 ments, including any vaccine, for lung cancer; or

17 “(3) a drug to curtail or prevent nicotine addic-
18 tion.

19 “(c) BOARD.—The Board established under section
20 7001 of the Health Equity and Accountability Act of 2022
21 shall monitor the program implemented under this sec-
22 tion.”.

23 (3) ACCESS TO UNAPPROVED THERAPIES.—Sec-
24 tion 561(e) of the Federal Food, Drug, and Cos-
25 metic Act (21 U.S.C. 360bbb(e)) is amended by in-

1 serting before the period the following: “and shall
2 include expanding access to drugs under section
3 529B, with substantial consideration being given to
4 whether the totality of information available to the
5 Secretary regarding the safety and effectiveness of
6 an investigational drug, as compared to the risk of
7 morbidity and death from the disease, indicates that
8 a patient may obtain more benefit than risk if treat-
9 ed with the drug”.

10 (4) CDC.—Title XV of the Public Health Serv-
11 ice Act (42 U.S.C. 300k et seq.) is amended by add-
12 ing at the end the following:

13 **“SEC. 1511. EARLY DISEASE RESEARCH AND MANAGEMENT**
14 **PROGRAM.**

15 “The Secretary shall establish and implement an
16 early disease research and management program targeted
17 at the high incidence and mortality rates of lung cancer
18 among minority and low-income populations.”.

19 (d) DEPARTMENT OF DEFENSE AND DEPARTMENT
20 OF VETERANS AFFAIRS.—The Secretary of Defense and
21 the Secretary of Veterans Affairs, each in coordination
22 with the Secretary of Health and Human Services, shall
23 engage—

24 (1) in the implementation within the Depart-
25 ment of Defense and the Department of Veterans

1 Affairs, as the case may be, of an early detection
2 and disease management research program for mem-
3 bers of the Armed Forces and veterans whose smok-
4 ing history and exposure to carcinogens during serv-
5 ice on active duty in the Armed Forces has increased
6 their risk for lung cancer; and

7 (2) in the implementation of coordinated care
8 programs for members of the Armed Forces and vet-
9 erans diagnosed with lung cancer.

10 (e) LUNG CANCER ADVISORY BOARD.—

11 (1) IN GENERAL.—The Secretary of Health and
12 Human Services shall convene a Lung Cancer Advi-
13 sory Board (referred to in this section as the
14 “Board”)—

15 (A) to monitor the programs established
16 under this section (and the amendments made
17 by this section); and

18 (B) to provide annual reports to the Con-
19 gress concerning benchmarks, expenditures,
20 lung cancer statistics, and the public health im-
21 pact of such programs.

22 (2) COMPOSITION.—The Board shall be com-
23 prised of—

24 (A) the Secretary of Health and Human
25 Services;

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1 (B) the Secretary of Defense;

2 (C) the Secretary of Veterans Affairs; and

3 (D) 2 representatives each from the fields
4 of clinical medicine focused on lung cancer,
5 lung cancer research, imaging, drug develop-
6 ment, and lung cancer advocacy, to be ap-
7 pointed by the Secretary of Health and Human
8 Services.

9 (f) AUTHORIZATION OF APPROPRIATIONS.—

10 (1) IN GENERAL.—To carry out this section
11 (and the amendments made by this section), there
12 are authorized to be appropriated \$75,000,000 for
13 fiscal year 2023 and such sums as may be necessary
14 for each of fiscal years 2024 through 2026.

15 (2) LUNG CANCER MORTALITY REDUCTION PRO-
16 GRAM.—The amounts appropriated under paragraph
17 (1) shall be allocated as follows:

18 (A) \$25,000,000 for fiscal year 2023, and
19 such sums as may be necessary for each of fis-
20 cal years 2024 through 2026, for the activities
21 described in section 417H(b)(1)(B) of the Pub-
22 lic Health Service Act, as added by subsection
23 (d);

24 (B) \$25,000,000 for fiscal year 2023, and
25 such sums as may be necessary for each of fis-

1 cal years 2024 through 2026, for the activities
2 described in section 417H(b)(1)(C) of the Pub-
3 lic Health Service Act;

4 (C) \$10,000,000 for fiscal year 2023, and
5 such sums as may be necessary for each of fis-
6 cal years 2024 through 2026, for the activities
7 described in section 417H(b)(1)(D) of the Pub-
8 lic Health Service Act; and

9 (D) \$15,000,000 for fiscal year 2023, and
10 such sums as may be necessary for each of fis-
11 cal years 2024 through 2026, for the activities
12 described in section 417H(b)(3) of the Public
13 Health Service Act.

14 **SEC. 7002. EXPANSION OF PROSTATE CANCER RESEARCH,**
15 **OUTREACH, SCREENING, TESTING, ACCESS,**
16 **AND TREATMENT EFFECTIVENESS.**

17 (a) FINDINGS.—Congress makes the following find-
18 ings:

19 (1) Prostate cancer is the second leading cause
20 of cancer death among men.

21 (2) In 2020, an estimated 191,930 individuals
22 in the United States will be diagnosed with prostate
23 cancer and approximately 33,330 will die from the
24 disease.

1 (3) Roughly 2,000,000 to 3,000,000 people in
2 the United States are living with a diagnosis of pros-
3 tate cancer and its consequences.

4 (4) Although prostate cancer generally affects
5 older individuals, younger men are also at risk for
6 the disease, and when prostate cancer appears in
7 early middle age, it frequently takes on a more ag-
8 gressive form.

9 (5) There are significant racial and ethnic dis-
10 parities that demand attention, for example, African
11 Americans have prostate cancer mortality rates that
12 are more than double those in the White population.

13 (6) Underserved rural populations have higher
14 rates of mortality compared to their urban counter-
15 parts, and innovative and cost-efficient methods to
16 improve rural access to high-quality care should take
17 advantage of advances in telehealth to diagnose and
18 treat prostate cancer when appropriate.

19 (7) Certain populations of veterans may have
20 nearly twice the incidence of prostate cancer as the
21 general population of the United States.

22 (8) Urologists may constitute the specialists
23 who diagnose and treat the vast majority of prostate
24 cancer patients.

1 (9) Although much basic and translational re-
2 search has been completed and much is currently
3 known, there are still many unanswered questions,
4 such as the extent to which known disparities are at-
5 tributable to disease etiology, access to care, or edu-
6 cation and awareness in the community.

7 (10) Causes of prostate cancer are not known.
8 There is not good information regarding how to dif-
9 ferentiate accurately, early on, between aggressive
10 and indolent forms of the disease. As a result, there
11 is significant overtreatment in prostate cancer.
12 There are no treatments that can durably arrest
13 growth or cure prostate cancer once it has metasta-
14 sized.

15 (11) A significant proportion of cases may be
16 clinically indolent and overdiagnosed, resulting in
17 significant overtreatment. More accurate tests will
18 allow men and their families to face less physical,
19 psychological, financial, and emotional trauma, and
20 billions of dollars could be saved in private and pub-
21 lic health care systems.

22 (12) Prostate cancer research and health care
23 programs across Federal agencies should be coordi-
24 nated to improve accountability and actively encour-
25 age the translation of research into practice and to

1 identify and implement best practices in order to
2 foster an integrated and consistent focus on effective
3 prevention, diagnosis, and treatment of the disease.

4 (b) PROSTATE CANCER COORDINATION AND EDU-
5 CATION.—

6 (1) INTERAGENCY PROSTATE CANCER COORDI-
7 NATION AND EDUCATION TASK FORCE.—Not later
8 than 180 days after the date of the enactment of
9 this Act, the Secretary of Veterans Affairs, in co-
10 operation with the Secretary of Defense and the Sec-
11 retary of Health and Human Services, shall estab-
12 lish an Interagency Prostate Cancer Coordination
13 and Education Task Force (in this section referred
14 to as the “Prostate Cancer Task Force”).

15 (2) DUTIES.—The Prostate Cancer Task Force
16 shall—

17 (A) develop a summary of advances in
18 prostate cancer research supported or con-
19 ducted by Federal agencies relevant to the diag-
20 nosis, prevention, and treatment of prostate
21 cancer, including psychosocial impairments re-
22 lated to prostate cancer treatment, and compile
23 a list of best practices that warrant broader
24 adoption in health care programs;

1 (B) consider establishing, and advocating
2 for, a guidance to enable physicians to allow
3 screening of men who are age 74 or older, on
4 a case-by-case basis, taking into account quality
5 of life and family history of prostate cancer;

6 (C) share and coordinate information on
7 research and health care program activities by
8 the Federal Government, including activities re-
9 lated to—

10 (i) determining how to improve re-
11 search and health care programs, including
12 psychosocial impairments related to pros-
13 tate cancer treatment;

14 (ii) identifying any gaps in the overall
15 research inventory and in health care pro-
16 grams;

17 (iii) identifying opportunities to pro-
18 mote translation of research into practice;
19 and

20 (iv) maximizing the effects of Federal
21 Government efforts by identifying opportu-
22 nities for collaboration and leveraging of
23 resources in research and health care pro-
24 grams that serve individuals who are sus-

1 ceptible to or diagnosed with prostate can-
2 cer;

3 (D) develop a comprehensive interagency
4 strategy and advise relevant Federal agencies in
5 the solicitation of proposals for collaborative,
6 multidisciplinary research and health care pro-
7 grams, including proposals to evaluate factors
8 that may be related to the etiology of prostate
9 cancer, that would—

10 (i) result in innovative approaches to
11 study emerging scientific opportunities or
12 eliminate knowledge gaps in research to
13 improve the prostate cancer research port-
14 folio of the Federal Government; and

15 (ii) outline key research questions,
16 methodologies, and knowledge gaps;

17 (E) develop a coordinated message related
18 to screening and treatment for prostate cancer
19 to be reflected in educational and beneficiary
20 materials for Federal health programs as such
21 materials are updated; and

22 (F) not later than two years after the date
23 of the establishment of the Prostate Cancer
24 Task Force, submit to the expert advisory pan-
25 els appointed under paragraph (4) to be re-

1 viewed and returned within 30 days, and then
2 within 90 days submitted to Congress, rec-
3 ommendations—

4 (i) regarding any appropriate changes
5 to research and health care programs, in-
6 cluding recommendations to improve the
7 research portfolio of the Department of
8 Veterans Affairs, the Department of De-
9 fense, the National Institutes of Health,
10 and other Federal agencies to ensure that
11 scientifically based strategic planning is
12 implemented in support of research and
13 health care program priorities;

14 (ii) designed to ensure that the re-
15 search and health care programs and ac-
16 tivities of the Department of Veterans Af-
17 fairs, the Department of Defense, the De-
18 partment of Health and Human Services,
19 and other Federal agencies are free of un-
20 necessary duplication;

21 (iii) regarding public participation in
22 decisions relating to prostate cancer re-
23 search and health care programs to in-
24 crease the involvement of patient adv-
25 cates, community organizations, and med-

1 ical associations representing a broad geo-
2 graphical area;

3 (iv) on how to best disseminate infor-
4 mation on prostate cancer research and
5 progress achieved by health care programs;

6 (v) on how to expand partnerships be-
7 tween public entities, including Federal
8 agencies, and private entities to encourage
9 collaborative, cross-cutting research and
10 health care delivery;

11 (vi) assessing any cost savings and ef-
12 ficiencies realized through the efforts iden-
13 tified in, and supported through, this sub-
14 section and recommending expansion of
15 those efforts that have proved most prom-
16 ising while also ensuring against any con-
17 flicts in directives in law;

18 (vii) identifying key priority action
19 items from among the recommendations
20 specified in clauses (i) through (vi); and

21 (viii) with respect to the level of fund-
22 ing needed by each agency to implement
23 such recommendations.

24 (3) MEMBERS OF THE PROSTATE CANCER TASK
25 FORCE.—The Prostate Cancer Task Force shall be

1 comprised of representatives from such Federal
2 agencies as the head of each such applicable agency
3 determines necessary, so as to coordinate a uniform
4 message relating to prostate cancer screening and
5 treatment where appropriate, including representa-
6 tives of each of the following:

7 (A) The Department of Veterans Affairs,
8 including representatives of each relevant pro-
9 gram area of the Department of Veterans Af-
10 fairs.

11 (B) The Prostate Cancer Research Pro-
12 gram of the Congressionally Directed Medical
13 Research Program of the Department of De-
14 fense.

15 (C) The Department of Health and
16 Human Services, including, at a minimum, rep-
17 resentatives of each of the following:

18 (i) The National Institutes of Health.

19 (ii) National research institutes and
20 centers, including the National Cancer In-
21 stitute, the National Institute of Allergy
22 and Infectious Diseases, and the Office of
23 Minority Health.

24 (iii) The Centers for Medicare & Med-
25 icaid Services.

1 (iv) The Food and Drug Administra-
2 tion.

3 (v) The Centers for Disease Control
4 and Prevention.

5 (vi) The Agency for Healthcare Re-
6 search and Quality.

7 (vii) The Health Resources and Serv-
8 ices Administration.

9 (4) APPOINTING EXPERT ADVISORY PANELS.—
10 The Prostate Cancer Task Force shall appoint ex-
11 pert advisory panels, as the task force determines
12 appropriate, to provide input and concurrence
13 from—

14 (A) individuals and organizations from the
15 medical, prostate cancer patient and advocate,
16 research, and delivery communities with exper-
17 tise in prostate cancer diagnosis, treatment,
18 and research, including practicing urologists,
19 primary care providers, and others; and

20 (B) individuals with expertise in education
21 and outreach to underserved populations af-
22 fected by prostate cancer.

23 (5) MEETINGS.—The Prostate Cancer Task
24 Force shall convene not less frequently than twice

1 each year, or more frequently as the Secretary of
2 Veterans Affairs determines to be appropriate.

3 (6) FEDERAL ADVISORY COMMITTEE ACT.—The
4 Federal Advisory Committee Act (5 U.S.C. App.)
5 shall apply to the Prostate Cancer Task Force.

6 (7) SUNSET DATE.—The Prostate Cancer Task
7 Force shall terminate on September 30, 2025.

8 (c) PROSTATE CANCER RESEARCH.—

9 (1) RESEARCH COORDINATION PROGRAM.—

10 (A) IN GENERAL.—The Secretary of Vet-
11 erans Affairs, in coordination with the Sec-
12 retary of Defense and the Secretary of Health
13 and Human Services, shall establish and carry
14 out a program to coordinate and intensify pros-
15 tate cancer research.

16 (B) ELEMENTS.—The program established
17 under subparagraph (A) shall—

18 (i) develop advances in diagnostic and
19 prognostic methods and tests, including
20 biomarkers and an improved prostate can-
21 cer screening blood test, including improve-
22 ments or alternatives to the prostate spe-
23 cific antigen test and additional tests to
24 distinguish indolent from aggressive dis-
25 ease;

- 1 (ii) develop a better understanding of
2 the etiology of the disease (including an
3 analysis of lifestyle factors proven to be in-
4 volved in higher rates of prostate cancer,
5 such as obesity and diet, and in different
6 ethnic, racial, and socioeconomic groups,
7 such as the African-American, Latino or
8 Hispanic, and American Indian popu-
9 lations and men with a family history of
10 prostate cancer) to improve prevention ef-
11 forts;
- 12 (iii) expand basic research into pros-
13 tate cancer, including studies of funda-
14 mental molecular and cellular mechanisms;
- 15 (iv) identify and provide clinical test-
16 ing of novel agents for the prevention and
17 treatment of prostate cancer;
- 18 (v) establish clinical registries for
19 prostate cancer;
- 20 (vi) use the National Institute of Bio-
21 medical Imaging and Bioengineering and
22 the National Cancer Institute for assess-
23 ment of appropriate imaging modalities;
24 and

1 (vii) address such other matters relat-
2 ing to prostate cancer research as may be
3 identified by the Federal agencies partici-
4 pating in such program.

5 (C) UNDERSERVED MINORITY GRANT PRO-
6 GRAM.—In carrying out the program estab-
7 lished under subparagraph (A), the Secretary
8 shall—

9 (i) award grants to eligible entities to
10 carry out components of the research out-
11 lined in subparagraph (B);

12 (ii) integrate and build upon existing
13 knowledge gained from comparative effec-
14 tiveness research; and

15 (iii) recognize and address—

16 (I) the racial and ethnic dispari-
17 ties in the incidence and mortality
18 rates of prostate cancer and men with
19 a family history of prostate cancer;

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

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1 (III) outreach and educational ef-
2 forts to raise awareness among the
3 populations described in subclause
4 (II); and
5 (IV) appropriate access and utili-
6 zation of imaging modalities.

7 (2) PROSTATE CANCER ADVISORY BOARD.—

8 (A) IN GENERAL.—There is established in
9 the Office of the Chief Scientist of the Food
10 and Drug Administration a Prostate Cancer
11 Scientific Advisory Board.

12 (B) DUTIES.—The board established under
13 subparagraph (A) shall be responsible for accel-
14 erating real-time sharing of the latest research
15 data and accelerating movement of new medi-
16 cines for the treatment of prostate cancer to
17 patients.

18 (d) TELEHEALTH AND RURAL ACCESS PILOT
19 PROJECTS.—

20 (1) ESTABLISHMENT OF PILOT PROJECTS.—

21 (A) IN GENERAL.—The Secretary of Vet-
22 erans Affairs, in cooperation with the Secretary
23 of Defense and the Secretary of Health and
24 Human Services (referred to in this subsection
25 collectively as the “Secretaries”) shall establish

1200

1 four-year telehealth pilot projects for the pur-
2 pose of analyzing the clinical outcomes and
3 cost-effectiveness associated with telehealth
4 services in a variety of geographic areas that
5 contain high proportions of medically under-
6 served populations, including African Ameri-
7 cans, Latinos or Hispanics, American Indians
8 or Alaska Natives, and those in rural areas.

9 (B) EFFICIENT AND EFFECTIVE CARE.—

10 Pilot projects established under subparagraph
11 (A) shall promote efficient use of specialist care
12 through better coordination of primary care and
13 physician extender teams in underserved areas
14 and more effectively employ tumor boards to
15 better counsel patients.

16 (2) ELIGIBLE ENTITIES.—

17 (A) IN GENERAL.—The Secretaries shall
18 select eligible entities to participate in the pilot
19 projects established under this subsection.

20 (B) PRIORITY.—In selecting eligible enti-
21 ties to participate in the pilot projects under
22 this subsection, the Secretaries shall give pri-
23 ority to entities located in medically under-
24 served areas, particularly those that include Af-
25 rican Americans, Latinos and Hispanics, and

1 facilities of the Indian Health Service, including
2 facilities operated by the Indian Health Service,
3 tribally operated facilities, and facilities admin-
4 istered by an Urban Indian organization (as de-
5 fined in section 4 of the Indian Health Care
6 Improvement Act (25 U.S.C. 1603)) pursuant
7 to title V of that Act (25 U.S.C. 1651 et seq.),
8 and those in rural areas.

9 (3) EVALUATION.—The Secretaries shall,
10 through the pilot projects established under this sub-
11 section, evaluate—

12 (A) the effective and economic delivery of
13 care in diagnosing and treating prostate cancer
14 with the use of telehealth services in medically
15 underserved and Tribal areas including collabo-
16 rative uses of health professionals and integra-
17 tion of the range of telehealth and other tech-
18 nologies;

19 (B) the effectiveness of improving the ca-
20 pacity of nonmedical providers and nonspecial-
21 ized medical providers to provide health services
22 for prostate cancer in medically underserved
23 and Tribal areas, including the exploration of
24 innovative medical home models with collabora-
25 tion between urologists, other relevant medical

1 specialists, including oncologists, radiologists,
2 and primary care teams, and coordination of
3 care through the efficient use of primary care
4 teams and physician extenders; and

5 (C) the effectiveness of using telehealth
6 services to provide prostate cancer treatment in
7 medically underserved areas, including the use
8 of tumor boards to facilitate better patient
9 counseling.

10 (4) REPORT.—Not later than one year after the
11 completion of the pilot projects under this sub-
12 section, the Secretaries shall submit to Congress a
13 report describing the outcomes of such pilot projects,
14 including any cost savings and efficiencies realized,
15 and providing recommendations, if any, for expand-
16 ing the use of telehealth services.

17 (e) EDUCATION AND AWARENESS.—

18 (1) CAMPAIGN.—

19 (A) IN GENERAL.—The Secretary of Vet-
20 erans Affairs shall develop a national education
21 campaign for prostate cancer.

22 (B) ELEMENTS.—The campaign developed
23 under subparagraph (A) shall involve the use of
24 written educational materials and public service
25 announcements consistent with the findings of

1 the Prostate Cancer Task Force under sub-
2 section (b) that are intended to encourage men
3 to seek prostate cancer screening when appro-
4 priate.

5 (2) RACIAL DISPARITIES AND THE POPULATION
6 OF MEN WITH A FAMILY HISTORY OF PROSTATE
7 CANCER.—In developing the campaign under para-
8 graph (1), the Secretary shall ensure that edu-
9 cational materials and public service announcements
10 used in the campaign are more readily available in
11 communities experiencing racial disparities in the in-
12 cidence and mortality rates of prostate cancer and to
13 men of any race classification with a family history
14 of prostate cancer.

15 (3) GRANTS.—In carrying out the campaign
16 under this subsection, the Secretary shall award
17 grants to nonprofit private entities to enable such
18 entities to test alternative outreach and education
19 strategies.

20 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
21 authorized to be appropriated to carry out this section for
22 the period of fiscal years 2023 through 2027 an amount
23 equal to the amount of savings for the Federal Govern-
24 ment projected to be achieved over such period by imple-
25 mentation of this section.

1 **SEC. 7003. PROSTATE RESEARCH, IMAGING, AND MEN'S**
2 **EDUCATION.**

3 (a) FINDINGS.—Congress makes the following find-
4 ings:

5 (1) Prostate cancer has reached epidemic pro-
6 portions, particularly among African-American men,
7 and strikes and kills men in numbers comparable to
8 the number of women who lose their lives from
9 breast cancer.

10 (2) Life-saving breakthroughs in screening, di-
11 agnosis, and treatment of breast cancer resulted
12 from the development of advanced imaging tech-
13 nologies led by the Federal Government.

14 (3) Men should have accurate and affordable
15 prostate cancer screening exams and minimally
16 invasive treatment tools, similar to what women have
17 for breast cancer.

18 (4) While it is important for men to take ad-
19 vantage of current prostate cancer screening tech-
20 niques, a recent National Cancer Institute study
21 demonstrated that the most common available meth-
22 ods of detecting prostate cancer (PSA blood test and
23 physical exams) are not foolproof, causing numerous
24 false alarms and false reassurances.

25 (5) The absence of advanced imaging tech-
26 nologies for prostate cancer causes the lack of accu-

1 rate information critical for clinical decisions, result-
2 ing in missed cancers and lost lives, as well as un-
3 necessary and costly medical procedures, with re-
4 lated complications.

5 (6) With prostate imaging tools, men and their
6 families would face less physical, psychological, fi-
7 nancial, and emotional trauma and billions of dollars
8 could be saved in private and public health care sys-
9 tems.

10 (b) RESEARCH AND DEVELOPMENT OF PROSTATE
11 CANCER IMAGING TECHNOLOGIES.—

12 (1) EXPANSION OF RESEARCH.—The Secretary
13 of Health and Human Services (referred to in this
14 section as the “Secretary”), acting through the Di-
15 rector of the National Institutes of Health and the
16 Administrator of the Health Resources and Services
17 Administration, and in consultation with the Sec-
18 retary of Defense, shall carry out a program to ex-
19 pand and intensify research to develop innovative
20 advanced imaging technologies for prostate cancer
21 detection, diagnosis, and treatment comparable to
22 state-of-the-art mammography technologies.

23 (2) EARLY STAGE RESEARCH.—In imple-
24 menting the program under paragraph (1), the Sec-
25 retary, acting through the Administrator of the

1 Health Resources and Services Administration, shall
2 carry out a grant program to encourage the early
3 stages of research in prostate imaging to develop
4 and implement new ideas, proof of concepts, and
5 pilot studies for high-risk technologic innovation in
6 prostate cancer imaging that would have a high po-
7 tential impact for improving patient care, including
8 individualized care, quality of life, and cost-effective-
9 ness.

10 (3) LARGE SCALE LATER STAGE RESEARCH.—

11 In implementing the program under paragraph (1),
12 the Secretary, acting through the Director of the
13 National Institutes of Health, shall utilize the Na-
14 tional Institute of Biomedical Imaging and Bio-
15 engineering and the National Cancer Institute for
16 advanced stages of research in prostate imaging, in-
17 cluding technology development and clinical trials for
18 projects determined by the Secretary to have dem-
19 onstrated promising preliminary results and proof of
20 concept.

21 (4) INTERDISCIPLINARY PRIVATE-PUBLIC PART-

22 NERSHIPS.—In developing the program under para-
23 graph (1), the Secretary, acting through the Admin-
24 istrator of the Health Resources and Services Ad-
25 ministration, shall establish interdisciplinary private-

1 public partnerships to develop and implement re-
2 search strategies for expedited innovation in imaging
3 and image-guided treatment and to conduct such re-
4 search.

5 (5) RACIAL DISPARITIES.—In developing the
6 program under paragraph (1), the Secretary shall
7 recognize and address—

8 (A) the racial disparities in the incidences
9 of prostate cancer and mortality rates with re-
10 spect to such disease; and

11 (B) any barriers in access to care and par-
12 ticipation in clinical trials that are specific to
13 racial minorities.

14 (6) AUTHORIZATION OF APPROPRIATIONS.—

15 (A) IN GENERAL.—Subject to subpara-
16 graph (B), there is authorized to be appro-
17 priated to carry out this subsection,
18 \$100,000,000 for each of fiscal years 2023
19 through 2027.

20 (B) SPECIFIC ALLOCATIONS.—Of the
21 amount authorized to be appropriated under
22 subparagraph (A) for each of the fiscal years
23 described in such subparagraph—

1 (i) no less than 10 percent may be
2 used to carry out the grant program under
3 paragraph (2); and

4 (ii) no more than 1 percent may be
5 used to carry out paragraph (4).

6 (c) PUBLIC AWARENESS AND EDUCATION CAM-
7 PAIGN.—

8 (1) NATIONAL CAMPAIGN.—The Secretary shall
9 carry out a national campaign to increase the aware-
10 ness and knowledge of individuals in the United
11 States with respect to the need for prostate cancer
12 screening and for improved detection technologies.

13 (2) REQUIREMENTS.—The national campaign
14 conducted under this subsection shall include—

15 (A) roles for the Health Resources Services
16 Administration, the Office of Minority Health
17 of the Department of Health and Human Serv-
18 ices, the Centers for Disease Control and Pre-
19 vention, and the Office of Minority Health and
20 Health Equity of the Centers for Disease Con-
21 trol and Prevention; and

22 (B) the development and distribution of
23 written educational materials, and the develop-
24 ment and placing of public service announce-
25 ments, that are intended to encourage men to

1 seek prostate cancer screening and to create
2 awareness of the need for improved imaging
3 technologies for prostate cancer screening and
4 diagnosis, including in vitro blood testing and
5 imaging technologies.

6 (3) RACIAL DISPARITIES.—In developing the
7 national campaign under paragraph (1), the Sec-
8 retary shall recognize and address—

9 (A) the racial disparities in the incidences
10 of prostate cancer and mortality rates with re-
11 spect to such disease; and

12 (B) any barriers in access to care and par-
13 ticipation in clinical trials that are specific to
14 racial minorities.

15 (4) GRANTS.—The Secretary shall establish a
16 program to award grants to nonprofit private enti-
17 ties to enable such entities to test alternative out-
18 reach and education strategies to increase the
19 awareness and knowledge of individuals in the
20 United States with respect to the need for prostate
21 cancer screening and improved imaging technologies.

22 (5) AUTHORIZATION OF APPROPRIATIONS.—
23 There is authorized to be appropriated to carry out
24 this subsection \$10,000,000 for each of fiscal years
25 2023 through 2027.

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1 (d) IMPROVING PROSTATE CANCER SCREENING
2 BLOOD TESTS.—

3 (1) IN GENERAL.—The Secretary, in coordina-
4 tion with the Secretary of Defense, shall support re-
5 search to develop an improved prostate cancer
6 screening blood test using in-vitro detection.

7 (2) AUTHORIZATION OF APPROPRIATIONS.—
8 There is authorized to be appropriated to carry out
9 this subsection, \$20,000,000 for each of fiscal years
10 2023 through 2027.

11 (e) REPORTING AND COMPLIANCE.—

12 (1) REPORT AND STRATEGY.—Not later than
13 12 months after the date of the enactment of this
14 Act, the Secretary shall submit to Congress a report
15 that details the strategy of the Secretary for imple-
16 menting the requirements of this section and the
17 status of such efforts.

18 (2) FULL COMPLIANCE.—Not later than 36
19 months after the date of the enactment of this Act,
20 and annually thereafter, the Secretary shall submit
21 to Congress a report that—

22 (A) describes the research and development
23 and public awareness and education campaigns
24 funded under this section;

1 (B) provides evidence that projects involv-
2 ing high-risk, high impact technologic innova-
3 tion, proof of concept, and pilot studies are
4 prioritized;

5 (C) provides evidence that the Secretary
6 recognizes and addresses any barriers in access
7 to care and participation in clinical trials that
8 are specific to racial minorities in the imple-
9 mentation of this section;

10 (D) contains assurances that all the other
11 provisions of this section are fully implemented;
12 and

13 (E) certifies compliance with the provisions
14 of this section, or in the case of a Federal agen-
15 cy that has not complied with any of such pro-
16 visions, an explanation as to such failure to
17 comply.

18 **SEC. 7004. PROSTATE CANCER DETECTION RESEARCH AND**
19 **EDUCATION.**

20 (a) PLAN TO DEVELOP AND VALIDATE A TEST OR
21 TESTS FOR PROSTATE CANCER.—

22 (1) IN GENERAL.—The Secretary of Health and
23 Human Services (referred to in this section as the
24 “Secretary”), acting through the Director of the Na-
25 tional Institutes of Health, shall establish an advi-

1 sory council on prostate cancer (referred to in this
2 section as the “advisory council”) to draft a plan for
3 the development and validation of an accurate test
4 or tests, such as biomarkers or imaging, to detect
5 and diagnose prostate cancer.

6 (2) ADVISORY COUNCIL.—

7 (A) MEMBERSHIP.—

8 (i) FEDERAL MEMBERS.—The advi-
9 sory council shall be comprised of the fol-
10 lowing experts:

11 (I) A designee of the Centers for
12 Disease Control and Prevention.

13 (II) A designee of the Centers for
14 Medicare & Medicaid Services.

15 (III) A designee of the Office of
16 the Director of the National Cancer
17 Institute.

18 (IV) A designee of the Director
19 of the Department of Defense Con-
20 gressionally Directed Medical Re-
21 search Programs.

22 (V) A designee of the Director of
23 the National Institute of Biomedical
24 Imaging and Bioengineering.

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1 (VI) A designee of the Director
2 of the National Institute of General
3 Medical Sciences.

4 (VII) A designee of the Director
5 of the National Institute on Minority
6 Health and Health Disparities.

7 (VIII) A designee of the Director
8 of the National Institutes of Health.

9 (IX) A designee of the Commis-
10 sioner of Food Drugs.

11 (X) A designee of the Director of
12 the Agency for Healthcare Research
13 and Quality.

14 (XI) A designee of the Director
15 of the Telemedicine and Advanced
16 Technology Research Center of the
17 Department of Defense.

18 (ii) NON-FEDERAL MEMBERS.—In ad-
19 dition to the members described in clause
20 (i), the advisory council shall include 8 ex-
21 pert members from outside the Federal
22 Government to be appointed by the Sec-
23 retary, which shall include—

24 (I) 2 prostate cancer patient ad-
25 vocates;

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1 (II) 2 health care providers with
2 a range of expertise and experience in
3 prostate cancer; and

4 (III) 4 leading researchers with
5 prostate cancer-related expertise in a
6 range of clinical disciplines.

7 (B) MEETINGS.—The advisory council
8 shall meet quarterly and such meetings shall be
9 open to the public.

10 (C) ADVICE.—The advisory council shall
11 advise the Secretary, or the Secretary's des-
12 ignee.

13 (D) ANNUAL REPORT.—Not later than 1
14 year after the date of enactment of this Act, the
15 advisory council shall provide to the Secretary,
16 or the Secretary's designee, and Congress—

17 (i) an initial evaluation of all federally
18 funded efforts in prostate cancer research
19 relating to the development and validation
20 of an accurate test or tests to detect and
21 diagnose prostate cancer;

22 (ii) a plan for the development and
23 validation of a reliable test or tests for the
24 detection and accurate diagnosis of pros-
25 tate cancer; and

1 (iii) a set of standards for prostate
2 cancer screening, developed in coordination
3 with the United States Preventive Services
4 Task Force, to ensure that any tools for
5 screening, detection, and diagnosis devel-
6 oped in accordance with the plan under
7 clause (ii) will meet the requirements of
8 the Task Force for recommendation as a
9 proven preventive or diagnostic service.

10 (E) TERMINATION.—The advisory council
11 shall terminate on December 31, 2026.

12 (3) FUNDING.—Notwithstanding any other pro-
13 vision of law, the Secretary may make available
14 \$1,000,000, from any unobligated amounts appro-
15 priated to the National Institutes of Health, for each
16 of fiscal years 2023 through 2027 to carry out this
17 subsection.

18 (b) COORDINATION AND INTENSIFICATION OF PROS-
19 TATE CANCER RESEARCH.—

20 (1) IN GENERAL.—The Director of the National
21 Institutes of Health, in consultation with the Sec-
22 retary of Defense, shall coordinate and intensify re-
23 search in accordance with the plan provided under
24 subsection (a)(2)(D)(ii), with particular attention
25 provided to leveraging existing research to develop

1 and validate a test or tests, such as biomarkers or
2 imaging, to detect and accurately diagnose prostate
3 cancer in order to improve quality of life for millions
4 of individuals in the United States, and decrease
5 health care system costs.

6 (2) FUNDING.—Notwithstanding any other pro-
7 vision of law, the Secretary may make available
8 \$30,000,000, from any unobligated amounts appro-
9 priated to the National Institutes of Health, for each
10 of fiscal years 2024 through 2028 to carry out this
11 subsection.

12 **SEC. 7005. NATIONAL PROSTATE CANCER COUNCIL.**

13 (a) NATIONAL PROSTATE CANCER COUNCIL.—

14 (1) ESTABLISHMENT.—There is established in
15 the Office of the Secretary of Health and Human
16 Services (referred to in this section as the “Sec-
17 retary”) the National Prostate Cancer Council on
18 Screening, Early Detection, Assessment, and Moni-
19 toring of Prostate Cancer (referred to in this section
20 as the “Council”).

21 (2) PURPOSE OF THE COUNCIL.—The Council
22 shall—

23 (A) develop and implement a national stra-
24 tegic plan for the accelerated creation, advance-
25 ment, and testing of diagnostic tools to improve

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1 screening, early detection, assessment, and
2 monitoring of prostate cancer, including—

3 (i) early detection of aggressive pros-
4 tate cancer to save lives;

5 (ii) monitoring of tumor response to
6 treatment, including recurrence and pro-
7 gression; and

8 (iii) accurate assessment and surveil-
9 lance of indolent disease to reduce unnec-
10 essary biopsies and treatment;

11 (B) provide information and coordination
12 of prostate cancer research and services across
13 all Federal agencies;

14 (C) review diagnostic tools and their over-
15 all effectiveness at screening, detecting, assess-
16 ing, and monitoring of prostate cancer;

17 (D) evaluate all programs in prostate can-
18 cer that are in existence on the date of enact-
19 ment of this Act, including Federal budget re-
20 quests and approvals and public-private part-
21 nerships;

22 (E) submit an annual report to the Sec-
23 retary and Congress on the creation and imple-
24 mentation of the national strategic plan under
25 subparagraph (A); and

1 (F) ensure the inclusion of men at high-
2 risk for prostate cancer, including men from
3 minority ethnic and racial populations and men
4 who are least likely to receive care, in clinical,
5 research, and service efforts, with the purpose
6 of decreasing health disparities.

7 (3) MEMBERSHIP.—

8 (A) FEDERAL MEMBERS.—The Council
9 shall be led by the Secretary or the Secretary's
10 designee and comprised of the following experts:

11 (i) Two representatives of the Na-
12 tional Institutes of Health, including 1 rep-
13 resentative of the National Institute of
14 Biomedical Imaging and Bioengineering
15 and 1 representative of the National Can-
16 cer Institute.

17 (ii) A representative of the Centers
18 for Disease Control and Prevention.

19 (iii) A representative of the Centers
20 for Medicare & Medicaid Services.

21 (iv) A designee of the Director of the
22 Department of Defense Congressionally
23 Directed Medical Research Programs.

24 (v) A designee of the Director of the
25 Office of Minority Health.

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1 (vi) A representative of the Food and
2 Drug Administration.

3 (vii) A representative of the Agency
4 for Healthcare Research and Quality.

5 (B) NON-FEDERAL MEMBERS.—In addi-
6 tion to the members described in subparagraph
7 (A), the Council shall include 14 expert mem-
8 bers from outside the Federal Government,
9 which shall include—

10 (i) 6 prostate cancer patient advoca-
11 cates, including—

12 (I) 2 patient-survivors;

13 (II) 2 caregivers of prostate can-
14 cer patients; and

15 (III) 2 representatives from na-
16 tional prostate cancer disease organi-
17 zations that fund research or have
18 demonstrated experience in providing
19 assistance to patients, families, and
20 medical professionals, including infor-
21 mation on health care options, edu-
22 cation, and referral; and

23 (ii) 8 health care stakeholders with
24 specific expertise in prostate cancer re-
25 search in the critical areas of clinical ex-

1 pertise, including medical oncology, radi-
2 ology, radiation oncology, urology, and pa-
3 thology.

4 (4) MEETINGS.—The Council shall meet quar-
5 terly and meetings shall be open to the public.

6 (5) ADVICE.—The Council shall advise the Sec-
7 retary, or the Secretary’s designee.

8 (6) ANNUAL REPORT.—The Council shall sub-
9 mit annual reports, beginning not later than 1 year
10 after the date of enactment of this Act, to the Sec-
11 retary or the Secretary’s designee and to Congress.
12 The annual report shall include—

13 (A) in the first year—

14 (i) an evaluation of all federally fund-
15 ed efforts in prostate cancer research and
16 gaps relating to the development and vali-
17 dation of diagnostic tools for prostate can-
18 cer; and

19 (ii) recommendations for priority ac-
20 tions to expand, eliminate, coordinate, or
21 condense programs based on the perform-
22 ance, mission, and purpose of the pro-
23 grams; and

24 (B) annually thereafter for 5 years—

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1 (i) an outline for the development and
2 implementation of a national research plan
3 for creation and validation of accurate di-
4 agnostic tools to improve prostate cancer
5 care in accordance with paragraph (1);

6 (ii) roles for the National Cancer In-
7 stitute, National Institute on Minority
8 Health and Health Disparities, and the Of-
9 fice of Minority Health of the Department
10 of Health and Human Services;

11 (iii) an analysis of the disparities in
12 the incidence and mortality rates of pros-
13 tate cancer in men at high risk of the dis-
14 ease, including individuals with family his-
15 tory, increasing age, or African-American
16 heritage; and

17 (iv) a review of the progress towards
18 the realization of the proposed strategic
19 plan.

20 (7) TERMINATION.—The Council shall termi-
21 nate on December 31, 2027.

1 **SEC. 7006. IMPROVED MEDICAID COVERAGE FOR CERTAIN**
2 **BREAST AND CERVICAL CANCER PATIENTS**
3 **IN THE TERRITORIES.**

4 (a) ELIMINATION OF FUNDING LIMITATIONS.—Sec-
5 tion 1108(g)(4) of the Social Security Act (42 U.S.C.
6 1308(g)(4)) is amended—

7 (1) by striking “paragraphs (1), (2), (3), and
8 (4) of”; and

9 (2) by adding at the end the following: “With
10 respect to fiscal years beginning with fiscal year
11 2023, payment for medical assistance for individuals
12 who are eligible for such assistance only on the basis
13 of section 1902(a)(10)(A)(ii)(XVIII) shall not be
14 taken into account in applying subsection (f) (as in-
15 creased in accordance with this subsection) to Puer-
16 to Rico, the Virgin Islands, Guam, the Northern
17 Mariana Islands, or American Samoa for such fiscal
18 year.”.

19 (b) APPLICATION OF ENHANCED FMAP FOR HIGH-
20 EST STATE.—Section 1905(b) of such Act (42 U.S.C.
21 1396d(b)) is amended by adding at the end the following:
22 “Notwithstanding the first sentence of this subsection,
23 with respect to medical assistance described in clause (4)
24 of such sentence that is furnished in Puerto Rico, the Vir-
25 gin Islands, Guam, the Northern Mariana Islands, or
26 American Samoa in a fiscal year, the Federal medical as-

1 sistance percentage is equal to the highest such percentage
2 applied under such clause for such fiscal year for any of
3 the 50 States or the District of Columbia that provides
4 such medical assistance for any portion of such fiscal
5 year.”.

6 (c) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to payment for medical assistance
8 for items and services furnished on or after October 1,
9 2023.

10 **SEC. 7007. CANCER PREVENTION AND TREATMENT DEM-**
11 **ONSTRATION FOR ETHNIC AND RACIAL MI-**
12 **NORITIES.**

13 (a) DEMONSTRATION.—

14 (1) IN GENERAL.—The Secretary of Health and
15 Human Services (in this section referred to as the
16 “Secretary”) shall conduct demonstration projects
17 for the purpose of developing models and evaluating
18 methods that—

19 (A) improve the quality of items and serv-
20 ices provided to target individuals in order to
21 facilitate reduced disparities in early detection
22 and treatment of cancer;

23 (B) improve clinical outcomes, satisfaction,
24 quality of life, appropriate use of items and
25 services covered under the Medicare program

1 under title XVIII of the Social Security Act (42
2 U.S.C. 1395 et seq.), and referral patterns with
3 respect to target individuals with cancer;

4 (C) eliminate disparities in the rate of pre-
5 ventive cancer screening measures, such as Pap
6 smears, prostate cancer screenings, colon and
7 colorectal cancer screenings, breast cancer
8 screenings, and computed tomography scans,
9 for lung cancer among target individuals;

10 (D) promote collaboration with community-
11 based organizations to ensure cultural com-
12 petency of health care professionals and lin-
13 guistic access for target individuals who are
14 persons with limited English proficiency; and

15 (E) encourage the incorporation of commu-
16 nity health workers to increase the efficiency
17 and appropriateness of cancer screening pro-
18 grams.

19 (2) COMMUNITY HEALTH WORKER DEFINED.—

20 In this section, the term “community health worker”
21 includes a community health advocate, a lay health
22 worker, a community health representative, a peer
23 health promoter, a community health outreach work-
24 er, and a promotore de salud, who promotes health

1 or nutrition within the community in which the indi-
2 vidual resides.

3 (3) TARGET INDIVIDUAL DEFINED.—In this
4 section, the term “target individual” means an indi-
5 vidual of a racial and ethnic minority group, as de-
6 fined in section 1707(g)(1) of the Public Health
7 Service Act (42 U.S.C. 300u–6(g)(1)), who is enti-
8 tled to benefits under part A, and enrolled under
9 part B, of title XVIII of the Social Security Act.

10 (b) PROGRAM DESIGN.—

11 (1) INITIAL DESIGN.—Not later than 1 year
12 after the date of the enactment of this Act, the Sec-
13 retary shall evaluate best practices in the private
14 sector, community programs, and academic research
15 of methods that reduce disparities among individuals
16 of racial and ethnic minority groups in the preven-
17 tion and treatment of cancer and shall design the
18 demonstration projects based on such evaluation.

19 (2) NUMBER AND PROJECT AREAS.—Not later
20 than 2 years after the date of the enactment of this
21 Act, the Secretary shall implement at least 9 dem-
22 onstration projects, including the following:

23 (A) Two projects, each of which shall tar-
24 get different ethnic subpopulations, for each of

1 the 5 following major racial and ethnic minority
2 groups:

3 (i) American Indians and Alaska Na-
4 tives, Eskimos, and Aleuts.

5 (ii) Asian Americans.

6 (iii) Blacks and African Americans.

7 (iv) Latinos and Hispanics.

8 (v) Native Hawaiians and other Pa-
9 cific Islanders.

10 (B) One project within the Pacific Islands
11 or United States insular areas.

12 (C) At least one project in a rural area.

13 (D) At least one project in an inner-city
14 area.

15 (3) EXPANSION OF PROJECTS; IMPLEMENTA-
16 TION OF DEMONSTRATION PROJECT RESULTS.—The
17 Secretary shall continue the existing demonstration
18 projects and may expand the number of demonstra-
19 tion projects if the initial report under subsection (c)
20 contains an evaluation that demonstration
21 projects—

22 (A) reduce expenditures under the Medi-
23 care program under title XVIII of the Social
24 Security Act (42 U.S.C. 1395 et seq.); or

1 (B) do not increase expenditures under
2 such Medicare program and reduce racial and
3 ethnic health disparities in the quality of health
4 care services provided to target individuals and
5 increase satisfaction of Medicare beneficiaries
6 and health care providers.

7 (c) REPORT TO CONGRESS.—

8 (1) IN GENERAL.—Not later than 2 years after
9 the date the Secretary implements the initial dem-
10 onstration projects, and biannually thereafter, the
11 Secretary shall submit to Congress a report regard-
12 ing the demonstration projects.

13 (2) CONTENT OF REPORT.—Each report under
14 paragraph (1) shall include the following:

15 (A) A description of the demonstration
16 projects.

17 (B) An evaluation of—

18 (i) the cost-effectiveness of the dem-
19 onstration projects;

20 (ii) the quality of the health care serv-
21 ices provided to target individuals under
22 the demonstration projects; and

23 (iii) beneficiary and health care pro-
24 vider satisfaction under the demonstration
25 projects.

1 (C) Any other information regarding the
2 demonstration projects that the Secretary de-
3 termines to be appropriate.

4 (d) WAIVER AUTHORITY.—The Secretary shall waive
5 compliance with the requirements of title XVIII of the So-
6 cial Security Act (42 U.S.C. 1395 et seq.) to such extent
7 and for such period as the Secretary determines is nec-
8 essary to conduct demonstration projects.

9 **SEC. 7008. REDUCING CANCER DISPARITIES WITHIN MEDI-**
10 **CARE.**

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

13 (1) DEVELOPMENT OF MEASURES.—The Sec-
14 retary of Health and Human Services (in this sec-
15 tion referred to as the “Secretary”) shall enter into
16 an agreement with an entity that specializes in de-
17 veloping quality measures for cancer care under
18 which the entity shall develop a uniform set of meas-
19 ures to evaluate disparities in the quality of cancer
20 care and annually update such set of measures.

21 (2) MEASURES TO BE INCLUDED.—Such set of
22 measures shall include, with respect to the treatment
23 of cancer, measures of patient outcomes, the process
24 for delivering medical care related to such treat-
25 ment, patient counseling and engagement in deci-

1 sion-making, patient experience of care, resource
2 use, and practice capabilities, such as care coordina-
3 tion.

4 (b) ESTABLISHMENT OF REPORTING PROCESS.—

5 (1) IN GENERAL.—The Secretary shall establish
6 a reporting process that requires and provides for a
7 method for health care providers specified under
8 paragraph (2) to submit to the Secretary and make
9 public data on the performance of such providers
10 during each reporting period through use of the
11 measures developed pursuant to subsection (a). Such
12 data shall be submitted in a form and manner and
13 at a time specified by the Secretary.

14 (2) SPECIFICATION OF PROVIDERS TO REPORT
15 ON MEASURES.—The Secretary shall specify the
16 classes of Medicare providers of services and sup-
17 pliers, including hospitals, cancer centers, physi-
18 cians, primary care providers, and specialty pro-
19 viders, that will be required under such process to
20 publicly report on the measures specified under sub-
21 section (a).

22 (3) ASSESSMENT OF CHANGES.—Under such
23 reporting process, the Secretary shall establish a for-
24 mat that assesses changes in both the absolute and
25 relative disparities in cancer care over time. These

1 measures shall be presented in an easily comprehen-
2 sible format, such as those presented in the final
3 publications relating to Healthy People 2010 or the
4 National Healthcare Disparities Report.

5 (4) INITIAL IMPLEMENTATION.—The Secretary
6 shall implement the reporting process under this
7 subsection for reporting periods beginning not later
8 than 6 months after the date that measures are first
9 established under subsection (a).

10 **Subtitle B—Viral Hepatitis and**
11 **Liver Cancer Control and Pre-**
12 **vention**

13 **SEC. 7051. VIRAL HEPATITIS AND LIVER CANCER CONTROL**
14 **AND PREVENTION.**

15 (a) SHORT TITLE.—This section may be cited as the
16 “Viral Hepatitis and Liver Cancer Control and Prevention
17 Act of 2022”.

18 (b) FINDINGS.—Congress finds the following:

19 (1) In the United States, nearly 5,000,000 per-
20 sons are living with the hepatitis B virus (referred
21 to in this section as “HBV”) or the hepatitis C virus
22 (referred to in this section as “HCV”).

23 (2) The Centers for Disease Control and Pre-
24 vention (referred to in this section as the “CDC”),
25 has recognized HCV as the Nation’s most common

1 chronic bloodborne virus infection and HBV as the
2 deadliest vaccine-preventable disease.

3 (3) HBV is transmitted through contact with
4 infectious blood, semen, or other bodily fluids and is
5 100 times more infectious than HIV. HCV is trans-
6 mitted by contact with infectious blood, particularly
7 through percutaneous exposures (such as puncture
8 through the skin).

9 (4) In the United States, chronic HBV and
10 HCV are the most common causes of liver cancer,
11 the second deadliest and fastest growing cancer in
12 this country. These viruses are the most common
13 cause of chronic liver disease, liver cirrhosis, and the
14 most common indications for liver transplantation.
15 In 2019, nearly 16,000 deaths per year in the
16 United States were attributed to chronic HBV and
17 HCV. Chronic HCV is also a leading cause of death
18 in Americans living with HIV/AIDS, many of those
19 living with HIV/AIDS are coinfecting with chronic
20 HBV, chronic HCV, or both.

21 (5) The CDC estimates that in 2019, 57,500
22 people in the United States were newly infected with
23 HCV and 20,700 people in the United States were
24 newly infected with HBV. These estimates could be
25 much higher due to many reasons, including lack of

1 screening education and awareness, and perceived
2 marginalization of the populations at risk.

3 (6) The CDC reported a 374 percent increase
4 in hepatitis C cases from 2010 to 2017, stemming
5 from the opioid, heroin, and overdose epidemics af-
6 fecting communities nationwide. From 2014 to
7 2015, the number of reported cases of acute hepa-
8 titis B infection in the United States rose for the
9 first time since 2006, increasing by 20.7 percent,
10 which is also largely attributable to the opioid epi-
11 demic.

12 (7) HBV and HCV disproportionately affect
13 certain populations in the United States. Although
14 representing only about 6 percent of the population,
15 Asian Americans and Pacific Islanders account for
16 half of all chronic HBV cases in the United States.
17 Baby boomers (those born between 1945 and 1965)
18 account for approximately 75 percent of domestic
19 chronic HCV cases. In addition, African Americans,
20 Latinos, and American Indian and Native Alaskans
21 are among the groups which have disproportionately
22 high rates of HBV or HCV infections in the United
23 States.

24 (8) Liver cancer is a leading cause of cancer
25 death among the Asian American and Pacific Is-

1 lander community. Asian and Pacific Islander men
2 and women are more than twice as likely to develop
3 liver cancer compared to the non-Hispanic White
4 population. The higher incidence rate of liver cancer
5 is partially explained by higher incidence rates of
6 hepatitis B and diabetes, which are comorbidities
7 shown to increase an individual's risk of developing
8 liver cancer.

9 (9) Chronic HBV and chronic HCV usually do
10 not cause symptoms early in the course of the dis-
11 ease, but after many years of a clinically "silent"
12 phase, CDC estimates show more than 33 percent of
13 infected individuals will develop cirrhosis, end-stage
14 liver disease, or liver cancer. Since most individuals
15 with chronic HBV, HCV, or both are unaware of
16 their infection, they do not know to take precautions
17 to prevent the spread of their infection and can un-
18 knowingly exacerbate their own disease progression.
19 For those chronically infected with HBV or HCV,
20 regular monitoring can lead to the early detection of
21 liver cancer at a stage where a treatment is still pos-
22 sible.

23 (10) For both chronic HBV and chronic HCV,
24 behavioral changes and appropriate medical care can
25 slow disease progression if diagnosis is made early.

1 Early diagnosis, which is determined through simple
2 blood tests, can reduce the risk of transmission and
3 disease progression through education and vaccina-
4 tion of household members and other susceptible
5 persons at risk.

6 (11) Treatment for chronic HCV can eradicate
7 the disease in approximately 90 percent of those cur-
8 rently treated. While there is no cure for chronic
9 HBV, available treatments can effectively suppress
10 viral replication in the overwhelming majority of
11 those treated, thereby reducing the risk of trans-
12 mission and progression to liver scarring or liver
13 cancer.

14 (12) The annual health care costs attributable
15 to HBV and HCV in the United States are signifi-
16 cant. For HBV, it is estimated to be approximately
17 \$2,500,000,000 (\$2,000 per infected person). In
18 2000, the lifetime cost of HBV, before the avail-
19 ability of most current therapies, was approximately
20 \$80,000 per chronically infected person, totaling
21 more than \$100,000,000,000. For HCV, medical
22 costs for patients are expected to increase from
23 \$30,000,000,000 in 2009 to over \$85,000,000,000
24 in 2024. Avoiding these costs by screening and diag-
25 nosing individuals earlier, and connecting them to

1 appropriate treatment and care, will save lives and
2 critical health care dollars. Currently, without a
3 comprehensive screening, testing, and diagnosis pro-
4 gram, most patients are diagnosed too late when
5 they need a liver transplant costing at least
6 \$314,000 for uncomplicated cases or when they have
7 liver cancer or end-stage liver disease which costs
8 \$30,980 to \$110,576 per hospital admission. As
9 health care costs continue to grow, it is critical that
10 the Federal Government invests in effective mecha-
11 nisms to avoid documented cost drivers.

12 (13) In 2021, the Department of Health and
13 Human Services released its “Viral Hepatitis Na-
14 tional Strategic Plan: A Roadmap for Elimination
15 for the United States, 2021–2025” (referred to in
16 this section as the “HHS Strategic Plan”). In
17 March 2017, the National Academies of Sciences,
18 Engineering, and Medicine released a report enti-
19 tled, “A National Strategy for the Elimination of
20 Hepatitis B and C: Phase Two Report” (referred to
21 in this section as the “NAS report”), recommending
22 specific actions to eliminate viral hepatitis as public
23 health problems in the United States by 2030.

24 (14) According to the NAS report, chronic
25 HBV and HCV infections cause substantial mor-

1 bidity and mortality despite being preventable and
2 treatable. Deficiencies in the implementation of es-
3 tablished guidelines for the prevention, diagnosis,
4 and medical management of chronic HBV and HCV
5 infections perpetuate personal and economic bur-
6 dens. Existing grants are not sufficient for the scale
7 of the health burden presented by HBV and HCV.

8 (15) Screening and testing for HBV and HCV
9 is aligned with the goals of Healthy People 2030 to
10 increase immunization rates, reduce rates of infec-
11 tious diseases, and improve health for people with
12 chronic infections. Awareness of disease and access
13 to prevention and treatment remain essential compo-
14 nents for reducing infectious disease transmission.

15 (16) Federal support is necessary to increase
16 knowledge and awareness of HBV and HCV and to
17 assist State and local prevention and control efforts
18 in reducing the morbidity and mortality of these
19 epidemics.

20 (17) The Secretary of Health and Human Serv-
21 ices has the discretion to carry out this section (in-
22 cluding the amendments made by this section) di-
23 rectly and through whichever of the agencies of the
24 Public Health Service the Secretary determines to be
25 appropriate, which may (in the Secretary's discre-

1 tion) include the Centers for Disease Control and
2 Prevention, the Health Resources and Services Ad-
3 ministration, the Substance Abuse and Mental
4 Health Services Administration, the National Insti-
5 tutes of Health (including the National Institute on
6 Minority Health and Health Disparities), and other
7 agencies of such Service.

8 (c) BIENNIAL ASSESSMENT OF HHS HEPATITIS B
9 AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH,
10 AND MEDICAL MANAGEMENT PLAN.—Title III of the
11 Public Health Service Act (42 U.S.C. 241 et seq.) is fur-
12 ther amended—

13 (1) by striking section 317N (42 U.S.C. 247b–
14 15); and

15 (2) by adding after part V the following:

16 **“PART W—BIENNIAL ASSESSMENT OF HHS HEPA-**
17 **TITIS B AND HEPATITIS C PREVENTION, EDU-**
18 **CATION, RESEARCH, AND MEDICAL MANAGE-**
19 **MENT PLAN**

20 **“SEC. 3990O. BIENNIAL UPDATE OF THE PLAN.**

21 “(a) IN GENERAL.—The Secretary shall conduct a bi-
22 ennial assessment of the Secretary’s plan for the preven-
23 tion, control, and medical management of, and education
24 and research relating to, hepatitis B and hepatitis C, for
25 the purposes of—

1 “(1) incorporating into such plan new knowl-
2 edge or observations relating to hepatitis B and hep-
3 atitis C (such as knowledge and observations that
4 may be derived from clinical, laboratory, and epide-
5 miological research and disease detection, preven-
6 tion, and surveillance outcomes);

7 “(2) addressing gaps in the coverage or effec-
8 tiveness of the plan; and

9 “(3) evaluating and, if appropriate, updating
10 recommendations, guidelines, or educational mate-
11 rials of the Centers for Disease Control and Preven-
12 tion or the National Institutes of Health for health
13 care providers or the public on viral hepatitis in
14 order to be consistent with the plan.

15 “(b) PUBLICATION OF NOTICE OF ASSESSMENTS.—
16 Not later than October 1 of the first even-numbered year
17 beginning after the date of the enactment of this part,
18 and October 1 of each even-numbered year thereafter, the
19 Secretary shall publish in the Federal Register a notice
20 of the results of the assessments conducted under sub-
21 section (a). Such notice shall include—

22 “(1) a description of any revisions to the plan
23 referred to in subsection (a) as a result of the as-
24 sessment;

1 “(2) an explanation of the basis for any such
2 revisions, including the ways in which such revisions
3 can reasonably be expected to further promote the
4 original goals and objectives of the plan; and

5 “(3) in the case of a determination by the Sec-
6 retary that the plan does not need revision, an expla-
7 nation of the basis for such determination.

8 **“SEC. 39900-1. ELEMENTS OF PROGRAM.**

9 “(a) EDUCATION AND AWARENESS PROGRAMS.—The
10 Secretary, acting through the Director of the Centers for
11 Disease Control and Prevention, the Administrator of the
12 Health Resources and Services Administration, and the
13 Assistant Secretary for Mental Health and Substance Use,
14 and in accordance with the plan referred to in section
15 39900(a), shall implement programs to increase aware-
16 ness and enhance knowledge and understanding of hepa-
17 titis B and hepatitis C. Such programs shall include—

18 “(1) the conduct of culturally and linguistically
19 appropriate health education in primary and sec-
20 ondary schools, college campuses, public awareness
21 campaigns, and community outreach activities (espe-
22 cially to the ethnic communities with high rates of
23 chronic hepatitis B and chronic hepatitis C and
24 other high-risk groups) to promote public awareness
25 and knowledge about—

1 “(A) the value of hepatitis A and hepatitis
2 B immunization;

3 “(B) risk factors, transmission, and pre-
4 vention of hepatitis B and hepatitis C;

5 “(C) the value of screening for the early
6 detection of hepatitis B and hepatitis C; and

7 “(D) options available for the treatment of
8 chronic hepatitis B and chronic hepatitis C;

9 “(2) the promotion of immunization programs
10 that increase awareness and access to hepatitis A
11 and hepatitis B vaccines for susceptible adults and
12 children;

13 “(3) the training of health care professionals
14 regarding the importance of vaccinating individuals
15 infected with hepatitis C and individuals who are at
16 risk for hepatitis C infection against hepatitis A and
17 hepatitis B;

18 “(4) the training of health care professionals
19 regarding the importance of vaccinating individuals
20 chronically infected with hepatitis B and individuals
21 who are at risk for chronic hepatitis B infection
22 against the hepatitis A virus;

23 “(5) the training of health care professionals
24 and health educators to make them aware of the
25 high rates of chronic hepatitis B and chronic hepa-

1 titis C in certain adult ethnic populations, and the
2 importance of prevention, detection, and medical
3 management of hepatitis B and hepatitis C and of
4 liver cancer screening;

5 “(6) the development and distribution of health
6 education curricula (including information relating
7 to the special needs of individuals infected with or
8 at risk of hepatitis B and hepatitis C, such as the
9 importance of prevention and early intervention, reg-
10 ular monitoring, the recognition of psychosocial
11 needs, appropriate treatment, and liver cancer
12 screening) for individuals providing hepatitis B and
13 hepatitis C counseling; and

14 “(7) support for the implementation of the cur-
15 ricula described in paragraph (6) by State and local
16 public health agencies.

17 “(b) IMMUNIZATION, PREVENTION, AND CONTROL
18 PROGRAMS.—

19 “(1) IN GENERAL.—The Secretary, acting
20 through the Director of the Centers for Disease
21 Control and Prevention, shall support the integra-
22 tion of activities described in paragraph (3) into ex-
23 isting clinical and public health programs at State,
24 local, territorial, and Tribal levels (including commu-
25 nity health clinics, programs for the prevention and

1 treatment of HIV/AIDS, sexually transmitted infec-
2 tions, and substance abuse, and programs for indi-
3 viduals in correctional settings).

4 “(2) COORDINATION OF DEVELOPMENT OF
5 FEDERAL SCREENING GUIDELINES.—

6 “(A) REFERENCES.—For purposes of this
7 subsection, the term ‘CDC Director’ means the
8 Director of the Centers for Disease Control and
9 Prevention, and the term ‘AHRQ Director’
10 means the Director of the Agency for
11 Healthcare Research and Quality.

12 “(B) AGENCY FOR HEALTHCARE RE-
13 SEARCH AND QUALITY.—Due to the rapidly
14 evolving standard of care associated with diag-
15 nosing and treating viral hepatitis infection, the
16 AHRQ Director shall convene the Preventive
17 Services Task Force under section 915(a) to re-
18 view its recommendation for screening for HBV
19 and HCV infection every 3 years.

20 “(3) ACTIVITIES.—

21 “(A) VOLUNTARY TESTING PROGRAMS.—

22 “(i) IN GENERAL.—The Secretary
23 shall establish a mechanism by which to
24 support and promote the development of
25 State, local, territorial, and Tribal vol-

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1 untary hepatitis B and hepatitis C testing
2 programs to screen the high-prevalence
3 populations to aid in the early identifica-
4 tion of chronically infected individuals.

5 “(ii) CONFIDENTIALITY OF THE TEST
6 RESULTS.—The Secretary shall prohibit
7 the use of the results of a hepatitis B or
8 hepatitis C test conducted by a testing pro-
9 gram developed or supported under this
10 subparagraph for any of the following:

11 “(I) Issues relating to health in-
12 surance.

13 “(II) To screen or determine
14 suitability for employment.

15 “(III) To discharge a person
16 from employment.

17 “(B) COUNSELING REGARDING VIRAL HEP-
18 ATITIS.—The Secretary shall support State,
19 local, territorial, and Tribal programs in a wide
20 variety of settings, including those providing
21 primary and specialty health care services in
22 nonprofit private and public sectors, to—

23 “(i) provide individuals with ongoing
24 risk factors for hepatitis B and hepatitis C

1 infection with client-centered education
2 and counseling which concentrates on—

3 “(I) promoting testing of individ-
4 uals that have been exposed to their
5 blood, family members, and their sex-
6 ual partners; and

7 “(II) changing behaviors that
8 place individuals at risk for infection;

9 “(ii) provide individuals chronically in-
10 fected with hepatitis B or hepatitis C with
11 education, health information, and coun-
12 seling to reduce their risk of—

13 “(I) dying from end-stage liver
14 disease and liver cancer; and

15 “(II) transmitting viral hepatitis
16 to others; and

17 “(iii) provide people chronically in-
18 fected with hepatitis B or hepatitis C who
19 are pregnant or of childbearing age with
20 culturally and linguistically appropriate
21 health information, such as how to prevent
22 hepatitis B perinatal infection, and to al-
23 leviate fears associated with pregnancy or
24 raising a family.

1 “(C) IMMUNIZATION.—The Secretary shall
2 support State, local, territorial, and Tribal ef-
3 forts to expand the current vaccination pro-
4 grams to protect every child in the Nation and
5 all susceptible adults, particularly those infected
6 with hepatitis C and high-prevalence ethnic
7 populations and other high-risk groups, from
8 the risks of acute and chronic hepatitis B infec-
9 tion by—

10 “(i) ensuring continued funding for
11 hepatitis B vaccination for all children 18
12 years of age or younger through the Vac-
13 cines for Children program;

14 “(ii) ensuring that the recommenda-
15 tions of the Advisory Committee on Immu-
16 nization Practices of the Centers for Dis-
17 ease Control and Prevention are followed
18 regarding hepatitis B vaccination for in-
19 fants, children, and adults;

20 “(iii) requiring proof of hepatitis B
21 vaccination for entry into public or private
22 daycare, preschool, elementary school, sec-
23 ondary school, and institutions of higher
24 education;

1 “(iv) expanding the availability of
2 hepatitis B vaccination for all adults to
3 protect them from becoming acutely or
4 chronically infected, including ethnic and
5 other populations with high prevalence
6 rates of chronic hepatitis B infection;

7 “(v) expanding the availability of hep-
8 atitis B vaccination for all adults, particu-
9 larly those of reproductive age (women and
10 men less than 45 years of age), to protect
11 them from the risk of hepatitis B infection;

12 “(vi) ensuring the vaccination of indi-
13 viduals infected, or at risk for infection,
14 with hepatitis C against hepatitis A, hepa-
15 titis B, and other infectious diseases, as
16 appropriate, for which such individuals
17 may be at increased risk; and

18 “(vii) ensuring the vaccination of indi-
19 viduals infected, or at risk for infection,
20 with hepatitis B against hepatitis A virus
21 and other infectious diseases, as appro-
22 priate, for which such individuals may be
23 at increased risk.

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1 “(D) MEDICAL REFERRAL.—The Secretary
2 shall support State, local, territorial, and Tribal
3 programs that support—

4 “(i) referral of persons chronically in-
5 fected with hepatitis B or hepatitis C—

6 “(I) for medical evaluation to de-
7 termine the appropriateness for
8 antiviral treatment to reduce the risk
9 of progression to cirrhosis and liver
10 cancer; and

11 “(II) for ongoing medical man-
12 agement including regular monitoring
13 of liver function and screening for
14 liver cancer; and

15 “(ii) referral of persons infected with
16 acute or chronic hepatitis B infection or
17 acute or chronic hepatitis C infection for
18 drug and alcohol abuse treatment where
19 appropriate.

20 “(4) INCREASED SUPPORT FOR ADULT VIRAL
21 HEPATITIS PREVENTION COORDINATORS.—The Sec-
22 retary, acting through the CDC Director, shall pro-
23 vide increased support to adult viral hepatitis pre-
24 vention coordinators in State, local, territorial, and
25 Tribal health departments in order to enhance the

1 additional management, networking, and technical
2 expertise needed to ensure successful integration of
3 hepatitis B and hepatitis C prevention and control
4 activities into existing public health programs.

5 “(c) EPIDEMIOLOGICAL SURVEILLANCE.—

6 “(1) IN GENERAL.—The Secretary, acting
7 through the Director of the Centers for Disease
8 Control and Prevention, shall support the establish-
9 ment and maintenance of a national chronic and
10 acute hepatitis B and hepatitis C surveillance pro-
11 gram, in order to identify—

12 “(A) trends in the incidence of acute and
13 chronic hepatitis B and acute and chronic hepa-
14 titis C;

15 “(B) trends in the prevalence of acute and
16 chronic hepatitis B and acute and chronic hepa-
17 titis C infection among groups that may be dis-
18 proportionately affected; and

19 “(C) trends in liver cancer and end-stage
20 liver disease incidence and deaths, caused by
21 chronic hepatitis B and chronic hepatitis C in
22 the high-risk ethnic populations.

23 “(2) SEROPREVALENCE AND LIVER CANCER
24 STUDIES.—The Secretary, acting through the Direc-
25 tor of the Centers for Disease Control and Preven-

1 tion, shall prepare a report outlining the population-
2 based seroprevalence studies currently underway, fu-
3 ture planned studies, the criteria involved in deter-
4 mining which seroprevalence studies to conduct,
5 defer, or suspend, and the scope of those studies, the
6 economic and clinical impact of hepatitis B and hep-
7 atitis C, and the impact of chronic hepatitis B and
8 chronic hepatitis C infections on the quality of life.
9 Not later than one year after the date of the enact-
10 ment of this part, the Secretary shall submit the re-
11 port to the Committee on Health, Education, Labor,
12 and Pensions of the Senate and the Committee on
13 Energy and Commerce of the House of Representa-
14 tives.

15 “(3) CONFIDENTIALITY.—The Secretary shall
16 not disclose any individually identifiable information
17 identified under paragraph (1) or derived through
18 studies under paragraph (2).

19 “(d) RESEARCH.—The Secretary, acting through the
20 Director of the Centers for Disease Control and Preven-
21 tion, the Director of the National Cancer Institute, and
22 the Director of the National Institutes of Health, shall—

23 “(1) conduct epidemiologic and community-
24 based research to develop, implement, and evaluate
25 best practices for hepatitis B and hepatitis C pre-

1 vention especially in the ethnic populations with high
2 rates of chronic hepatitis B and chronic hepatitis C
3 and other high-risk groups;

4 “(2) conduct research on hepatitis B and hepa-
5 titis C natural history, pathophysiology, improved
6 treatments and prevention (such as the hepatitis C
7 vaccine), and noninvasive tests that help to predict
8 the risk of progression to liver cirrhosis and liver
9 cancer;

10 “(3) conduct research that will lead to better
11 noninvasive or blood tests to screen for liver cancer,
12 and more effective treatments of liver cancer caused
13 by chronic hepatitis B and chronic hepatitis C; and

14 “(4) conduct research comparing the effective-
15 ness of screening, diagnostic, management, and
16 treatment approaches for chronic hepatitis B, chron-
17 ic hepatitis C, and liver cancer in the affected com-
18 munities.

19 “(e) UNDERSERVED AND DISPROPORTIONATELY AF-
20 FECTED POPULATIONS.—In carrying out this section, the
21 Secretary shall provide expanded support for individuals
22 with limited access to health education, testing, and health
23 care services and groups that may be disproportionately
24 affected by hepatitis B and hepatitis C.

1 “(f) EVALUATION OF PROGRAM.—The Secretary
2 shall develop benchmarks for evaluating the effectiveness
3 of the programs and activities conducted under this sec-
4 tion and make determinations as to whether such bench-
5 marks have been achieved.

6 **“SEC. 39900-2. GRANTS.**

7 “(a) IN GENERAL.—The Secretary may award grants
8 to, or enter into contracts or cooperative agreements with,
9 States, political subdivisions of States, territories, Indian
10 Tribes, or nonprofit entities that have special expertise re-
11 lating to hepatitis B, hepatitis C, or both, to carry out
12 activities under this part.

13 “(b) APPLICATION.—To be eligible for a grant, con-
14 tract, or cooperative agreement under subsection (a), an
15 entity shall prepare and submit to the Secretary an appli-
16 cation at such time, in such manner, and containing such
17 information as the Secretary may require.

18 **“SEC. 39900-3. AUTHORIZATION OF APPROPRIATIONS.**

19 “There are authorized to be appropriated to carry out
20 this part \$90,000,000 for fiscal year 2023, \$110,000,000
21 for fiscal year 2024, \$130,000,000 for fiscal year 2025,
22 and \$150,000,000 for fiscal year 2026.”.

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1 **SEC. 7052. LIVER CANCER AND DISEASE PREVENTION,**
2 **AWARENESS, AND PATIENT TRACKING**
3 **GRANTS.**

4 Subpart I of part D of title III of the Public Health
5 Service Act (42 U.S.C. 254b et seq.) is amended by adding
6 at the end the following new section:

7 **“SEC. 330Q. LIVER CANCER AND DISEASE PREVENTION,**
8 **AWARENESS, AND PATIENT TRACKING**
9 **GRANTS.**

10 “(a) PREVENTION INITIATIVE GRANT PROGRAM.—

11 “(1) IN GENERAL.—The Secretary, acting
12 through the Director of the Centers for Disease
13 Control and Prevention, may award grants and
14 enter into cooperative agreements with entities for
15 the purpose of expanding and supporting—

16 “(A) prevention activities (including pro-
17 viding screenings, vaccinations, or other pre-
18 ventative interventions) for conditions known to
19 increase an individual’s risk of developing a
20 major liver disease, such as liver cancer, hepa-
21 titis B, hepatitis C, nonalcoholic fatty liver dis-
22 ease, nonalcoholic steatohepatitis, and cirrhosis
23 of the liver;

24 “(B) activities relating to detection and
25 provision of guidance for individuals at high

1 risk for contracting liver cancer and other liver
2 diseases; and

3 “(C) viral hepatitis surveillance to provide
4 for timely and accurate information regarding
5 progress to eliminate viral hepatitis.

6 “(2) REPORT.—An entity that receives a grant
7 or cooperative agreement under paragraph (1) shall
8 submit to the Secretary, at a time specified by the
9 Secretary, a report describing each activity carried
10 out pursuant to such paragraph and evaluating the
11 effectiveness of such activity in promoting prevention
12 and treatment of liver cancer and other liver dis-
13 eases.

14 “(3) AUTHORIZATION OF APPROPRIATIONS.—
15 For purposes of carrying out this subsection, there
16 is authorized to be appropriated \$90,000,000 for
17 each of fiscal years 2023 through 2027.

18 “(b) AWARENESS INITIATIVE GRANT PROGRAM.—

19 “(1) IN GENERAL.—The Secretary, acting
20 through the Director of the Centers for Disease
21 Control and Prevention, may award grants to eligi-
22 ble entities for the purpose of raising awareness for
23 liver cancer and other liver diseases, which may in-
24 clude the production, dissemination, and distribution
25 of informational materials targeted towards commu-

1 nities and populations with a higher risk for devel-
2 oping liver cancer and other liver diseases.

3 “(2) ELIGIBLE ENTITIES.—To be eligible to re-
4 ceive a grant under paragraph (1), an entity shall
5 submit to the Secretary an application, at such time,
6 in such manner, and containing such information as
7 the Secretary may require, including a description of
8 how the entity, in disseminating information on liver
9 cancer and other liver diseases pursuant to para-
10 graph (1), will—

11 “(A) with respect to any community or
12 population, consult with members of such com-
13 munity or population and provide such informa-
14 tion in a manner that is culturally and linguis-
15 tically appropriate for such community or popu-
16 lation;

17 “(B) highlight the range of preventative
18 measures and treatments available for liver can-
19 cer and other liver diseases;

20 “(C) integrate information on available
21 hepatitis B and hepatitis C testing programs
22 into any liver cancer presentations carried out
23 by the entity; and

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1 “(D) address communities and populations
2 with a higher risk for contracting liver cancer
3 and other liver diseases.

4 “(3) PREFERENCE.—In awarding grants under
5 paragraph (1), the Secretary shall give preference to
6 entities that—

7 “(A) work with a Federally qualified
8 health center;

9 “(B) are community-based organizations;
10 or

11 “(C) serve communities and populations
12 with a higher risk for contracting liver cancer
13 and other liver diseases.

14 “(4) REPORT.—An entity that receives a grant
15 under paragraph (1) shall submit to the Secretary,
16 at a time specified by the Secretary, a report de-
17 scribing each activity carried out pursuant to such
18 paragraph and evaluating the effectiveness of such
19 activity in raising awareness for liver cancer and
20 other liver diseases.

21 “(5) AUTHORIZATION OF APPROPRIATIONS.—
22 For purposes of carrying out this subsection, there
23 is authorized to be appropriated \$10,000,000 for
24 each of fiscal years 2023 through 2027.”.

1 **Subtitle C—Acquired Bone Marrow**
2 **Failure Diseases**

3 **SEC. 7101. ACQUIRED BONE MARROW FAILURE DISEASES.**

4 (a) **SHORT TITLE.**—This section may be cited as the
5 “Bone Marrow Failure Disease Research and Treatment
6 Act”.

7 (b) **FINDINGS.**—The Congress finds the following:

8 (1) Between 20,000 and 30,000 people in the
9 United States are diagnosed each year with
10 myelodysplastic syndromes, aplastic anemia, parox-
11 ysmal nocturnal hemoglobinuria, and other acquired
12 bone marrow failure diseases.

13 (2) Acquired bone marrow failure diseases have
14 a debilitating and often fatal impact on those diag-
15 nosed with these diseases.

16 (3) While some treatments for acquired bone
17 marrow failure diseases can prolong and improve the
18 quality of patients’ lives, there is no single cure for
19 these diseases.

20 (4) The prevalence of acquired bone marrow
21 failure diseases in the United States will continue to
22 grow as the general public ages.

23 (5) Evidence exists suggesting that acquired
24 bone marrow failure diseases occur more often in

1 minority populations, particularly in Asian-American
2 and Latino or Hispanic populations.

3 (6) The National Heart, Lung, and Blood Insti-
4 tute and the National Cancer Institute have con-
5 ducted important research into the causes of and
6 treatments for acquired bone marrow failure dis-
7 eases.

8 (7) The National Marrow Donor Program Reg-
9 istry has made significant contributions to the fight
10 against bone marrow failure diseases by connecting
11 millions of potential marrow donors with individuals
12 and families suffering from these conditions.

13 (8) Despite these advances, a more comprehen-
14 sive Federal strategic effort among numerous Fed-
15 eral agencies is needed to discover a cure for ac-
16 quired bone marrow failure disorders.

17 (9) Greater Federal surveillance of acquired
18 bone marrow failure diseases is needed to gain a bet-
19 ter understanding of the causes of acquired bone
20 marrow failure diseases.

21 (10) The Federal Government should increase
22 its research support for and engage with public and
23 private organizations in developing a comprehensive
24 approach to combat and cure acquired bone marrow
25 failure diseases.

1 (c) NATIONAL ACQUIRED BONE MARROW FAILURE
2 DISEASE REGISTRY.—Title III of the Public Health Serv-
3 ice Act (42 U.S.C. 241 et seq.) is amended by inserting
4 after section 317V, as added by section 1009, the fol-
5 lowing:

6 **“SEC. 317W. NATIONAL ACQUIRED BONE MARROW FAILURE**
7 **DISEASE REGISTRY.**

8 “(a) ESTABLISHMENT OF REGISTRY.—

9 “(1) IN GENERAL.—Not later than 6 months
10 after the date of the enactment of this section, the
11 Secretary, acting through the Director of the Cen-
12 ters for Disease Control and Prevention, shall—

13 “(A) develop a system to collect data on
14 acquired bone marrow failure diseases; and

15 “(B) establish and maintain a national and
16 publicly available registry, to be known as the
17 National Acquired Bone Marrow Failure Dis-
18 ease Registry, in accordance with paragraph
19 (3).

20 “(2) RECOMMENDATIONS OF ADVISORY COM-
21 MITTEE.—In carrying out this subsection, the Sec-
22 retary shall take into consideration the recommenda-
23 tions of the Advisory Committee on Acquired Bone
24 Marrow Failure Diseases established under sub-
25 section (b).

1 “(3) PURPOSES OF REGISTRY.—The National
2 Acquired Bone Marrow Failure Disease Registry
3 shall—

4 “(A) identify the incidence and prevalence
5 of acquired bone marrow failure diseases in the
6 United States;

7 “(B) be used to collect and store data on
8 acquired bone marrow failure diseases, includ-
9 ing data concerning—

10 “(i) the age, race or ethnicity, general
11 geographic location, sex, and family history
12 of individuals who are diagnosed with ac-
13 quired bone marrow failure diseases, and
14 any other characteristics of such individ-
15 uals determined appropriate by the Sec-
16 retary;

17 “(ii) the genetic and environmental
18 factors that may be associated with devel-
19 oping acquired bone marrow failure dis-
20 eases;

21 “(iii) treatment approaches for deal-
22 ing with acquired bone marrow failure dis-
23 eases;

24 “(iv) outcomes for individuals treated
25 for acquired bone marrow failure diseases,

1 including outcomes for recipients of stem
2 cell therapeutic products as contained in
3 the database established pursuant to sec-
4 tion 379A; and

5 “(v) any other factors pertaining to
6 acquired bone marrow failure diseases de-
7 termined appropriate by the Secretary; and
8 “(C) be made available—

9 “(i) to the general public; and

10 “(ii) to researchers to facilitate fur-
11 ther research into the causes of, and treat-
12 ments for, acquired bone marrow failure
13 diseases in accordance with standard prac-
14 tices of the Centers for Disease Control
15 and Prevention.

16 “(b) ADVISORY COMMITTEE.—

17 “(1) ESTABLISHMENT.—Not later than 6
18 months after the date of the enactment of this sec-
19 tion, the Secretary, acting through the Director of
20 the Centers for Disease Control and Prevention,
21 shall establish an advisory committee, to be known
22 as the Advisory Committee on Acquired Bone Mar-
23 row Failure Diseases.

24 “(2) MEMBERS.—The members of the Advisory
25 Committee on Acquired Bone Marrow Failure Dis-

1 eases shall be appointed by the Secretary, acting
2 through the Director of the Centers for Disease
3 Control and Prevention, and shall include at least
4 one representative from each of the following:

5 “(A) A national patient advocacy organiza-
6 tion with experience advocating on behalf of pa-
7 tients suffering from acquired bone marrow
8 failure diseases.

9 “(B) The National Institutes of Health, in-
10 cluding at least one representative from each
11 of—

12 “(i) the National Cancer Institute;

13 “(ii) the National Heart, Lung, and
14 Blood Institute; and

15 “(iii) the Office of Rare Diseases.

16 “(C) The Centers for Disease Control and
17 Prevention.

18 “(D) Clinicians with experience in—

19 “(i) diagnosing or treating acquired
20 bone marrow failure diseases; or

21 “(ii) medical data registries.

22 “(E) Epidemiologists who have experience
23 with data registries.

1 “(F) Publicly or privately funded research-
2 ers who have experience researching acquired
3 bone marrow failure diseases.

4 “(G) The entity operating the C.W. Bill
5 Young Cell Transplantation Program estab-
6 lished pursuant to section 379 and the entity
7 operating the C.W. Bill Young Cell Transplan-
8 tation Program Outcomes Database.

9 “(3) RESPONSIBILITIES.—The Advisory Com-
10 mittee on Acquired Bone Marrow Failure Diseases
11 shall provide recommendations to the Secretary on
12 the establishment and maintenance of the National
13 Acquired Bone Marrow Failure Disease Registry, in-
14 cluding recommendations on the collection, mainte-
15 nance, and dissemination of data.

16 “(4) PUBLIC AVAILABILITY.—The Secretary
17 shall make the recommendations of the Advisory
18 Committee on Acquired Bone Marrow Failure Dis-
19 ease publicly available.

20 “(c) GRANTS.—The Secretary, acting through the
21 Director of the Centers for Disease Control and Preven-
22 tion, may award grants to, and enter into contracts and
23 cooperative agreements with, public or private nonprofit
24 entities for the management of, as well as the collection,

1 analysis, and reporting of data to be included in, the Na-
2 tional Acquired Bone Marrow Failure Disease Registry.

3 “(d) DEFINITION.—In this section, the term ‘ac-
4 quired bone marrow failure disease’ means—

5 “(1) myelodysplastic syndromes;

6 “(2) aplastic anemia;

7 “(3) paroxysmal nocturnal hemoglobinuria;

8 “(4) pure red cell aplasia;

9 “(5) acute myeloid leukemia that has pro-
10 gressed from myelodysplastic syndromes; or

11 “(6) large granular lymphocytic leukemia.

12 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
13 is authorized to be appropriated to carry out this section
14 \$3,000,000 for each of fiscal years 2023 through 2027.”.

15 (d) PILOT STUDIES THROUGH THE AGENCY FOR
16 TOXIC SUBSTANCES AND DISEASE REGISTRY.—

17 (1) PILOT STUDIES.—The Secretary of Health
18 and Human Services, acting through the Director of
19 the Agency for Toxic Substances and Disease Reg-
20 istry, shall conduct pilot studies to determine which
21 environmental factors, including exposure to toxins,
22 may cause acquired bone marrow failure diseases.

23 (2) COLLABORATION WITH THE RADIATION IN-
24 JURY TREATMENT NETWORK.—In carrying out the
25 directives of this section, the Secretary of Health

1 and Human Services may collaborate with the Radi-
2 ation Injury Treatment Network of the C.W. Bill
3 Young Cell Transplantation Program established
4 pursuant to section 379 of the Public Health Service
5 Act (42 U.S.C. 274k) to—

6 (A) augment data for the pilot studies au-
7 thorized by this section;

8 (B) access technical assistance that may be
9 provided by the Radiation Injury Treatment
10 Network; or

11 (C) perform joint research projects.

12 (3) AUTHORIZATION OF APPROPRIATIONS.—

13 There is authorized to be appropriated to carry out
14 this subsection \$1,000,000 for each of fiscal years
15 2023 through 2027.

16 (e) MINORITY-FOCUSED PROGRAMS ON ACQUIRED
17 BONE MARROW FAILURE DISEASES.—Title XVII of the
18 Public Health Service Act (42 U.S.C. 300u et seq.) is
19 amended by inserting after section 1707A the following:

20 **“SEC. 1707B. MINORITY-FOCUSED PROGRAMS ON AC-**
21 **QUIRED BONE MARROW FAILURE DISEASE.**

22 **“(a) INFORMATION AND REFERRAL SERVICES.—**

23 **“(1) IN GENERAL.—**Not later than 6 months
24 after the date of the enactment of this section, the
25 Secretary, acting through the Deputy Assistant Sec-

1 retary for Minority Health, shall establish and co-
2 ordinate outreach and informational programs tar-
3 geted to minority populations affected by acquired
4 bone marrow failure diseases.

5 “(2) PROGRAM REQUIREMENTS.—Minority-fo-
6 cused outreach and informational programs author-
7 ized by this section at the National Minority Health
8 Resource Center supported under section 1707(b)(8)
9 (including by means of the Center’s website, through
10 appropriate locations such as the Center’s knowledge
11 center, and through appropriate programs such as
12 the Center’s resource persons network) and through
13 minority health consultants located at each Depart-
14 ment of Health and Human Services regional of-
15 fice—

16 “(A) shall make information about treat-
17 ment options and clinical trials for acquired
18 bone marrow failure diseases publicly available;
19 and

20 “(B) shall provide referral services for
21 treatment options and clinical trials.

22 “(b) HISPANIC AND ASIAN-AMERICAN AND PACIFIC
23 ISLANDER OUTREACH.—

24 “(1) IN GENERAL.—The Secretary, acting
25 through the Deputy Assistant Secretary for Minority

1 Health, shall undertake a coordinated outreach ef-
2 fort to connect Hispanic, Asian-American, and Pa-
3 cific Islander communities with comprehensive serv-
4 ices focused on treatment of, and information about,
5 acquired bone marrow failure diseases.

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

12 “(c) GRANTS AND COOPERATIVE AGREEMENTS.—

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

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

24 “(3) SCOPE OF RESEARCH.—Research funded
25 under this subsection shall examine factors affecting

1 the incidence of acquired bone marrow failure dis-
2 eases in minority populations.

3 “(d) DEFINITION.—In this section, the term ‘ac-
4 quired bone marrow failure disease’ has the meaning given
5 to such term in section 317W(d).

6 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
7 is authorized to be appropriated to carry out this section
8 \$2,000,000 for each of fiscal years 2023 through 2027”.

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

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

17 (2) AUTHORIZATION OF APPROPRIATIONS.—
18 There is authorized to be appropriated to carry out
19 this subsection \$2,000,000 for each of fiscal years
20 2023 through 2027.

21 (g) DEFINITION.—In this section, the term “acquired
22 bone marrow failure disease” has the meaning given such
23 term in section 317W(d) of the Public Health Service Act,
24 as added by subsection (c).

1 **Subtitle D—Cardiovascular Dis-**
2 **ease, Chronic Disease, Obesity,**
3 **and Other Disease Issues**

4 **SEC. 7151. GUIDELINES FOR DISEASE SCREENING FOR MI-**
5 **NORITY PATIENTS.**

6 (a) IN GENERAL.—The Secretary of Health and
7 Human Services (in this section referred to as the “Sec-
8 retary”), acting through the Director of the Agency for
9 Healthcare Research and Quality, shall convene a series
10 of meetings to develop guidelines for disease screening for
11 minority patient populations that have a higher than aver-
12 age risk for many chronic diseases and cancers.

13 (b) PARTICIPANTS.—In convening meetings under
14 subsection (a), the Secretary shall ensure that meeting
15 participants include representatives of—

- 16 (1) professional societies and associations;
- 17 (2) minority health organizations;
- 18 (3) health care researchers and providers, in-
19 cluding those with expertise in minority health;
- 20 (4) Federal health agencies, including the Of-
21 fice of Minority Health, the National Institute on
22 Minority Health and Health Disparities, and the
23 National Institutes of Health; and
- 24 (5) other experts as the Secretary determines
25 appropriate.

1 (c) DISEASES.—Screening guidelines for minority
2 populations shall be developed as appropriate under sub-
3 section (a) for—

4 (1) hypertension;

5 (2) hypercholesterolemia;

6 (3) diabetes;

7 (4) cardiovascular disease;

8 (5) cancers, including breast, prostate, colon,
9 cervical, and lung cancer;

10 (6) other pulmonary problems including sleep
11 apnea;

12 (7) asthma;

13 (8) kidney diseases;

14 (9) eye diseases and disorders, including glau-
15 coma;

16 (10) HIV/AIDS and sexually transmitted infec-
17 tions;

18 (11) uterine fibroids;

19 (12) autoimmune diseases, including lupus;

20 (13) mental health conditions;

21 (14) dental health conditions and oral diseases,
22 including oral cancer;

23 (15) environmental and related health illnesses
24 and conditions;

25 (16) sickle cell disease and sickle cell trait;

- 1 (17) violence and injury prevention and control;
2 (18) genetic and related conditions;
3 (19) heart disease and stroke;
4 (20) tuberculosis;
5 (21) chronic obstructive pulmonary disease;
6 (22) musculoskeletal diseases, arthritis, and
7 obesity; and
8 (23) other diseases determined appropriate by
9 the Secretary.

10 (d) DISSEMINATION.—Not later than 2 years after
11 the date of enactment of this Act, the Secretary shall pub-
12 lish and disseminate to health care provider organizations
13 the guidelines developed under subsection (a).

14 (e) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated to carry out this section
16 such sums as may be necessary for each of fiscal years
17 2023 through 2027.

18 **SEC. 7152. CDC WISEWOMAN SCREENING PROGRAM.**

19 Section 1509 of the Public Health Service Act (42
20 U.S.C. 300n–4a) is amended—

21 (1) in subsection (a)—

22 (A) by striking the heading and inserting
23 “IN GENERAL.—”; and

24 (B) in the matter preceding paragraph (1),
25 by striking “may make grants” and all that fol-

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1 lows through “purpose” and inserting the fol-
2 lowing: “may make grants to such States for
3 the purpose”; and

4 (2) in subsection (d)(1), by striking “there are
5 authorized” and all that follows through the period
6 and inserting “there are authorized to be appro-
7 priated \$23,000,000 for fiscal year 2023,
8 \$25,300,000 for fiscal year 2024, \$27,800,000 for
9 fiscal year 2025, \$30,800,000 for fiscal year 2026,
10 and \$34,000,000 for fiscal year 2027.”.

11 **SEC. 7153. REPORT ON CARDIOVASCULAR CARE FOR**
12 **WOMEN AND MINORITIES.**

13 Part P of title III of the Public Health Service Act
14 (42 U.S.C. 280g et seq.), as amended by section
15 5201(a)(6), is amended by adding at the end the following:

16 **“SEC. 399V-9. REPORT ON CARDIOVASCULAR CARE FOR**
17 **WOMEN AND MINORITIES.**

18 “Not later than September 30, 2023, and annually
19 thereafter, the Secretary shall prepare and submit to Con-
20 gress a report on the quality of and access to care for
21 women and minorities with heart disease, stroke, and
22 other cardiovascular diseases. The report shall contain rec-
23 ommendations for eliminating disparities in, and improv-
24 ing the treatment of, heart disease, stroke, and other car-
25 diovascular diseases in women, racial and ethnic minori-

1 ties, those for whom English is not their primary lan-
2 guage, and individuals with disabilities.”.

3 **SEC. 7154. COVERAGE OF COMPREHENSIVE TOBACCO CES-**
4 **SATION SERVICES IN MEDICAID, CHIP, AND**
5 **PRIVATE HEALTH INSURANCE.**

6 (a) REQUIRING MEDICAID COVERAGE OF COUN-
7 SELING AND PHARMACOTHERAPY FOR CESSATION OF TO-
8 BACCO USE AND TEMPORARY ENHANCED FMAP FOR
9 COVERAGE OF TOBACCO CESSATION SERVICES.—Section
10 1905 of the Social Security Act (42 U.S.C. 1396d) is
11 amended—

12 (1) by amending subsection (a)(4)(D) to read
13 as follows:

14 “(D) counseling and pharmacotherapy for
15 cessation of tobacco use by individuals who are
16 eligible under the State plan (as defined in sub-
17 section (bb)); and”;

18 (2) in subsection (b), by inserting “(bb)(2),”
19 after “(aa),”; and

20 (3) by striking subsection (bb) and inserting
21 the following:

22 “(bb) COUNSELING AND PHARMACOTHERAPY FOR
23 CESSATION OF TOBACCO USE.—

24 “(1) IN GENERAL.—For purposes of this title,
25 the term ‘counseling and pharmacotherapy for ces-

1 sation of tobacco use by individuals who are eligible
2 under the State plan’ means diagnostic, therapy,
3 and counseling services and pharmacotherapy (in-
4 cluding the coverage of prescription and nonprescrip-
5 tion tobacco cessation agents approved by the Food
6 and Drug Administration) for the cessation of to-
7 bacco use by individuals who use tobacco products or
8 who are being treated for tobacco use that is fur-
9 nished—

10 “(A) by or under the supervision of a phy-
11 sician; or

12 “(B) by any other health care professional
13 who—

14 “(i) is legally authorized to furnish
15 such services under State law (or the State
16 regulatory mechanism provided by State
17 law) of the State in which the services are
18 furnished; and

19 “(ii) is authorized to receive payment
20 for other services under this title or is des-
21 ignated by the Secretary for this purpose;
22 which is recommended in the guideline entitled,
23 ‘Treating Tobacco Use and Dependence: 2008
24 Update: A Clinical Practice Guideline’ pub-
25 lished by the Public Health Service in May

1 2008 (or any subsequent modification of such
2 guideline) or is recommended for the cessation
3 of tobacco use by the United States Preventive
4 Services Task Force or any additional interven-
5 tion approved by the Food and Drug Adminis-
6 tration as safe and effective in helping smokers
7 quit.

8 “(2) TEMPORARY ENHANCED FMAP FOR COV-
9 ERAGE OF TOBACCO CESSATION SERVICES.—Not-
10 withstanding subsection (b), for calendar quarters
11 occurring during the period beginning on the date of
12 the enactment of this paragraph and ending 2 years
13 after the last day of the emergency period described
14 in section 1135(g)(1)(B), the Federal medical assist-
15 ance percentage with respect to amounts expended
16 by a State for medical assistance for counseling and
17 pharmacotherapy for cessation of tobacco use by in-
18 dividuals who are eligible under the State plan (as
19 defined in paragraph (1)) shall be equal to 100 per-
20 cent.”.

21 (b) NO COST SHARING.—

22 (1) IN GENERAL.—Subsections (a)(2) and
23 (b)(2) of section 1916 of the Social Security Act (42
24 U.S.C. 1396o), as amended by section 2007(d)(4),
25 are each amended—

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1 (A) in subparagraph (B), by striking “,
2 and counseling” and all that follows through
3 “section 1905(bb)(2)(A)”;

4 (B) in subparagraph (I), by striking “or”
5 after the comma;

6 (C) in subparagraph (J), by striking “;
7 and” and inserting “, or”; and

8 (D) by adding at the end the following new
9 subparagraph:

10 “(K) counseling and pharmacotherapy for
11 cessation of tobacco use by individuals who are
12 eligible under the State plan (as defined in sec-
13 tion 1905(bb)) and covered outpatient drugs (as
14 defined in subsection (k)(2) of section 1927 and
15 including nonprescription drugs described in
16 subsection (d)(2) of such section) that are pre-
17 scribed for purposes of promoting tobacco ces-
18 sation in accordance with the guideline specified
19 in section 1905(bb); and”.

20 (2) APPLICATION TO ALTERNATIVE COST SHAR-
21 ING.—Section 1916A(b)(3)(B) of the Social Security
22 Act (42 U.S.C. 1396o–1(b)(3)(B)) is amended—

23 (A) in clause (iii), by striking “, and coun-
24 seling and pharmacotherapy for cessation of to-

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1 bacco use by pregnant women (as defined in
2 section 1905(bb))”; and

3 (B) by adding at the end the following new
4 clause:

5 “(xiv) Counseling and
6 pharmacotherapy for cessation of tobacco
7 use by individuals who are eligible under
8 the State plan (as defined in section
9 1905(bb)) and covered outpatient drugs
10 (as defined in subsection (k)(2) of section
11 1927 and including nonprescription drugs
12 described in subsection (d)(2) of such sec-
13 tion) that are prescribed for purposes of
14 promoting tobacco cessation in accordance
15 with the guideline specified in section
16 1905(bb).”.

17 (c) EXCEPTION FROM OPTIONAL RESTRICTION
18 UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—
19 Section 1927(d)(2)(F) of the Social Security Act (42
20 U.S.C. 1396r–8(d)(2)(F)) is amended to read as follows:

21 “(F) Nonprescription drugs, except, when
22 recommended in accordance with the guideline
23 referred to in section 1905(bb), agents ap-
24 proved by the Food and Drug Administration

1 under the over-the-counter monograph process
2 for purposes of promoting tobacco cessation.”.

3 (d) STATE MONITORING AND PROMOTING OF COM-
4 PREHENSIVE TOBACCO CESSATION SERVICES UNDER
5 MEDICAID.—Section 1902(a) of the Social Security Act
6 (42 U.S.C. 1396a(a)), as amended by section
7 4251(d)(3)(A), is amended—

8 (1) in paragraph (87), by striking “and” at the
9 end;

10 (2) in paragraph (88), by striking the period at
11 the end and inserting “; and”; and

12 (3) by inserting after paragraph (8) the fol-
13 lowing new paragraph:

14 “(89) provide for the State to monitor and pro-
15 mote the use of comprehensive tobacco cessation
16 services under the State plan (including conducting
17 an outreach campaign to increase awareness of the
18 benefits of using such services) among—

19 “(A) individuals entitled to medical assist-
20 ance under the State plan who use tobacco
21 products; and

22 “(B) clinicians and others who provide
23 services to individuals entitled to medical assist-
24 ance under the State plan.”.

1 (e) FEDERAL REIMBURSEMENT FOR OUTREACH
2 CAMPAIGN.—Section 1903(a) of the Social Security Act
3 (42 U.S.C. 1396b(a)) is amended—

4 (1) in paragraph (6)(B), by striking “plus” at
5 the end;

6 (2) in paragraph (7), by striking the period at
7 the end and inserting “; plus”; and

8 (3) by inserting after paragraph (7) the fol-
9 lowing new paragraph:

10 “(8) with respect to the development, imple-
11 mentation, and evaluation of an outreach campaign
12 to—

13 “(A) increase awareness of comprehensive
14 tobacco cessation services covered in the State
15 plan among—

16 “(i) individuals who are likely to be el-
17 igible for medical assistance under the
18 State plan; and

19 “(ii) clinicians and others who provide
20 services to individuals who are likely to be
21 eligible for medical assistance under the
22 State plan; and

23 “(B) increase awareness of the benefits of
24 using comprehensive tobacco cessation services
25 covered in the State plan among—

1 “(i) individuals who are likely to be el-
2 ible for medical assistance under the
3 State plan; and

4 “(ii) clinicians and others who provide
5 services to individuals who are likely to be
6 eligible for medical assistance under the
7 State plan about the benefits of using com-
8 prehensive tobacco cessation services;
9 for calendar quarters occurring during the pe-
10 riod beginning on the date of the enactment of
11 this paragraph and ending on 2 years after the
12 last day of the emergency period described in
13 section 1135(g)(1)(B), an amount equal to 100
14 percent of the sums expended during each quar-
15 ter which are attributable to such development,
16 implementation, and evaluation, and for cal-
17 endar quarters succeeding such period, an
18 amount equal to Federal medical assistance
19 percentage determined under section 1905(b) of
20 the sums expended during each quarter which
21 are so attributable.”.

22 (f) NO PRIOR AUTHORIZATION FOR TOBACCO CES-
23 SATION DRUGS UNDER MEDICAID.—Section 1927(d) of
24 the Social Security Act (42 U.S.C. 1396r–8(d)) is amend-
25 ed—

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1 (1) in paragraph (1)(A), by striking “A State”
2 and inserting “Subject to paragraph (8), a State”;
3 and

4 (2) by adding at the end the following new
5 paragraph:

6 “(8) NO PRIOR AUTHORIZATION PROGRAMS FOR
7 TOBACCO CESSATION DRUGS.—A State plan may not
8 require, as a condition of coverage or payment for
9 a covered outpatient drug, the approval of an agent
10 to promote smoking cessation (including agents ap-
11 proved by the Food and Drug Administration) or to-
12 bacco cessation.”.

13 (g) EXCLUSION OF ENHANCED PAYMENTS FROM
14 TERRITORIAL CAPS.—Notwithstanding any other provi-
15 sion of law, for purposes of section 1108 of the Social Se-
16 curity Act (42 U.S.C. 1308), with respect to any addi-
17 tional amount paid to a territory as a result of the applica-
18 tion of section 1905(bb)(2) of the Social Security Act (42
19 U.S.C. 1396d(bb)(2))—

20 (1) the limitation on payments to territories
21 under subsections (f) and (g) of such section 1108
22 shall not apply to such additional amounts; and

23 (2) such additional amounts shall be dis-
24 regarded in applying such subsections.

1 (h) REQUIRING CHIP COVERAGE OF COUNSELING
2 AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO
3 USE.—

4 (1) IN GENERAL.—Section 2103(c)(2) of the
5 Social Security Act (42 U.S.C. 1397cc(c)(2)) is
6 amended by adding at the end the following new
7 subparagraph:

8 “(D) Counseling and pharmacotherapy for
9 cessation of tobacco use by individuals who are
10 eligible under the State child health plan.”.

11 (2) COUNSELING AND PHARMACOTHERAPY FOR
12 CESSATION OF TOBACCO USE DEFINED.—Section
13 2110(c) of the Social Security Act (42 U.S.C.
14 1397jj(c)) is amended by adding at the end the fol-
15 lowing new paragraph:

16 “(10) COUNSELING AND PHARMACOTHERAPY
17 FOR CESSATION OF TOBACCO USE.—The term ‘coun-
18 seling and pharmacotherapy for cessation of tobacco
19 use’ means diagnostic, therapy, and counseling serv-
20 ices and pharmacotherapy (including the coverage of
21 prescription and nonprescription tobacco cessation
22 agents approved by the Food and Drug Administra-
23 tion) for the cessation of tobacco use by individuals
24 who use tobacco products or who are being treated
25 for tobacco use that are furnished—

1 “(A) by or under the supervision of a phy-
2 sician; or

3 “(B) by any other health care professional
4 who—

5 “(i) is legally authorized to furnish
6 such services under State law (or the State
7 regulatory mechanism provided by State
8 law) of the State in which the services are
9 furnished; and

10 “(ii) is authorized to receive payment
11 for other services under this title or is des-
12 ignated by the Secretary for this purpose;
13 which is recommended in the guideline entitled,
14 ‘Treating Tobacco Use and Dependence: 2008
15 Update: A Clinical Practice Guideline’ pub-
16 lished by the Public Health Service in May
17 2008 (or any subsequent modification of such
18 guideline) or is recommended for the cessation
19 of tobacco use by the United States Preventive
20 Services Task Force or any additional interven-
21 tion approved by the Food and Drug Adminis-
22 tration as safe and effective in helping smokers
23 quit.”.

1 (i) NO COST SHARING.—Section 2103(e) of the So-
2 cial Security Act (42 U.S.C. 1397cc(e)) is amended by
3 adding at the end the following new paragraph:

4 “(5) NO COST SHARING ON BENEFITS FOR
5 COUNSELING AND PHARMACOTHERAPY FOR CES-
6 SATION OF TOBACCO USE.—The State child health
7 plan may not impose deductibles, coinsurance, or
8 other cost sharing with respect to benefits for coun-
9 seling and pharmacotherapy for cessation of tobacco
10 use (as defined in section 2110(c)(10)) and prescrip-
11 tion drugs that are covered under a State child
12 health plan that are prescribed for purposes of pro-
13 moting tobacco cessation in accordance with the
14 guideline specified in section 2110(c)(10)(B).”.

15 (j) EXCEPTION FROM OPTIONAL RESTRICTION
16 UNDER CHIP PRESCRIPTION DRUG COVERAGE.—Section
17 2103 of the Social Security Act (42 U.S.C. 1397cc) is
18 amended by adding at the end the following new sub-
19 section:

20 “(g) EXCEPTION FROM OPTIONAL RESTRICTION
21 UNDER CHIP PRESCRIPTION DRUG COVERAGE.—The
22 State child health plan may exclude or otherwise restrict
23 nonprescription drugs, except, in the case of—

24 “(1) pregnant women when recommended in ac-
25 cordance with the guideline specified in section

1 2110(c)(10)(B), agents approved by the Food and
2 Drug Administration under the over-the-counter
3 monograph process for purposes of promoting to-
4 bacco cessation; and

5 “(2) individuals who are eligible under the
6 State child health plan when recommended in ac-
7 cordance with the Guideline referred to in section
8 2110(c)(10)(B), agents approved by the Food and
9 Drug Administration under the over-the-counter
10 monograph process for purposes of promoting to-
11 bacco cessation.”.

12 (k) STATE MONITORING AND PROMOTING OF COM-
13 PREHENSIVE TOBACCO CESSATION SERVICES UNDER
14 CHIP.—Section 2102 of the Social Security Act (42
15 U.S.C. 1397bb) is amended by adding at the end the fol-
16 lowing new subsection:

17 “(d) STATE MONITORING AND PROMOTING OF COM-
18 PREHENSIVE TOBACCO CESSATION SERVICES UNDER
19 CHIP.—A State child health plan shall include a descrip-
20 tion of the procedures to be used by the State to monitor
21 and promote the use of comprehensive tobacco cessation
22 services under the State plan (including conducting an
23 outreach campaign to increase awareness of the benefits
24 of using such services) among—

1 “(1) individuals entitled to medical assistance
2 under the State child health plan who use tobacco
3 products; and

4 “(2) clinicians and others who provide services
5 to individuals entitled to medical assistance under
6 the State child health plan.”.

7 (1) FEDERAL REIMBURSEMENT FOR CHIP COV-
8 ERAGE AND OUTREACH CAMPAIGN.—

9 (1) IN GENERAL.—Section 2105(a) of the So-
10 cial Security Act (42 U.S.C. 1397ee(a)) is amended
11 by adding at the end the following new paragraph:

12 “(5) FEDERAL REIMBURSEMENT FOR CHIP
13 COVERAGE OF COMPREHENSIVE TOBACCO CES-
14 SATION SERVICES AND OUTREACH CAMPAIGN.—In
15 addition to the payments made under paragraph (1)
16 for calendar quarters occurring during the period be-
17 ginning on the date of the enactment of this para-
18 graph and ending on 2 years after the last day of
19 the emergency period described in section
20 1135(g)(1)(B), the Secretary shall pay—

21 “(A) an amount equal to 100 percent of
22 the sums expended during each quarter which
23 are attributable to the cost of furnishing coun-
24 seling and pharmacotherapy for cessation of to-
25 bacco use by individuals who are eligible under

1 the State child health plan (net of any pay-
2 ments made to the State under paragraph (1)
3 with respect to such counseling and
4 pharmacotherapy); plus

5 “(B) an amount equal to 100 percent of
6 the sums expended during each quarter which
7 are attributable to the development, implemen-
8 tation, and evaluation of an outreach campaign
9 to—

10 “(i) increase awareness of comprehen-
11 sive tobacco cessation services covered in
12 the State child health plan among—

13 “(I) individuals who are likely to
14 be eligible for medical assistance
15 under the State child health plan; and

16 “(II) clinicians and others who
17 provide services to individuals who are
18 likely to be eligible for medical assist-
19 ance under the State child health
20 plan; and

21 “(ii) increase awareness of the bene-
22 fits of using comprehensive tobacco ces-
23 sation services covered in the State child
24 health plan among—

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1 “(I) individuals who are likely to
2 be eligible for medical assistance
3 under the State child health plan; and
4 “(II) clinicians and others who
5 provide services to individuals who are
6 likely to be eligible for medical assist-
7 ance under the State child health plan
8 about the benefits of using com-
9 prehensive tobacco cessation serv-
10 ices.”.

11 (2) ADJUSTMENT OF CHIP ALLOTMENTS.—Sec-
12 tion 2104(m) of the Social Security Act (42 U.S.C.
13 1397dd(m)) is amended—

14 (A) in paragraph (2)(B), by striking “ and
15 (12)” and inserting “(12), and (13)”; and

16 (B) by adding at the end the following new
17 paragraph:

18 “(13) ADJUSTING ALLOTMENTS TO ACCOUNT
19 FOR FEDERAL PAYMENTS FOR CHIP COVERAGE OF
20 COMPREHENSIVE TOBACCO CESSATION SERVICES
21 AND OUTREACH CAMPAIGN.—If a State (including
22 the District of Columbia and each commonwealth
23 and territory) receives a payment for a fiscal year
24 under section 2105(a)(5), the allotment determined

1 for the State for such fiscal year shall be increased
2 by the amount of such payment.”.

3 (m) NO PRIOR AUTHORIZATION FOR TOBACCO CES-
4 SATION DRUGS UNDER CHIP.—Section 2103 of the So-
5 cial Security Act (42 U.S.C. 1397cc), as amended by sub-
6 section (c), is further amended—

7 (1) in subsection (c)(2)(A), by inserting “(in ac-
8 cordance with subsection (h))” after “Coverage of
9 prescription drugs”; and

10 (2) by adding at the end the following new sub-
11 section:

12 “(h) NO PRIOR AUTHORIZATION PROGRAMS FOR TO-
13 BACCO CESSATION DRUGS.—A State child health plan
14 may not require, as a condition of coverage or payment
15 for a prescription drugs, the approval of an agent to pro-
16 mote smoking cessation (including agents approved by the
17 Food and Drug Administration) or tobacco cessation.”.

18 (n) COMPREHENSIVE COVERAGE OF TOBACCO CES-
19 SATION COVERAGE IN PRIVATE HEALTH INSURANCE.—
20 Section 2713 of the Public Health Service Act (42 U.S.C.
21 300gg–13) is amended by adding at the end the following:

22 “(d) NO PRIOR AUTHORIZATION.—A group health
23 plan and a health insurance issuer offering group or indi-
24 vidual health insurance coverage shall not impose any
25 prior authorization requirement for tobacco cessation

1 counseling and pharmacotherapy that has in effect a rat-
2 ing of ‘A’ or ‘B’ in the current recommendations of the
3 United States Preventive Services Task Force.”.

4 (o) RULE OF CONSTRUCTION.—None of the amend-
5 ments made by this section shall be construed to limit cov-
6 erage of any counseling or pharmacotherapy for individ-
7 uals under 18 years of age.

8 (p) EFFECTIVE DATE.—The amendments made by
9 this section shall take effect on the first day of the first
10 fiscal year that begins on or after the date of enactment
11 of this Act.

12 **SEC. 7155. CLINICAL RESEARCH FUNDING FOR ORAL**
13 **HEALTH.**

14 (a) IN GENERAL.—The Secretary of Health and
15 Human Services shall expand and intensify the conduct
16 and support of the research activities of the National In-
17 stitutes of Health and the National Institute of Dental
18 and Craniofacial Research to improve the oral health of
19 the population through the prevention and management
20 of oral diseases and conditions.

21 (b) INCLUDED RESEARCH ACTIVITIES.—Research
22 activities under subsection (a) shall include—

23 (1) comparative effectiveness research and clin-
24 ical disease management research addressing early
25 childhood cancer and oral cancer; and

1 (2) awarding of grants and contracts to support
2 the training and development of health services re-
3 searchers, comparative effectiveness researchers, and
4 clinical researchers whose research improves the oral
5 health of the population.

6 **SEC. 7156. GUIDE ON EVIDENCE-BASED STRATEGIES FOR**
7 **PUBLIC HEALTH DEPARTMENT OBESITY PRE-**
8 **VENTION PROGRAMS.**

9 (a) DEVELOPMENT AND DISSEMINATION OF AN EVI-
10 DENCE-BASED STRATEGIES GUIDE.—The Secretary of
11 Health and Human Services (referred to in this section
12 as the “Secretary”), acting through the Director of the
13 Centers for Disease Control and Prevention, not later than
14 2 years after the date of enactment of this Act, shall—

15 (1) develop a guide on evidence-based strategies
16 for State, territorial, and local health departments to
17 use to build and maintain effective obesity preven-
18 tion and reduction programs, and, in consultation
19 with stakeholders that have expertise in Tribal
20 health, a guide on such evidence-based strategies
21 with respect to Indian Tribes and Tribal organiza-
22 tions for such Indian Tribes and Tribal organiza-
23 tions to use for such purpose, both of which guides
24 shall—

1 (A) describe an integrated program struc-
2 ture for implementing interventions proven to
3 be effective in preventing and reducing the inci-
4 dence of obesity; and

5 (B) recommend—

6 (i) optimal resources, including staff-
7 ing and infrastructure, for promoting nu-
8 trition and obesity prevention and reduc-
9 tion; and

10 (ii) strategies for effective obesity pre-
11 vention programs for State and local
12 health departments, Indian Tribes, and
13 Tribal organizations, including strategies
14 related to—

15 (I) the application of evidence-
16 based and evidence-informed practices
17 to prevent and reduce obesity rates;

18 (II) the development, implemen-
19 tation, and evaluation of obesity pre-
20 vention and reduction strategies for
21 specific communities and populations;

22 (III) demonstrated knowledge of
23 obesity prevention practices that re-
24 duce associated preventable diseases,

1 health conditions, death, and health
2 care costs;

3 (IV) best practices for the coordi-
4 nation of efforts to prevent and re-
5 duce obesity and related chronic dis-
6 eases;

7 (V) addressing the underlying
8 risk factors and social determinants of
9 health that impact obesity rates; and

10 (VI) interdisciplinary coordina-
11 tion between relevant public health of-
12 ficials specializing in fields such as
13 nutrition, physical activity, epidemi-
14 ology, communications, and policy im-
15 plementation, and collaboration be-
16 tween public health officials and com-
17 munity-based organizations; and

18 (2) disseminate the guides and current re-
19 search, evidence-based practices, tools, and edu-
20 cational materials related to obesity prevention, con-
21 sistent with the guides, to State and local health de-
22 partments, Indian Tribes, and Tribal organizations.

23 (b) TECHNICAL ASSISTANCE.—The Secretary, acting
24 through the Director of the Centers for Disease Control
25 and Prevention, shall provide technical assistance to State

1 and local health departments, Indian Tribes, and Tribal
2 organizations to support such health departments in im-
3 plementing the guides developed under subsection (a)(1).

4 (c) INDIAN TRIBES; TRIBAL ORGANIZATIONS.—In
5 this section, the terms “Indian Tribe” and “Tribal organi-
6 zation” have the meanings given the terms in section 4
7 of the Indian Self-Determination and Education Assist-
8 ance Act (25 U.S.C. 5304).

9 **SEC. 7157. STEPHANIE TUBBS JONES UTERINE FIBROID RE-**
10 **SEARCH AND EDUCATION ACT.**

11 (a) RESEARCH WITH RESPECT TO UTERINE
12 FIBROIDS.—

13 (1) RESEARCH.—The Secretary of Health and
14 Human Services (referred to in this section as the
15 “Secretary”) shall expand, intensify, and coordinate
16 programs for the conduct and support of research
17 with respect to uterine fibroids.

18 (2) ADMINISTRATION AND COORDINATION.—
19 The Secretary shall carry out the conduct and sup-
20 port of research pursuant to paragraph (1), in co-
21 ordination with the appropriate institutes, offices,
22 and centers of the National Institutes of Health and
23 any other relevant Federal agency, as determined by
24 the Director of the National Institutes of Health.

1 (3) AUTHORIZATION OF APPROPRIATIONS.—For
2 the purpose of carrying out this subsection, there
3 are authorized to be appropriated \$30,000,000 for
4 each of fiscal years 2023 through 2027.

5 (b) RESEARCH WITH RESPECT TO MEDICAID COV-
6 ERAGE OF UTERINE FIBROIDS TREATMENT.—

7 (1) RESEARCH.—The Secretary (or the Sec-
8 retary’s designee) shall establish a research data-
9 base, or expand an existing research database, to
10 collect data on services furnished to individuals diag-
11 nosed with uterine fibroids under a State plan (or a
12 waiver of such a plan) under the Medicaid program
13 under title XIX of the Social Security Act (42
14 U.S.C. 1396 et seq.) or under a State child health
15 plan (or a waiver of such a plan) under the Chil-
16 dren’s Health Insurance Program under title XXI of
17 such Act (42 U.S.C. 1397aa et seq.) for the treat-
18 ment of such fibroids for purposes of assessing the
19 frequency at which such individuals are furnished
20 such services.

21 (2) REPORT.—

22 (A) IN GENERAL.—Not later than the date
23 that is two years after the date of the enact-
24 ment of this Act, the Secretary shall submit to
25 Congress a report on the amount of Federal

1 and State expenditures with respect to services
2 furnished for the treatment of uterine fibroids
3 under State plans (or waivers of such plans)
4 under the Medicaid program under such title
5 XIX and State child health plans (or waivers of
6 such plans) under the Children's Health Insur-
7 ance Program under such title XXI.

8 (B) COORDINATION.—The Secretary shall
9 coordinate the development and submission of
10 the report required under subparagraph (A)
11 with any other relevant Federal agency, as de-
12 termined by the Secretary.

13 (c) EDUCATION AND DISSEMINATION OF INFORMA-
14 TION WITH RESPECT TO UTERINE FIBROIDS.—

15 (1) UTERINE FIBROIDS PUBLIC EDUCATION
16 PROGRAM.—The Secretary shall develop and dis-
17 seminate to the public information regarding uterine
18 fibroids, including information on—

19 (A) the awareness, incidence, and preva-
20 lence of uterine fibroids among individuals, in-
21 cluding all minority individuals;

22 (B) the elevated risk for minority individ-
23 uals to develop uterine fibroids; and

24 (C) the availability, as medically appro-
25 priate, of the range of treatment options for

1 symptomatic uterine fibroids, including non-
2 hysterectomy treatments and procedures.

3 (2) DISSEMINATION OF INFORMATION.—The
4 Secretary may disseminate information under para-
5 graph (1) directly or through arrangements with
6 intra-agency initiatives, nonprofit organizations, con-
7 sumer groups, institutions of higher education (as
8 defined in section 101 of the Higher Education Act
9 of 1965 (20 U.S.C. 1001)), or Federal, State, or
10 local public private partnerships.

11 (3) AUTHORIZATION OF APPROPRIATIONS.—For
12 the purpose of carrying out this subsection, there
13 are authorized to be appropriated such sums as may
14 be necessary for each of fiscal years 2023 through
15 2027.

16 **Subtitle E—HIV/AIDS**

17 **SEC. 7201. STATEMENT OF POLICY.**

18 It is the policy of the United States to achieve an
19 AIDS-free generation, and to—

20 (1) expand access to lifesaving antiretroviral
21 therapy for people living with HIV and immediately
22 link people to continuous and coordinated high-qual-
23 ity care when they learn they are living with HIV;

24 (2) expand targeted efforts to prevent HIV in-
25 fection using a combination of effective, evidence-

1 based approaches, including routine HIV screening,
2 and universal access to HIV prevention tools, includ-
3 ing preexposure prophylaxis, in communities dis-
4 proportionately impacted by HIV, particularly com-
5 munities of color;

6 (3) ensure laws, policies, and regulations do not
7 impede access to prevention, treatment, and care for
8 people living with HIV or disproportionately im-
9 pacted by HIV;

10 (4) accelerate research for more efficacious HIV
11 prevention and treatments tools, a cure, and a vac-
12 cine; and

13 (5) respect the human rights and dignity of
14 persons living with HIV.

15 **SEC. 7202. FINDINGS.**

16 The Congress finds the following:

17 (1) Over 1,100,000 people are estimated to be
18 living with HIV in the United States according to
19 the Centers for Disease Control and Prevention, 14
20 percent of whom are unaware they are living with
21 HIV.

22 (2) The Centers for Disease Control and Pre-
23 vention estimates that, in 2019, there were approxi-
24 mately 34,800 people newly diagnosed with HIV.
25 New HIV infections declined 8 percent from 37,800

1 in 2015, after a period of general stability. From
2 2015 to 2019, new infections among young gay and
3 bisexual men (ages 13 to 24) dropped 33 percent
4 overall, with declines in young men of all races, but
5 African Americans, Hispanics, and Latinos continue
6 to be severely and disproportionately affected.

7 (3) HIV disproportionately affects certain popu-
8 lations in the United States. Though Blacks/African
9 Americans represent approximately 13 percent of
10 the population, they account for almost half (44 per-
11 cent) of all people living with HIV in the United
12 States. Black/African-American men who have sex
13 with men account for 26 percent of all new HIV in-
14 fections and have remained stable from 2010 to
15 2019.

16 (4) Disparities continue to exist among Latinos
17 and Hispanics; in 2019, Latinos and Hispanics
18 made up 18 percent of the United States population
19 and 30 percent of new infections.

20 (5) Though the rate of new infections among
21 American Indians and Alaska Natives (referred to in
22 this section as “AI/AN”) is proportional to their
23 population size, from 2015 to 2019, the annual
24 number of HIV diagnoses increased among Amer-
25 ican Indians and Alaska Natives.

1 (6) Asian Americans account for about 2 per-
2 cent of new HIV infections, but in 2013, 22 percent
3 were undiagnosed, the highest rate of undiagnosed
4 HIV among any race or ethnicity. Between 2010
5 and 2016, the number of Asian Americans receiving
6 an HIV diagnosis increased by 42 percent.

7 (7) The latest data from the Centers for Dis-
8 ease Control and Prevention indicates that new in-
9 fections among women remained stable for women in
10 2019.

11 (8) The history of HIV shows that culturally
12 relevant and gender-responsive supportive services,
13 including psychosocial support, treatment literacy,
14 case management, and transportation are necessary
15 strategies to reach and engage women and girls in
16 medical care.

17 (9) From 2015 through 2019 in the United
18 States and 6 dependent areas, the number of diag-
19 noses of HIV infection for transgender adults and
20 adolescents increased. In 2019, among transgender
21 adults and adolescents, the largest percentage (93
22 percent) of diagnoses of HIV infections was for
23 transgender male-to-female (MTF) people. By age,
24 in 2019, the largest percentage (24 percent) of diag-
25 noses of HIV infection among transgender persons

1 was for transgender MTF adults and adolescents
2 aged 20 to 24 years, followed by transgender MTF
3 adults and adolescents aged 25 to 29 years (23 per-
4 cent).

5 (10) Stigma and discrimination contribute to
6 such disparities.

7 (11) The Centers for Disease Control and Pre-
8 vention has determined that increasing the propor-
9 tion of people who know their HIV status is an es-
10 sential component of comprehensive HIV treatment
11 and prevention efforts and that early diagnosis is
12 critical in order for people with HIV to receive life-
13 extending therapy. Additionally, the Centers for Dis-
14 ease Control and Prevention recommends routine
15 HIV screening in health care settings for all patients
16 aged 13 to 64, regardless of risk.

17 (12) In 1998, Congress created the National
18 Minority AIDS Initiative to provide technical assist-
19 ance, build capacity, and strengthen outreach efforts
20 among local institutions and community-based orga-
21 nizations that serve racial and ethnic minorities liv-
22 ing with or vulnerable to HIV.

23 (13) To combat the HIV epidemic in the United
24 States, the National HIV/AIDS Strategy (referred
25 to in this section as “NHAS”) provides a framework

1 of increasing access to care, reducing new infections,
2 and eliminating HIV-related health disparities. The
3 vision of NHAS is “The United States will be a
4 place where new HIV infections are prevented, every
5 person knows their status, and every person with
6 HIV has high-quality care and treatment, lives free
7 from stigma and discrimination, and can achieve
8 their full potential for health and well-being across
9 the lifespan. This vision includes all people, regard-
10 less of age, sex, gender identity, sexual orientation,
11 race, ethnicity, religion, disability, geographic loca-
12 tion, or socioeconomic circumstance.”.

13 (14) In January 2019, the Department of
14 Health and Human Services began implementing the
15 initiative “Ending the HIV Epidemic: A Plan for
16 America”. The initiative seeks to reduce the number
17 of new HIV infections in the United States by 75
18 percent by 2025, and then by at least 90 percent by
19 2030, for an estimated 250,000 total HIV infection
20 averted.

21 (15) At present, many States and United
22 States territories have criminal statutes based on
23 “exposure” to HIV. Most of these laws were adopted
24 before the availability of effective antiretroviral
25 treatment for HIV/AIDS.

1 (16) Research shows that stable housing leads
2 to better health outcomes for those living with HIV.
3 Inadequate or unstable housing is not only a barrier
4 to effective treatment, but also increases the likeli-
5 hood of engaging in risky behaviors leading to HIV
6 infection. Insecure housing puts people with HIV/
7 AIDS at risk of premature death from exposure to
8 other diseases, poor nutrition, and lack of medical
9 care.

10 (17) Due to advances in treatment, many peo-
11 ple living with HIV today are living healthy lives and
12 have the ability and desire to fully participate in all
13 aspects of community life, including employment.
14 Research associates being employed with tremendous
15 economic, social, and health benefits for many people
16 living with HIV.

17 (18) Despite the tremendous progress made in
18 the treatment and prevention of HIV/AIDS, dis-
19 criminatory policies stemming from continued stig-
20 matization of HIV/AIDS and the LGBTQ+ commu-
21 nity continue to plague the scientific community.
22 This includes blood donation guidance updated by
23 Food and Drug Administration in 2020 that rec-
24 ommends a 3-month deferral policy for gay and bi-
25 sexual men before they are eligible to donate blood.

1 Health agencies in the United States must imple-
2 ment blood donation policies that are grounded in
3 science and that do not unfairly single out any
4 group of individuals.

5 (19) The common benefits associated with em-
6 ployment include income, autonomy, productivity,
7 status within society, daily structure, making a con-
8 tribution to one's community, and increased skills
9 and self-esteem. Research also indicates that many
10 people with disabilities, including people living with
11 HIV, report perceiving themselves as being less dis-
12 abled or not disabled at all, when working. Further-
13 more, some studies link working with better physical
14 and mental health outcomes for people living with
15 HIV when compared to those who are not working.
16 Preliminary data also suggest that transitioning to
17 employment is associated with reduced HIV-related
18 health risk behavior for many people.

19 (20) In July 2012, the Food and Drug Admin-
20 istration approved the first drug to be used as pre-
21 exposure prophylaxis (PrEP). PrEP reduces the risk
22 of HIV infection in HIV-negative individuals. Stud-
23 ies have shown that PrEP reduces HIV transmission
24 from sex by about 99 percent when taken consist-
25 ently. Despite increases in PrEP uptake, PrEP use

1 remains low among gay and bisexual men of color.
2 The Centers for Disease Control and Prevention
3 found that uptake was lower among African-Amer-
4 ican (26 percent) and Latino (30 percent) men com-
5 pared with White men (42 percent). Similarly, PrEP
6 awareness was lower among African-American (86
7 percent) and Latino (87 percent) men compared
8 with White men (95 percent). While clinical research
9 on transgender populations and PrEP is currently
10 limited, the Centers for Disease Control and Preven-
11 tion recommends PrEP use in transgender popu-
12 lations. In September 2019, the Food and Drug Ad-
13 ministration approved the second drug to be used as
14 PrEP.

15 (21) Syringe service programs have been associ-
16 ated with lowered HIV infections, lower hepatitis C
17 infections, and increased linkage to substance use
18 treatment.

19 (22) There is now conclusive scientific evidence
20 that a person living with HIV who is on
21 antiretroviral therapy and is durably virally sup-
22 pressed (defined as having a consistent viral load of
23 less than 200 copies/ml) does not sexually transmit
24 HIV. The conclusive evidence about the highly effec-
25 tive preventative benefits of antiretroviral therapy

1 provides an unprecedented opportunity to improve
2 the lives of people living with HIV, improve treat-
3 ment uptake and adherence, and advocate for ex-
4 panded access to treatment and care.

5 **SEC. 7203. ADDITIONAL FUNDING FOR AIDS DRUG ASSIST-**
6 **ANCE PROGRAM TREATMENTS.**

7 Section 2623 of the Public Health Service Act (42
8 U.S.C. 300ff–31b) is amended by adding at the end the
9 following:

10 “(c) ADDITIONAL FUNDING FOR AIDS DRUG AS-
11 SISTANCE PROGRAM TREATMENTS.—In addition to
12 amounts otherwise authorized to be appropriated for car-
13 rying out this subpart, there are authorized to be appro-
14 priated such sums as may be necessary to carry out sec-
15 tions 2612(b)(3)(B) and 2616 for each of fiscal years
16 2023 through 2026.”.

17 **SEC. 7204. ENHANCING THE NATIONAL HIV SURVEILLANCE**
18 **SYSTEM.**

19 (a) GRANTS.—The Secretary of Health and Human
20 Services, acting through the Director of the Centers for
21 Disease Control and Prevention, shall make grants to
22 States to support integration of public health surveillance
23 systems into all electronic health records in order to allow
24 rapid communications between the clinical setting and
25 health departments, by means that include—

1 (1) providing technical assistance and policy
2 guidance to State and local health departments, clin-
3 ical providers, and other agencies serving individuals
4 with HIV to improve the interoperability of data sys-
5 tems relevant to monitoring HIV care and sup-
6 portive services;

7 (2) capturing longitudinal data pertaining to
8 the initiation and ongoing prescription or dispensing
9 of antiretroviral therapy for individuals diagnosed
10 with HIV (such as through pharmacy-based report-
11 ing);

12 (3) obtaining information—

13 (A) on a voluntary basis, on sexual orienta-
14 tion and gender identity; and

15 (B) on sources of coverage (or the lack of
16 coverage) for medical treatment (including cov-
17 erage through the Medicaid program under title
18 XIX of the Social Security Act (42 U.S.C. 1396
19 et seq.), the Medicare program under title
20 XVIII of such Act (42 U.S.C. 1395 et seq.), the
21 program under title XXVI of the Public Health
22 Service Act (42 U.S.C. 300ff–11 et seq.); com-
23 monly referred to as the “Ryan White HIV/
24 AIDS Program”), other public funding, private

1 insurance, and health maintenance organiza-
2 tions); and

3 (4) obtaining and using current geographic
4 markers of residence (such as current address, zip
5 code, partial zip code, and census block).

6 (b) PRIVACY AND SECURITY SAFEGUARDS.—In car-
7 rying out this section, the Secretary of Health and Human
8 Services shall ensure that appropriate privacy and security
9 safeguards are met to prevent unauthorized disclosure of
10 protected health information and compliance with the
11 HIPAA privacy and security law (as defined in section
12 3009 of the Public Health Service Act (42 U.S.C. 300jj–
13 19)) and other relevant laws and regulations.

14 (c) PROHIBITION AGAINST IMPROPER USE OF
15 DATA.—No grant under this section may be used to allow
16 or facilitate the collection or use of surveillance or clinical
17 data or records—

18 (1) for punitive measures of any kind, civil or
19 criminal, against the subject of such data or records;
20 or

21 (2) for imposing any requirement or restriction
22 with respect to an individual without the individual's
23 written consent.

24 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
25 out this section, there are authorized to be appropriated

1 such sums as may be necessary for each of fiscal years
2 2023 through 2026.

3 **SEC. 7205. EVIDENCE-BASED STRATEGIES FOR IMPROVING**
4 **LINKAGE TO, AND RETENTION IN, APPRO-**
5 **PRIATE CARE.**

6 (a) STRATEGIES.—The Secretary of Health and
7 Human Services, in collaboration with the Director of the
8 Centers for Disease Control and Prevention, the Assistant
9 Secretary for Mental Health and Substance Use, the Di-
10 rector of the Office of AIDS Research, the Administrator
11 of the Health Resources and Services Administration, and
12 the Administrator of the Centers for Medicare & Medicaid
13 Services, shall—

14 (1) identify evidence-based strategies most ef-
15 fective at addressing the multifaceted issues that im-
16 pede disease status awareness with respect to HIV/
17 AIDS and linkage to, and retention in, appropriate
18 care, taking into consideration health care systems
19 issues, clinic and provider issues, and individual psy-
20 chosocial, environmental, and other contextual fac-
21 tors;

22 (2) support the wide-scale implementation of
23 the evidence-based strategies identified pursuant to
24 paragraph (1), including through incorporating such
25 strategies into health care coverage supported by the

1 Medicaid program under title XIX of the Social Se-
2 curity Act (42 U.S.C. 1396 et seq.), the program
3 under title XXVI of the Public Health Service Act
4 (42 U.S.C. 300ff–11 et seq.; commonly referred to
5 as the “Ryan White HIV/AIDS Program”), and
6 health plans purchased through an Exchange estab-
7 lished under title I of the Patient Protection and Af-
8 fordable Care Act (Public Law 111–148); and

9 (3) not later than 1 year after the date of the
10 enactment of this Act, submit a report to the Con-
11 gress on the status of activities under paragraphs
12 (1) and (2).

13 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
14 out this section, there are authorized to be appropriated
15 such sums as may be necessary for fiscal years 2023
16 through 2026.

17 **SEC. 7206. IMPROVING ENTRY INTO, AND RETENTION IN,**
18 **CARE AND ANTIRETROVIRAL ADHERENCE**
19 **FOR PERSONS WITH HIV.**

20 (a) SENSE OF CONGRESS.—It is the sense of Con-
21 gress that AIDS research has led to scientific advance-
22 ments that have—

23 (1) saved the lives of millions of people living
24 with HIV;

1 (2) prevented millions of individuals from re-
2 ceiving new diagnoses of HIV; and

3 (3) had broad benefits that extend far beyond
4 helping people at risk for, or living with, HIV.

5 (b) IN GENERAL.—The Secretary of Health and
6 Human Services, acting through the Director of the Na-
7 tional Institutes of Health, shall expand, intensify, and co-
8 ordinate operational and translational research and other
9 activities of the National Institutes of Health regarding
10 methods—

11 (1) to increase adoption of evidence-based ad-
12 herence strategies within HIV care and treatment
13 programs;

14 (2) to increase HIV testing and case detection
15 rates;

16 (3) to reduce HIV-related health disparities;

17 (4) to ensure that research to improve adher-
18 ence to HIV care and treatment programs address
19 the unique concerns of women;

20 (5) to integrate HIV prevention and care serv-
21 ices with mental health and substance use preven-
22 tion and treatment delivery systems;

23 (6) to increase knowledge on the implementa-
24 tion of preexposure prophylaxis (referred to in this
25 section as “PrEP”), including with respect to—

1311

1 (A) who can benefit most from PrEP;

2 (B) how to provide PrEP safely and effi-
3 ciently;

4 (C) how to integrate PrEP with other es-
5 sential prevention methods such as condoms;
6 and

7 (D) how to ensure high levels of adherence;
8 and

9 (7) to increase knowledge of “undetectable and
10 untransmittable”, when a person living with HIV
11 who is on antiretroviral therapy and is durably
12 virally suppressed (defined as having a consistent
13 viral load of less than 200 copies/ml) cannot sexually
14 transmit HIV.

15 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
16 out this section, there are authorized to be appropriated
17 such sums as may be necessary for fiscal years 2023
18 through 2026.

19 **SEC. 7207. SERVICES TO REDUCE HIV/AIDS IN RACIAL AND**
20 **ETHNIC MINORITY COMMUNITIES.**

21 (a) IN GENERAL.—For the purpose of reducing new
22 HIV diagnoses in racial and ethnic minority communities,
23 the Secretary of Health and Human Services, acting
24 through the Deputy Assistant Secretary for Minority

1 Health, may make grants to public health agencies and
2 faith-based organizations to conduct—

3 (1) outreach activities related to HIV preven-
4 tion and testing activities;

5 (2) HIV prevention activities;

6 (3) HIV testing activities; and

7 (4) public health education campaigns on ac-
8 cessing HIV prevention medication.

9 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
10 out this section, there are authorized to be appropriated
11 such sums as may be necessary for fiscal years 2023
12 through 2026.

13 **SEC. 7208. MINORITY AIDS INITIATIVE.**

14 (a) EXPANDED FUNDING.—The Secretary of Health
15 and Human Services, in collaboration with the Deputy As-
16 sistant Secretary for Minority Health, the Director of the
17 Centers for Disease Control and Prevention, the Adminis-
18 trator of the Health Resources and Services Administra-
19 tion, and the Assistant Secretary for Mental Health and
20 Substance Use, shall provide funds and carry out activities
21 to expand the Minority AIDS Initiative.

22 (b) USE OF FUNDS.—The additional funds made
23 available under this section may be used, through the Mi-
24 nority AIDS Initiative, to support the following activities:

1 (1) Providing technical assistance and infra-
2 structure support to reduce HIV/AIDS in minority
3 populations.

4 (2) Increasing minority populations' access to
5 HIV prevention and care services.

6 (3) Building strong community programs and
7 partnerships to address HIV prevention and the
8 health care needs of specific racial and ethnic minor-
9 ity populations.

10 (c) PRIORITY INTERVENTIONS.—Within the racial
11 and ethnic minority populations referred to in subsection
12 (b), priority in conducting intervention services shall be
13 given to—

14 (1) men who have sex with men;

15 (2) youth;

16 (3) persons who engage in intravenous drug
17 abuse;

18 (4) women;

19 (5) homeless individuals;

20 (6) individuals incarcerated or in the penal sys-
21 tem;

22 (7) transgender individuals; and

23 (8) nonbinary individuals

24 (d) AUTHORIZATION OF APPROPRIATIONS.—For car-
25 rying out this section, there are authorized to be appro-

1 priated \$610,000,000 for fiscal year 2023 and such sums
2 as may be necessary for each of fiscal years 2024 through
3 2027.

4 **SEC. 7209. HEALTH CARE PROFESSIONALS TREATING INDIVIDUALS WITH HIV.**
5

6 (a) IN GENERAL.—The Secretary of Health and
7 Human Services, acting through the Administrator of the
8 Health Resources and Services Administration, shall ex-
9 pand, intensify, and coordinate workforce initiatives of the
10 Health Resources and Services Administration to increase
11 the capacity of the health workforce focusing primarily on
12 HIV to meet the demand for culturally competent care,
13 and may award grants for any of the following:

14 (1) Development of curricula for training pri-
15 mary care providers in HIV/AIDS prevention and
16 care, including routine HIV testing.

17 (2) Support to expand access to culturally and
18 linguistically accessible benefits counselors, trained
19 peer navigators, and mental and behavioral health
20 professionals with expertise in HIV.

21 (3) Training health care professionals to pro-
22 vide care to individuals living with HIV.

23 (4) Development by grant recipients under title
24 XXVI of the Public Health Service Act (42 U.S.C.
25 300ff–11 et seq.; commonly referred to as the “Ryan

1 White HIV/AIDS Program”) and other persons, of
2 policies for providing culturally relevant and sen-
3 sitive treatment to individuals living with HIV, with
4 particular emphasis on treatment to racial and eth-
5 nic minorities, men who have sex with men, and
6 women, young people, and children living with HIV.

7 (5) Development and implementation of pro-
8 grams to increase the use of telehealth to respond to
9 HIV-specific health care needs in rural and minority
10 communities, with particular emphasis given to
11 medically underserved communities and insular
12 areas.

13 (6) Evaluating interdisciplinary medical pro-
14 vider care team models that promote high-quality
15 care, with particular emphasis on care to racial and
16 ethnic minorities.

17 (7) Training health care professionals to make
18 them aware of the high rates of chronic hepatitis B
19 and chronic hepatitis C in adult racial and ethnic
20 minority populations, and the importance of preven-
21 tion, detection, and medical management of hepatitis
22 B and hepatitis C and of liver cancer screening.

23 (8) Development of curricula for training pri-
24 mary care providers that HIV and tuberculosis are
25 significant mutual comorbidities, and that a patient

1 who tests positive for one disease should be offered
2 and encouraged to receive testing for the other.

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2023 through 2026.

7 SEC. 7210. HIV/AIDS PROVIDER LOAN REPAYMENT PRO-
8 GRAM.

9 (a) IN GENERAL.—The Secretary may enter into an
10 agreement with any physician, nurse practitioner, or phy-
11 sician 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

18 (B) in an area with a high incidence of
19 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.

1 (b) MANNER OF PAYMENTS.—The payments de-
2 scribed in subsection (a) shall be made by the Secretary
3 as follows:

4 (1) Upon completion by the physician, nurse
5 practitioner, or physician assistant for whom the
6 payments are to be made of the first year of the
7 service specified in the agreement entered into with
8 the Secretary under subsection (a), the Secretary
9 shall pay 30 percent of the principal of and the in-
10 terest on the individual's professional education
11 loans.

12 (2) Upon completion by the physician, nurse
13 practitioner, or physician assistant of the second
14 year of such service, the Secretary shall pay another
15 30 percent of the principal of and the interest on
16 such loans.

17 (3) Upon completion by that individual of a
18 third year of such service, the Secretary shall pay
19 another 25 percent of the principal of and the inter-
20 est on such loans.

21 (c) APPLICABILITY OF CERTAIN PROVISIONS.—Sub-
22 part III of part D of title III of the Public Health Service
23 Act (42 U.S.C. 254l et seq.) shall, except as inconsistent
24 with this section, apply to the program carried out under
25 this section in the same manner and to the same extent

1 as such provisions apply to the National Health Service
2 Corps loan repayment program.

3 (d) REPORTS.—Not later than 18 months after the
4 date of the enactment of this Act, and annually thereafter,
5 the Secretary shall prepare and submit to Congress a re-
6 port describing the program carried out under this section,
7 including statements regarding the following:

8 (1) The number of physicians, nurse practi-
9 tioners, and physician assistants enrolled in the pro-
10 gram.

11 (2) The number and amount of loan repay-
12 ments provided through the program.

13 (3) The placement location of loan repayment
14 recipients at facilities described in subsection (a)(1).

15 (4) The default rate on such loans and actions
16 required.

17 (5) The amount of outstanding default funds
18 with respect to such loans.

19 (6) To the extent that it can be determined, the
20 reason for the default on such a loan.

21 (7) The demographics of individuals partici-
22 pating in the program.

23 (8) An evaluation of the overall costs and bene-
24 fits of the program.

25 (e) DEFINITIONS.—In this section:

1 (1) HIV/AIDS.—The term “HIV/AIDS” means
2 human immunodeficiency virus and acquired im-
3 mune deficiency syndrome.

4 (2) NURSE PRACTITIONER.—The term “nurse
5 practitioner” means a registered nurse who has com-
6 pleted an accredited graduate degree program in ad-
7 vanced nurse practice and has successfully passed a
8 national certification exam.

9 (3) PHYSICIAN.—The term “physician” means
10 a graduate of a school of medicine who has com-
11 pleted postgraduate training in general or pediatric
12 medicine.

13 (4) PHYSICIAN ASSISTANT.—The term “physi-
14 cian assistant” means a medical provider who com-
15 pleted an accredited physician assistant training pro-
16 gram and successfully passed the Physician Assist-
17 ant National Certifying Examination.

18 (5) PROFESSIONAL EDUCATION LOAN.—The
19 term “professional education loan”—

20 (A) means a loan that is incurred for the
21 cost of attendance (including tuition, other rea-
22 sonable educational expenses, and reasonable
23 living costs) at a school of medicine, school of
24 nursing, or physician assistant training pro-
25 gram; and

1 (B) includes only the portion of the loan
2 that is outstanding on the date the physician,
3 nurse practitioner, or physician assistant in-
4 volved begins the service specified in the agree-
5 ment under subsection (a).

6 (6) RYAN WHITE-FUNDED.—The term “Ryan
7 White-funded” means, with respect to a facility, re-
8 ceiving funds under title XXVI of the Public Health
9 Service Act (42 U.S.C. 300ff–11 et seq.).

10 (7) SECRETARY.—The term “Secretary” means
11 the Secretary of Health and Human Services.

12 (8) SCHOOL OF MEDICINE.—The term “school
13 of medicine” has the meaning given to that term in
14 section 799B of the Public Health Service Act (42
15 U.S.C. 295p).

16 (9) TITLE X-FUNDED.—The term “title X-fund-
17 ed” means, with respect to a facility, receiving funds
18 under title X of the Public Health Service Act (42
19 U.S.C. 300 et seq.).

20 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
21 out this section, there are authorized to be appropriated
22 such sums as may be necessary for fiscal years 2023
23 through 2026.

1 **SEC. 7211. DENTAL EDUCATION LOAN REPAYMENT PRO-**
2 **GRAM.**

3 (a) IN GENERAL.—The Secretary may enter into an
4 agreement with any dentist under which—

5 (1) the dentist agrees to serve as a dentist for
6 a period of not less than 2 years at a facility with
7 a critical shortage of dentists (as determined by the
8 Secretary) in an area with a high incidence of HIV/
9 AIDS; and

10 (2) the Secretary agrees to make payments in
11 accordance with subsection (b) on the dental edu-
12 cation loans of the dentist.

13 (b) MANNER OF PAYMENTS.—The payments de-
14 scribed in subsection (a) shall be made by the Secretary
15 as follows:

16 (1) Upon completion by the dentist for whom
17 the payments are to be made of the first year of the
18 service specified in the agreement entered into with
19 the Secretary under subsection (a), the Secretary
20 shall pay 30 percent of the principal of and the in-
21 terest on the dental education loans of the dentist.

22 (2) Upon completion by the dentist of the sec-
23 ond year of such service, the Secretary shall pay an-
24 other 30 percent of the principal of and the interest
25 on such loans.

1 (3) Upon completion by that individual of a
2 third year of such service, the Secretary shall pay
3 another 25 percent of the principal of and the inter-
4 est on such loans.

5 (c) APPLICABILITY OF CERTAIN PROVISIONS.—Sub-
6 part III of part D of title III of the Public Health Service
7 Act (42 U.S.C. 254l et seq.) shall, except as inconsistent
8 with this section, apply to the program carried out under
9 this section in the same manner and to the same extent
10 as such provisions apply to the National Health Service
11 Corps Loan Repayment Program.

12 (d) REPORTS.—Not later than 18 months after the
13 date of the enactment of this Act, and annually thereafter,
14 the Secretary shall prepare and submit to the Congress
15 a report describing the program carried out under this sec-
16 tion, including statements regarding the following:

17 (1) The number of dentists enrolled in the pro-
18 gram.

19 (2) The number and amount of loan repay-
20 ments provided through the program.

21 (3) The placement location of loan repayment
22 recipients at facilities described in subsection (a)(1).

23 (4) The default rate on such loans and actions
24 required.

1 (5) The amount of outstanding default funds
2 with respect to such loans.

3 (6) To the extent that it can be determined, the
4 reason for the default on such a loan.

5 (7) The demographics of individuals partici-
6 pating in the program.

7 (8) An evaluation of the overall costs and bene-
8 fits of the program.

9 (e) DEFINITIONS.—In this section:

10 (1) DENTAL EDUCATION LOAN.—The term
11 “dental education loan”—

12 (A) means a loan that is incurred for the
13 cost of attendance (including tuition, other rea-
14 sonable educational expenses, and reasonable
15 living costs) at a school of dentistry; and

16 (B) includes only the portion of the loan
17 that is outstanding on the date the dentist in-
18 volved begins the service specified in the agree-
19 ment under subsection (a).

20 (2) DENTIST.—The term “dentist” means a
21 graduate of a school of dentistry who has completed
22 postgraduate training in general or pediatric den-
23 tistry.

1 (3) HIV/AIDS.—The term “HIV/AIDS” means
2 human immunodeficiency virus and acquired im-
3 mune deficiency syndrome.

4 (4) SCHOOL OF DENTISTRY.—The term “school
5 of dentistry” has the meaning given to that term in
6 section 799B of the Public Health Service Act (42
7 U.S.C. 295p).

8 (5) SECRETARY.—The term “Secretary” means
9 the Secretary of Health and Human Services.

10 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
11 out this section, there are authorized to be appropriated
12 such sums as may be necessary for each of fiscal years
13 2023 through 2026.

14 **SEC. 7212. REDUCING NEW HIV INFECTIONS AMONG IN-**
15 **JECTING DRUG USERS.**

16 (a) SENSE OF CONGRESS.—It is the sense of Con-
17 gress that providing sterile syringes and sterilized equip-
18 ment to injecting drug users substantially reduces risk of
19 HIV infection, increases the probability that they will ini-
20 tiate drug treatment, and does not increase drug use.

21 (b) IN GENERAL.—The Secretary of Health and
22 Human Services may provide grants and technical assist-
23 ance for the purpose of reducing the rate of HIV infections
24 among injecting drug users through a comprehensive
25 package of services for such users, including the provision

1 of sterile syringes, education and outreach, access to infec-
2 tious disease testing, overdose prevention, and treatment
3 for drug dependence.

4 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
5 out this section, there are authorized to be appropriated
6 such sums as may be necessary for fiscal years 2023
7 through 2026.

8 **SEC. 7213. REPORT ON IMPACT OF HIV/AIDS IN VULNER-**
9 **ABLE POPULATIONS.**

10 (a) IN GENERAL.—The Secretary of Health and
11 Human Services shall submit to Congress and the Presi-
12 dent an annual report on the impact of HIV/AIDS for
13 racial and ethnic minority communities, women, and youth
14 aged 24 and younger.

15 (b) CONTENTS.—The report under subsection (a)
16 shall include information on the—

17 (1) progress that has been made in reducing
18 the impact of HIV/AIDS in such communities;

19 (2) opportunities that exist to make additional
20 progress in reducing the impact of HIV/AIDS in
21 such communities;

22 (3) challenges that may impede such additional
23 progress; and

1 (4) Federal funding necessary to achieve sub-
2 stantial reductions in HIV/AIDS in racial and ethnic
3 minority communities.

4 **SEC. 7214. NATIONAL HIV/AIDS OBSERVANCE DAYS.**

5 (a) NATIONAL OBSERVANCE DAYS.—It is the sense
6 of Congress that national observance days highlighting the
7 impact of HIV on communities of color include the fol-
8 lowing:

9 (1) National Black HIV/AIDS Awareness Day.

10 (2) National Latino AIDS Awareness Day.

11 (3) National Asian and Pacific Islander HIV/
12 AIDS Awareness Day.

13 (4) National Native American HIV/AIDS
14 Awareness Day.

15 (5) National Youth HIV/AIDS Awareness Day.

16 (b) CALL TO ACTION.—It is the sense of Congress
17 that the President should call on members of communities
18 of color—

19 (1) to become involved at the local community
20 level in HIV testing, policy, and advocacy;

21 (2) to become aware, engaged, and empowered
22 on the HIV epidemic within their communities; and

23 (3) to urge members of their communities to re-
24 duce risk factors, practice safe sex and other preven-

1 tive measures, be tested for HIV, and seek care
2 when appropriate.

3 **SEC. 7215. REVIEW OF ALL FEDERAL AND STATE LAWS,**
4 **POLICIES, AND REGULATIONS REGARDING**
5 **THE CRIMINAL PROSECUTION OF INDIVID-**
6 **UALS FOR HIV-RELATED OFFENSES.**

7 (a) FINDINGS.—Congress makes the following find-
8 ings:

9 (1) At present, 32 States and 2 United States
10 territories have criminal statutes based on perceived
11 exposure to HIV, rather than behaviors motivated by
12 an intent to harm, presenting a significant risk of
13 transmission and resulting in actual transmission of
14 HIV to another. 11 States have HIV-specific laws
15 that make spitting or biting a felony, even though it
16 is not possible to transmit HIV via saliva. 24 States
17 require persons who are aware that they have HIV
18 to disclose their status to sexual partners, regardless
19 of whether they are noninfectious. 14 of these 24
20 States also require disclosure to needle-sharing part-
21 ners. 25 States criminalize 1 or more behaviors that
22 pose a low or negligible risk for HIV transmission.

23 (2) HIV-specific criminal laws are classified as
24 felonies in 28 States. In 3 States, a person's expo-
25 sure to another to HIV does not subject the person

1 to criminal prosecution for that act alone but may
2 result in a sentence enhancement. 18 States impose
3 sentences of up to 10 years per violation, 7 States
4 impose sentences between 11 and 20 years, and 5
5 States impose sentences of greater than 20 years.

6 (3) When members of the Armed Forces ac-
7 quire HIV, they are issued orders that require them
8 to disclose and use a condom under all cir-
9 cumstances, including when the known risk of trans-
10 mission is 0. Failure to disclose can result in pros-
11 ecution under the Uniform Code of Military Justice
12 (UCMJ).

13 (4) The number of prosecutions, arrests, and
14 instances where HIV-based charges are used to in-
15 duce plea agreements is unknown. Because State-
16 level prosecution and arrest data are not readily
17 available in any national legal database, the societal
18 impact of these laws may be underestimated, and
19 most cases that go to trial are not reduced to writ-
20 ten, published opinions.

21 (5) State and Federal criminal law does not
22 currently reflect the 4 decades of medical advances
23 and discoveries made with regard to transmission
24 and treatment of HIV/AIDS.

1 (6) According to the CDC, correct and con-
2 sistent male or female condom use, or adherence to
3 a preexposure prophylaxis (PrEP) regimen that re-
4 sults in viral suppression, are very effective in pre-
5 venting HIV transmission. However, most State
6 HIV-specific laws and prosecutions do not treat the
7 use of a condom during sexual intercourse or adher-
8 ence to PrEP as a mitigating factor or evidence that
9 the defendant did not intend to transmit HIV.

10 (7) Criminal laws and prosecutions do not take
11 into account the benefits of effective antiretroviral
12 medications, which suppress the virus to extremely
13 low levels and further reduce the already low risk of
14 transmitting HIV to near 0.

15 (8) In addition to HIV-specific criminal laws,
16 general criminal laws are often misused to prosecute
17 people based on their HIV status. Although HIV,
18 and even AIDS, currently is viewed as a treatable,
19 chronic, medical condition, people living with HIV
20 have been charged under aggravated assault, at-
21 tempted murder, and even bioterrorism statutes be-
22 cause prosecutors, courts, and legislators continue to
23 view and characterize the blood, semen, and saliva of
24 people living with HIV as a “deadly weapon”.

1 (9) Multiple peer-reviewed studies demonstrate
2 that HIV-specific laws do not reduce risk-taking be-
3 havior or increase disclosure by people living with or
4 at risk of HIV, and there is increasing evidence that
5 these laws reduce the willingness to get tested. Fur-
6 thermore, placing legal responsibility for preventing
7 the transmission of HIV and other pathogens that
8 can be sexually transmitted exclusively on people di-
9 agnosed with a sexually transmitted infection under-
10 mines the public health message that all people are
11 responsible for practicing behaviors that protect
12 themselves from HIV and other sexually transmitted
13 infections. Unfortunately, some State laws that cre-
14 ate an expectation of disclosure work against public
15 health communication and discourage risk-reduction
16 measures that could prevent transmission as a result
17 of those who are acutely infected and unaware of
18 their status.

19 (10) The identity of an individual subject to an
20 HIV-based prosecution is broadcast through media
21 reports, potentially destroying employment opportu-
22 nities and relationships and violating the person's
23 right to privacy.

24 (11) Individuals who are convicted after an
25 HIV-based prosecution often must register as sex of-

1 fenders, even in cases involving consensual sexual
2 activity. Their employability is destroyed, and their
3 family relationships are fractured.

4 (12) The United Nations, including the Joint
5 United Nations Programme on HIV/AIDS
6 (UNAIDS), urges governments to “limit criminaliza-
7 tion to cases of intentional transmission”. This re-
8 quirement would limit prosecutions to situations
9 “where a person knows his or her HIV-positive sta-
10 tus, acts with the intention to transmit HIV, and
11 does in fact transmit it”. UNAIDS also recommends
12 that criminal law should not be applied to cases
13 where there is no significant risk of transmission.

14 (13) In 2010, the Federal Government released
15 the first ever National HIV/AIDS Strategy (NHAS),
16 which addressed HIV-specific criminal laws, stating:
17 “While we understand the intent behind these laws,
18 they may not have the desired effect and they may
19 make people less willing to disclose their status by
20 making people feel at even greater risk of discrimi-
21 nation. In some cases, it may be appropriate for leg-
22 islators to reconsider whether existing laws continue
23 to further the public interest and public health. In
24 many instances, the continued existence and enforce-
25 ment of these types of laws run counter to scientific

1 evidence about routes of HIV transmission and may
2 undermine the public health goals of promoting HIV
3 screening and treatment.”. The NHAS also states
4 that State legislatures should consider reviewing
5 HIV-specific criminal statutes to ensure that they
6 are consistent with current knowledge of HIV trans-
7 mission and support public health approaches to pre-
8 venting and treating HIV.

9 (14) The Global Commission on HIV and the
10 Law was launched in June 2010 to examine laws
11 and practices that criminalize people living with and
12 vulnerable to HIV and to develop evidence-based rec-
13 ommendations for effective HIV responses. The
14 Commission calls for “governments, civil society and
15 international bodies to repeal punitive laws and
16 enact laws that facilitate and enable effective re-
17 sponses to HIV prevention, care and treatment serv-
18 ices for all who need them”. The Commission rec-
19 ommends against the enactment of “laws that ex-
20 plicitly criminalize HIV transmission, exposure or
21 non-disclosure of HIV status, which are counter-
22 productive”.

23 (15) In February 2019, the Department of
24 Health and Human Services (HHS) launched “End-
25 ing the HIV Epidemic: A Plan for America”, a new

1 initiative with an ambitious goal to end the domestic
2 HIV epidemic in 10 years by reducing new cases of
3 HIV by 75 percent by 2025 and by 90 percent by
4 2030. In this plan, HHS notes that stigma “can be
5 a debilitating barrier preventing people living with,
6 or at risk for, HIV from receiving the health care,
7 services, and respect they need and deserve”. Many
8 of the States and jurisdictions identified as a pri-
9 ority for the first 5 years of the plan have stigma-
10 based criminal statutes for perceived exposure to
11 HIV. These statutes run counter to the goals of this
12 new initiative and stand in the way of ending the do-
13 mestic HIV epidemic.

14 (b) SENSE OF CONGRESS REGARDING LAWS OR REG-
15 ULATIONS DIRECTED AT PEOPLE LIVING WITH HIV.—
16 It is the sense of Congress that Federal and State laws,
17 policies, and regulations regarding people living with
18 HIV—

19 (1) should not place unique or additional bur-
20 dens on such individuals solely as a result of their
21 HIV status; and

22 (2) should instead demonstrate a public health-
23 oriented, evidence-based, medically accurate, and
24 contemporary understanding of—

1 (A) the multiple factors that lead to HIV
2 transmission;

3 (B) the relative risk of demonstrated HIV
4 transmission routes;

5 (C) the current health implications of liv-
6 ing with HIV;

7 (D) the associated benefits of treatment
8 and support services for people living with HIV;
9 and

10 (E) the impact of punitive HIV-specific
11 laws, policies, regulations, and judicial prece-
12 dents and decisions on public health, on people
13 living with or affected by HIV, and on their
14 families and communities.

15 (c) REVIEW OF FEDERAL AND STATE LAWS.—

16 (1) REVIEW OF FEDERAL AND STATE LAWS.—

17 (A) IN GENERAL.—Not later than 90 days
18 after the date of the enactment of this Act, the
19 Attorney General, the Secretary of Health and
20 Human Services, and the Secretary of Defense
21 acting jointly (in this section referred to as the
22 “designated officials”) shall initiate a national
23 review of Federal and State laws, including the
24 Uniform Code of Military Justice (referred to in
25 this section as the “UCMJ”), policies, regula-

tions, and judicial precedents and decisions regarding criminal and related civil commitment cases involving people living with HIV/AIDS.

(B) CONSULTATION.—In carrying out the review under subparagraph (A), the designated officials shall seek to include diverse participation from, and consultation with, each of the following:

9 (i) Each State.

10 (ii) State attorneys general (or their
11 representatives).

(iii) State public health officials (or their representatives).

(iv) State judicial and court system officers, including judges, district attorneys, prosecutors, defense attorneys, law enforcement, and correctional officers.

(v) Members of the United States
Armed Forces, including members of other
Federal services subject to the UCMJ.

(vi) People living with HIV/AIDS, particularly those who have been subject to HIV-related prosecution or who are from minority communities whose members have

1 been disproportionately subject to HIV-
2 specific arrests and prosecution.

3 (vii) Legal advocacy and HIV/AIDS
4 service organizations that work with people
5 living with HIV/AIDS.

6 (viii) Nongovernmental health organi-
7 zations that work on behalf of people living
8 with HIV/AIDS, including syringe services
9 programs, LGBTQ-focused health organi-
10 zations, and organizations who serve peo-
11 ple who engage in sex work.

12 (ix) Trade organizations or associa-
13 tions representing persons or entities de-
14 scribed in clauses (i) through (vii).

15 (C) RELATION TO OTHER REVIEWS.—In
16 carrying out the review under subparagraph
17 (A), the designated officials may utilize other
18 existing reviews of criminal and related civil
19 commitment cases involving people living with
20 HIV, including any such review conducted by
21 any Federal or State agency or any public
22 health, legal advocacy, or trade organization or
23 association if the designated officials determines
24 that such reviews were conducted in accordance
25 with the principles set forth in subsection (b).

(2) REPORT.—Not later than 180 days after initiating the review required under 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 UCMJ, a summary of the relevant laws, policies, regulations, and judicial precedents and decisions regarding criminal cases involving people living with HIV, including the following:

(i) A determination of whether such laws, policies, regulations, and judicial precedents and decisions place any unique or additional burdens upon people living with HIV.

(ii) A determination of whether such laws, policies, regulations, and judicial precedents and decisions demonstrate a public health-oriented, evidence-based, medically accurate, and contemporary understanding of—

(I) the multiple factors that lead to HIV transmission;

(II) the relative risk of HIV transmission routes, including that a

1 person that has an undetectable viral
2 load cannot transmit HIV;

3 (III) the current health implica-
4 tions of living with HIV, including
5 data disaggregated by race and eth-
6 nicity;

7 (IV) the current status of pro-
8 viding protection to people who en-
9 gage in survival sex work against
10 whom condom possession has been
11 used as evidence of intent to commit
12 a crime;

13 (V) States that have the classi-
14 fication of mandatory sex offenders;

15 (VI) the associated benefits of
16 treatment and support services for
17 people living with HIV; and

18 (VII) the impact of punitive
19 HIV-specific laws and policies on pub-
20 lic health, on people living with or af-
21 fected by HIV, and on their families
22 and communities, including people
23 who are in abusive, dependent, violent,
24 or nonconsensual relationships and

1 are unable to both negotiate the use
2 of condoms and status disclosure.

3 (iii) An analysis of the public health
4 and legal implications of such laws, poli-
5 cies, regulations, and judicial precedents
6 and decisions, including an analysis of the
7 consequences of having a similar penal
8 scheme applied to comparable situations
9 involving other communicable diseases.

10 (iv) An analysis of the proportionality
11 of punishments imposed under HIV-spe-
12 cific laws, policies, regulations, and judicial
13 precedents, taking into consideration pen-
14 alties attached to violation of State laws
15 against similar degrees of endangerment or
16 harm, such as driving while intoxicated or
17 transmission of other communicable dis-
18 eases, or more serious harms, such as ve-
19 hicular manslaughter offenses.

20 (B) An analysis of common elements
21 shared between State laws, policies, regulations,
22 and judicial precedents.

23 (C) A set of best practice recommendations
24 directed to State governments, including State
25 attorneys general, public health officials, and

1 judicial officers, in order to ensure that laws,
2 policies, regulations, and judicial precedents re-
3 garding people living with HIV are in accord-
4 ance with the principles set forth in subsection
5 (b).

6 (D) Recommendations for adjustments to
7 the UCMJ, including discontinuing the use of a
8 service member's HIV diagnosis as the basis for
9 prosecution, enhanced penalties, or discharge
10 from military service, in order to ensure that
11 laws, policies, regulations, and judicial prece-
12 dents regarding people living with HIV are in
13 accordance with the principles set forth in sub-
14 section (b). Such recommendations should in-
15 clude any necessary and appropriate changes to
16 “Orders to Follow Preventative Medicine Re-
17 quirements”.

18 (3) GUIDANCE.—Not later than 90 days after
19 the date of the release of the report required by
20 paragraph (2), the Attorney General and the Sec-
21 retary of Health and Human Services shall jointly
22 develop and publicly release updated guidance for
23 States based on the set of best practice rec-
24 ommendations required under paragraph (2)(C) in
25 order to assist States dealing with criminal and re-

1 lated civil commitment cases regarding people living
2 with HIV.

3 (4) MONITORING AND EVALUATION SYSTEM.—

4 Not later than 60 days after the date of the release
5 of the guidance required under paragraph (3), the
6 Attorney General and the Secretary of Health and
7 Human Services shall jointly establish an integrated
8 monitoring and evaluation system that includes,
9 where appropriate, objective and quantifiable per-
10 formance goals and indicators to measure progress
11 toward statewide implementation in each State of
12 the best practice recommendations required under
13 paragraph (2)(C).

14 (5) MODERNIZATION OF FEDERAL LAWS, POLI-
15 CIES, AND REGULATIONS.—Not later than 90 days
16 after the date of the release of the report required
17 under paragraph (2), the designated officials shall
18 develop and transmit to the President and the Con-
19 gress, and make publicly available, such proposals as
20 may be necessary to implement adjustments to Fed-
21 eral laws, policies, or regulations, including the
22 UCMJ, based on the recommendations required
23 under paragraph (2)(D), either through Executive
24 order or through changes to statutory law.

1 (d) RULE OF CONSTRUCTION.—Nothing in this sec-
2 tion shall be construed to discourage the prosecution of
3 individuals who intentionally transmit or attempt to trans-
4 mit HIV to another individual.

5 (e) NO ADDITIONAL APPROPRIATIONS AUTHOR-
6 IZED.—This section shall not be construed to increase the
7 amount of appropriations that are authorized to be appro-
8 priated for any fiscal year.

9 **SEC. 7216. EXPANDING SUPPORT FOR CONDOMS IN PRIS-**
10 **ONS.**

11 (a) SENSE OF CONGRESS REGARDING DISTRIBUTION
12 OF SEXUAL BARRIER PROTECTION DEVICES IN STATE
13 PRISON SYSTEMS.—It is the sense of the Congress that
14 States shall allow for the legal distribution of sexual bar-
15 rier protection devices in State correctional facilities to re-
16 duce the prevalence and spread of STIs in those facilities.

17 (b) AUTHORITY TO ALLOW COMMUNITY ORGANIZA-
18 TIONS TO PROVIDE STI COUNSELING, STI PREVENTION
19 EDUCATION, AND SEXUAL BARRIER PROTECTION DE-
20 VICES IN FEDERAL CORRECTIONAL FACILITIES.—

21 (1) DIRECTIVE TO ATTORNEY GENERAL.—Not
22 later than 30 days after the date of enactment of
23 this Act, the Attorney General shall direct the Direc-
24 tor of the Bureau of Prisons to allow community or-
25 ganizations to, in accordance with all relevant Fed-

1 eral laws and regulations that govern visitation in
2 Federal correctional facilities—

3 (A) distribute sexual barrier protection de-
4 vices in Federal correctional facilities; and

5 (B) engage in STI counseling and STI pre-
6 vention education in Federal correctional facili-
7 ties.

8 (2) INFORMATION REQUIREMENT.—Any com-
9 munity organization permitted to distribute sexual
10 barrier protection devices under paragraph (1) shall
11 ensure that the individuals to whom the devices are
12 distributed are informed about the proper use and
13 disposal of sexual barrier protection devices in ac-
14 cordance with established public health practices.
15 Any community organization conducting STI coun-
16 seling or STI prevention education under paragraph
17 (1) shall offer comprehensive sexuality education.

18 (3) POSSESSION OF DEVICE PROTECTED.—A
19 Federal correctional facility may not, because of the
20 possession or use of a sexual barrier protection de-
21 vice—

22 (A) take adverse action against an incar-
23 cerated individual; or

24 (B) consider possession or use as evidence
25 of prohibited activity for the purpose of any

1 Federal correctional facility administrative pro-
2 ceeding.

3 (4) IMPLEMENTATION.—The Attorney General
4 and the Director of the Bureau of Prisons shall im-
5 plement this section according to established public
6 health practices in a manner that protects the
7 health, safety, and privacy of incarcerated individ-
8 uals and of correctional facility staff.

9 (c) SURVEY OF AND REPORT ON CORRECTIONAL FA-
10 CILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF
11 STIs.—

12 (1) SURVEY.—Not later than 180 days after
13 the date of enactment of this Act, and annually
14 thereafter for 5 years, the Attorney General, after
15 consulting with the Secretary of Health and Human
16 Services, State officials, and community organiza-
17 tions, shall, to the maximum extent practicable, con-
18 duct a survey of all Federal and State correctional
19 facilities, to determine the following:

20 (A) COUNSELING, TREATMENT, AND SUP-
21 PORTIVE SERVICES.—Whether the correctional
22 facility—

23 (i) requires incarcerated individuals to
24 participate in counseling, treatment, and
25 supportive services related to STIs; or

1 (ii) offers such programs to incarcer-
2 ated individuals.

3 (B) ACCESS TO SEXUAL BARRIER PROTEC-
4 TION DEVICES.—Whether incarcerated individ-
5 uals can—

6 (i) possess sexual barrier protection
7 devices;

8 (ii) purchase sexual barrier protection
9 devices;

10 (iii) purchase sexual barrier protection
11 devices at a reduced cost; or

12 (iv) obtain sexual barrier protection
13 devices without cost.

14 (C) INCIDENCE OF SEXUAL VIOLENCE.—
15 The incidence of sexual violence and assault
16 committed by incarcerated individuals and by
17 correctional facility staff.

18 (D) PREVENTION EDUCATION OFFERED.—
19 The type of prevention education, information,
20 or training offered to incarcerated individuals
21 and correctional facility staff regarding sexual
22 violence and the spread of STIs, including
23 whether such education, information, or train-
24 ing—

1 (i) constitutes comprehensive sexuality
2 education;

3 (ii) is compulsory for new incarcerated
4 individuals and for new correctional facility
5 staff; and

6 (iii) is offered on an ongoing basis.

7 (E) STI TESTING.—Whether the correc-
8 tional facility tests incarcerated individuals for
9 STIs or gives them the option to undergo such
10 testing—

11 (i) at intake;

12 (ii) on a regular basis; and

13 (iii) prior to release.

14 (F) STI TEST RESULTS.—The number of
15 incarcerated individuals who are tested for STIs
16 and the outcome of such tests at each correc-
17 tional facility, disaggregated to include results
18 for—

19 (i) the type of STI tested for;

20 (ii) the race and ethnicity of an indi-
21 vidual tested;

22 (iii) the age of an individual tested;

23 and

24 (iv) the gender of the individual test-
25 ed.

1 (G) PRERELEASE REFERRAL POLICY.—

2 Whether incarcerated individuals are informed
3 prior to release about STI-related services or
4 other health services in their communities, in-
5 cluding free and low-cost counseling and treat-
6 ment options.

7 (H) PRERELEASE REFERRALS MADE.—

8 The number of referrals to community-based
9 organizations or public health facilities offering
10 STI-related or other health services provided to
11 incarcerated individuals prior to release, and
12 the type of counseling or treatment for which
13 the referral was made.

14 (I) REINSTATEMENT OF MEDICAID BENE-
15 FITS.—Whether—

16 (i) the correctional facility assists in-
17 carcerated individuals that were enrolled in
18 the State Medicaid program prior to their
19 incarceration in reinstating their enroll-
20 ment upon release; and

21 (ii) such individuals receive referrals
22 as described in subparagraph (G) to enti-
23 ties that accept the State Medicaid pro-
24 gram, including, if applicable—

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1 (I) the number of such individ-
2 uals, including those diagnosed with
3 HIV, that have been reinstated;

4 (II) a list of obstacles to rein-
5 stating enrollment or to making deter-
6 minations of eligibility for reinstate-
7 ment, if any; and

8 (III) the number of individuals
9 denied enrollment.

10 (J) OTHER ACTIONS TAKEN.—Whether the
11 correctional facility has taken any other action,
12 in conjunction with community organizations or
13 otherwise, to reduce the prevalence and spread
14 of STIs in that facility.

15 (2) PRIVACY.—In conducting the survey under
16 paragraph (1), the Attorney General shall not re-
17 quest or retain the identity of any individual who
18 has sought or been offered counseling, treatment,
19 testing, or prevention education information regard-
20 ing an STI (including information about sexual bar-
21 rier protection devices), or who has tested positive
22 for an STI.

23 (3) REPORT.—

24 (A) IN GENERAL.—The Attorney General
25 shall transmit to Congress and make publicly

1 available the results of the survey required
2 under paragraph (1), both for the United
3 States as a whole and disaggregated as to each
4 State and each correctional facility.

5 (B) DEADLINES.—To the maximum extent
6 possible, the Attorney General shall—

7 (i) issue the first report under sub-
8 paragraph (A) not later than 1 year after
9 the date of enactment of this Act; and

10 (ii) issue reports under subparagraph
11 (A) annually thereafter for 5 years.

12 (d) STRATEGY.—

13 (1) DIRECTIVE TO ATTORNEY GENERAL.—The
14 Attorney General, in consultation with the Secretary
15 of Health and Human Services, State officials, and
16 community organizations, shall develop and imple-
17 ment a 5-year strategy to reduce the prevalence and
18 spread of STIs in Federal and State correctional fa-
19 cilities. To the maximum extent possible, the strat-
20 egy shall be developed, transmitted to Congress, and
21 made publicly available not later than 180 days after
22 the transmission of the first report required under
23 subsection (c)(3).

1 (2) CONTENTS OF STRATEGY.—The strategy
2 developed under paragraph (1) shall include the fol-
3 lowing:

4 (A) PREVENTION EDUCATION.—A plan for
5 improving prevention education, information,
6 and training offered to incarcerated individuals
7 and correctional facility staff, including infor-
8 mation and training on sexual violence and the
9 spread of STIs, and comprehensive sexuality
10 education.

11 (B) SEXUAL BARRIER PROTECTION DEVICE
12 ACCESS.—A plan for expanding access to sexual
13 barrier protection devices in correctional facili-
14 ties.

15 (C) SEXUAL VIOLENCE REDUCTION.—A
16 plan for reducing the incidence of sexual vio-
17 lence among incarcerated individuals and cor-
18 rectional facility staff.

19 (D) COUNSELING AND SUPPORTIVE SERV-
20 ICES.—A plan for expanding access to coun-
21 seling and supportive services related to STIs in
22 correctional facilities.

23 (E) TESTING.—A plan for testing incarcer-
24 ated individuals for STIs during intake, during

1 regular health exams, and prior to release
2 that—

3 (i) is conducted in accordance with
4 guidelines established by the Centers for
5 Disease Control and Prevention;

6 (ii) includes pretest counseling;

7 (iii) requires that incarcerated individ-
8 uals are notified of their option to decline
9 testing at any time;

10 (iv) requires that incarcerated individ-
11 uals are confidentially notified of their test
12 results in a timely manner; and

13 (v) ensures that incarcerated individ-
14 uals testing positive for STIs receive post-
15 test counseling, care, treatment, and sup-
16 portive services.

17 (F) TREATMENT.—A plan for ensuring
18 that correctional facilities have the necessary
19 medicine and equipment to treat and monitor
20 STIs and for ensuring that incarcerated indi-
21 viduals living with or testing positive for STIs
22 receive and have access to care and treatment
23 services.

24 (G) STRATEGIES FOR DEMOGRAPHIC
25 GROUPS.—A plan for developing and imple-

menting 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 community and health facilities that—

(i) provide counseling, testing, care, and treatment services;

(ii) may receive individuals recently released from incarceration who are living with STIs; and

(iii) accept payment through the State Medicaid program.

(I) ENROLLMENT IN STATE MEDICAID PROGRAMS.—Plans to ensure that—

(i) incarcerated individuals who were enrolled in their State Medicaid program prior to incarceration in a correctional facility are automatically reenrolled in such program upon their release; and

(ii) incarcerated individuals who were not enrolled in their State Medicaid program prior to incarceration, and who are

1 diagnosed with HIV while incarcerated in
2 a correctional facility, are automatically
3 enrolled in such program upon their re-
4 lease.

5 (J) OTHER PLANS.—Any other plans de-
6 veloped by the Attorney General for reducing
7 the spread of STIs or improving the quality of
8 health care in correctional facilities.

9 (K) MONITORING SYSTEM.—A monitoring
10 system that establishes performance goals re-
11 lated to reducing the prevalence and spread of
12 STIs in correctional facilities and which, where
13 feasible, expresses such goals in quantifiable
14 form.

15 (L) MONITORING SYSTEM PERFORMANCE
16 INDICATORS.—Performance indicators that
17 measure or assess the achievement of the per-
18 formance goals described in subparagraph (K).

19 (M) COST ESTIMATE.—A detailed estimate
20 of the funding necessary to implement the
21 strategy at the Federal and State levels for all
22 5 years, including the amount of funds required
23 by community organizations to implement the
24 parts of the strategy in which they take part.

1 (3) REPORT.—Not later than 1 year after the
2 date of the enactment of this Act, and annually
3 thereafter, the Attorney General shall transmit to
4 Congress and make publicly available an annual
5 progress report regarding the implementation and
6 effectiveness of the strategy described in paragraph
7 (1). The progress report shall include an evaluation
8 of the implementation of the strategy using the mon-
9 itoring system and performance indicators provided
10 for in subparagraphs (K) and (L) of paragraph (2).

11 (e) AUTHORIZATION OF APPROPRIATIONS.—

12 (1) IN GENERAL.—There are authorized to be
13 appropriated such sums as may be necessary to
14 carry out this section for each of fiscal years 2023
15 through 2027.

16 (2) AVAILABILITY OF FUNDS.—Amounts made
17 available under paragraph (1) are authorized to re-
18 main available until expended.

19 (f) DEFINITIONS.—In this section:

20 (1) COMMUNITY ORGANIZATION.—The term
21 “community organization” means a public health
22 care facility or a nonprofit organization that pro-
23 vides health- or STI-related services according to es-
24 tablished public health standards.

1 (2) COMPREHENSIVE SEXUALITY EDUCATION.—

2 The term “comprehensive sexuality education”
3 means sexuality education—

4 (A) that includes information about absti-
5 nence and about the proper use and disposal of
6 sexual barrier protection devices; and

7 (B) that is—

8 (i) evidence-based;

9 (ii) medically accurate;

10 (iii) age and developmentally appro-
11 priate;

12 (iv) gender and identity sensitive;

13 (v) culturally and linguistically appro-
14 priate; and

15 (vi) structured to promote critical
16 thinking, self-esteem, respect for others,
17 and the development of healthy attitudes
18 and relationships.

19 (3) CORRECTIONAL FACILITY.—The term “cor-
20 rectional facility” means any prison, penitentiary,
21 adult detention facility, juvenile detention facility,
22 jail, or other facility to which individuals may be
23 sent after conviction of a crime or act of juvenile de-
24 linquency within the United States.

1 (4) INCARCERATED INDIVIDUAL.—The term
2 “incarcerated individual” means any individual who
3 is serving a sentence in a correctional facility after
4 conviction of a crime.

5 (5) SEXUAL BARRIER PROTECTION DEVICE.—
6 The term “sexual barrier protection device” means
7 any physical device approved, cleared, or otherwise
8 authorized by the Food and Drug Administration
9 that has not been tampered with and which reduces
10 the probability of STI transmission or infection be-
11 tween sexual partners, including female condoms,
12 male condoms, and dental dams.

13 (6) SEXUALLY TRANSMITTED INFECTION.—The
14 term “sexually transmitted infection” or “STI”
15 means any disease or infection that is commonly
16 transmitted through sexual activity, including HIV,
17 gonorrhea, chlamydia, syphilis, genital herpes, viral
18 hepatitis, and human papillomavirus.

19 (7) STATE.—The term “State” includes the
20 District of Columbia, American Samoa, the Com-
21 monwealth of the Northern Mariana Islands, Guam,
22 Puerto Rico, and the United States Virgin Islands.

23 (8) STATE MEDICAID PROGRAM.—The term
24 “State Medicaid program” means the State plan (or

1 a waiver of such plan) under title XIX of the Social
2 Security Act (42 U.S.C. 1396 et seq.).

3 **SEC. 7217. AUTOMATIC REINSTATEMENT OR ENROLLMENT**
4 **IN MEDICAID FOR PEOPLE WHO TEST POSI-**
5 **TIVE FOR HIV BEFORE REENTERING COMMU-**
6 **NITIES.**

7 (a) IN GENERAL.—Section 1902(e) of the Social Se-
8 curity Act (42 U.S.C. 1396a(e)) is amended by adding at
9 the end the following:

10 “(17) ENROLLMENT OF EX-OFFENDERS.—

11 “(A) AUTOMATIC ENROLLMENT OR REIN-
12 STATEMENT.—

13 “(i) IN GENERAL.—The State plan
14 shall provide for the automatic enrollment
15 or reinstatement of enrollment of an eligi-
16 ble individual—

17 “(I) if such individual is sched-
18 uled to be released from a public insti-
19 tution due to the completion of sen-
20 tence, not less than 30 days prior to
21 the scheduled date of the release; and

22 “(II) if such individual is to be
23 released from a public institution on
24 parole or on probation, as soon as
25 possible after the date on which the

1 determination to release such indi-
2 vidual was made, and before the date
3 such individual is released.

4 “(ii) EXCEPTION.—If a State makes a
5 determination that an individual is not eli-
6 gible to be enrolled under the State plan—

7 “(I) on or before the date by
8 which the individual would be enrolled
9 under clause (i), such clause shall not
10 apply to such individual; or

11 “(II) after such date, the State
12 may terminate the enrollment of such
13 individual.

14 “(B) RELATIONSHIP OF ENROLLMENT TO
15 PAYMENT FOR SERVICES.—

16 “(i) IN GENERAL.—Subject to sub-
17 paragraph (A)(ii), an eligible individual
18 who is enrolled, or whose enrollment is re-
19 instated, under subparagraph (A) shall be
20 eligible for all services for which medical
21 assistance is provided under the State plan
22 after the date that the eligible individual is
23 released from the public institution.

24 “(ii) RELATIONSHIP TO PAYMENT
25 PROHIBITION FOR INMATES.—No provision

1 of this paragraph may be construed to per-
2 mit payment for care or services for which
3 payment is excluded under subdivision (A)
4 following the last numbered paragraph of
5 section 1905(a).

6 “(C) TREATMENT OF CONTINUOUS ELIGI-
7 BILITY.—

8 “(i) SUSPENSION FOR INMATES.—Any
9 period of continuous eligibility under this
10 title shall be suspended on the date an in-
11 dividual enrolled under this title becomes
12 an inmate of a public institution (except as
13 a patient of a medical institution).

14 “(ii) DETERMINATION OF REMAINING
15 PERIOD.—Notwithstanding any changes to
16 State law related to continuous eligibility
17 during the time that an individual is an in-
18 mate of a public institution (except as a
19 patient of a medical institution), subject to
20 clause (iii), with respect to an eligible indi-
21 vidual who was subject to a suspension
22 under clause (i), on the date that such in-
23 dividual is released from a public institu-
24 tion the suspension of continuous eligibility
25 under such clause shall be lifted for a pe-

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1 riod that is equal to the time remaining in
2 the period of continuous eligibility for such
3 individual on the date that such period was
4 suspended under such clause.

5 “(iii) EXCEPTION.—If a State makes
6 a determination that an individual is not
7 eligible to be enrolled under the State
8 plan—

9 “(I) on or before the date that
10 the suspension of continuous eligibility
11 is lifted under clause (ii), such clause
12 shall not apply to such individual; or

13 “(II) after such date, the State
14 may terminate the enrollment of such
15 individual.

16 “(D) AUTOMATIC ENROLLMENT OR REIN-
17 STATEMENT OF ENROLLMENT DEFINED.—For
18 purposes of this paragraph, the term ‘automatic
19 enrollment or reinstatement of enrollment’
20 means that the State determines eligibility for
21 medical assistance under the State plan without
22 a program application from, or on behalf of, the
23 eligible individual, but an individual can only be
24 automatically enrolled in the State Medicaid
25 plan if the individual affirmatively consents to

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1 being enrolled through affirmation in writing,
2 by telephone, orally, through electronic signa-
3 ture, or through any other means specified by
4 the Secretary.

5 “(E) ELIGIBLE INDIVIDUAL DEFINED.—
6 For purposes of this paragraph, the term ‘eligi-
7 ble individual’ means an individual who is an
8 inmate of a public institution (except as a pa-
9 tient in a medical institution)—

10 “(i) who was enrolled under the State
11 plan for medical assistance immediately be-
12 fore becoming an inmate of such an insti-
13 tution; or

14 “(ii) who is diagnosed with human im-
15 munodeficiency virus.”.

16 (b) SUPPLEMENTAL FUNDING FOR STATE IMPLE-
17 MENTATION OF AUTOMATIC REINSTATEMENT OF MED-
18 ICAID BENEFITS.—

19 (1) IN GENERAL.—Subject to paragraph (3),
20 with respect to a State, for each of the first 4 cal-
21 endar quarters in which the State plan meets the re-
22 quirements of paragraph (17) of section 1902(e) of
23 the Social Security Act (42 U.S.C. 1396a(e)) (as
24 added by subsection (a)), the Federal matching pay-
25 ments (including payments based on the Federal

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1 medical assistance percentage) made to such State
2 under section 1903 of the Social Security Act (42
3 U.S.C. 1396b) for the State expenditures described
4 in paragraph (2) shall be increased by 5 percentage
5 points.

6 (2) EXPENDITURES.—The expenditures de-
7 scribed in this paragraph are the following:

8 (A) Expenditures for which payment is
9 available under section 1903 of the Social Secu-
10 rity Act (42 U.S.C. 1396b) and which are at-
11 tributable to strengthening the State's enroll-
12 ment and administrative resources for the pur-
13 pose of improving processes for enrolling (or re-
14 instating the enrollment of) eligible individuals
15 (as such term is defined in subparagraph (E) of
16 paragraph (16) of section 1902(e) of the Social
17 Security Act (42 U.S.C. 1396a(e)) (as amended
18 by subsection (a))).

19 (B) Expenditures for medical assistance
20 (as such term is defined in section 1905(a) of
21 the Social Security Act (42 U.S.C. 1396d(a)))
22 provided to such eligible individuals.

23 (3) REQUIREMENTS; LIMITATION.—

24 (A) REPORT.—A State is not eligible for
25 an increase in its Federal matching payments

1 under paragraph (1) unless the State agrees to
2 submit to the Secretary of Health and Human
3 Services, and make publicly available, a report
4 that contains the information required under
5 paragraph (4) by the end of the 1-year period
6 during which the State receives increased Fed-
7 eral matching payments in accordance with that
8 paragraph.

9 (B) MAINTENANCE OF ELIGIBILITY.—

10 (i) IN GENERAL.—Subject to clause
11 (ii), a State is not eligible for an increase
12 in its Federal matching payments under
13 paragraph (1) if eligibility standards,
14 methodologies, or procedures under its
15 State plan under title XIX of the Social
16 Security Act (42 U.S.C. 1396 et seq.), or
17 waiver of such a plan, are more restrictive
18 than the eligibility standards, methodolo-
19 gies, or procedures, respectively, under
20 such plan or waiver as in effect on the date
21 of enactment of this Act.

22 (ii) STATE REINSTATEMENT OF ELIGI-
23 BILITY PERMITTED.—A State that has re-
24 stricted eligibility standards, methodolo-
25 gies, or procedures under its State plan

1 under title XIX of the Social Security Act
2 (42 U.S.C. 1396 et seq.), or a waiver of
3 such plan, after the date of enactment of
4 this Act, is no longer ineligible under
5 clause (i) beginning with the first calendar
6 quarter in which the State has reinstated
7 eligibility standards, methodologies, or pro-
8 cedures that are no more restrictive than
9 the eligibility standards, methodologies, or
10 procedures, respectively, under such plan
11 (or waiver) as in effect on such date.

12 (C) LIMITATION OF MATCHING PAYMENTS
13 TO 100 PERCENT.—In no case shall an increase
14 in Federal matching payments under paragraph
15 (1) result in Federal matching payments that
16 exceed 100 percent of State expenditures.

17 (4) REQUIRED REPORT INFORMATION.—The in-
18 formation that is required in the report under para-
19 graph (3)(A) shall include—

20 (A) the results of an evaluation of the im-
21 pact of the implementation of the requirements
22 of paragraph (17) of section 1902(e) of the So-
23 cial Security Act (42 U.S.C. 1396a(e)) on im-
24 proving the State's processes for enrolling indi-

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1 viduals who are released from public institu-
2 tions under the State Medicaid plan;

3 (B) the number of individuals who were
4 automatically enrolled (or whose enrollment was
5 reinstated) under such paragraph during the 1-
6 year period during which the State received in-
7 creased payments under this subsection; and

8 (C) any other information that is required
9 by the Secretary of Health and Human Serv-
10 ices.

11 (c) EFFECTIVE DATE.—

12 (1) IN GENERAL.—Except as provided in para-
13 graph (2), the amendments made by subsection (a)
14 shall take effect 180 days after the date of the en-
15 actment of this Act.

16 (2) RULE FOR CHANGES REQUIRING STATE
17 LEGISLATION.—In the case of a State plan for med-
18 ical assistance under title XIX of the Social Security
19 Act (42 U.S.C. 1396 et seq.) which the Secretary of
20 Health and Human Services determines requires
21 State legislation (other than legislation appro-
22 priating funds) in order for the plan to meet the ad-
23 ditional requirement imposed by the amendments
24 made by subsection (a), the State plan shall not be
25 regarded as failing to comply with the requirements

1 of such title solely on the basis of its failure to meet
2 this additional requirement before the first day of
3 the first calendar quarter beginning after the close
4 of the first regular session of the State legislature
5 that begins after the date of the enactment of this
6 Act. For purposes of the previous sentence, in the
7 case of a State that has a 2-year legislative session,
8 each year of such session shall be deemed to be a
9 separate regular session of the State legislature.

10 **SEC. 7218. STOP HIV IN PRISON.**

11 (a) **SHORT TITLE.**—This section may be cited as the
12 “Stop HIV in Prison Act”.

13 (b) **HIV POLICY.**—The Director of the Bureau of
14 Prisons (referred to in this section as the “Director”) shall
15 develop a comprehensive policy to provide HIV testing,
16 treatment, and prevention for inmates within the correc-
17 tional setting and upon reentry.

18 (c) **PURPOSE.**—The purposes of the policy required
19 to be developed under subsection (b) shall be as follows:

20 (1) To stop the spread of HIV among inmates.

21 (2) To protect guards and other personnel at
22 correctional facilities from HIV infection.

23 (3) To provide comprehensive medical treat-
24 ment to inmates who are living with HIV.

1 (4) To promote HIV awareness and prevention
2 among inmates.

3 (5) To encourage inmates to take personal re-
4 sponsibility for their health.

5 (6) To reduce the risk that inmates will trans-
6 mit HIV to other persons in the community fol-
7 lowing their release from a correctional facility.

8 (d) CONSULTATION.—The Director shall consult with
9 appropriate officials of the Department of Health and
10 Human Services, the Office of National Drug Control Pol-
11 icy, the Office of National AIDS Policy, and the Centers
12 for Disease Control and Prevention regarding the develop-
13 ment of the policy required under subsection (b).

14 (e) TIME LIMIT.—Not later than 1 year after the
15 date of enactment of this Act, the Director shall draft ap-
16 propriate regulations to implement the policy required to
17 be developed under subsection (b).

18 (f) REQUIREMENTS FOR POLICY.—The policy re-
19 quired to be developed under subsection (b) shall provide
20 for the following:

21 (1) TESTING AND COUNSELING UPON IN-
22 TAKE.—

23 (A) Health care personnel shall provide
24 routine HIV testing to all inmates as a part of
25 a comprehensive medical examination imme-

1 diately following admission to a facility. Health
2 care personnel need not provide routine HIV
3 testing to an inmate who is transferred to a fa-
4 cility from another facility if the inmate's med-
5 ical records are transferred with the inmate and
6 indicate that the inmate has been tested pre-
7 viously.

8 (B) With respect to all inmates admitted
9 to a facility prior to the effective date of the
10 policy—

11 (i) health care personnel shall provide
12 routine HIV testing by not later than 180
13 days after such effective date; and

14 (ii) HIV testing described in clause (i)
15 may be performed in conjunction with
16 other health services provided to these in-
17 mates by health care personnel.

18 (C) All HIV tests under this paragraph
19 shall comply with the opt-out provision under
20 paragraph (9).

21 (2) PRE-TEST AND POST-TEST COUNSELING.—

22 Health care personnel shall provide confidential pre-
23 test and post-test counseling to all inmates who are
24 tested for HIV. Counseling may be included with

1 other general health counseling provided to inmates
2 by health care personnel.

3 (3) HIV PREVENTION EDUCATION.—

4 (A) Health care personnel shall improve
5 HIV awareness through frequent educational
6 programs for all inmates. HIV educational pro-
7 grams may be provided by community-based or-
8 ganizations, local health departments, and in-
9 mate peer educators.

10 (B) HIV educational materials shall be
11 made available to all inmates at orientation, at
12 health care clinics, at regular educational pro-
13 grams, and prior to release. Both written and
14 audiovisual materials shall be made available to
15 all inmates.

16 (C)(i) The HIV educational programs and
17 materials under this paragraph shall include in-
18 formation on—

19 (I) modes of transmission, including
20 transmission through tattooing, sexual con-
21 tact, and intravenous drug use;

22 (II) prevention methods;

23 (III) treatment; and

24 (IV) disease progression.

1 (ii) The programs and materials shall be
2 culturally sensitive, written or designed for low-
3 literacy levels, available in a variety of lan-
4 guages, and present scientifically accurate in-
5 formation in a clear and understandable man-
6 ner.

7 (4) HIV TESTING UPON REQUEST.—

8 (A) Health care personnel shall allow in-
9 mates to obtain HIV tests upon request once
10 per year or whenever an inmate has a reason to
11 believe the inmate may have been exposed to
12 HIV. Health care personnel shall, both orally
13 and in writing, inform inmates, during orienta-
14 tion and periodically throughout incarceration,
15 of their right to obtain HIV tests.

16 (B) Health care personnel shall encourage
17 inmates to request HIV tests if the inmate is
18 sexually active, has been raped, uses intra-
19 venous drugs, receives a tattoo, or if the inmate
20 is concerned that the inmate may have been ex-
21 posed to HIV.

22 (C) An inmate's request for an HIV test
23 shall not be considered an indication that the
24 inmate has put themselves at risk of infection

1 or committed a violation of the rules of the cor-
2 rectional facility.

3 (5) HIV TESTING OF PREGNANT WOMAN.—

4 (A) Health care personnel shall provide
5 routine HIV testing to all inmates who become
6 pregnant.

7 (B) All HIV tests under this paragraph
8 shall comply with the opt-out provision under
9 paragraph (9).

10 (6) COMPREHENSIVE TREATMENT.—

11 (A) Health care personnel shall provide all
12 inmates who test positive for HIV—

13 (i) timely, comprehensive medical
14 treatment;

15 (ii) confidential counseling on man-
16 aging their medical condition and pre-
17 venting its transmission to other persons;
18 and

19 (iii) voluntary partner notification
20 services.

21 (B) Health care provided under this para-
22 graph shall be consistent with Department of
23 Health and Human Services guidelines and
24 standard medical practice. Health care per-
25 sonnel shall discuss treatment options, the im-

1 portance of adherence to antiretroviral therapy,
2 and the side effects of medications with inmates
3 receiving treatment.

4 (C) Health care personnel and pharmacy
5 personnel shall ensure that the facility for-
6 mulary contains all Food and Drug Administra-
7 tion-approved medications necessary to provide
8 comprehensive treatment for inmates living with
9 HIV, and that the facility maintains adequate
10 supplies of such medications to meet inmates'
11 medical needs. Health care personnel and phar-
12 macy personnel shall also develop and imple-
13 ment automatic renewal systems for these medi-
14 cations to prevent interruptions in care.

15 (D) Correctional staff, health care per-
16 sonnel, and pharmacy personnel shall develop
17 and implement distribution procedures to en-
18 sure timely and confidential access to medica-
19 tions.

20 (7) PROTECTION OF CONFIDENTIALITY.—

21 (A) Health care personnel shall develop
22 and implement procedures to ensure the con-
23 fidentiality of inmate tests, diagnoses, and
24 treatment. Health care personnel and correc-
25 tional staff shall receive regular training on the

1 implementation of these procedures. Penalties
2 for violations of inmate confidentiality by health
3 care personnel or correctional staff shall be
4 specified and strictly enforced.

5 (B) HIV testing, counseling, and treat-
6 ment shall be provided in a confidential setting
7 where other routine health services are provided
8 and in a manner that allows the inmate to re-
9 quest and obtain these services as routine med-
10 ical services.

11 (8) TESTING, COUNSELING, AND REFERRAL
12 PRIOR TO REENTRY.—

13 (A) Health care personnel shall provide
14 routine HIV testing to all inmates not earlier
15 than 90 days prior to their release and reentry
16 into the community. Inmates who are already
17 known to be infected need not be tested again.
18 This requirement may be waived if an inmate's
19 release occurs without sufficient notice to the
20 Director to allow health care personnel to per-
21 form a routine HIV test and notify the inmate
22 of the results.

23 (B) All HIV tests under this paragraph
24 shall comply with the opt-out provision under
25 paragraph (9).

1 (C) With respect to all inmates who test
2 positive for HIV and all inmates who already
3 are known to have HIV, health care personnel
4 shall provide—

5 (i) confidential prerelease counseling
6 on managing their medical condition in the
7 community, accessing appropriate treat-
8 ment and services in the community, and
9 preventing the transmission of their condi-
10 tion to family members and other persons
11 in the community;

12 (ii) referrals to appropriate health
13 care providers and social service agencies
14 in the community that meet the inmate's
15 individual needs, including voluntary part-
16 ner notification services and prevention
17 counseling services for people living with
18 HIV; and

19 (iii) a 30-day supply of any medically
20 necessary medications the inmate is cur-
21 rently receiving.

22 (9) OPT-OUT PROVISION.—Inmates shall have
23 the right to refuse routine HIV testing. Inmates
24 shall be informed both orally and in writing of this
25 right. Oral and written disclosure of this right may

1 be included with other general health information
2 and counseling provided to inmates by health care
3 personnel. If an inmate refuses a routine test for
4 HIV, health care personnel shall make a note of the
5 inmate's refusal in the inmate's confidential medical
6 records. However, the inmate's refusal shall not be
7 considered a violation of the rules of the correctional
8 facility or result in disciplinary action.

9 (10) EXCLUSION OF TESTS PERFORMED UNDER
10 SECTION 4014(b) FROM THE DEFINITION OF ROU-
11 TINE HIV TESTING.—HIV testing of an inmate
12 under section 4014(b) of title 18, United States
13 Code, is not routine HIV testing for the purposes of
14 the opt-out provision under paragraph (9). Health
15 care personnel shall document the reason for testing
16 under section 4014(b) of title 18, United States
17 Code, in the inmate's confidential medical records.

18 (11) TIMELY NOTIFICATION OF TEST RE-
19 SULTS.—Health care personnel shall provide timely
20 notification to inmates of the results of HIV tests.

21 (g) CHANGES IN EXISTING LAW.—

22 (1) SCREENING IN GENERAL.—Section 4014(a)
23 of title 18, United States Code, is amended—

24 (A) by striking “for a period of 6 months
25 or more”;

1 (B) by striking “, as appropriate,”; and

2 (C) by striking “if such individual is deter-
3 mined to be at risk for infection with such virus
4 in accordance with the guidelines issued by the
5 Bureau of Prisons relating to infectious disease
6 management” and inserting “unless the indi-
7 vidual declines. The Attorney General shall also
8 cause such individual to be so tested before re-
9 lease from that incarceration unless the indi-
10 vidual declines.”.

11 (2) INADMISSIBILITY OF HIV TEST RESULTS IN
12 CIVIL AND CRIMINAL PROCEEDINGS.—Section
13 4014(d) of title 18, United States Code, is amended
14 by inserting “or under the Stop HIV in Prison Act”
15 after “under this section”.

16 (3) SCREENING AS PART OF ROUTINE SCREEN-
17 ING.—Section 4014(e) of title 18, United States
18 Code, is amended by adding at the end the fol-
19 lowing: “Such rules shall also provide that the initial
20 test under this section be performed as part of the
21 routine health screening conducted at intake.”.

22 (h) REPORTING REQUIREMENTS.—

23 (1) REPORT ON HEPATITIS, LIVER, AND OTHER
24 DISEASES.—Not later than 1 year after the date of
25 enactment of this Act, the Director shall submit to

1 Congress a report on the policies and procedures of
2 the Bureau of Prisons to provide testing, treatment,
3 and prevention education programs for hepatitis,
4 liver failure, and other liver-related diseases trans-
5 mitted through sexual activity, intravenous drug use,
6 or other means. The Director shall consult with ap-
7 propriate officials of the Department of Health and
8 Human Services, the Office of National Drug Con-
9 trol Policy, the Office of National AIDS Policy, and
10 the Centers for Disease Control and Prevention re-
11 garding the development of this report.

12 (2) ANNUAL REPORTS.—

13 (A) GENERALLY.—Not later than 2 years
14 after the date of enactment of this Act, and an-
15 nually thereafter, the Director submit to Con-
16 gress a report on the incidence among inmates
17 of diseases transmitted through sexual activity
18 and intravenous drug use.

19 (B) MATTERS PERTAINING TO VARIOUS
20 DISEASES.—Each report under subparagraph
21 (A) shall discuss—

22 (i) the incidence among inmates of
23 HIV, hepatitis, and other diseases trans-
24 mitted through sexual activity and intra-
25 venous drug use; and

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1 (ii) updates on the testing, treatment,
2 and prevention education programs for
3 these diseases conducted by the Bureau of
4 Prisons.

5 (C) MATTERS PERTAINING TO HIV
6 ONLY.—Each report under subparagraph (A)
7 shall also include—

8 (i) the number of inmates who tested
9 positive for HIV upon intake;

10 (ii) the number of inmates who tested
11 positive for HIV prior to reentry;

12 (iii) the number of inmates who were
13 not tested for HIV prior to reentry because
14 they were released without sufficient no-
15 tice;

16 (iv) the number of inmates who opted-
17 out of taking an HIV test;

18 (v) the number of inmates who were
19 tested under section 4014(b) of title 18,
20 United States Code; and

21 (vi) the number of inmates under
22 treatment for HIV.

23 (D) CONSULTATION.—The Director shall
24 consult with appropriate officials of the Depart-
25 ment of Health and Human Services, the Office

1 of National Drug Control Policy, the Office of
2 National AIDS Policy, and the Centers for Dis-
3 ease Control and Prevention regarding the de-
4 velopment of each report under subparagraph
5 (A).

6 **SEC. 7219. TRANSFER OF FUNDS FOR IMPLEMENTATION OF**
7 **ENDING THE HIV EPIDEMIC: A PLAN FOR**
8 **AMERICA.**

9 Title II of the Public Health Service Act (42 U.S.C.
10 202 et seq.) is amended by inserting after section 241 (42
11 U.S.C. 238j) the following:

12 **“SEC. 241A. TRANSFER OF FUNDS FOR IMPLEMENTATION**
13 **OF NATIONAL HIV/AIDS STRATEGY.**

14 “(a) **TRANSFER AUTHORIZATION.**—Of the discre-
15 tionary appropriations made available to the Department
16 of Health and Human Services for any fiscal year for pro-
17 grams and activities that, as determined by the Secretary,
18 pertain to HIV, the Secretary may transfer up to 1 per-
19 cent of such appropriations to the Office of the Assistant
20 Secretary for Health for implementation of the Ending the
21 HIV Epidemic: A Plan for America.

22 “(b) **CONGRESSIONAL NOTIFICATION.**—Not less than
23 30 days before making any transfer under this section,
24 the Secretary shall give notice of the transfer to the Con-
25 gress.

1 “(c) DEFINITIONS.—In this section, the term ‘End-
2 ing the HIV Epidemic: A Plan for America’ means the
3 initiative of the Department of Health and Human Serv-
4 ices that seeks to reduce the number of new HIV infec-
5 tions in the United States by 75 percent by 2025, and
6 then by at least 90 percent by 2030, for an estimated
7 250,000 total HIV infections averted.”.

8 **SEC. 7220. PREP ACCESS AND COVERAGE.**

9 (a) COVERAGE OF HIV TESTING AND PREVENTION
10 SERVICES.—

11 (1) PRIVATE INSURANCE.—

12 (A) IN GENERAL.—Section 2713(a) of the
13 Public Health Service Act (42 U.S.C. 300gg–
14 13(a)) is amended—

15 (i) in paragraph (2), by striking “;
16 and” and inserting a semicolon;

17 (ii) in paragraph (3), by striking the
18 period and inserting a semicolon;

19 (iii) in paragraph (4), by striking the
20 period and inserting a semicolon;

21 (iv) in paragraph (5), by striking the
22 period and inserting “; and”; and

23 (v) by adding at the end the following:

24 “(6) any prescription drug approved by the
25 Food and Drug Administration for the prevention of

1 HIV (other than a drug subject to preauthorization
2 requirements consistent with section 2729A), admin-
3 istrative fees for such drugs, laboratory and other
4 diagnostic procedures associated with the use of
5 such drugs, and clinical follow up and monitoring,
6 including any related services recommended in cur-
7 rent United States Public Health Service clinical
8 practice guidelines, without limitation.”.

9 (B) PROHIBITION ON PREAUTHORIZATION
10 REQUIREMENTS.—Subpart II of part A of title
11 XXVII of the Public Health Service Act (42
12 U.S.C. 300gg–11 et seq.), as amended by sec-
13 tion 7602(d), is amended by adding at the end
14 the following:

15 **“SEC. 2729A. PROHIBITION ON PREAUTHORIZATION RE-**
16 **QUIREMENTS WITH RESPECT TO CERTAIN**
17 **SERVICES.**

18 “A group health plan or a health insurance issuer of-
19 fering group or individual health insurance coverage shall
20 not impose any preauthorization requirements with re-
21 spect to coverage of the services described in section
22 2713(a)(1)(E), except that a plan or issuer may impose
23 preauthorization requirements with respect to coverage of
24 a particular drug approved under section 505(c) of the
25 Federal Food, Drug, and Cosmetic Act or section 351(a)

1 of this Act if such plan or issuer provides coverage without
2 any preauthorization requirements for a drug that is ther-
3 apeutically equivalent.”.

4 (2) COVERAGE UNDER FEDERAL EMPLOYEES
5 HEALTH BENEFITS PROGRAM.—Section 8904 of title
6 5, United States Code, is amended by adding at the
7 end the following:

8 “(c) Any health benefits plan offered under this chap-
9 ter shall include benefits for, and may not impose any cost
10 sharing requirements for, any prescription drug approved
11 by the Food and Drug Administration for the prevention
12 of HIV, administrative fees for such drugs, laboratory and
13 other diagnostic procedures associated with the use of
14 such drugs, and clinical follow up and monitoring, includ-
15 ing any related services recommended in current United
16 States Public Health Service clinical practice guidelines,
17 without limitation.”.

18 (3) MEDICAID.—

19 (A) IN GENERAL.—Section 1905 of the So-
20 cial Security Act (42 U.S.C. 1396d), as pre-
21 viously amended by this Act, is amended—

22 (i) in subsection (a)(4)—

23 (I) by striking “; and (D)” and
24 inserting “; (D)”;

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1 (II) by striking “; and (E)” and
2 inserting “; (E)”;

3 (III) by striking “; and (F)” and
4 inserting “; (F)”;

5 (IV) by striking the semicolon at
6 the end and inserting “; and (G) HIV
7 prevention services;”;

8 (ii) by adding at the end the following
9 new subsection:

10 “(pp) HIV PREVENTION SERVICES.—For purposes
11 of subsection (a)(4)(G), the term ‘HIV prevention serv-
12 ices’ means prescription drugs for the prevention of HIV
13 acquisition, administrative fees for such drugs, laboratory
14 and other diagnostic procedures associated with the use
15 of such drugs, and clinical follow up and monitoring, in-
16 cluding any related services recommended in current
17 United States Public Health Service clinical practice
18 guidelines, without limitation.”.

19 (B) NO COST-SHARING.—Title XIX of the
20 Social Security Act (42 U.S.C. 1396 et seq.) is
21 amended—

22 (i) in section 1916, by inserting “HIV
23 prevention services described in section
24 1905(a)(4)(G),” after “section
25 1905(a)(4)(C),” each place it appears; and

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1 (ii) in section 1916A(b)(3)(B), by
2 adding at the end the following new clause:

3 “(xii) HIV prevention services de-
4 scribed in section 1905(a)(4)(G).”.

5 (C) INCLUSION IN BENCHMARK COV-
6 ERAGE.—Section 1937(b)(7) of the Social Secu-
7 rity Act (42 U.S.C. 1396u–7(b)(7)) is amend-
8 ed—

9 (i) in the paragraph header, by insert-
10 ing “AND HIV PREVENTION SERVICES”
11 after “SUPPLIES”; and

12 (ii) by striking “includes for any indi-
13 vidual described in section 1905(a)(4)(C),
14 medical assistance for family planning
15 services and supplies in accordance with
16 such section” and inserting “includes med-
17 ical assistance for HIV prevention services
18 described in section 1905(a)(4)(G), and in-
19 cludes, for any individual described in sec-
20 tion 1905(a)(4)(C), medical assistance for
21 family planning services and supplies in ac-
22 cordance with such section”.

23 (4) CHIP.—

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1 (A) IN GENERAL.—Section 2103 of the So-
2 cial Security Act (42 U.S.C. 1397cc), as
3 amended by section 2007(d)(5), is amended—

4 (i) in subsection (a), by striking “and
5 (12)” and inserting “(12), and (13)”; and

6 (ii) in subsection (c), by adding at the
7 end the following new paragraph:

8 “(13) HIV PREVENTION SERVICES.—Regard-
9 less of the type of coverage elected by a State under
10 subsection (a), the child health assistance provided
11 for a targeted low-income child, and, in the case of
12 a State that elects to provide pregnancy-related as-
13 sistance pursuant to section 2112, the pregnancy-re-
14 lated assistance provided for a targeted low-income
15 pregnant woman (as such terms are defined for pur-
16 poses of such section), shall include coverage of HIV
17 prevention services (as defined in section 1905(jj)).”.

18 (B) NO COST-SHARING.—Section
19 2103(e)(2) of the Social Security Act (42
20 U.S.C. 1397cc(e)(2)) is amended by inserting
21 “HIV prevention services described in sub-
22 section (c)(13),” before “or for pregnancy-re-
23 lated assistance”.

24 (C) EFFECTIVE DATE.—

1 (i) IN GENERAL.—Subject to clause
2 (ii), the amendments made by paragraph
3 (3) and this paragraph shall take effect on
4 January 1, 2023.

5 (ii) DELAY PERMITTED IF STATE LEG-
6 ISLATION REQUIRED.—In the case of a
7 State plan approved under title XIX or
8 XXI of the Social Security Act which the
9 Secretary of Health and Human Services
10 determines requires State legislation (other
11 than legislation appropriating funds) in
12 order for the plan to meet the additional
13 requirements imposed by this subsection,
14 the State plan shall not be regarded as
15 failing to comply with the requirements of
16 such title solely on the basis of the failure
17 of the plan to meet such additional re-
18 quirements before the 1st day of the 1st
19 calendar quarter beginning after the close
20 of the 1st regular session of the State leg-
21 islature that ends after the 1-year period
22 beginning with the date of the enactment
23 of this Act. For purposes of the preceding
24 sentence, in the case of a State that has a
25 2-year legislative session, each year of the

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1 session is deemed to be a separate regular
2 session of the State legislature.

3 (5) COVERAGE AND ELIMINATION OF COST-
4 SHARING UNDER MEDICARE.—

5 (A) COVERAGE OF HIV PREVENTION SERV-
6 ICES UNDER PART B.—

7 (i) COVERAGE.—

8 (I) IN GENERAL.—Section
9 1861(s)(2) of the Social Security Act
10 (42 U.S.C. 1395x(s)(2)), as amended
11 by section 4251(c)(1) and 6011(a)(1),
12 is amended—

13 (aa) in subparagraph (II),
14 by striking “and” at the end;

15 (bb) in subparagraph (JJ),
16 by striking the period at the end
17 and inserting “; and”; and

18 (cc) by adding at the end
19 the following new subparagraph:

20 “(KK) HIV prevention services (as defined in
21 subsection (ppp));”.

22 (II) DEFINITION.—Section 1861
23 of the Social Security Act (42 U.S.C.
24 1395x), as amended by sections
25 2007(b), 4221(a), 4251(c)(2), and

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1 6011(a)(2), is amended by adding at
2 the end the following new subsection:

3 “(ppp) HIV PREVENTION SERVICES.—The term
4 ‘HIV prevention services’ means—

5 “(1) drugs or biologicals approved by the Food
6 and Drug Administration for the prevention of HIV;

7 “(2) administrative fees for such drugs;

8 “(3) laboratory and other diagnostic procedures
9 associated with the use of such drugs; and

10 “(4) clinical follow up and monitoring, including
11 any related services recommended in current United
12 States Public Health Service clinical practice guide-
13 lines, without limitation.”.

14 (ii) ELIMINATION OF COINSURANCE.—

15 Section 1833(a)(1) of the Social Security
16 Act (42 U.S.C. 1395l(a)(1)), as amended
17 by sections 4251(c)(3) and 6011(a)(4), is
18 amended—

19 (I) by striking “and” and before
20 “(FF)”; and

21 (II) by inserting before the semi-
22 colon at the end the following: “and
23 (GG) with respect to HIV prevention
24 services (as defined in section
25 1861(ppp)), the amount paid shall be

1 100 percent of (i) except as provided
2 in clause (ii), the lesser of the actual
3 charge for the service or the amount
4 determined under the fee schedule
5 that applies to such services under
6 this part, and (ii) in the case of such
7 services that are covered OPD serv-
8 ices (as defined in subsection
9 (t)(1)(B)), the amount determined
10 under subsection (t)”.
11

12 (iii) EXEMPTION FROM PART B DE-
13 DUCTIBLE.—Section 1833(b) of the Social
14 Security Act (42 U.S.C. 1395l(b)) is
15 amended—

16 (I) in paragraph (11), by striking
17 “and” at the end; and

18 (II) in paragraph (12), by strik-
19 ing the period at the end and insert-
20 ing “, and (13) such deductible shall
21 not apply with respect to HIV preven-
22 tion services (as defined in section
23 1861(l)).”.

24 (iv) EFFECTIVE DATE.—The amend-
 ments made by this subparagraph shall

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1 apply to items and services furnished on or
2 after January 1, 2023.

3 (B) ELIMINATION OF COST-SHARING FOR
4 DRUGS FOR THE PREVENTION OF HIV UNDER
5 PART D.—

6 (i) IN GENERAL.—Section 1860D–
7 2(b) of the Social Security Act (42 U.S.C.
8 1395w–102(b)) is amended—

9 (I) in paragraph (1)(A), in the
10 matter preceding clause (i), by strik-
11 ing “The coverage” and inserting
12 “Subject to paragraph (8), the cov-
13 erage”;

14 (II) in paragraph (2)—

15 (aa) in subparagraph (A), in
16 the matter preceding clause (i),
17 by striking “and (D)” and insert-
18 ing “and (D) and paragraph
19 (8)”;

20 (bb) in subparagraph (C)(i),
21 in the matter preceding subclause
22 (I), by striking “paragraph (4)”
23 and inserting “paragraphs (4)
24 and (8)”;

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1 (cc) in subparagraph (D)(i),
2 in the matter preceding subclause
3 (I), by striking “paragraph (4)”
4 and inserting “paragraphs (4)
5 and (8)”;

6 (III) in paragraph (3)(A), in the
7 matter preceding clause (i), by strik-
8 ing “and (4)” and inserting “(4), and
9 (8)”;

10 (IV) in paragraph (4)(A)(i), in
11 the matter preceding subclause (I), by
12 striking “The coverage” and inserting
13 “Subject to paragraph (8), the cov-
14 erage”; and

15 (V) by adding at the end the fol-
16 lowing new paragraph:

17 “(8) ELIMINATION OF COST-SHARING FOR
18 DRUGS FOR THE PREVENTION OF HIV.—

19 “(A) IN GENERAL.—For plan year 2023
20 and each subsequent plan year, there shall be
21 no cost-sharing under this part (including
22 under section 1814D–14) for covered part D
23 drugs that are for the prevention of HIV.

“(B) COST-SHARING.—For purposes of subparagraph (A), the elimination of cost-sharing shall include the following:

“(i) NO APPLICATION OF DEDUCTIBLE.—The waiver of the deductible under paragraph (1).

“(ii) NO APPLICATION OF COINSURANCE.—The waiver of coinsurance under paragraph (2).

“(iii) NO APPLICATION OF INITIAL COVERAGE LIMIT.—The initial coverage limit under paragraph (3) shall not apply.

“(iv) NO COST SHARING ABOVE ANNUAL OUT-OF-POCKET THRESHOLD.—The waiver of cost sharing under paragraph (4).”.

(ii) CONFORMING AMENDMENTS TO COST-SHARING FOR LOW-INCOME INDIVIDUALS.—Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended—

(I) in paragraph (1), in the matter preceding subparagraph (A), by striking “In the case” and inserting

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1 “Subject to section 1860D–2(b)(8), in
2 the case”; and

3 (II) in paragraph (2), in the mat-
4 ter preceding subparagraph (A), by
5 striking “In the case” and inserting
6 “Subject to section 1860D–2(b)(8), in
7 the case”.

8 (6) COVERAGE OF HIV PREVENTION TREAT-
9 MENT BY DEPARTMENT OF VETERANS AFFAIRS.—

10 (A) ELIMINATION OF MEDICATION COPAY-
11 MENTS.—Section 1722A(a) of title 38, United
12 States Code, is amended by adding at the end
13 the following new paragraph:

14 “(5) Paragraph (1) does not apply to a medication
15 for the prevention of HIV.”.

16 (B) ELIMINATION OF HOSPITAL CARE AND
17 MEDICAL SERVICES COPAYMENTS.—Section
18 1710 of such title is amended—

19 (i) in subsection (f)—

20 (I) by redesignating paragraph
21 (5) as paragraph (6); and

22 (II) by inserting after paragraph
23 (4) the following new paragraph (5):

24 “(5) A veteran shall not be liable to the United States
25 under this subsection for any amounts for laboratory and

1 other diagnostic procedures associated with the use of any
2 prescription drug approved by the Food and Drug Admin-
3 istration for the prevention of HIV, administrative fees for
4 such drugs, or for laboratory or other diagnostic proce-
5 dures associated with the use of such drugs, or clinical
6 follow up and monitoring, including any related services
7 recommended in current United States Public Health
8 Service clinical practice guidelines, without limitation.”;
9 and

10 (ii) in subsection (g)(3), by adding at
11 the end the following new subparagraph:

12 “(C) Any prescription drug approved by the
13 Food and Drug Administration for the prevention of
14 HIV, administrative fees for such drugs, laboratory
15 and other diagnostic procedures associated with the
16 use of such drugs, and clinical follow up and moni-
17 toring, including any related services recommended
18 in current United States Public Health Service clin-
19 ical practice guidelines, without limitation.”.

20 (C) INCLUSION AS PREVENTIVE HEALTH
21 SERVICE.—Section 1701(9) of such title is
22 amended—

23 (i) in subparagraph (K), by striking “;
24 and” and inserting a semicolon;

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1 (ii) by redesignating subparagraph
2 (L) as subparagraph (M); and
3 (iii) by inserting after subparagraph
4 (K) the following new subparagraph (L):

5 “(L) any prescription drug approved by
6 the Food and Drug Administration for the pre-
7 vention of HIV, administrative fees for such
8 drugs, laboratory and other diagnostic proce-
9 dures associated with the use of such drugs,
10 and clinical follow up and monitoring, including
11 any related services recommended in current
12 United States Public Health Service clinical
13 practice guidelines, without limitation; and”.

14 (7) COVERAGE OF HIV PREVENTION TREAT-
15 MENT BY DEPARTMENT OF DEFENSE.—

16 (A) IN GENERAL.—Chapter 55 of title 10,
17 United States Code, is amended by inserting
18 after section 1079c the following new section:

19 **“§ 1079d. Coverage of HIV prevention treatment**

20 “(a) IN GENERAL.—The Secretary of Defense shall
21 ensure coverage under the TRICARE program of HIV
22 prevention treatment described in subsection (b) for any
23 beneficiary under section 1074(a) of this title.

24 “(b) HIV PREVENTION TREATMENT DESCRIBED.—
25 HIV prevention treatment described in this subsection in-

1 cludes any prescription drug approved by the Food and
2 Drug Administration for the prevention of HIV, adminis-
3 trative fees for such drugs, laboratory and other diagnostic
4 procedures associated with the use of such drugs, and clin-
5 ical follow up and monitoring, including any related serv-
6 ices recommended in current United States Public Health
7 Service clinical practice guidelines, without limitation.

8 “(c) NO COST-SHARING.—Notwithstanding section
9 1075, 1075a, or 1074g(a)(6) of this title or any other pro-
10 vision of law, there is no cost-sharing requirement for HIV
11 prevention treatment covered under this section.”.

12 (B) CLERICAL AMENDMENT.—The table of
13 sections at the beginning of such chapter is
14 amended by inserting after the item relating to
15 section 1079c the following new item:

“1079d. Coverage of HIV prevention treatment.”.

16 (8) INDIAN HEALTH SERVICE TESTING, MONI-
17 TORING, AND PRESCRIPTION DRUGS FOR THE PRE-
18 VENTION OF HIV.—Title II of the Indian Health
19 Care Improvement Act is amended by inserting after
20 section 223 (25 U.S.C. 1621v) the following:

21 **“SEC. 224. TESTING, MONITORING, AND PRESCRIPTION**
22 **DRUGS FOR THE PREVENTION OF HIV.**

23 “(a) IN GENERAL.—The Secretary, acting through
24 the Service, Indian tribes, and tribal organizations, shall
25 provide, without limitation, funding for any prescription

1 drug approved by the Food and Drug Administration for
2 the prevention of human immunodeficiency virus (com-
3 monly known as ‘HIV’), administrative fees for that drug,
4 laboratory and other diagnostic procedures associated with
5 the use of that drug, and clinical follow-up and moni-
6 toring, including any related services recommended in cur-
7 rent United States Public Health Service clinical practice
8 guidelines.

9 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated such sums as may be
11 necessary to carry out this section.”.

12 (9) EFFECTIVE DATE.—The amendments made
13 by paragraphs (1), (2), (5), (6), (7), and (8) shall
14 take effect with respect to plan years beginning on
15 or after January 1, 2023.

16 (b) PROHIBITION ON DENIAL OF COVERAGE OR IN-
17 CREASE IN PREMIUMS OF LIFE, DISABILITY, OR LONG-
18 TERM CARE INSURANCE FOR INDIVIDUALS TAKING MEDI-
19 CATION FOR THE PREVENTION OF HIV ACQUISITION.—

20 (1) PROHIBITION.—Notwithstanding any other
21 provision of law, it shall be unlawful to—

22 (A) decline or limit coverage of a person
23 under any life insurance policy, disability insur-
24 ance policy, or long-term care insurance policy,
25 on account of the individual taking medication

1 for the purpose of preventing the acquisition of
2 HIV;

3 (B) preclude an individual from taking
4 medication for the purpose of preventing the ac-
5 quisition of HIV as a condition of receiving a
6 life insurance policy, disability insurance policy,
7 or long-term care insurance policy;

8 (C) consider whether an individual is tak-
9 ing medication for the purpose of preventing
10 the acquisition of HIV in determining the pre-
11 mium rate for coverage of such individual under
12 a life insurance policy, disability insurance pol-
13 icy, or long-term care insurance policy; or

14 (D) otherwise discriminate in the offering,
15 issuance, cancellation, amount of such coverage,
16 price, or any other condition of a life insurance
17 policy, disability insurance policy, or long-term
18 care insurance policy for an individual, based
19 solely and without any additional actuarial risks
20 upon whether the individual is taking medica-
21 tion for the purpose of preventing the acquisi-
22 tion of HIV.

23 (2) ENFORCEMENT.—A State insurance regu-
24 lator may take such actions to enforce paragraph (1)

1 as are specifically authorized under the laws of such
2 State.

3 (3) DEFINITIONS.—In this subsection:

4 (A) DISABILITY INSURANCE POLICY.—The
5 term “disability insurance policy” means a con-
6 tract under which an entity promises to pay a
7 person a sum of money in the event that an ill-
8 ness or injury resulting in a disability prevents
9 such person from working.

10 (B) LIFE INSURANCE POLICY.—The term
11 “life insurance policy” means a contract under
12 which an entity promises to pay a designated
13 beneficiary a sum of money upon the death of
14 the insured.

15 (C) LONG-TERM CARE INSURANCE POL-
16 ICY.—The term “long-term care insurance pol-
17 icy” means a contract for which the only insur-
18 ance protection provided under the contract is
19 coverage of qualified long-term care services (as
20 defined in section 7702B(c) of the Internal
21 Revenue Code of 1986).

22 (c) PATIENT CONFIDENTIALITY.—The Secretary of
23 Health and Human Services shall amend the regulations
24 promulgated under section 264(c) of the Health Insurance
25 Portability and Accountability Act of 1996 (42 U.S.C.

1 1320d–2 note), as necessary, to ensure that individuals
2 are able to access the benefits described in section
3 2713(a)(1)(E) of the Public Health Service Act (as
4 amended by section 7602(d)) under a family plan without
5 any other individual enrolled in such family plan, including
6 a primary subscriber or policyholder of such plan, being
7 informed of such use of such benefits.

8 (d) PRE-EXPOSURE PROPHYLAXIS AND POST-EXPO-
9 SURE PROPHYLAXIS FUNDING.—Part P of title III of the
10 Public Health Service Act (42 U.S.C. 280g et seq.), as
11 amended by section 7153, is further amended by adding
12 at the end the following:

13 **“SEC. 399V–10. PRE-EXPOSURE PROPHYLAXIS AND POST-EX-**
14 **POSURE PROPHYLAXIS FUNDING.**

15 “(a) IN GENERAL.—Not later than 1 year after the
16 date of enactment of this section, the Secretary shall es-
17 tablish a program that awards grants to States, terri-
18 tories, Indian Tribes, and directly eligible entities for the
19 establishment and support of pre-exposure prophylaxis
20 (referred to in this section as ‘PrEP’) and post-exposure
21 prophylaxis (referred to in this section as ‘PEP’) HIV pro-
22 grams.

23 “(b) APPLICATIONS.—To be eligible to receive a
24 grant under subsection (a), a State, territory, Indian
25 Tribe, or directly eligible entity shall—

1 “(1) submit an application to the Secretary at
2 such time, in such manner, and containing such in-
3 formation as the Secretary may require, including a
4 plan describing how any funds awarded will be used
5 to increase access to PrEP for uninsured and under-
6 insured individuals and reduce disparities in access
7 to PrEP and PEP for uninsured and underinsured
8 individuals and reduce disparities in access to PrEP
9 and PEP; and

10 “(2) appoint a PrEP and PEP grant adminis-
11 trator to manage the program.

12 “(c) DIRECTLY ELIGIBLE ENTITY.—For purposes of
13 this section, the term ‘directly eligible entity’—

14 “(1) means a Federally qualified health center
15 or other nonprofit entity engaged in providing PrEP
16 and PEP information and services; and

17 “(2) may include—

18 “(A) a Federally qualified health center
19 (as defined in section 1861(aa)(4) of the Social
20 Security Act (42 U.S.C. 1395x(aa)(4)));

21 “(B) a family planning grantee (other than
22 States) funded under section 1001 of the Public
23 Health Service Act (42 U.S.C. 300);

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1 “(C) a rural health clinic (as defined in
2 section 1861(aa)(2) of the Social Security Act
3 (42 U.S.C. 1395x(aa)(2)));

4 “(D) a health facility operated by or pur-
5 suant to a contract with the Indian Health
6 Service;

7 “(E) a community-based organization, clin-
8 ic, hospital, or other health facility that pro-
9 vides services to individuals at risk for or living
10 with HIV; and

11 “(F) a nonprofit private entity providing
12 comprehensive primary care to populations at
13 risk of HIV, including faith-based and commu-
14 nity-based organizations.

15 “(d) AWARDS.—In determining whether to award a
16 grant, and the grant amount for each grant awarded, the
17 Secretary shall consider the grant application and the
18 need for PrEP and PEP services in the area, the number
19 of uninsured and underinsured individuals in the area, and
20 how the State, territory, or Indian Tribe coordinates
21 PrEP and PEP activities with the directly funded entity,
22 if the State, territory, or Indian Tribe applies for the
23 funds.

24 “(e) USE OF FUNDS.—

1 “(1) IN GENERAL.—Any State, territory, Indian
2 Tribe, or directly eligible entity that is awarded
3 funds under subsection (a) shall use such funds for
4 eligible PrEP and PEP expenses.

5 “(2) ELIGIBLE PREP EXPENSES.—The Sec-
6 retary shall publish a list of expenses that qualify as
7 eligible PrEP and PEP expenses for purposes of this
8 section, which shall include—

9 “(A) any prescription drug approved by
10 the Food and Drug Administration for the pre-
11 vention of HIV, administrative fees for such
12 drugs, laboratory and other diagnostic proce-
13 dures associated with the use of such drugs,
14 and clinical follow up and monitoring, including
15 any related services recommended in current
16 United States Public Health Service clinical
17 practice guidelines, without limitation;

18 “(B) outreach and public education activi-
19 ties directed toward populations overrepresented
20 in the domestic HIV epidemic that increase
21 awareness about the existence of PrEP and
22 PEP, provide education about access to and
23 health care coverage of PrEP and PEP, PrEP
24 and PEP adherence programs, and counter

1 stigma associated with the use of PrEP and
2 PEP; and

3 “(C) outreach activities directed toward
4 physicians and other providers that provide
5 education about PrEP and PEP.

6 “(f) REPORT TO CONGRESS.—The Secretary shall, in
7 each of the first 5 years beginning one year after the date
8 of the enactment of this section, submit to Congress, and
9 make public on the internet website of the Department
10 of Health and Human Services, a report on the impact
11 of any grants provided to States, territories, and Indian
12 Tribes and directly eligible entities for the establishment
13 and support of pre-exposure prophylaxis programs under
14 this section.

15 “(g) AUTHORIZATION OF APPROPRIATIONS.—To
16 carry out this section, there are authorized to be appro-
17 priated such sums as may be necessary for each of fiscal
18 years 2023 through 2028.”.

19 (e) CLARIFICATION.—This section, including the
20 amendments made by this section, shall apply notwith-
21 standing any other provision of law, including Public Law
22 103–141.

23 (f) PRIVATE RIGHT OF ACTION.—Any person ag-
24 grieved by a violation of this section, including the amend-
25 ments made by this section, may commence a civil action

1 in an appropriate United States District Court or other
2 court of competent jurisdiction to obtain relief as allowed
3 by law as either an individual or member of a class. If
4 the plaintiff is the prevailing party in such an action, the
5 court shall order the defendant to pay the costs and rea-
6 sonable attorney fees of the plaintiff.

7 **Subtitle F—Diabetes**

8 **SEC. 7251. RESEARCH, TREATMENT, AND EDUCATION.**

9 Subpart 3 of part C of title IV of the Public Health
10 Service Act (42 U.S.C. 285c et seq.) is amended by adding
11 at the end the following new section:

12 **“SEC. 434B. DIABETES IN MINORITY POPULATIONS.**

13 “(a) IN GENERAL.—The Director of NIH shall ex-
14 pand, intensify, and support ongoing research and other
15 activities with respect to prediabetes and diabetes, particu-
16 larly type 2, in minority populations.

17 “(b) RESEARCH.—

18 “(1) DESCRIPTION.—Research under subsection

19 (a) shall include investigation into—

20 “(A) the causes of diabetes, including so-
21 cioeconomic, geographic, clinical, environmental,
22 genetic, and other factors that may contribute
23 to increased rates of diabetes in minority popu-
24 lations; and

1 “(B) the causes of increased incidence of
2 diabetes complications in minority populations,
3 and possible interventions to decrease such inci-
4 dence.

5 “(2) INCLUSION OF MINORITY PARTICIPANTS.—
6 In conducting and supporting research described in
7 subsection (a), the Director of NIH shall seek to in-
8 clude minority participants as study subjects in clin-
9 ical trials.

10 “(c) REPORT; COMPREHENSIVE PLAN.—

11 “(1) IN GENERAL.—The Diabetes Mellitus
12 Interagency Coordinating Committee shall—

13 “(A) prepare and submit to the Congress,
14 not later than 6 months after the date of enact-
15 ment of this section, a report on Federal re-
16 search and public health activities with respect
17 to prediabetes and diabetes in minority popu-
18 lations; and

19 “(B) develop and submit to Congress, not
20 later than 1 year after the date of enactment of
21 this section, an effective and comprehensive
22 Federal plan (including all appropriate Federal
23 health programs) to address prediabetes and di-
24 abetes in minority populations.

1 “(2) CONTENTS.—The report under paragraph
2 (1)(A) shall at minimum address each of the fol-
3 lowing:

4 “(A) Research on diabetes and prediabetes
5 in minority populations, including such research
6 on—

7 “(i) genetic, behavioral, socio-
8 economic, and environmental factors;

9 “(ii) prevention of diabetes within
10 these populations and who have individuals
11 at increased risk of developing diabetes;

12 “(iii) prevention of complications
13 among individuals in these populations who
14 have already developed diabetes; and

15 “(iv) barriers to health care access
16 and diabetes treatment within populations
17 at increased risk of developing diabetes.

18 “(B) Surveillance and data collection on
19 diabetes and prediabetes in minority popu-
20 lations, including with respect to—

21 “(i) efforts to better determine the
22 prevalence of diabetes among Asian-Amer-
23 ican and Pacific Islander subgroups; and

24 “(ii) efforts to coordinate data collec-
25 tion on the American Indian population.

1 “(C) Community-based interventions to ad-
2 dress diabetes and prediabetes targeting minor-
3 ity populations, including—

4 “(i) the evidence base for such inter-
5 ventions;

6 “(ii) the cultural appropriateness of
7 such interventions; and

8 “(iii) efforts to educate the public on
9 the causes and consequences of diabetes.

10 “(D) Education and training programs for
11 health professionals (including community
12 health workers) on the prevention and manage-
13 ment of diabetes and its related complications
14 that is supported by the Health Resources and
15 Services Administration, including such pro-
16 grams supported by—

17 “(i) the National Health Service
18 Corps; or

19 “(ii) the community health centers
20 program under section 330.

21 “(d) EDUCATION.—The Director of NIH shall—

22 “(1) through the National Institute on Minority
23 Health and Health Disparities and the National Di-
24 abetes Education Program—

1 “(A) make grants to programs funded
2 under section 464z-4 for the purpose of estab-
3 lishing a medical education program for health
4 care professionals to be more involved in weight
5 counseling, obesity research, nutrition, and
6 shared decision-making; and

7 “(B) provide for the participation of mi-
8 nority health professionals in diabetes-focused
9 research programs; and

10 “(2) make grants to programs that establish a
11 professional pipeline that will increase the participa-
12 tion of minority individuals in diabetes-focused
13 health fields by expanding Minority Access to Re-
14 search Careers program internships and mentoring
15 opportunities for the purposes of recruitment.

16 “(e) DEFINITIONS.—For purposes of this section:

17 “(1) DIABETES MELLITUS INTERAGENCY CO-
18 ORDINATING COMMITTEE.—The ‘Diabetes Mellitus
19 Interagency Coordinating Committee’ means the Di-
20 abetes Mellitus Interagency Coordinating Committee
21 established under section 429.

22 “(2) MINORITY POPULATION.—The term ‘mi-
23 nority population’ means a racial and ethnic minor-
24 ity group, as defined in section 1707.”.

1 **SEC. 7252. RESEARCH, EDUCATION, AND OTHER ACTIVI-**
2 **TIES.**

3 Part B of title III of the Public Health Service Act
4 (42 U.S.C. 243 et seq.), as amended by section 7101, is
5 further amended by inserting after section 317W the fol-
6 lowing section:

7 **“SEC. 317X. DIABETES IN MINORITY POPULATIONS.**

8 “(a) RESEARCH AND OTHER ACTIVITIES.—

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

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

17 “(A) Further enhancing the National
18 Health and Nutrition Examination Survey by
19 oversampling Asian Americans, Native Hawai-
20 ians, and Pacific Islanders in appropriate geo-
21 graphic areas to better determine the preva-
22 lence of diabetes in such populations as well as
23 to improve the data collection of diabetes pene-
24 tration disaggregated into major ethnic groups
25 within such populations. The Secretary shall en-
26 sure that any such oversampling does not re-

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1 duce the oversampling of other minority popu-
2 lations including African-American and Latino
3 populations.

4 “(B) Through the Division of Diabetes
5 Translation—

6 “(i) providing for prevention research
7 to better understand how to influence
8 health care systems changes to improve
9 quality of care being delivered to such pop-
10 ulations;

11 “(ii) carrying out model demonstra-
12 tion projects to design, implement, and
13 evaluate effective diabetes prevention and
14 control interventions for minority popu-
15 lations, including culturally appropriate
16 community-based interventions;

17 “(iii) developing and implementing a
18 strategic plan to reduce diabetes in minor-
19 ity populations through applied research to
20 reduce disparities and culturally and lin-
21 guistically appropriate community-based
22 interventions;

23 “(iv) supporting, through the national
24 diabetes prevention program under section
25 399V–3, diabetes prevention program sites

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1 in underserved regions highly impacted by
2 diabetes; and

3 “(v) implementing, through the na-
4 tional diabetes prevention program under
5 section 399V–3, a demonstration program
6 developing new metrics measuring health
7 outcomes related to diabetes that can be
8 stratified by specific minority populations.

9 “(b) EDUCATION.—The Secretary, acting through
10 the Director of the Centers for Disease Control and Pre-
11 vention, shall direct the Division of Diabetes Translation
12 to conduct and support both programs to educate the pub-
13 lic on diabetes in minority populations and programs to
14 educate minority populations about the causes and effects
15 of diabetes.

16 “(c) DIABETES; HEALTH PROMOTION, PREVENTION
17 INITIATIVES, AND ACCESS.—The Secretary, acting
18 through the Director of the Centers for Disease Control
19 and Prevention and the National Diabetes Education Pro-
20 gram, shall conduct and support programs to educate spe-
21 cific minority populations through culturally appropriate
22 and linguistically appropriate information campaigns and
23 initiatives about prevention of, and managing, diabetes.

1 “(d) DEFINITION.—For purposes of this section, the
2 term ‘minority population’ means a racial and ethnic mi-
3 nority group, as defined in section 1707.”.

4 **SEC. 7253. PROGRAMS TO EDUCATE HEALTH PROVIDERS**
5 **ON THE CAUSES AND EFFECTS OF DIABETES**
6 **IN MINORITY POPULATIONS.**

7 Part P of title III of the Public Health Service Act
8 (42 U.S.C. 280g et seq.), as amended by section 7220,
9 is further amended by adding at the end the following new
10 section:

11 **“SEC. 399V-11. PROGRAMS TO EDUCATE HEALTH PRO-**
12 **VIDERS ON THE CAUSES AND EFFECTS OF DI-**
13 **ABETES IN MINORITY POPULATIONS.**

14 “(a) IN GENERAL.—The Secretary, acting through
15 the Administrator of the Health Resources and Services
16 Administration, shall conduct and support programs de-
17 scribed in subsection (b) to educate health professionals
18 on the causes and effects of diabetes in minority popu-
19 lations.

20 “(b) PROGRAMS.—Programs described in this sub-
21 section, with respect to education on diabetes in minority
22 populations, shall include the following:

23 “(1) Giving priority, under the primary care
24 training and enhancement program under section
25 747—

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1 “(A) to awarding grants to focus on or ad-
2 dress diabetes; and

3 “(B) to adding minority populations to the
4 list of vulnerable populations that should be
5 served by such grants.

6 “(2) Providing additional funds for the Health
7 Careers Opportunity Program, the Centers of Excel-
8 lence, and the Minority Faculty Fellowship Program
9 to partner with the Office of Minority Health under
10 section 1707 and the National Institutes of Health
11 to strengthen programs for career opportunities fo-
12 cused on diabetes treatment and care within under-
13 served regions highly impacted by diabetes.

14 “(3) Developing a diabetes focus within, and
15 providing additional funds for, the National Health
16 Service Corps scholarship program—

17 “(A) to place individuals in areas that are
18 disproportionately affected by diabetes and to
19 provide diabetes treatment and care in such
20 areas; and

21 “(B) to provide such individuals continuing
22 medical education specific to diabetes care.”.

1 **SEC. 7254. RESEARCH, EDUCATION, AND OTHER ACTIVITIES**
2 **REGARDING DIABETES IN AMERICAN INDIAN**
3 **POPULATIONS.**

4 Part P of title III of the Public Health Service Act
5 (42 U.S.C. 280g et seq.), as amended by section 7253,
6 is further amended by adding at the end the following sec-
7 tion:

8 **“SEC. 399V-12. RESEARCH, EDUCATION, AND OTHER ACTIVI-**
9 **TIES REGARDING DIABETES IN AMERICAN IN-**
10 **DIAN POPULATIONS.**

11 “In addition to activities under sections 317X, 399V–
12 11, and 434B, the Secretary, acting through the Indian
13 Health Service and in collaboration with other appropriate
14 Federal agencies, shall—

15 “(1) conduct and support research and other
16 activities with respect to diabetes; and

17 “(2) coordinate the collection of data on clini-
18 cally and culturally appropriate diabetes treatment,
19 care, prevention, and services by health care profes-
20 sionals to the American Indian population.”.

21 **SEC. 7255. UPDATED REPORT ON HEALTH DISPARITIES.**

22 The Secretary of Health and Human Services shall
23 seek to enter into an arrangement with the National Acad-
24 emy of Medicine under which the National Academy will—

25 (1) not later than 1 year after the date of en-
26 actment of this Act, submit to Congress an updated

1 version of the 2003 report entitled “Unequal Treat-
2 ment: Confronting Racial and Ethnic Disparities in
3 Health Care”; and

4 (2) in such updated version, address how racial
5 and ethnic health disparities have changed since the
6 publication of the original report.

7 **Subtitle G—Lung Disease**

8 **SEC. 7301. NATIONAL ASTHMA BURDEN.**

9 Congress finds as follows:

10 (1) The prevalence of asthma has increased
11 since 1980 and affects more than 26,000,000 people
12 in the United States.

13 (2) Significant disparities in asthma morbidity
14 and mortality exist for both adults and children par-
15 ticularly for low-income and minority populations,
16 particularly African Americans and Puerto Ricans.

17 (3) African-American children are twice as like-
18 ly to have asthma as White children.

19 (4) In 2016, almost 4,500,000 non-Hispanic
20 African Americans reported having asthma. African
21 Americans with asthma are 3 times as likely to visit
22 the emergency department and twice as likely to get
23 hospitalized as White patients with asthma.

24 (5) Puerto Ricans are 3.4 times as likely to die
25 from asthma compared with all other Hispanic or

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1 Latino groups. Overall Hispanic Americans are 30
2 percent more likely to be hospitalized for asthma
3 than non-Hispanic Whites.

4 (6) The majority of adults with asthma are
5 women.

6 **SEC. 7302. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**
7 **FOR DISEASE CONTROL AND PREVENTION.**

8 Section 317I of the Public Health Service Act (42
9 U.S.C. 247b–10) is amended to read as follows:

10 **“SEC. 317I. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**
11 **FOR DISEASE CONTROL AND PREVENTION.**

12 “(a) PROGRAM FOR PROVIDING INFORMATION AND
13 EDUCATION TO THE PUBLIC.—The Secretary, acting
14 through the Director of the Centers for Disease Control
15 and Prevention, shall collaborate with State and local
16 health departments to conduct activities, including the
17 provision of information and education to the public re-
18 garding asthma including—

19 “(1) deterring the harmful consequences of un-
20 controlled asthma; and

21 “(2) disseminating health education and infor-
22 mation regarding prevention of asthma episodes and
23 strategies for managing asthma.

24 “(b) DEVELOPMENT OF STATE ASTHMA PLANS.—
25 The Secretary, acting through the Director of the Centers

1 for Disease Control and Prevention, shall collaborate with
2 State and local health departments to develop State plans
3 incorporating public health responses to reduce the burden
4 of asthma, particularly regarding disproportionately af-
5 fected populations.

6 “(c) COMPILATION OF DATA.—The Secretary, acting
7 through the Director of the Centers for Disease Control
8 and Prevention, shall, in cooperation with State and local
9 public health officials—

10 “(1) conduct asthma surveillance activities to
11 collect data on the prevalence and severity of asth-
12 ma, the effectiveness of public health asthma inter-
13 ventions, and the quality of asthma management, in-
14 cluding—

15 “(A) collection of data among people with
16 asthma to monitor the impact on health and
17 quality of life;

18 “(B) surveillance of health care facilities;
19 and

20 “(C) collection of data not containing indi-
21 vidually identifiable information from electronic
22 health records or other electronic communica-
23 tions;

24 “(2) compile and annually publish data regard-
25 ing the prevalence and incidence of childhood asth-

1 ma, the child mortality rate, and the number of hos-
2 pital admissions and emergency department visits by
3 children associated with asthma nationally and in
4 each State and at the county level by age, sex, race,
5 and ethnicity, as well as lifetime and current preva-
6 lence; and

7 “(3) compile and annually publish data regard-
8 ing the prevalence and incidence of adult asthma,
9 the adult mortality rate, and the number of hospital
10 admissions and emergency department visits by
11 adults associated with asthma nationally and in each
12 State and at the county level by age, sex, race, eth-
13 nicity, industry, and occupation, as well as lifetime
14 and current prevalence.

15 “(d) COORDINATION OF DATA COLLECTION.—The
16 Director of the Centers for Disease Control and Preven-
17 tion, in conjunction with State and local health depart-
18 ments, shall coordinate data collection activities under
19 paragraphs (2) and (3) of subsection (c) so as to maximize
20 comparability of results.

21 “(e) COLLABORATION.—

22 “(1) IN GENERAL.—The Centers for Disease
23 Control and Prevention may collaborate with na-
24 tional, State, and local nonprofit organizations to

1 provide information and education about asthma,
2 and to strengthen such collaborations when possible.

3 “(2) SPECIFIC ACTIVITIES.—The Director of
4 the Centers for Disease Control and Prevention, act-
5 ing through the Division of Population Health of the
6 Centers, may expand activities relating to asthma
7 with non-Federal partners, especially State-level en-
8 tities.

9 “(f) REPORTS TO CONGRESS.—

10 “(1) IN GENERAL.—Not later than 3 years
11 after the date of the enactment of the Health Equity
12 and Accountability Act of 2022, and once 2 years
13 thereafter, the Secretary shall, in consultation with
14 patient groups, nonprofit organizations, medical so-
15 cieties, and other relevant governmental and non-
16 governmental entities, submit to Congress a report
17 that—

18 “(A) catalogs, with respect to asthma pre-
19 vention, management, and surveillance—

20 “(i) the activities of the Federal Gov-
21 ernment, including an assessment of the
22 progress of the Federal Government and
23 States, with respect to achieving the goals
24 of the Healthy People 2030 initiative; and

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1 “(ii) the activities of other entities
2 that participate in the program under this
3 section, including nonprofit organizations,
4 patient advocacy groups, and medical soci-
5 eties; and

6 “(B) makes recommendations for the fu-
7 ture direction of asthma activities, in consulta-
8 tion with researchers from the National Insti-
9 tutes of Health and other member bodies of the
10 Asthma Disparities Subcommittee, including—

11 “(i) a description of how the Federal
12 Government may improve its response to
13 asthma, including identifying any barriers
14 that may exist;

15 “(ii) a description of how the Federal
16 Government may continue, expand, and
17 improve its private-public partnerships
18 with respect to asthma including identi-
19 fying any barriers that may exist;

20 “(iii) identification of steps that may
21 be taken to reduce the—

22 “(I) morbidity, mortality, and
23 overall prevalence of asthma;

24 “(II) financial burden of asthma
25 on society;

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1 “(III) burden of asthma on dis-
2 proportionately affected areas, par-
3 ticularly those in medically under-
4 served populations (as defined in sec-
5 tion 330(b)(3)); and

6 “(IV) burden of asthma as a
7 chronic disease that can be worsened
8 by environmental exposures;

9 “(iv) the identification of programs
10 and policies that have achieved the steps
11 described under clause (iii), and steps that
12 may be taken to expand such programs
13 and policies to benefit larger populations;
14 and

15 “(v) recommendations for future re-
16 search and interventions.

17 “(2) SUBSEQUENT REPORTS.—

18 “(A) CONGRESSIONAL REQUEST.—During
19 the 5-year period following the submission of
20 the second report under paragraph (1), the Sec-
21 retary shall submit updates and revisions of the
22 report upon the request of the Congress.

23 “(B) FIVE-YEAR REEVALUATION.—At the
24 end of the 5-year period referred to in subpara-
25 graph (A), the Secretary shall—

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1 “(i) evaluate the analyses and rec-
2 ommendations made in previous reports;
3 and

4 “(ii) determine whether an additional
5 report is needed and if so submit such an
6 updated report to the Congress, including
7 appropriate recommendations.

8 “(g) AUTHORIZATION OF APPROPRIATIONS FUND-
9 ING.—In addition to any other authorization of appropria-
10 tions that is available to the Centers for Disease Control
11 and Prevention for the purpose of carrying out this sec-
12 tion, there is authorized to be appropriated to such Cen-
13 ters \$65,000,000 for the period of fiscal years 2023
14 through 2027 for the purpose of carrying out this sec-
15 tion.”.

16 **SEC. 7303. INFLUENZA AND PNEUMONIA VACCINATION**
17 **CAMPAIGN.**

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

20 (1) enhance the annual campaign by the De-
21 partment of Health and Human Services to increase
22 the number of people vaccinated each year for influ-
23 enza and pneumonia; and

24 (2) include in such campaign the use of written
25 educational materials, public service announcements,

1 physician education, and any other means which the
2 Secretary deems effective.

3 (b) MATERIALS AND ANNOUNCEMENTS.—In carrying
4 out the annual campaign described in subsection (a), the
5 Secretary of Health and Human Services shall ensure
6 that—

7 (1) educational materials and public service an-
8 nouncements are readily and widely available in
9 communities experiencing disparities in the incidence
10 and mortality rates of influenza and pneumonia; and

11 (2) the campaign uses targeted, culturally ap-
12 propriate messages and messengers to reach under-
13 served communities.

14 (c) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated to carry out this section
16 such sums as may be necessary for each of fiscal years
17 2023 through 2027.

18 **SEC. 7304. CHRONIC OBSTRUCTIVE PULMONARY DISEASE.**

19 (a) FINDINGS.—Congress finds as follows:

20 (1) Chronic obstructive pulmonary disease (re-
21 ferred to in this subsection as “COPD”) refers to
22 chronic bronchitis and emphysema, incurable dis-
23 eases that make it difficult to exhale all the air from
24 one’s lungs, and that can cause persistent coughing,
25 shortness of breath, and sputum.

1 (2) COPD exacerbations—episodes of acute dif-
2 ficulty breathing and moderate to severe fatigue—
3 are dangerous, and their treatment often requires
4 hospitalization.

5 (3) While smoking is the primary risk factor for
6 COPD, other risk factors include air pollution, occu-
7 pational exposures, heredity, a history of childhood
8 respiratory infections, and socioeconomic status.

9 (4) It is estimated that over 16,000,000 adults
10 in the United States have COPD.

11 (5) COPD is a leading cause of death in the
12 United States, claiming over 156,000 lives in 2019.

13 (6) Since 2000, deaths for women with COPD
14 have exceeded deaths in men.

15 (7) Although African Americans have a lower
16 prevalence of COPD in the United States, research-
17 ers have shown that African Americans may be
18 underdiagnosed. Furthermore, research has shown
19 that African Americans develop COPD with less cu-
20 mulative smoke exposure and at a younger age.

21 (b) IN GENERAL.—The Director of the Centers for
22 Disease Control and Prevention shall conduct, support,
23 and expand public health strategies, prevention, diagnosis,
24 surveillance, and public and professional awareness activi-
25 ties regarding chronic obstructive pulmonary disease.

1 (c) CHRONIC DISEASE PREVENTION PROGRAMS.—

2 The Director of the National Heart, Lung, and Blood In-
3 stitute shall carry out the following:

4 (1) Conduct public education and awareness ac-
5 tivities with patient and professional organizations
6 to stimulate earlier diagnosis and improve patient
7 outcomes from treatment of chronic obstructive pul-
8 monary disease. To the extent known and relevant,
9 such public education and awareness activities shall
10 reflect differences in chronic obstructive pulmonary
11 disease by cause (tobacco, environmental, occupa-
12 tional, biological, and genetic) and include a focus
13 on outreach to undiagnosed and, as appropriate, mi-
14 nority populations.

15 (2) Supplement and expand upon the activities
16 of the National Heart, Lung, and Blood Institute by
17 making grants to nonprofit organizations, State and
18 local jurisdictions, and Indian Tribes for the purpose
19 of reducing the burden of chronic obstructive pul-
20 monary disease, especially in disproportionately im-
21 pacted communities, through public health interven-
22 tions and related activities.

23 (3) Coordinate with the Centers for Disease
24 Control and Prevention, the Indian Health Service,
25 the Health Resources and Services Administration,

1 and the Department of Veterans Affairs to develop
2 pilot programs to demonstrate best practices for the
3 diagnosis and management of chronic obstructive
4 pulmonary disease.

5 (4) Develop improved techniques and identify
6 best practices, in coordination with the Secretary of
7 Veterans Affairs, for assisting chronic obstructive
8 pulmonary disease patients to successfully stop
9 smoking, including identification of subpopulations
10 with different needs. Initiatives under this para-
11 graph may include research to determine whether
12 successful smoking cessation strategies are different
13 for chronic obstructive pulmonary disease patients
14 compared to such strategies for patients with other
15 chronic diseases.

16 (d) ENVIRONMENTAL AND OCCUPATIONAL HEALTH
17 PROGRAMS.—The Director of the Centers for Disease
18 Control and Prevention shall—

19 (1) support research into the environmental and
20 occupational causes and biological mechanisms that
21 contribute to chronic obstructive pulmonary disease;
22 and

23 (2) develop and disseminate public health inter-
24 ventions that will lessen the impact of environmental

1 and occupational causes of chronic obstructive pul-
2 monary disease.

3 (e) DATA COLLECTION.—Not later than 180 days
4 after the date of enactment of this Act, the Director of
5 the National Heart, Lung, and Blood Institute and the
6 Director of the Centers for Disease Control and Preven-
7 tion, acting jointly, shall assess the depth and quality of
8 information on chronic obstructive pulmonary disease that
9 is collected in surveys and population studies conducted
10 by the Centers for Disease Control and Prevention, includ-
11 ing whether there are additional opportunities for informa-
12 tion to be collected in the National Health and Nutrition
13 Examination Survey, the National Health Interview Sur-
14 vey, and the Behavioral Risk Factors Surveillance System
15 surveys.

16 (f) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated to carry out this section
18 such sums as may be necessary for each of fiscal years
19 2023 through 2027.

20 **Subtitle H—Tuberculosis**

21 **SEC. 7351. ELIMINATION OF ALL FORMS OF TUBERCULOSIS.**

22 (a) SHORT TITLE.—This subtitle may be cited as the
23 “End Tuberculosis Act”.

24 (b) FINDINGS.—Congress makes the following find-
25 ings:

1 (1) In the United States, 7,174 people were di-
2 agnosed with tuberculosis (referred to in this section
3 as “TB”) in 2020.

4 (2) Disparities in TB exist and significantly im-
5 pact minority communities in the United States. The
6 Centers for Disease Control and Prevention (re-
7 ferred to in this section as “CDC”) finds that 89
8 percent of people diagnosed with TB disease in 2020
9 self-identified as racial and ethnic minorities.

10 (3) African Americans comprised 19.6 percent
11 of people diagnosed with TB disease during 2020.
12 The population-adjusted rate of TB among African
13 Americans is 1.5 times higher than the national
14 total, and 8.0 times higher than among Whites.

15 (4) Asian Americans, Native Hawaiians, and
16 other Pacific Islanders comprised 37.4 percent of
17 people diagnosed with TB disease during 2020. The
18 population-adjusted rate of TB among Asian Ameri-
19 cans is 6 times higher than the national total, and
20 33.25 times higher than among Whites. The popu-
21 lation-adjusted rate of TB among Native Hawaiians
22 and other Pacific Islanders is 8.5 times higher than
23 the national total, and 46.75 times higher than
24 among Whites.

1 (5) Hispanics and Latinos comprised 29.7 per-
2 cent of people diagnosed with TB disease during
3 2020. The population-adjusted rate of TB among
4 Hispanics and Latinos is 1.6 times higher than the
5 national total, and 8.75 times higher than among
6 Whites.

7 (6) TB is both preventable and curable, but the
8 current rate of decline of TB in the United States
9 remains too slow to achieve TB elimination in this
10 century.

11 (7) TB is transmitted through the air when a
12 person who has TB disease in their lungs coughs or
13 sneezes. People who are in close proximity to the
14 person with TB can breathe in the TB bacteria, and
15 the bacteria will initially settle in their lungs. Living
16 conditions related to poverty, such as crowded hous-
17 ing and poor ventilation, can greatly increase the
18 risk of transmission. Without proper and timely di-
19 agnosis and access to treatment, the TB bacteria
20 may grow and spread to other parts of their body.

21 (8) As many as 13,000,000 people in the
22 United States may have latent TB infection (re-
23 ferred to in this section as “LTBI”). People with
24 LTBI have TB bacteria in their bodies, but their
25 immune system is containing the bacteria, and they

1 are not sick, nor do they have any current risk of
2 spreading TB to others. LTBI can activate into in-
3 fectionous, life-threatening TB if not treated. Modeling
4 has shown that eliminating TB is not possible with-
5 out addressing LTBI.

6 (9) Comorbidities associated with TB include
7 cancer, diabetes mellitus, and HIV. People with
8 these medical conditions and compromised immune
9 systems are more likely to develop active TB disease
10 and to have worse outcomes from TB. Many of the
11 communities placed at highest risk of other adverse
12 health outcomes and injustices are also dispropor-
13 tionately impacted by TB, and these include people
14 experiencing homelessness and housing instability,
15 people in congregate living and carceral settings, and
16 people born outside of the United States.

17 (10) Forms of active TB that do not show drug
18 resistance are classified as drug-susceptible TB (re-
19 ferred to in this section as “DS-TB”). Drug-resist-
20 ant TB (referred to in this section as “DR-TB”) is
21 a rising threat to the public health of the United
22 States. DR-TB that exhibits resistance to two or
23 more first-line drugs is referred to as multi-drug re-
24 sistant TB (referred to in this section as “MDR-
25 TB”). MDR-TB that also is resistant to at least

1 one fluoroquinolone, and at least one additional
2 group A second-line medicine is classified as exten-
3 sively drug-resistant TB (referred to in this section
4 as “XDR-TB”).

5 (11) Approximately 56 people in the United
6 States were diagnosed with MDR-TB in 2020. One
7 person was diagnosed with XDR-TB in the same
8 year.

9 (12) In the United States, \$503,000,000 was
10 spent in 2020 to treat TB; direct treatment costs
11 average \$20,211 to treat a patient with DS-TB,
12 \$182,186 to treat a patient with MDR-TB, and
13 \$567,708 to treat a patient with XDR-TB. When
14 factoring in productivity losses during treatment,
15 DS-TB averages \$24,661, MDR-TB averages
16 \$347,324, and XDR-TB averages \$729,039. Treat-
17 ment is often difficult, with daily complex multi-pill
18 regimens, with side-effects ranging from hearing and
19 vision loss to mental health issues.

20 (13) Recognizing the public health, economic,
21 and societal costs to the threat of MDR-TB, the
22 National Action Plan to Combat MDR-TB was de-
23 veloped by the White House to provide the United
24 States with a comprehensive three-pronged strategy
25 to address MDR-TB by strengthening domestic ca-

1 capacity to combat MDR–TB; improve international
2 capacity and cooperation to combat MDR–TB; and
3 accelerate basic and applied research and develop-
4 ment for new therapies, diagnostics, and prevention
5 strategies to combat MDR–TB.

6 (14) Additional Federal support is necessary to
7 expand TB control efforts in case finding and treat-
8 ment to address LTBI in a national prevention ini-
9 tiative. Key policy and research breakthroughs in-
10 crease the success of a TB prevention initiative: the
11 U.S. Preventative Services Task Force recommenda-
12 tion’s “B” rating, screening for LTBI among high-
13 risk adults as a covered service increases the likeli-
14 hood that impacted racial and ethnic minority
15 groups can get tested for TB; a new, shorter course
16 treatment regimen reduces the length of treatment
17 for LTBI from every day for 6 to 9 months to one
18 dose per week for 12 weeks, increasing the likelihood
19 of treatment completion; and the use of blood-based
20 diagnostic tests, Interferon-gamma release assays or
21 IGRAs, increases the ability to detect LTBI among
22 patients in affected communities.

23 (15) The right to health, and the right to
24 science as a necessary human right to help achieve
25 the right to health, is enshrined in Articles 25 and

1 27 of the Universal Declaration of Human Rights.
2 These fundamental human rights cannot be achieved
3 when anyone lacks access to TB prevention or treat-
4 ment, and when the benefits of scientific innovation
5 are not extended to people with all forms of TB.

6 **SEC. 7352. ADDITIONAL FUNDING FOR STATES IN COM-**
7 **BATING AND ELIMINATING TUBERCULOSIS.**

8 Section 317E(h) of the Public Health Act (42 U.S.C.
9 247b–6(h)) is amended by adding at the end the following:

10 “(3) ADDITIONAL FUNDING FOR STATES IN
11 COMBATING AND ELIMINATING TUBERCULOSIS.—In
12 addition to amounts otherwise authorized to be ap-
13 propriated to carry out this section, there are au-
14 thorized to be appropriated such sums as may be
15 necessary to carry out this section for each of fiscal
16 years 2023 through 2024.”.

17 **SEC. 7353. STRENGTHENING CLINICAL RESEARCH FUND-**
18 **ING FOR TUBERCULOSIS.**

19 (a) IN GENERAL.—The Secretary of Health and
20 Human Services shall expand and intensify support for
21 current and prospective research activities of the National
22 Institutes of Health, the Biomedical Advanced Research
23 and Development Authority, and the Centers for Disease
24 Control and Prevention Division of Tuberculosis Elim-
25 nation to develop new therapeutics, diagnostics, vaccines,

1 and other prevention modalities in addressing all forms
2 of tuberculosis (referred to in this section as “TB”).

3 (b) INCLUDED RESEARCH ACTIVITIES.—Research
4 activities under subsection (a) shall include—

5 (1) research and development, and pathways to
6 approval, for novel, safe drugs and drug regimens
7 for the treatment of TB, including in adolescent and
8 pediatric populations and in pregnant and lactating
9 people;

10 (2) research to develop rapid diagnostic tests
11 for all forms of TB, including diagnostics that can
12 be used for pediatric populations and people living
13 with HIV, diagnostics that can detect extra pul-
14 monary TB and drug resistance, and diagnostics
15 that can be used at the point of care;

16 (3) research to advance basic knowledge of the
17 pathogenesis of TB and its major comorbidities, in-
18 cluding HIV and diabetes mellitus;

19 (4) research to improve knowledge and under-
20 standings of the role of latency in TB and the fac-
21 tors that increase the risk of latent TB infection
22 progressing to active, symptomatic TB disease;

23 (5) awarding grants and contracts to specifi-
24 cally develop new and needed vaccines to address
25 TB;

1 (6) awarding grants and contracts to support
2 the training and development of clinical researchers
3 whose research improves the landscape of tools to
4 combat TB; and

5 (7) awarding grants and contracts to support
6 capacity-building and develop clinical trial site infra-
7 structure in the United States and in TB endemic
8 countries to support the aforementioned research ac-
9 tivities.

10 **Subtitle I—Osteoarthritis and**
11 **Musculoskeletal Diseases**

12 **SEC. 7401. FINDINGS.**

13 Congress finds as follows:

14 (1) Eighty percent of African-American women
15 and nearly 74 percent of Hispanic men are either
16 overweight or obese, speeding the onset and progres-
17 sion of knee arthritis.

18 (2) Arthritis affects 58,500,000 people in the
19 United States, and that number will rise to
20 78,000,000 by the year 2040.

21 (3) 32,500,000 people in the United States suf-
22 fer from osteoarthritis, the most common form of ar-
23 thritis, making it the leading cause of disability in
24 the United States. Osteoarthritis is sometimes re-
25 ferred to as degenerative joint disease.

1 (4) Obesity accelerates the onset of arthritis: 70
2 percent of obese adults with mild osteoarthritis of
3 the knee at age 60 will develop advanced end-stage
4 disease by age 80. In contrast, just 43 percent of
5 non-obese adults will have end-stage disease over the
6 same time period.

7 (5) Arthritis affects 1 in 4 people in the United
8 States and is the single greatest cause of chronic
9 pain and disability in the United States.

10 (6) Women, Black Americans, and Hispanics
11 have more severe arthritis and functional limitations.
12 These same individuals are more likely to be obese
13 and diabetic, and have a higher incidence of heart
14 diseases.

15 (7) Arthritis costs \$304,000,000,000 a year, in-
16 cluding \$140,000,000,000 in direct costs (medical)
17 and \$164,000,000,000 in indirect costs (lost earn-
18 ings).

19 (8) Obesity and other chronic health conditions
20 exacerbate the debilitating impact of arthritis, lead-
21 ing to inactivity, loss of independence, and a per-
22 petual cycle of comorbid chronic conditions.

23 (9) Sixty-one percent of arthritis sufferers are
24 women, and women represent 64 percent of an esti-
25 mated 43,000,000 annual visits to physicians' offices

1 and outpatient clinics where arthritis was the pri-
2 mary diagnosis. Women also represented 60 percent
3 of approximately 1,000,000 hospitalizations that oc-
4 curred in 2003 for which arthritis was the primary
5 diagnosis.

6 (10) Women ages 65 and older have up to 2½
7 times more disabilities than men of the same age.
8 Higher rates of obesity and arthritis among this
9 group explained up to 48 percent of the gender gap
10 in disability, above all other common chronic health
11 conditions.

12 (11) The primary indication for total knee
13 arthroplasty (referred to in this section as “TKA”),
14 also known as knee replacement, is relief of signifi-
15 cant, disabling pain caused by severe arthritis.

16 (12) Knee replacement is surgery for people
17 with severe knee damage. Knee replacement can re-
18 lieve pain and allow an individual to be more active.
19 The process for a total knee replacement involves
20 the surgeon removing damaged cartilage and bone
21 from the surface of the knee joint and replacing the
22 cartilage and bone with a man-made surface of
23 metal and plastic. In a partial knee replacement, the
24 surgeon only replaces part of the knee joint.

1 (13) Total hip replacement, also called total hip
2 arthroplasty (referred to in this section as “THA”),
3 is used if hip pain interferes with daily activities and
4 more conservative treatments have not helped. Ar-
5 thritis damage is the most common reason to need
6 hip replacement.

7 (14) The odds of a family practice physician
8 recommending TKA to a male patient with moderate
9 arthritis are twice that of a female patient, while the
10 odds of an orthopedic surgeon recommending TKA
11 to a male patient with moderate arthritis are 22
12 times that of a female patient.

13 (15) Black Americans with doctor-diagnosed ar-
14 thritis have a higher prevalence of severe pain attrib-
15 utable to arthritis, compared with White Americans
16 (34.0 percent versus 22.6 percent). Black Ameri-
17 cans, compared to White Americans, report a higher
18 proportion of work limitations (39.5 percent versus
19 28.0 percent) and a higher prevalence of arthritis-at-
20 tributable work limitation (6.6 percent versus 4.6
21 percent).

22 (16) Hispanics are 50 percent more likely than
23 non-Hispanic Whites to report needing assistance
24 with at least one instrumental activity of daily living
25 and to have difficulty walking.

1 (17) Black Americans and Hispanics were 1.3
2 times more likely to have activity limitation, 1.6
3 times more likely to have work limitations, and 1.9
4 times more likely to have severe joint pain than
5 Whites.

6 (18) In 2003, the National Academy of Medi-
7 cine reported that the rates of TKA and THA
8 among Black American and Hispanic patients are
9 significantly lower than for Whites—even for those
10 with equitable health care coverage such as through
11 Medicare or the Department of Veterans Affairs.

12 (19) According to the Centers for Disease Con-
13 trol and Prevention, in 2000, Black American Medi-
14 care enrollees were 37 percent less likely than White
15 Medicare enrollees to undergo total knee replace-
16 ments. In 2006, the disparity increased to 39 per-
17 cent.

18 (20) Even after adjusting for insurance and
19 health access, Hispanics and Black Americans are
20 almost 50 percent less likely to undergo total knee
21 replacement than Whites.

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1 **SEC. 7402. OSTEOARTHRITIS AND OTHER MUSCULO-**
2 **SKELETAL HEALTH-RELATED ACTIVITIES OF**
3 **THE CENTERS FOR DISEASE CONTROL AND**
4 **PREVENTION.**

5 (a) EDUCATION AND AWARENESS ACTIVITIES.—The
6 Secretary of Health and Human Services, acting through
7 the Director of the Centers for Disease Control and Pre-
8 vention, shall direct the National Center for Chronic Dis-
9 ease Prevention and Health Promotion to conduct and ex-
10 pand the Health Community Program and Arthritis Pro-
11 gram to educate the public on—

12 (1) the causes of, preventive health actions for,
13 and effects of arthritis, lupus, and other musculo-
14 skeletal conditions in minority patient populations;
15 and

16 (2) the effects of such conditions on other
17 comorbidities including obesity, hypertension, and
18 cardiovascular disease.

19 (b) PROGRAMS ON ARTHRITIS AND MUSCULO-
20 SKELETAL CONDITIONS.—Education and awareness pro-
21 grams of the Centers for Disease Control and Prevention
22 on arthritis and other musculoskeletal conditions in minor-
23 ity communities shall—

24 (1) be culturally and linguistically appropriate
25 to minority patients, targeting musculoskeletal

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1 health promotion and prevention programs of each
2 major ethnic group, including—

3 (A) Native Americans and Alaska Natives;

4 (B) Asian Americans;

5 (C) African Americans and Blacks;

6 (D) Hispanic and Latino Americans; and

7 (E) Native Hawaiians and Pacific Island-
8 ers; and

9 (2) include public awareness campaigns directed
10 toward these patient populations that emphasize the
11 importance of musculoskeletal health, physical activ-
12 ity, diet and healthy lifestyle, and weight reduction
13 for overweight and obese patients.

14 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
15 out this section, there are authorized to be appropriated
16 such sums as are necessary for fiscal year 2023 and each
17 subsequent fiscal year.

18 **SEC. 7403. GRANTS FOR COMPREHENSIVE OSTEO-**
19 **ARTHRITIS AND MUSCULOSKELETAL DIS-**
20 **EASE HEALTH EDUCATION WITHIN HEALTH**
21 **PROFESSIONS SCHOOLS.**

22 (a) PROGRAM AUTHORIZED.—The Secretary of
23 Health and Human Services (in this section referred to
24 as the “Secretary”), in coordination with the Secretary of
25 Education, shall award grants, on a competitive basis, to

1 academic health science centers, health professions
2 schools, and institutions of higher education to enable
3 such centers, schools, and institutions to provide people
4 with comprehensive education on arthritis and musculo-
5 skeletal health, particularly—

6 (1) obesity-related musculoskeletal diseases;

7 (2) arthritis and osteoarthritis;

8 (3) arthritis and musculoskeletal health dispari-
9 ties; and

10 (4) the relationship between arthritis and mus-
11 culoskeletal diseases and metabolic activity, psycho-
12 logical health, and comorbidities such as diabetes,
13 cardiovascular disease, lupus, and hypertension.

14 (b) DURATION.—Grants awarded under this section
15 shall be for a period of 5 years.

16 (c) APPLICATIONS.—An academic health science cen-
17 ter, health professions school, or institution of higher edu-
18 cation seeking a grant under this section shall submit an
19 application to the Secretary at such time, in such manner,
20 and containing such information as the Secretary may re-
21 quire.

22 (d) PRIORITY.—In awarding grants under this sec-
23 tion, the Secretary shall give priority to an institution of
24 higher education that—

1 (1) has an enrollment of needy students, as de-
2 fined in section 318(b) of the Higher Education Act
3 of 1965 (20 U.S.C. 1059e(b));

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

6 (3) is a Tribal College or University, as defined
7 in section 316(b) of such Act (20 U.S.C. 1059c(b));

8 (4) is an Alaska Native-serving institution, as
9 defined in section 317(b) of such Act (20 U.S.C.
10 1059d(b));

11 (5) is a Native Hawaiian-serving institution, as
12 defined in section 317(b) of such Act (20 U.S.C.
13 1059d(b));

14 (6) is a Predominately Black Institution, as de-
15 fined in section 318(b) of such Act (20 U.S.C.
16 1059e(b));

17 (7) is a Native American-serving, non-Tribal in-
18 stitution, as defined in section 319(b) of such Act
19 (20 U.S.C. 1059f(b));

20 (8) is an Asian American and Native American
21 Pacific Islander-serving institution, as defined in
22 section 320(b) of such Act (20 U.S.C. 1059g(b)); or

23 (9) is a minority institution, as defined in sec-
24 tion 365 of such Act (20 U.S.C. 1067k), with an en-

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1 rollment of needy students, as defined in section 312
2 of such Act (20 U.S.C. 1058).

3 (e) USES OF FUNDS.—An academic health science
4 center, health professions school, or institution of higher
5 education receiving a grant under this section may use the
6 grant funds to integrate issues relating to comprehensive
7 arthritis and musculoskeletal health into the academic or
8 support sectors of the center, school, or institution in
9 order to reach a large number of students, by carrying
10 out 1 or more of the following activities:

11 (1) Developing educational content for issues
12 relating to comprehensive arthritis and musculo-
13 skeletal health education that will be incorporated
14 into first-year orientation or core courses.

15 (2) Creating innovative technology-based ap-
16 proaches to deliver arthritis and musculoskeletal
17 health education to students, faculty, and staff.

18 (3) Developing and employing peer-outreach
19 and education programs to generate discussion, edu-
20 cate, and raise awareness among students about
21 issues relating to arthritis and musculoskeletal
22 health disorders, and their relationship to diabetes,
23 hypertension, cardiovascular disease, psychological
24 health, and other comorbid conditions.

25 (f) REPORT TO CONGRESS.—

1 (1) IN GENERAL.—Not later than 1 year after
2 the date of the enactment of this Act, and annually
3 thereafter for a period of 5 years, the Secretary shall
4 prepare and submit to the appropriate committees of
5 Congress a report on the activities to provide health
6 professions students with comprehensive arthritis
7 and musculoskeletal health education funded under
8 this section.

9 (2) REPORT ELEMENTS.—The report described
10 in paragraph (1) shall include information about—

11 (A) the number of entities that are receiv-
12 ing a grant under this section;

13 (B) the specific activities supported by
14 grants under this section;

15 (C) the number of students served by pro-
16 grams supported by grants under this section;
17 and

18 (D) the status of evaluations of such pro-
19 grams.

20 (g) DEFINITION OF INSTITUTION OF HIGHER EDU-
21 CATION.—In this section, the term “institution of higher
22 education” has the meaning given such term in section
23 101(b) of the Higher Education Act of 1965 (20 U.S.C.
24 1001(b)).

1 **Subtitle J—Sleep and Circadian**
2 **Rhythm Disorders**

3 **SEC. 7451. SHORT TITLE; FINDINGS.**

4 (a) **SHORT TITLE.**—This subtitle may be cited as the
5 “Sleep and Circadian Rhythm Disorders Health Dispari-
6 ties Act”.

7 (b) **FINDINGS.**—Congress finds the following:

8 (1) Decrements in sleep health such as sleep
9 apnea, insufficient sleep time, and insomnia, affect
10 50,000,000 to 70,000,000 adults in the United
11 States. An estimated 25,000,000 adults in the
12 United States have sleep apnea, a chronic disorder
13 characterized by one or more pauses in breathing
14 which can last from a few seconds to minutes. They
15 may occur 30 times or more an hour, disrupting
16 sleep and resulting in excessive daytime sleepiness
17 and loss in productivity.

18 (2) Seventy percent of high school students are
19 not getting enough sleep on school nights, while 35
20 percent of people in the United States get fewer
21 than 7 hours of sleep per night, and roughly 1,550
22 fatal motor vehicle crashes per year are caused by
23 drowsy drivers.

24 (3) Insufficient sleep and insomnia are more
25 prevalent in women. Women who are pregnant and

1 have sleep apnea are at an increased risk of cardio-
2 vascular complications during pregnancy. The im-
3 pact of disparities in sleep health is associated with
4 a growing number of health problems, including the
5 following:

6 (A) Hypertension.

7 (B) Cancer.

8 (C) Stroke.

9 (D) Cardiac arrhythmia.

10 (E) Chronic heart failure and heart dis-
11 ease.

12 (F) Diabetes.

13 (G) Cognitive functioning and behavior.

14 (H) Depression and bipolar disorder.

15 (I) Substance abuse.

16 (4) A sleep disparity exists in that poor sleep
17 quality is strongly associated with poverty, race, and
18 social determinants of health. Factors such as em-
19 ployment, education, and health status, amongst
20 others, significantly mediated this effect only in poor
21 subjects, suggesting a differential vulnerability to
22 these factors in poor relative to nonpoor individuals
23 in the context of sleep quality.

24 (5) Black Americans sleep worse than White
25 Americans. Black Americans take longer to fall

1 asleep, report poorer sleep quality, have more light
2 and less deep sleep, and nap more often and longer.

3 (6) Black Americans and individuals in lower
4 socioeconomic status groups may be at an increased
5 risk for sleep disturbances and associated health
6 consequences.

7 (7) Among young Black Americans, the likeli-
8 hood of having sleep disordered breathing and exhib-
9 iting risk factors for poor sleep is twice that in
10 young White Americans. Frequent snoring is more
11 common among Black American and Hispanic
12 women and Hispanic men compared to non-Hispanic
13 White Americans, independent of other factors in-
14 cluding obesity.

15 (8) Black Americans with sleep-disordered
16 breathing develop symptoms at a younger age than
17 Caucasians but appear less likely to be diagnosed
18 and treated in a timely manner. This delay may at
19 least in part be due to reduced access to care.

20 (9) Sleep loss contributes to increased risk for
21 chronic conditions such as obesity, diabetes, and hy-
22 pertension, all of which have increased prevalence in
23 underserved, underrepresented minorities. Racial
24 and ethnic disparities related to obesity may also

1 contribute to disparities in health outcomes related
2 to sleep-disordered breathing.

3 (10) Underrepresented minorities in the United
4 States report an insomnia rate of 12.9 percent com-
5 pared to only 6.6 percent for White Americans.

6 (11) Black women have a higher incidence of
7 insomnia than Black men, perhaps related in part to
8 higher risk for chronic persisting symptoms.

9 **SEC. 7452. SLEEP AND CIRCADIAN RHYTHM DISORDERS RE-**
10 **SEARCH ACTIVITIES OF THE NATIONAL IN-**
11 **STITUTES OF HEALTH.**

12 (a) IN GENERAL.—The Director of the National In-
13 stitutes of Health, acting through the Director of the Na-
14 tional Heart, Lung, and Blood Institute, shall—

15 (1) continue to expand research activities ad-
16 dressing sleep health disparities; and

17 (2) continue implementation of the NIH Sleep
18 Disorders Research Plan across all institutes and
19 centers of the National Institutes of Health to im-
20 prove treatment and prevention of sleep health dis-
21 parities.

22 (b) REQUIRED RESEARCH ACTIVITIES.—In con-
23 ducting or supporting research relating to sleep and circa-
24 dian rhythm, the Director of the National Heart, Lung,
25 and Blood Institute shall—

1 (1) advance epidemiology and clinical research
2 to achieve a more complete understanding of dispari-
3 ties in domains of sleep health and across population
4 subgroups for which cardiovascular and metabolic
5 health disparities exist, including—

6 (A) prevalence and severity of sleep apnea;

7 (B) habitual sleep duration;

8 (C) sleep timing and regularity; and

9 (D) insomnia;

10 (2) develop study designs and analytical ap-
11 proaches to explain and predict multilevel and life-
12 course determinants of sleep health and to elucidate
13 the sleep-related causes of cardiovascular and meta-
14 bolic health disparities across the age spectrum, in-
15 cluding such determinants and causes that are—

16 (A) environmental;

17 (B) biological or genetic;

18 (C) psychosocial;

19 (D) societal;

20 (E) political; or

21 (F) economic;

22 (3) determine the contribution of sleep impair-
23 ments such as sleep apnea, insufficient sleep dura-
24 tion, irregular sleep schedules, and insomnia to un-

1 explained disparities in cardiovascular and metabolic
2 risk and disease outcomes;

3 (4) develop study designs, data sampling and
4 collection tools, and analytical approaches to opti-
5 mize understanding of mediating and moderating
6 factors, and feedback mechanisms coupling sleep to
7 cardiovascular and metabolic health disparities;

8 (5) advance research to understand cultural
9 and linguistic barriers (on the person, provider, or
10 system level) to access to care, medical diagnosis,
11 and treatment of sleep disorders in diverse popu-
12 lation groups;

13 (6) develop and test multilevel interventions (in-
14 cluding sleep health education in diverse commu-
15 nities) to reduce disparities in sleep health that will
16 impact the ability to improve disparities in cardio-
17 vascular and metabolic risk or disease;

18 (7) create opportunities to integrate sleep and
19 health disparity science by strategically utilizing re-
20 sources (involving existing or anticipated cohorts)
21 and exchanging scientific data and ideas (including
22 through cross-over into scientific meetings); and

23 (8) enhance the diversity and foster career de-
24 velopment of young investigators involved in sleep
25 and health disparities science.

1 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section, there are authorized to be appropriated
3 such sums as may be necessary for fiscal year 2023 and
4 each subsequent fiscal year.

5 **SEC. 7453. SLEEP AND CIRCADIAN RHYTHM HEALTH DIS-**
6 **PARITIES-RELATED ACTIVITIES OF THE CEN-**
7 **TERS FOR DISEASE CONTROL AND PREVEN-**
8 **TION.**

9 (a) IN GENERAL.—The Director of the Centers for
10 Disease Control and Prevention shall conduct, support,
11 and expand public health strategies and prevention, diag-
12 nosis, surveillance, and public and professional awareness
13 activities regarding sleep and circadian rhythm disorders.

14 (b) FINDINGS.—Congress finds as follows:

15 (1) Sleep disorders and sleep deficiency unre-
16 lated to a primary sleep disorder are underdiagnosed
17 and are increasingly detrimental to health status.

18 (2) The consequences to society include addi-
19 tional diseases, motor vehicle accidents, decreased
20 longevity, elevated direct medical costs, and indirect
21 costs related to work absenteeism and property dam-
22 age.

23 (c) REQUIRED SURVEILLANCE AND EDUCATION
24 AWARENESS ACTIVITIES.—In conducting or supporting
25 research relating to sleep and circadian rhythm disorders

1 surveillance and education awareness activities, the Direc-
2 tor of the Centers for Disease Control and Prevention
3 shall—

4 (1) ensure that such activities are culturally
5 and linguistically appropriate to minority patients,
6 targeting sleep and circadian rhythm health pro-
7 motion and prevention programs of each major eth-
8 nic group, including—

9 (A) Native Americans and Alaska Natives;

10 (B) Asian Americans;

11 (C) African Americans and Blacks;

12 (D) Hispanic and Latino-Americans; and

13 (E) Native Hawaiians and Pacific Island-
14 ers;

15 (2) collect and compile national and State sur-
16 veillance data on sleep disorders health disparities;

17 (3) continue to develop and implement new
18 sleep questions in public health surveillance systems
19 to increase public awareness of sleep health and
20 sleep disorders and their impact on health;

21 (4) publish monthly reports highlighting geo-
22 graphic, racial, and ethnic disparities in sleep health,
23 as well as relationships between insufficient sleep
24 and chronic disease, health risk behaviors, and other

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1 outcomes as determined necessary by the Director;
2 and

3 (5) include public awareness campaigns that in-
4 form patient populations from major ethnic groups
5 about the prevalence of sleep and circadian rhythm
6 disorders and emphasize the importance of sleep
7 health.

8 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
9 out this section, there are authorized to be appropriated
10 such sums as may be necessary for fiscal year 2023 and
11 each subsequent fiscal year.

12 **SEC. 7454. GRANTS FOR COMPREHENSIVE SLEEP AND CIR-**
13 **CADIAN HEALTH EDUCATION WITHIN**
14 **HEALTH PROFESSIONS SCHOOLS.**

15 (a) PROGRAM AUTHORIZED.—The Secretary of
16 Health and Human Services (referred to in this section
17 as the “Secretary”), in coordination with the Secretary of
18 Education, shall award grants, on a competitive basis, to
19 academic health science centers, health professions
20 schools, and institutions of higher education to enable
21 such centers, schools, and institutions to provide people
22 with comprehensive education on sleep and circadian
23 health, particularly—

24 (1) poor sleep health;

25 (2) sleep disorders;

1 (3) sleep health disparities; and

2 (4) the relationship between sleep and circadian
3 health on metabolic activity, neurological activity,
4 comorbidities, and other diseases.

5 (b) DURATION.—Grants awarded under this section
6 shall be for a period of 5 years.

7 (c) APPLICATIONS.—An academic health science cen-
8 ter, health professions school, or institution of higher edu-
9 cation seeking a grant under this section shall submit an
10 application to the Secretary at such time, in such manner,
11 and containing such information as the Secretary may re-
12 quire.

13 (d) PRIORITY.—In awarding grants under this sec-
14 tion, the Secretary shall give priority to an institution of
15 higher education that—

16 (1) has an enrollment of needy students, as de-
17 fined in section 318(b) of the Higher Education Act
18 of 1965 (20 U.S.C. 1059e(b));

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

21 (3) is a Tribal College or University, as defined
22 in section 316(b) of such Act (20 U.S.C. 1059c(b));

23 (4) is an Alaska Native-serving institution, as
24 defined in section 317(b) of such Act (20 U.S.C.
25 1059d(b));

1 (5) is a Native Hawaiian-serving institution, as
2 defined in section 317(b) of such Act (20 U.S.C.
3 1059d(b));

4 (6) is a Predominately Black Institution, as de-
5 fined in section 318(b) of such Act (20 U.S.C.
6 1059e(b));

7 (7) is a Native American-serving, nontribal in-
8 stitution, as defined in section 319(b) of such Act
9 (20 U.S.C. 1059f(b));

10 (8) is an Asian American and Native American
11 Pacific Islander-serving institution, as defined in
12 section 320(b) of such Act (20 U.S.C. 1059g(b)); or

13 (9) is a minority institution, as defined in sec-
14 tion 365 of such Act (20 U.S.C. 1067k), with an en-
15 rollment of needy students, as defined in section 312
16 of such Act (20 U.S.C. 1058).

17 (e) USES OF FUNDS.—An academic health science
18 center, health professions school, or institution of higher
19 education receiving a grant under this section may use the
20 grant funds to integrate issues relating to comprehensive
21 sleep and circadian health into the academic or support
22 sectors of the center, school, or institution, in order to
23 reach a large number of students, by carrying out 1 or
24 more of the following activities:

1 (1) Developing educational content for issues
2 relating to comprehensive sleep and circadian health
3 education that will be incorporated into first-year
4 orientation or core courses.

5 (2) Creating innovative technology-based ap-
6 proaches to deliver sleep health education to stu-
7 dents, faculty, and staff.

8 (3) Developing and employing peer-outreach
9 and education programs to generate discussion, edu-
10 cate, and raise awareness among students about
11 issues relating to poor quality sleep, sleep and circa-
12 dian disorders, and the role sleep health plays in
13 other diseases and comorbidities.

14 (f) REPORT TO CONGRESS.—

15 (1) IN GENERAL.—Not later than 1 year after
16 the date of the enactment of this Act, and annually
17 thereafter for a period of 5 years, the Secretary shall
18 prepare and submit to the appropriate committees of
19 Congress a report on the activities to provide health
20 professions students with comprehensive sleep and
21 circadian health education funded under this section.

22 (2) REPORT ELEMENTS.—The report described
23 in paragraph (1) shall include information about—

24 (A) the number of entities that are receiv-
25 ing a grant under this section;

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1 (B) the specific activities supported by
2 grants under this section;

3 (C) the number of students served by pro-
4 grams supported by grants under this section;
5 and

6 (D) the status of evaluations of programs
7 supported by such grants.

8 (g) DEFINITION OF INSTITUTION OF HIGHER EDU-
9 CATION.—In this section, the term “institution of higher
10 education” has the meaning given such term in section
11 101(b) of the Higher Education Act of 1965 (20 U.S.C.
12 1001(b)).

13 **SEC. 7455. REPORT ON IMPACT OF SLEEP AND CIRCADIAN**
14 **HEALTH DISORDERS IN VULNERABLE AND**
15 **RACIAL/ETHNIC POPULATIONS.**

16 (a) IN GENERAL.—Not later than 1 year after the
17 date of enactment of this Act, the Secretary of Health and
18 Human Services shall submit to Congress and the Presi-
19 dent a report on the impact of sleep and circadian health
20 disorders for racial and ethnic minority communities and
21 other vulnerable populations.

22 (b) CONTENTS.—The report under subsection (a)
23 shall include information on the—

1 (1) progress that has been made in reducing
2 the impact of sleep and circadian health disorders in
3 such communities and populations;

4 (2) opportunities that exist to make additional
5 progress in reducing the impact of sleep and circa-
6 dian health disorders in such communities and popu-
7 lations;

8 (3) challenges that may impede such additional
9 progress; and

10 (4) Federal funding necessary to achieve sub-
11 stantial reductions in sleep and circadian health dis-
12 orders in racial and ethnic minority communities.

13 **Subtitle K—Kidney Disease Re-**
14 **search, Surveillance, Preven-**
15 **tion, and Treatment**

16 **SEC. 7501. KIDNEY DISEASE, RESEARCH, SURVEILLANCE,**
17 **PREVENTION, AND TREATMENT.**

18 (a) **SHORT TITLE.**—This subtitle may be cited as the
19 “Kidney Disease Research, Surveillance, Prevention and
20 Treatment Improvement Act of 2022”.

21 (b) **FINDINGS.**—Congress makes the following find-
22 ings:

23 (1) Kidney diseases impact 37,000,000 individ-
24 uals in the United States.

1 (2) Black Americans comprise just 13 percent
2 of the United States population, but 33 percent of
3 the United States dialysis patient population. Com-
4 pared to White Americans, kidney failure prevalence
5 is about 3.7 times greater in Black Americans, 1.4
6 times greater in Native Americans, and 1.5 times
7 greater in Asian Americans.

8 (3) Peritoneal dialysis and home hemodialysis
9 use is 40–50 percent lower among Black Americans
10 and Hispanics.

11 (4) Every racial and ethnic minority group in
12 the United States is significantly less likely to be
13 treated with home dialysis than Whites, and demo-
14 graphic and clinical characteristics are insufficient to
15 explain this differential use.

16 (5) Black Americans on dialysis, irrespective of
17 dialysis modality, and Hispanics undergoing PD or
18 in-center HD, are significantly less likely than their
19 White counterparts to receive a kidney transplant.

20 (6) Black Americans, Hispanics, and Asian
21 Americans are less likely to receive living donor kid-
22 ney transplants than Whites. Efforts to reduce dis-
23 parities in live donor kidney transplantation for
24 Black American, Hispanic, and Asian patients with
25 kidney failure have been largely unsuccessful.

1 (7) Medicare and Medicaid patients are less
2 likely to receive a preemptive transplant from a de-
3 ceased donor compared to private insurance patients
4 (5 percent and 11 percent versus 24 percent), and
5 Black and Hispanic patients are less likely to receive
6 a preemptive transplant from a deceased donor com-
7 pared with White patients even after changes to the
8 kidney allocation system (5 percent of Black patients
9 and 5 percent of Hispanic patients compared with
10 18 percent of White patients).

11 (8) Low-income populations are significantly
12 more likely to progress to kidney failure.

13 (9) Low socioeconomic status is associated with
14 increased incidence of chronic kidney disease, pro-
15 gression to kidney failure, inadequate dialysis treat-
16 ment, and reduced access to kidney transplantation.

17 (10) The 3 goals of Executive Order 13879 of
18 July 10, 2019 (84 Fed. Reg. 33817; relating to Ad-
19 vancing American Kidney Health), recognize the
20 need for more transplants, better prevention and
21 education, and improved access to treatment modali-
22 ties.

23 **SEC. 7502. KIDNEY DISEASE RESEARCH IN MINORITY POPU-**
24 **LATIONS.**

25 (a) IN GENERAL.—

1 (1) RESEARCH AND TRAINING CENTERS.—Sec-
2 tion 431(c)(3) of the Public Health Service Act (42
3 U.S.C. 285c–5(c)(3)) is amended—

4 (A) in subparagraph (B), by striking
5 “and” at the end;

6 (B) in subparagraph (C), by striking
7 “and” at the end; and

8 (C) by adding at the end the following:

9 “(D) improving data science through im-
10 provement in bioinformatics, data integration,
11 and data sharing;

12 “(E) defining the chronic kidney disease
13 mechanism and identifying new therapeutic tar-
14 gets for chronic kidney disease using specific
15 tools, including mapping the genetic architec-
16 ture of kidney function and disease and trans-
17 lating genetic maps to disease-causing genes
18 and mechanisms, especially among minority
19 populations;

20 “(F) improving models of human disease
21 including better humanized animal models, im-
22 proved reproducibility, and functional character-
23 ization of kidney organoids, and accelerating
24 the development of in vivo imaging technologies;
25 and

1 “(G) developing cell-specific drug delivery
2 systems and gene editing, including targeted
3 systems for the delivery of therapeutic com-
4 pounds to specific kidney compartments or cell
5 types and accelerating the implementation of
6 gene editing and gene therapy for the treatment
7 of kidney diseases in vivo; and”.

8 (2) INCLUSION OF MINORITY PARTICIPANTS.—

9 In conducting and supporting research described in
10 the amendment made by paragraph (1), the Director
11 of the National Institutes of Health shall work with
12 the Director of the National Institute on Minority
13 Health and Health Disparities to improve the num-
14 ber of minority participants as study subjects in
15 clinical trials. Such work may include—

16 (A) developing and sustaining clinical trial
17 consortia that can recruit patients with chronic
18 kidney disease to ensure adequate capacity for
19 assessment of kidney outcomes and increase the
20 enrollment of underrepresented populations;

21 (B) encouraging the use of novel designs in
22 clinical trials to enhance the recruitment and
23 retention of underrepresented populations which
24 will enhance the generalizability of study find-
25 ings;

1 (C) supporting outreach initiatives that in-
2 corporate acknowledgment of both historical
3 and current grounds for participation reluc-
4 tance, and that prioritize demonstrating trust-
5 worthiness, in order to enhance the ability to
6 promote and effectively convey the benefits of
7 clinical research participation;

8 (D) completing clinical trials that test
9 interventions to improve patient quality of life
10 and address patient-reported outcomes; and

11 (E) encouraging inclusion of persons with
12 chronic kidney disease in clinical trials of treat-
13 ments for nonkidney diseases.

14 (b) REPORT; COMPREHENSIVE PLAN.—Section 429
15 of the Public Health Services Act (42 U.S.C. 285c–3) is
16 amended by adding at the end the following:

17 “(c) REPORT BY KIDNEY, UROLOGIC, AND HEMATO-
18 LOGIC DISEASES COORDINATING COMMITTEE.—

19 “(1) IN GENERAL.—The Kidney, Urologic, and
20 Hematologic Diseases Coordinating Committee, in
21 coordination with the Chronic Kidney Disease Initia-
22 tive at the Centers for Disease Control and Preven-
23 tion, shall—

24 “(A) prepare and submit to the Congress,
25 not later than 6 months after the date of enact-

1 ment of this subsection, a report on Federal re-
2 search and public health activities with respect
3 to kidney disease in minority populations; and

4 “(B) develop and submit to the Congress,
5 the Secretary, the Director of the National In-
6 stitutes of Health, and the Advisory Board es-
7 tablished under section 430 for the diseases for
8 which the Committee was established, not later
9 than 1 year after the date of enactment of this
10 subsection, an effective and comprehensive Fed-
11 eral plan (including all appropriate Federal
12 health programs) to address kidney disease in
13 minority populations.

14 “(2) CONTENTS.—The report under paragraph
15 (1)(A) shall at minimum address each of the fol-
16 lowing:

17 “(A) Research on kidney disease in minor-
18 ity populations, including such research on—

19 “(i) genetic, behavioral, and environ-
20 mental factors;

21 “(ii) prevention and complications
22 among individuals within these populations
23 who have already developed kidney disease;

24 “(iii) the delivery of evidenced-based
25 care for all chronic kidney disease stages,

1 especially in underrepresented and under-
2 served populations;

3 “(iv) expanding support for a root-
4 cause analysis approach to disparities, in-
5 cluding causes, detection, and management
6 of chronic kidney disease for underserved
7 populations;

8 “(v) developing research teams that
9 engage with community organizations to
10 develop and implement interventions which
11 halt or delay development and progression
12 of chronic kidney disease; and

13 “(vi) continued support of observa-
14 tional studies of kidney disease measures
15 and outcomes.

16 “(B) Surveillance and data collection on
17 kidney disease in minority populations, includ-
18 ing with respect to—

19 “(i) efforts to better determine the
20 prevalence of kidney disease among Asian-
21 American and Pacific Islander subgroups;
22 and

23 “(ii) efforts to coordinate data collec-
24 tion on the American Indian population.

1 “(C) Community-based interventions to ad-
2 dress kidney disease targeting minority popu-
3 lations, including—

4 “(i) the evidence bases for such inter-
5 ventions;

6 “(ii) the cultural appropriateness of
7 such interventions; and

8 “(iii) efforts to educate the public on
9 the causes and consequences of kidney dis-
10 ease.

11 “(D) Education and training programs for
12 health professionals (including community
13 health workers) on the prevention and manage-
14 ment of kidney disease and its related complica-
15 tions that are supported by the Health Re-
16 sources and Services Administration, including
17 such programs supported by the Bureau of
18 Health Workforce, the Bureau of Primary
19 Health Care, and the Health Systems Bureau.
20 This shall include—

21 “(i) identification of effective strate-
22 gies to increase implementation of proven
23 therapies to slow chronic kidney disease in-
24 cidence and progression, especially in high-
25 risk underrepresented populations; and

1 “(ii) identification of effective practice
2 improvement strategies in large and small
3 health systems to reduce chronic kidney
4 disease incidence and progression.”.

5 **SEC. 7503. KIDNEY DISEASE ACTION PLAN.**

6 (a) IN GENERAL.—The Director of the Centers for
7 Disease Control and Prevention shall conduct, support,
8 and expand public health strategies, prevention, diagnosis,
9 surveillance, and public and professional awareness activi-
10 ties regarding kidney disease.

11 (b) NATIONAL ACTION PLAN.—

12 (1) DEVELOPMENT.—Pursuant to section 426
13 of the Public Health Service Act (42 U.S.C. 285c),
14 not later than 2 years after the date of the enact-
15 ment of this Act, the Director of the National Insti-
16 tute of Diabetes and Digestive and Kidney Diseases,
17 in consultation with the Director of the National In-
18 stitute on Minority Health and Health Disparities
19 and the Director of the Centers for Disease Control
20 and Prevention, shall develop a national action plan
21 to address kidney disease in the United States with
22 participation from patients, caregivers, health pro-
23 fessionals, patient advocacy organizations, research-
24 ers, providers, public health professionals, and other
25 stakeholders.

1 (2) CONTENTS.—At a minimum, such plan
2 shall include recommendations for—

3 (A) public health interventions for the pur-
4 pose of implementation of the national plan;

5 (B) biomedical, health services, and public
6 health research on kidney disease; and

7 (C) inclusion of kidney disease in the
8 health data collections of all Federal agencies.

9 (c) KIDNEY DISEASE PREVENTION PROGRAMS.—The
10 Director of the Centers for Disease Control and Preven-
11 tion, through the Chronic Kidney Disease Initiative, shall
12 carry out the following:

13 (1) Conduct public education and awareness ac-
14 tivities with patient and professional organizations
15 to stimulate earlier diagnosis and improve patient
16 outcomes from treatment of kidney disease. To the
17 extent known and relevant, such public education
18 and awareness activities shall reflect differences in
19 kidney disease by cause (such as hypertension, dia-
20 betes, lupus nephritis, COVID–19, and polycystic
21 kidney disease) and include a focus on outreach to
22 undiagnosed and, as appropriate, minority popu-
23 lations.

24 (2) Supplement and expand upon the activities
25 of the Centers for Disease Control and Prevention

1 by making grants to nonprofit organizations, State
2 and local jurisdictions, and Indian Tribes for the
3 purpose of reducing the burden of kidney disease,
4 especially in disproportionately impacted commu-
5 nities, through public health interventions and re-
6 lated activities.

7 (3) Coordinate with the National Institute of
8 Diabetes and Digestive and Kidney Diseases, the In-
9 dian Health Service, the Health Resources and Serv-
10 ices Administration, and the Department of Vet-
11 erans Affairs to develop pilot programs to dem-
12 onstrate best practices for the diagnosis and man-
13 agement of kidney disease.

14 (4) Develop improved techniques and identify
15 best practices, in coordination with the Secretary of
16 Veterans Affairs, for assisting kidney disease pa-
17 tients.

18 (d) DATA COLLECTION.—Not later than 180 days
19 after the date of enactment of this Act, the Director of
20 the National Institute of Diabetes and Digestive and Kid-
21 ney Diseases and the Director of the Centers for Disease
22 Control and Prevention, acting jointly, shall assess the
23 depth and quality of information on kidney disease that
24 is collected in surveys and population studies conducted
25 by the Centers for Disease Control and Prevention, includ-

1 ing whether there are additional opportunities for informa-
2 tion to be collected in the National Health and Nutrition
3 Examination Survey, the National Health Interview Sur-
4 vey, and the Behavioral Risk Factor Surveillance System
5 surveys. The Director of the National Institute of Diabetes
6 and Digestive and Kidney Diseases shall include the re-
7 sults of such assessment in the national action plan under
8 subsection (b).

9 (e) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated to carry out this section
11 \$1,000,000 for fiscal year 2023, \$1,000,000 for fiscal year
12 2024, \$1,000,000 for fiscal year 2025, \$1,000,000 for fis-
13 cal year 2026, and \$1,000,000 for fiscal year 2027.

14 **SEC. 7504. HOME DIALYSIS AND INCREASING END-STAGE**
15 **RENAL DISEASE TREATMENT MODALITIES IN**
16 **MINORITY COMMUNITIES ACTION PLAN.**

17 (a) IN GENERAL.—Section 1881(b)(14) of the Social
18 Security Act (42 U.S.C. 1395rr(b)(14)) is amended by
19 adding at the end the following new subparagraph:

20 “(J)(i) For services furnished on or after the
21 date which is 1 year after the date of the enactment
22 of this subparagraph which are staff-assisted home
23 dialysis (as defined in clause (iv)(III)), the Secretary
24 shall increase the single payment that would other-
25 wise apply under this paragraph for renal dialysis

1 services furnished to new and respite individuals in
2 accordance with the payment system established
3 under clause (iii) by qualified providers.

4 “(ii)(I) Subject to subclause (II), staff-assisted
5 home dialysis may only be furnished during—

6 “(aa) with respect to an individual de-
7 scribed in subclause (iv)(I)(aa), one 90-day pe-
8 riod which may be renewed up to two 30-day
9 periods; and

10 “(bb) with respect to an individual de-
11 scribed in subclause (iv)(I)(bb) and not with-
12 standing whether such an individual receives
13 any respite care under part A, any 30-day pe-
14 riod.

15 “(II) Notwithstanding the limits described in
16 subclause (I), staff-assisted home dialysis may be
17 furnished for as long as the Secretary determines
18 appropriate to an individual who—

19 “(aa) is blind;

20 “(bb) has a cognitive or neurological im-
21 pairment (including a stroke, Alzheimer’s, de-
22 mentia, amyotrophic lateral sclerosis, or any
23 other impairment determined by the Secretary);
24 or

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1 “(cc) has any other illness or injury that
2 reduces mobility (including cerebral palsy, spi-
3 nal cord injuries, or any other illness or injury
4 determined by the Secretary).

5 “(iii) The Secretary shall establish an add-on to
6 the single payment under this paragraph through
7 regulations to determine the amounts payable to
8 qualified providers for staff-assisted home dialysis.
9 In establishing such system add-on payment, the
10 Secretary may consider—

11 “(I) the costs of furnishing staff-assisted
12 home dialysis;

13 “(II) consultations with dialysis providers,
14 dialysis patients, private payers, and Medicare
15 Advantage plans;

16 “(III) payment amounts for similar items
17 and services under parts A and B; and

18 “(IV) payment amounts established by
19 Medicare Advantage plans under part C, group
20 health plans, and health insurance coverage of-
21 fered by health insurance issuers.

22 “(iv) In this subparagraph:

23 “(I) The term ‘new and respite individual’
24 means an individual described in subsection (a)
25 who is—

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1 “(aa) initiating either peritoneal or
2 home hemodialysis;

3 “(bb) receiving home dialysis and is
4 unable to self-dialyze due to illness, injury,
5 caregiver issues, or other temporary cir-
6 cumstances; or

7 “(cc) returning to home dialysis after
8 a period of hospitalization.

9 “(II) The term ‘qualified provider’ means
10 a trained professional (as determined by the
11 Secretary, including nurses and certified patient
12 technicians) who furnishes renal dialysis serv-
13 ices and—

14 “(aa) meets requirements (as deter-
15 mined by the Secretary) that ensures com-
16 petency in patient care and modality
17 usage; and

18 “(bb) provides in-person assistance to
19 a patient for an appropriate number of di-
20 alysis sessions (as determined by the Sec-
21 retary) at least 75 percent of staff-assisted
22 home dialysis sessions during a period de-
23 scribed in clause (ii)(I).

24 “(III)(aa) The term ‘staff-assisted home
25 dialysis’ means home dialysis using trained pro-

1 professionals to assist individuals who have been
2 determined to have end stage renal disease, and
3 the frequency of such home dialysis is deter-
4 mined by such professionals in coordination
5 with the patient and his or her care partner,
6 and outlined in a patient plan of care.

7 “(bb) The term ‘care partner’ means any-
8 one who is designated by the patient who as-
9 sists the individual with the furnishing of home
10 dialysis.

11 “(cc) The term ‘patient plan of care’ has
12 the meaning given such term in section 494.90
13 of title 42, Code of Federal Regulations.”.

14 (b) PATIENT EDUCATION AND TRAINING RELATING
15 TO STAFF-ASSISTED HOME DIALYSIS.—Section
16 1881(b)(5) of the Social Security Act (42 U.S.C.
17 1395rr(b)(5)) is amended—

18 (1) in subparagraph (C), by striking at the end
19 “and”;

20 (2) in subparagraph (D), by striking the period
21 at the end and inserting a semicolon; and

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

23 “(E) educate patients of the opportunity to
24 receive staff-assisted home dialysis (as defined
25 in paragraph (14)(J)(iv)(III)) during the period

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1 beginning 30 days after the first day such facil-
2 ity furnishes renal dialysis services to an indi-
3 vidual and ending 60 days after such day; and

4 “(F) provide for nurses, certified patient
5 technicians, social workers and or other profes-
6 sionals to train patients and their care partners
7 in skills and procedures needed to perform
8 home dialysis (as defined in paragraph
9 (14)(J)(iv)(III)) treatment—

10 “(i) regularly and independently;

11 “(ii) through telehealth services or
12 through group training (as described in the
13 interpretive guidance relating to tag num-
14 ber V590 of ‘Advance Copy–End Stage
15 Renal Disease (ESRD) Program Interpre-
16 tive Guidance Version 1.1’ (published on
17 10 October 3, 2008)) in accordance with
18 the Federal regulations (concerning the
19 privacy of individually identifiable health
20 information) promulgated under section
21 264(c) of the Health Insurance Portability
22 and Accountability Act of 1996; and

23 “(iii) in the home or residence of a
24 patient, in a dialysis facility, or the place

1 in which the patient intends to receive per-
2 form staff-assisted home dialysis.”.

3 (c) NATIONAL ACTION PLAN.—

4 (1) DEVELOPMENT.—Not later than 2 years
5 after the date of the enactment of this Act, the Di-
6 rector of the National Institute of Diabetes and Di-
7 gestive and Kidney Diseases, in consultation with
8 the Director of the Centers for Disease Control and
9 Prevention, shall develop a national action plan to
10 increase the number of home dialyzers and choice in
11 dialysis treatment modality in the United States
12 with participation from patients, caregivers, health
13 professionals, patient advocacy organizations, re-
14 searchers, providers, public health professionals, and
15 other stakeholders in minority communities.

16 (2) CONTENTS.—At a minimum, such plan
17 shall include recommendations for—

18 (A) public health officials for the purpose
19 of implementation of the national plan;

20 (B) biomedical, health services, and public
21 health research on home dialysis and modalities
22 in minority communities; and

23 (C) inclusion of dialysis location and mo-
24 dality in the health data collections of all Fed-
25 eral agencies.

1 (d) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 \$1,000,000 for fiscal year 2023, \$1,000,000 for fiscal year
4 2024, \$1,000,000 for fiscal year 2025, \$1,000,000 for fis-
5 cal year 2026, and \$1,000,000 for fiscal year 2027.

6 **SEC. 7505. INCREASING KIDNEY TRANSPLANTS IN MINOR-**
7 **ITY POPULATIONS.**

8 (a) IN GENERAL.—The Director of the National In-
9 stitutes of Health shall expand, intensify, and support on-
10 going research and other activities with respect to kidney
11 transplants in minority populations.

12 (b) CMS DATA COLLECTION AND REPORTING.—The
13 Centers for Medicare & Medicaid Services shall collect and
14 report annual data on dialysis facility and nephrologist
15 performance on transplant referral, with an emphasis on
16 data relating to patients of color.

17 (c) OPTN DATA COLLECTION AND REPORTING.—
18 The Organ Procurement and Transplantation Network
19 shall collect and the Scientific Registry of Transplant Re-
20 cipients shall report annual data, broken down by demo-
21 graphic and socioeconomic characteristics, on individual
22 transplant center performance as it relates to patients re-
23 ferred, evaluated, waitlisted, and successfully trans-
24 planted.

1 (d) TRANSPLANT CENTER DATA.—Each organ trans-
2 plant center shall report on the percent of appropriate
3 waitlisted patients (including socioeconomic and demo-
4 graphic data) giving and receiving annual informed con-
5 sent for offers for suboptimal kidneys (such as kidneys
6 with a kidney donor profile index of greater than 85 per-
7 cent or kidney age 50 with diabetes, or age greater than
8 60).

9 (e) ORGAN PROCUREMENT ORGANIZATION DATA.—
10 Each organ procurement organization shall report annual
11 data on referrals, refusals (patient or doctor), and accept-
12 ance of organs by hospital, ZIP Code, race, ethnicity, and
13 age strata except as prohibited by need for confidentiality.

14 (f) DATA TRANSPARENCY FOR PATIENTS.—Each
15 organ transplant center shall provide to each patient of
16 such center, on an annual basis—

17 (1) the number of times an organ was offered
18 to the patient, declined, and transplanted into an-
19 other patient from organs within a 500 mile radius;
20 and

21 (2) the number of times an organ was offered
22 to and declined for the patient from a low risk donor
23 which was subsequently transplanted into another
24 patient.

1 (g) IMPROVED TRANSPLANTATION EDUCATION.—

2 The Centers for Medicare & Medicaid Services shall certify
3 a nonbiased, third-party organization to accredit organ
4 transplant education.

5 (h) RESEARCH.—Research under subsection (a) shall
6 include investigation into—

7 (1) the causes of lower rates of kidney trans-
8 plants in minority populations, including socio-
9 economic, geographic, clinical, environmental, ge-
10 netic, and other factors that may contribute to lower
11 rates of kidney transplants in minority populations;
12 and

13 (2) possible interventions to increase kidney
14 transplants.

15 (i) REPORT; COMPREHENSIVE PLAN.—

16 (1) IN GENERAL.—The Secretary of Health and
17 Human Services shall—

18 (A) prepare and submit to the Congress,
19 not later than 6 months after the date of enact-
20 ment of this section, a report on Federal re-
21 search and public health activities with respect
22 to kidney transplants as a treatment for end-
23 stage renal disease in minority populations; and

24 (B) develop and submit to the Congress,
25 not later than 1 year after the date of enact-

1 ment of this section, an effective and com-
2 prehensive Federal plan (including all appro-
3 priate Federal health programs) to increase the
4 number of kidney transplants in minority popu-
5 lations.

6 (2) CONTENTS.—The report under paragraph
7 (1)(A) shall at a minimum address each of the fol-
8 lowing:

9 (A) Research on kidney transplants in mi-
10 nority populations, including such research on
11 financial, insurance coverage, genetic, behav-
12 ioral, and environmental factors.

13 (B) Surveillance and data collection on
14 kidney transplants in minority populations, in-
15 cluding with respect to—

16 (i) efforts to increase kidney trans-
17 plants among Asian-American and Pacific
18 Islander subgroups with end-stage renal
19 disease; and

20 (ii) efforts to increase kidney trans-
21 plants in the American Indian population.

22 (C) Community-based efforts to increase
23 kidney transplants targeting minority popu-
24 lations, including—

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- 1 (i) the evidence base for such in-
2 creases;
3 (ii) the cultural appropriateness of
4 such increases; and
5 (iii) efforts to educate the public on
6 kidney transplants.

7 (D) Education and training programs for
8 health professionals (including community
9 health workers) on the kidney transplants that
10 are supported by the Health Resources and
11 Services Administration, including such pro-
12 grams supported by the Bureau of Health
13 Workforce, the Bureau of Primary Health Care,
14 and the Health Systems Bureau.

15 **SEC. 7506. ENVIRONMENTAL AND OCCUPATIONAL HEALTH**
16 **PROGRAMS.**

17 The Director of the Centers for Disease Control and
18 Prevention shall—

- 19 (1) support research into the environmental and
20 occupational causes and biological mechanisms that
21 contribute to kidney disease; and
22 (2) develop and disseminate public health inter-
23 ventions that will lessen the impact of environmental
24 and occupational causes of kidney disease.

1 **SEC. 7507. UNDERSTANDING THE TREATMENT PATTERNS**
2 **ASSOCIATED WITH PROVIDING CARE AND**
3 **TREATMENT OF KIDNEY FAILURE IN MINOR-**
4 **ITY POPULATIONS.**

5 (a) STUDY.—The Secretary of Health and Human
6 Services (in this section referred to as the “Secretary”)
7 shall conduct a study on treatment patterns associated
8 with providing care, under the Medicare program under
9 title XVIII of the Social Security Act (42 U.S.C. 1395
10 et seq.), under the Medicaid program under title XIX of
11 such Act (42 U.S.C. 1396 et seq.), and through private
12 health insurance, to minority populations that are dis-
13 proportionately affected by kidney failure.

14 (b) REPORT.—Not later than 1 year after the date
15 of the enactment of this Act, the Secretary shall submit
16 to Congress a report on the study conducted under sub-
17 section (a), together with such recommendations as the
18 Secretary determines to be appropriate.

19 **SEC. 7508. IMPROVING ACCESS IN UNDERSERVED AREAS.**

20 (a) DEFINITION OF PRIMARY CARE SERVICES.—Sec-
21 tion 331(a)(3)(D) of the Public Health Service Act (42
22 U.S.C. 254d(a)(3)(D)) is amended by inserting “nephrol-
23 ogy,” after “dentistry,”.

24 (b) NATIONAL HEALTH SERVICE CORPS SCHOLAR-
25 SHIP PROGRAM.—Section 338A(a)(2) of the Public Health
26 Service Act (42 U.S.C. 254l(a)(2)) is amended by insert-

1 ing “, which may include kidney health professionals” be-
2 fore the period at the end.

3 (c) NATIONAL HEALTH SERVICE CORPS LOAN RE-
4 PAYMENT PROGRAM.—Section 338B(a)(2) of the Public
5 Health Service Act (42 U.S.C. 254l–1(a)(2)) is amended
6 by inserting “, which may include kidney health profes-
7 sionals” before the period at the end.

8 **SEC. 7509. THE JACK REYNOLDS MEMORIAL MEDIGAP EX-**
9 **PANSION ACT; MEDIGAP COVERAGE FOR**
10 **BENEFICIARIES WITH END-STAGE RENAL DIS-**
11 **EASE.**

12 (a) GUARANTEED AVAILABILITY OF MEDIGAP POLI-
13 CIES TO ALL ESRD MEDICARE BENEFICIARIES.—

14 (1) IN GENERAL.—Section 1882(s) of the So-
15 cial Security Act (42 U.S.C. 1395ss(s)) is amend-
16 ed—

17 (A) in paragraph (2)—

18 (i) in subparagraph (A), by striking
19 “is 65” and all that follows through the
20 period at the end and inserting the fol-
21 lowing: “is—

22 “(i) 65 years of age or older and is en-
23 rolled for benefits under part B; or

24 “(ii) is entitled to benefits under 226A(b)
25 and is enrolled for benefits under part B.”; and

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1 (ii) in subparagraph (D), in the mat-
2 ter preceding clause (i), by inserting “(or
3 is entitled to benefits under 226A(b))”
4 after “is 65 years of age or older”; and
5 (B) in paragraph (3)(B)—

6 (i) in clause (ii), by inserting “(or is
7 entitled to benefits under 226A(b))” after
8 “is 65 years of age or older”; and

9 (ii) in clause (vi), by inserting “(or
10 under 226A(b))” after “at age 65”.

11 (2) EFFECTIVE DATE.—The amendments made
12 by paragraph (1) shall apply to Medicare supple-
13 mental policies effective on or after January 1,
14 2023.

15 (b) ADDITIONAL ENROLLMENT PERIOD FOR CER-
16 TAIN INDIVIDUALS.—

17 (1) ONE-TIME ENROLLMENT PERIOD.—

18 (A) IN GENERAL.—In the case of an indi-
19 vidual described in paragraph (2), the Secretary
20 of Health and Human Services shall establish a
21 one-time enrollment period during which such
22 an individual may enroll in any Medicare sup-
23 plemental policy under section 1882 of the So-
24 cial Security Act (42 U.S.C. 1395ss) of the in-
25 dividual’s choosing.

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1 (B) ENROLLMENT PERIOD.—The enroll-
2 ment period established under subparagraph
3 (A) shall begin on January 1, 2023, and shall
4 end June 30, 2023.

5 (2) INDIVIDUAL DESCRIBED.—An individual de-
6 scribed in this paragraph is an individual who—

7 (A) is entitled to hospital insurance bene-
8 fits under part A of title XVIII of the Social
9 Security Act under section 226A(b) of such Act
10 (42 U.S.C. 426–1(b));

11 (B) is enrolled for benefits under part B of
12 such title XVIII; and

13 (C) would not, but for the provisions of,
14 and amendments made by, subsection (a) be eli-
15 gible for the guaranteed issue of a Medicare
16 supplemental policy under paragraph (2) or (3)
17 of section 1882(s) of such Act (42 U.S.C.
18 1395ss(s)).

19 **Subtitle L—Diversity in Clinical**
20 **Trials**

21 **SEC. 7551. FDA REVIEW OF CLINICAL TRIAL BEST PRAC-**
22 **TICES.**

23 The Commissioner of Food and Drugs shall—

24 (1) aggregate information on the accumulated
25 experience of sponsors of drugs that develop and

1 execute clinical trial diversity plans during drug de-
2 velopment;

3 (2) include in such aggregated information an
4 analysis from the perspectives of the Food and Drug
5 Administration and such sponsors of which actions
6 worked or which did not work to enhance clinical
7 trial diversity;

8 (3) not later than September 30, 2024, convene
9 a public meeting, including representatives from the
10 regulated industry and patient organizations, to dis-
11 cuss findings and recommendations for specific ac-
12 tions that have led to measurable improvements in
13 the representation of racial and ethnic populations
14 in clinical research; and

15 (4) not later than September 30, 2025, update
16 the guidance of the Food and Drug Administration
17 titled “Enhancing the Diversity of Clinical Trial
18 Populations—Eligibility Criteria, Enrollment Prac-
19 tices, and Trial Designs” to align such guidance
20 with findings and recommendations that were dis-
21 cussed at the meeting under paragraph (3).

1 **SEC. 7552. DIVERSIFYING INVESTIGATIONS VIA EQUITABLE**
2 **RESEARCH STUDIES FOR EVERYONE TRIALS**
3 **ACT.**

4 (a) GUIDANCE ON DECENTRALIZED CLINICAL
5 TRIALS.—

6 (1) DEFINITION.—In this subsection, the term
7 “decentralized clinical trials” includes clinical trials
8 that are executed through a broad spectrum of op-
9 tions, such as telemedicine or other mobile or digital
10 technologies, to allow for the remote collection and
11 assessment of clinical trial data from participants,
12 including in the home or office setting.

13 (2) GUIDANCE.—Not later than 6 months after
14 the date of enactment of this Act, the Secretary of
15 Health and Human Services (referred to in this sec-
16 tion as the “Secretary”), acting through the Com-
17 missioner of Food and Drugs (referred to in this
18 section as the “Commissioner”), shall issue a draft
19 guidance that addresses how to conduct decentral-
20 ized clinical trials with meaningful demographic di-
21 versity, including racial, ethnic, age, gender, and ge-
22 ographic diversity in patient engagement, enroll-
23 ment, and participation, including how to appro-
24 priately use digital health technologies or other re-
25 mote assessment options, such as telemedicine, to
26 support such trials. Not later than 6 months after

1 the date the public comment period for the draft
2 guidance ends, the Secretary shall issue a final guid-
3 ance.

4 (3) CONTENT OF GUIDANCE.—The guidance
5 under paragraph (2) shall address the following:

6 (A) Strategies to engage with prospective
7 clinical trial participants and community part-
8 ners, such as patient advocacy groups with di-
9 verse representation, to incorporate input of
10 such patients and partners into the design of
11 decentralized clinical trials.

12 (B) Recommendations for—

- 13 (i) protocol design approaches;
14 (ii) appropriate clinical endpoints;
15 (iii) institutional review board com-
16 position and ensuring that such boards in-
17 clude members with expertise in decentral-
18 ized clinical trials;
19 (iv) delegation of clinical research or-
20 ganization responsibilities and suitable
21 proxies for clinical research organizations;
22 and
23 (v) simplifying informed consent.

24 (C) Recommendations for how digital
25 health technology or other remote assessment

1 options, such as telemedicine, could support de-
2 centralized clinical trials, including guidance on
3 appropriate technological platforms and medi-
4 ums, data collection and use, data integrity,
5 and communication to study participants
6 through digital technology.

7 (D) Recommendations for appropriate
8 methods of patient recruitment and retention,
9 including institutional review board oversight,
10 patient communication, and the role of study
11 participants and community partners as advo-
12 cates to facilitate clinical trial recruitment, par-
13 ticularly with respect to underrepresented popu-
14 lations.

15 (E) Information regarding when and how a
16 study sponsor may solicit a meeting with the
17 Secretary regarding the issues described in sub-
18 paragraphs (A) through (D).

19 (4) INTERNATIONAL HARMONIZATION.—After
20 issuing the final guidance under paragraph (2), the
21 Secretary, acting through the Commissioner, may
22 work with foreign regulators pursuant to existing
23 memoranda of understanding governing exchange of
24 information to facilitate international harmonization
25 of the regulation of decentralized clinical trials and

1 use of digital health technology or other remote as-
2 sessment options.

3 (b) ENCOURAGEMENT OF CLINICAL TRIAL ENROLL-
4 MENT BY RACIALLY AND ETHNICALLY DIVERSE POPU-
5 LATIONS.—

6 (1) NO COST PROVISION OF DIGITAL HEALTH
7 TECHNOLOGIES.—The free provision of digital
8 health technologies by drug or device manufacturers
9 to their clinical trial participants shall not be consid-
10 ered a violation of section 1128A of the Social Secu-
11 rity Act (commonly known as the “Civil Monetary
12 Penalties Law”) (42 U.S.C. 1320a–7a), section
13 1128B of the Social Security Act (42 U.S.C. 1320a–
14 7b), or sections 3729 through 3733 of title 31,
15 United States Code, (commonly known as the “False
16 Claims Act”), provided that—

17 (A) the use of digital health technologies
18 will facilitate in any phase of clinical develop-
19 ment the inclusion of diversity of patient popu-
20 lations, such as underrepresented racial and
21 ethnic minorities, low-income populations, and
22 the elderly;

23 (B) the digital health technologies will fa-
24 cilitate individuals participation, or are nec-
25 essary to such participation;

1 (C) all features of the digital health tech-
2 nologies that are unrelated to use in the clinical
3 trial are disabled or only allowed to remain acti-
4 vated to model real-world usage of the digital
5 technology; and

6 (D) the clinical trial sponsor requires par-
7 ticipants to return, purchase, or disable the dig-
8 ital health technologies by the conclusion of the
9 trial.

10 (2) GRANTS AND CONTRACTS.—

11 (A) IN GENERAL.—The Secretary may
12 issue grants to, and enter into contracts with,
13 entities to support community education, out-
14 reach, and recruitment activities for clinical
15 trials with respect to drugs, including vaccines
16 for diseases or conditions which have a dis-
17 proportionate impact on underrepresented pop-
18 ulations (including on racial and ethnic minor-
19 ity populations), including for the diagnosis,
20 prevention, or treatment of COVID–19. Such
21 activities may include—

22 (i) working with community clinical
23 trial sites, including community health cen-
24 ters, academic health centers, and other fa-
25 cilities;

(ii) training health care personnel including potential clinical trial investigators, with a focus on significantly increasing the number of underrepresented racial and ethnic minority health care personnel who are clinical trial investigators at the community sites for ongoing clinical trials;

(iii) engaging community stakeholders to encourage participation in clinical trials, especially in underrepresented racial and ethnic minority communities; and

(iv) fostering partnerships with community-based organizations serving underrepresented racial and ethnic minority populations, including labor organizations and frontline health care workers.

(B) PRIORITY FOR GRANT AND CONTRACT AWARDS.—In awarding grants and contracts under this paragraph, the Secretary shall prioritize entities that—

(i) develop educational, recruitment, and training materials in multiple languages; or

(ii) undertake clinical trial outreach efforts in more diverse racial and ethnic

1 communities that are traditionally under-
2 represented in clinical trials, such as Trib-
3 al areas.

4 (C) AUTHORIZATION OF APPROPRIA-
5 TIONS.—There is authorized to be appropriated
6 for fiscal years 2023 and 2024 such sums as
7 may be necessary to carry out this paragraph.

8 (c) CLARIFICATION THAT CERTAIN REMUNERATION
9 RELATED TO PARTICIPATION IN CLINICAL TRIALS DOES
10 NOT CONSTITUTE REMUNERATION UNDER THE FED-
11 ERAL CIVIL MONEY PENALTIES LAW.—

12 (1) IN GENERAL.—Section 1128A(i)(6)(F) of
13 the Social Security Act (42 U.S.C. 1320a-
14 7a(i)(6)(F)) is amended by inserting “(including re-
15 munerated offered or transferred to an individual to
16 promote the participation in an approved clinical
17 trial, as defined in subsection (d) of the first section
18 2709 of the Public Health Service Act (relating to
19 coverage for individuals participating in approved
20 clinical trials), as so designated by section
21 1563(c)(10)(C) of the Patient Protection and Af-
22 fordable Care Act, that is registered with the data-
23 base of clinical trials maintained by the National Li-
24 brary of Medicine (or any successor database), so
25 long as such remuneration facilitates equitable inclu-

1 sion of patients from all relevant demographic and
2 socioeconomic populations and is related to patient
3 participation in the approved clinical trial)” after
4 “promotes access to care”.

5 (2) EFFECTIVE DATE.—The amendment made
6 by paragraph (1) shall apply to remuneration pro-
7 vided on or after the date of the enactment of this
8 Act.

9 (d) NATIONAL ACADEMY OF MEDICINE STUDY.—

10 (1) IN GENERAL.—The Secretary shall seek to
11 enter into an arrangement with the National Acad-
12 emy of Medicine under which the National Academy
13 agrees to study and propose a design for a national
14 interoperable data platform to improve access to
15 health data, and other relevant data needs, during
16 public health emergencies.

17 (2) REPORT.—The arrangement under para-
18 graph (1) shall provide for submission by the Na-
19 tional Academy of Medicine to the Secretary and
20 Congress, not later than 120 days after the date of
21 enactment of this Act, of a report on the results of
22 the study under paragraph (1) and the design pro-
23 posed based on such study.

1 **SEC. 7553. CLINICAL TRIAL DIVERSITY.**

2 (a) DIVERSITY REQUIREMENTS FOR APPLICATIONS
3 FOR FEDERAL FUNDING FOR CLINICAL TRIALS.—

4 (1) APPLICATIONS.—Beginning on the date of
5 the enactment of this Act, the Secretary of Health
6 and Human Services, acting through the Director of
7 the National Institutes of Health (in this subsection
8 referred to as the “Secretary”), shall require that an
9 entity seeking to conduct a clinical trial investigating
10 a drug or device (as those terms are defined in sec-
11 tion 201 of the Federal Food, Drug, and Cosmetic
12 Act (21 U.S.C. 321)) or biological product (as de-
13 fined in section 351(i) of the Public Health Service
14 Act (42 U.S.C. 262(i))) that is funded by the Na-
15 tional Institutes of Health and conducted at any na-
16 tional research institute or national center, to sub-
17 mit an application (or renewal thereof) for such
18 funding that includes—

19 (A) clear and measurable goals for the re-
20 cruitment and retention of participants that re-
21 flect—

22 (i) the race, ethnicity, age, and gender
23 or sex of patients with the disease or con-
24 dition being investigated; or

25 (ii) the race, ethnicity, age, and gen-
26 der or sex of the general population of the

1 United States if the prevalence of the dis-
2 ease or condition is not known;

3 (B) a rationale for the goals specified
4 under subparagraph (A) that specifies—

5 (i) how investigators will calculate the
6 number of participants for each population
7 category that reflect the population groups
8 specified in subparagraph (A); and

9 (ii) strategies that will be used to en-
10 roll and retain participants across the dif-
11 ferent racial, ethnic, age, and gender or
12 sex categories;

13 (C) a detailed plan for how the clinical
14 trial will achieve the goals specified under sub-
15 paragraph (A) that specifies—

16 (i) the requirements for researchers,
17 in conducting the trial to analyze the popu-
18 lation groups specified in subparagraph
19 (A) separately;

20 (ii) the role of community partners or
21 community institutional review boards in
22 reviewing the plans; and

23 (iii) how the trial will recruit a study
24 population that is—

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1 (I) in proportion to the preva-
2 lence of the disease or condition in
3 such groups relative to the prevalence
4 of the disease or condition in the over-
5 all population of the United States;

6 (II) in sufficient numbers to ob-
7 tain clinically and statistically mean-
8 ingful determinations of the safety
9 and effectiveness of the drug being
10 studied in the respective race, eth-
11 nicity, age, and gender or sex groups;
12 and

13 (III) consistent with the guidance
14 under section 505(b)(1) of the Fed-
15 eral Food, Drug, and Cosmetic Act
16 (21 U.S.C. 355(b)(1)) and guidance
17 issued by the National Institutes of
18 Health on the inclusion of women and
19 minorities in clinical trials;

20 (D) the entity's plan for implementing, or
21 an explanation of why the entity cannot imple-
22 ment, alternative clinical trial follow-up require-
23 ments that are less burdensome for trial partici-
24 pants, such as—

25 (i) requiring fewer follow-up visits;

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1 (ii) allowing phone follow-up or home
2 visits by nurse trial coordinators (in lieu of
3 in-person visits by patients);

4 (iii) allowing for online follow-up op-
5 tions;

6 (iv) permitting the patient's primary
7 care provider to perform some of the fol-
8 low-up visit requirements and to reimburse
9 the patient for any out-of-pocket costs in-
10 curred by the patient for such follow-up
11 visits;

12 (v) allowing for weekend hours for re-
13 quired follow-up visits;

14 (vi) allowing virtual or telemedicine
15 visits;

16 (vii) use of wearable technology to
17 record key health parameters; and

18 (viii) use of alternate labs or imaging
19 centers, which may be closer to the resi-
20 dence of the patients participating in the
21 trial; and

22 (E) the entity's education and training re-
23 quirements for researchers and other individ-
24 uals conducting or supporting the clinical trial
25 with respect to diversity and health inequities in

1 underrepresented populations, including a re-
2 quirement to consult with, and review materials
3 made available by, such committees, task forces,
4 and working groups other entities the Secretary
5 determines are appropriate, including the fol-
6 lowing:

7 (i) The Equity Committee of the Na-
8 tional Institutes of Health.

9 (ii) The National Advisory Council on
10 Minority Health and Health Disparities.

11 (iii) The Advisory Committee on Re-
12 search on Women's Health.

13 (iv) The Sexual & Gender Minority
14 Research Coordinating Committee of the
15 National Institutes of Health.

16 (v) The Tribal Health Research Co-
17 ordinating Committee of the National In-
18 stitutes of Health.

19 (2) TERMS.—

20 (A) IN GENERAL.—As a condition on the
21 receipt of funding through the National Insti-
22 tutes of Health, as described in paragraph (1),
23 with respect to a clinical trial, the sponsor of
24 the clinical trial shall agree to terms requiring
25 that—

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1 (i) the aggregate demographic infor-
2 mation of trial participants be shared on
3 an annual basis with the Secretary while
4 participant recruitment and data collection
5 in such trial is ongoing, and that such in-
6 formation is provided with respect to—

7 (I) underrepresented populations,
8 including populations grouped by race,
9 ethnicity, age, sex, gender identity
10 and expression, geographic region,
11 primary written and spoken language,
12 disability status, sexual orientation,
13 socioeconomic status, occupation, and
14 other relevant factors; and

15 (II) such populations that reflect
16 the prevalence of the disease or condi-
17 tion that is the subject of the clinical
18 trial involved (as available and as ap-
19 propriate to the scientific objective for
20 the study, as determined by the Direc-
21 tor of the National Institutes of
22 Health);

23 (ii) the sponsor submits to the pro-
24 gram officer and grants management spe-
25 cialist of the specific National Institutes of

1 Health national research institute or na-
2 tional center, as frequently as such officer
3 or specialist determines necessary, the re-
4 tention rate of participants in the clinical
5 trial, disaggregated by race, ethnicity, gen-
6 der or sex, and age;

7 (iii) both the clinical trial researchers
8 and the applicant reviewers complete edu-
9 cation and training programs on diversity
10 in clinical trials; and

11 (iv) at the conclusion of the trial, the
12 sponsor submits to the Secretary the num-
13 ber of participants in the trial,
14 disaggregated by race, ethnicity, age, and
15 gender or sex.

16 (B) PRIVACY PROTECTIONS.—Any data
17 shared under subparagraph (A) may not in-
18 clude any individually identifiable information
19 or protected health information with respect to
20 clinical trial participants and shall only be dis-
21 closed to the extent allowed under Federal pri-
22 vacy laws.

23 (3) EXCEPTION.—In lieu of submitting an ap-
24 plication under paragraph (1) and documentation of
25 goals as required by subparagraph (A) of such para-

1 graph, an applicant may provide reasoning (other
2 than cost) for why the recruitment of each of the
3 population groups specified in subparagraph (A) of
4 paragraph (1) is not necessary and why such re-
5 cruitment is not scientifically justified or possible.

6 (4) PUBLICATION.—The Secretary shall—

7 (A) publish on a public website of the Na-
8 tional Institutes of Health, upon receipt of an
9 application to which paragraph (1) applies or
10 reasoning under paragraph (3)—

11 (i) a summary of the disease being
12 targeted in the clinical trial that is the
13 subject of the application and the preva-
14 lence of such disease across race, ethnicity,
15 gender or sex, age, and clinical trial rep-
16 resentation in each such category;

17 (ii) the goals specified in such applica-
18 tion, as required by paragraph (1)(A); or

19 (iii) the reasoning described in para-
20 graph (3); and

21 (B) ensure that, in publishing information
22 relating to an application or reasoning under
23 subparagraph (A), the design of the study in-
24 volved is not disclosed.

25 (5) REMEDIATION.—

1 (A) IN GENERAL.—In the case of a clinical
2 trial subject to paragraph (1) that fails to meet
3 the condition specified pursuant to paragraph
4 (1) by such date as may be agreed upon by the
5 sponsor of the trial and the program officer and
6 grants management specialist of the specific
7 National Institutes of Health national research
8 institute or national center, the Secretary shall
9 require the sponsor of that clinical trial, not
10 later than 60 days after such date occurs—

11 (i) to develop, in consultation with the
12 Secretary and advocacy and community-
13 based organizations representing individ-
14 uals who are members of relevant demo-
15 graphic groups specified in paragraph
16 (1)(A), a strategic plan to increase partici-
17 pation in such clinical trial of such individ-
18 uals; and

19 (ii) to submit to the Secretary, such
20 strategic plan.

21 (B) PUBLICATION.—The Secretary shall
22 make publicly available on the website of the
23 National Institutes of Health, the strategic plan
24 received under subparagraph (A) as soon as
25 possible after receipt. The Secretary shall en-

1 sure that, in publishing such plan under the
2 preceding sentence, the design of the study in-
3 volved is not disclosed.

4 (C) IMPLEMENTATION.—The sponsor of
5 the clinical trial that is the subject of the stra-
6 tegic plan published under subparagraph (B),
7 shall, not later than 60 days after such date as
8 may be agreed upon by the sponsor of the trial
9 and the appropriate program officer and grants
10 management specialist of the National Insti-
11 tutes of Health, implement the strategic plan.

12 (D) TECHNICAL ASSISTANCE.—The Sec-
13 retary may provide technical assistance to a
14 sponsor of a clinical trial, as necessary for the
15 sponsor to meet the requirements of subpara-
16 graph (C).

17 (6) PENALTIES IN CASE OF FAILURE OF REME-
18 DIATION.—

19 (A) IN GENERAL.—In the case of a clinical
20 trial subject to paragraph (1) that, after the
21 close of the 60-day period specified in para-
22 graph (5)(C), continues to fail to meet the con-
23 dition specified pursuant to paragraph (1)(A),
24 the Secretary shall—

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1 (i) hold the noncompeting continu-
2 ation of funding received through the grant
3 involved;

4 (ii) apply specific conditions on the
5 award of funds to such sponsor to conduct
6 such clinical trial; or

7 (iii) terminate such funding.

8 (B) WAIVER.—

9 (i) IN GENERAL.—In the case of a
10 clinical trial subject to the penalty under
11 subparagraph (A) that fails to meet the
12 condition referred to in such subpara-
13 graph, the sponsor of such clinical trial
14 may, prior to the conclusion of the 60-day
15 period referred to in subparagraph (A),
16 submit an application to the relevant pro-
17 gram officer and grants specialist request-
18 ing a waiver of such condition. Such an ap-
19 plication shall specify reasoning for why
20 the recruitment of each of the population
21 groups specified in subparagraph (A) of
22 paragraph (1) is not necessary or why such
23 recruitment is not scientifically justified or
24 possible.

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1 (ii) REVIEW.—Not later than 30 days
2 after a date agreed upon by the sponsor of
3 the trial and the appropriate program offi-
4 cer and grants management specialist of
5 the National Institutes of Health, the Sec-
6 retary shall—

7 (I) complete the review of such
8 application; and

9 (II) make a determination to ap-
10 prove or deny the application.

11 (iii) NO ADDITIONAL PENALTIES.—No
12 additional penalties may be applied with
13 respect to a sponsor of a clinical trial
14 under subparagraph (A) during the 30-day
15 period specified in clause (ii).

16 (C) TERMINATION OF FUNDING.—In the
17 case of a clinical trial described in subpara-
18 graph (B)(i), the Secretary may elect to termi-
19 nate funding described in paragraph (1) for the
20 clinical trial if no request for a waiver under
21 subparagraph (B) is received by the conclusion
22 60-day period referred to in subparagraph (A).

23 (7) WAIVER FOR CERTAIN CLINICAL TRIALS.—

24 (A) IN GENERAL.—In the case of a clinical
25 trial that received funding through the National

1 Institutes of Health and is ongoing as of the
2 date of the enactment of this Act, the sponsor
3 of such clinical trial is exempt from the require-
4 ments of (and associated penalties imposed by)
5 this section.

6 (B) REPORT.—The Secretary shall include
7 in the triennial report required to be submitted
8 under section 403 of the Public Health Service
9 Act (42 U.S.C. 283), a list of all clinical trials
10 receiving funding through the National Insti-
11 tutes of Health—

12 (i) that requested and received waiv-
13 ers under this subsection; or

14 (ii) with respect to which funding has
15 been terminated pursuant to this sub-
16 section.

17 (8) STUDY.—

18 (A) IN GENERAL.—The Comptroller Gen-
19 eral of the United States shall conduct a study
20 that—

21 (i) examines which actions Federal
22 agencies have taken to address barriers to
23 participation in federally-funded clinical
24 trials by the demographic groups specified
25 in paragraph (1)(A); and

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1 (ii) identifies challenges, if any, in im-
2 plementing such actions.

3 (B) REPORT.—Not later than 1 year after
4 the date of the enactment of this Act, the
5 Comptroller General of the United States shall
6 submit to Congress a report on the findings of
7 the study conducted under subparagraph (A).

8 (9) NONDISCRIMINATION.—Section 1557 of the
9 Patient Protection and Affordable Care Act (42
10 U.S.C. 18116) shall apply with respect to a clinical
11 trial subject to paragraph (1).

12 (b) ELIMINATING COST BARRIERS.—

13 (1) STUDY ON MODERNIZATION OF HUMAN
14 SUBJECT REGULATIONS.—Not later than 2 years
15 after the date of the enactment of this Act, the Sec-
16 retary of Health and Human Services, acting
17 through the Director of the National Institutes of
18 Health (referred to in this subsection as the “Sec-
19 retary”), shall conduct and complete a study on—

20 (A) the need for review of human subject
21 regulations specified in part 46 of title 45, Code
22 of Federal Regulations (or successor regula-
23 tions), and related guidance;

24 (B) the modernization of such regulations
25 and guidance to establish updated guidelines for

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1 reimbursement of out-of-pocket expenses of
2 human subjects, compensation of human sub-
3 jects for time spent participating in the clinical
4 trial, and incentives for recruitment of human
5 subjects; and

6 (C) the need for updated safe harbor rules
7 under section 1001.952 of title 42, Code of
8 Federal Regulations (or successor regulations)
9 and section 1128B of the Social Security Act
10 (commonly referred to as the Federal Anti-
11 Kickback Statute (42 U.S.C. 1320a–7b)) with
12 respect to the assistance provided under this
13 subsection.

14 (2) REIMBURSEMENT FOR COSTS ASSOCIATED
15 WITH CLINICAL TRIAL PARTICIPATION.—As a condi-
16 tion on receipt of any funding provided through the
17 National Institutes of Health to conduct a clinical
18 trial investigating a drug or device (as those terms
19 are defined in section 201 of the Federal Food,
20 Drug, and Cosmetic Act (21 U.S.C. 321)) or biologi-
21 cal product (as defined in section 351(i) of the Pub-
22 lic Health Service Act (42 U.S.C. 262(i))), the Sec-
23 retary shall require that the sponsor of such clinical
24 trial—

1 (A) works with institutional review boards
2 and program officers of the National Institutes
3 of Health to determine when reimbursement for
4 the costs associated with clinical trial participa-
5 tion is warranted; and

6 (B) subject to paragraph (3), provides to
7 clinical trial participants reimbursement for ex-
8 penses (using funds other than funds supplied
9 through the National Institutes of Health) in-
10 curred as a result of that participation, which
11 may include—

- 12 (i) missed or forgone salary;
13 (ii) language assistance, including in-
14 terpreter services;
15 (iii) food expenses;
16 (iv) childcare expenses;
17 (v) lodging expenses;
18 (vi) transportation expenses; or
19 (vii) other expenses as identified by
20 the participant, subject to review by the
21 clinical trial sponsor, at its discretion, on a
22 case-by-case basis.

23 (3) PROVISION OF COSTS ASSOCIATED WITH
24 CLINICAL TRIAL PARTICIPATION.—

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1 (A) APPLICATION AND DOCUMENTA-
2 TION.—

3 (i) IN GENERAL.—A sponsor of a clin-
4 ical trial to which subsection (a)(1) applies,
5 may require that, in order to receive reim-
6 bursement as described in paragraph (2), a
7 participant complete an application and
8 share with the sponsor such documentation
9 of expenses described in such paragraph,
10 as the sponsor may require.

11 (ii) TIMING.—Not later than 30 days
12 after the date on which a sponsor of a clin-
13 ical trial receives an application under
14 clause (i), the sponsor shall—

15 (I) review the application; and

16 (II) provide for reimbursement of
17 eligible expenses documented in such
18 application, as determined at the dis-
19 cretion of the clinical trial sponsor on
20 a case-by-case basis.

21 (B) ENFORCEMENT.—A sponsor of a clin-
22 ical trial to which subsection (a)(1) applies,
23 shall submit on an annual basis, as part of the
24 progress reports submitted to the Secretary
25 pursuant to section 402(j) of the Public Health

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1 Service Act (42 U.S.C. 282(j)), during the data
2 collection period of the clinical trial, to the Sec-
3 retary an accounting of the reimbursements
4 made to clinical trial participants under sub-
5 paragraph (A). Such data shall—

6 (i) include relevant aggregate data
7 with respect to each population group spec-
8 ified in subsection (a)(2)(A)(i) when such
9 data will not compromise the identities of
10 study participants and in a manner con-
11 sistent with applicable privacy protections;
12 and

13 (ii) not later than 6 months after re-
14 ceipt by the Secretary, be published on a
15 public website of the National Institutes of
16 Health.

17 (c) PUBLIC AWARENESS AND EDUCATION CAM-
18 PAIGN.—

19 (1) NATIONAL CAMPAIGN.—The Secretary of
20 Health and Human Services, acting through the Di-
21 rector of the National Institutes of Health and the
22 Commissioner of Food and Drugs (referred to in
23 this subsection as the “Secretary”), in consultation
24 with the stakeholders specified in paragraph (5),
25 shall carry out a national campaign to increase the

1 awareness and knowledge of individuals in the
2 United States with respect to the need for diverse
3 clinical trials among the demographic groups identi-
4 fied pursuant to subsection (a)(1)(A).

5 (2) REQUIREMENTS.—The national campaign
6 conducted shall include—

7 (A) the development and distribution of
8 written educational materials, and the develop-
9 ment and placing of public service announce-
10 ments, that are intended to encourage individ-
11 uals who are members of the demographic
12 groups identified pursuant to subsection
13 (a)(2)(A)(i)(I) to seek to participate in clinical
14 trials;

15 (B) such efforts as are reasonable and nec-
16 essary to ensure meaningful access by con-
17 sumers with limited English proficiency;

18 (C) the development and distribution of
19 best practices and training for recruiting under-
20 represented study populations, including a
21 method for sharing such best practices among
22 clinical trial sponsors, providers, community-
23 based organizations who assist with recruit-
24 ment, and with the public; and

1 (D) the conduct of focus groups to better
2 understand the concerns and fears of certain
3 underrepresented groups who may be reluctant
4 to participate in clinical trials.

5 (3) HEALTH INEQUITIES.—In developing the
6 national campaign under paragraph (1), the Sec-
7 retary shall recognize and address—

8 (A) health inequities among individuals
9 who are members of the population groups
10 specified in subsection (a)(2)(A)(i) with respect
11 to access to care and participation in clinical
12 trials; and

13 (B) any barriers in access to care and par-
14 ticipation in clinical trials that are specific to
15 individuals who are members of such groups.

16 (4) GRANTS.—The Secretary shall establish a
17 program to award grants to nonprofit private enti-
18 ties, including community based organizations and
19 faith communities, institutions of higher education
20 eligible to receive funds under section 371 of the
21 Higher Education Act of 1965 (20 U.S.C. 1067q)
22 and national organizations that serve underrep-
23 resented populations and community pharmacies to
24 enable such entities—

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1 (A) to test alternative outreach and edu-
2 cation strategies to increase the awareness and
3 knowledge of individuals in the United States,
4 with respect to the need for diverse clinical
5 trials that reflect the race, ethnicity, age, and
6 gender or sex of patients with the disease or
7 condition being investigated; and

8 (B) to cover administrative costs of such
9 entities in assisting in diversifying clinical trials
10 subject to subsection (a).

11 (5) STAKEHOLDERS SPECIFIED.—The stake-
12 holders specified in this paragraph are the following:

13 (A) Representatives of the Health Re-
14 sources Services Administration, the Office of
15 Minority Health of the Department of Health
16 and Human Services, the Centers for Disease
17 Control and Prevention, and the National Insti-
18 tutes of Health.

19 (B) Community-based resources and advo-
20 cates.

21 (6) AUTHORIZATION OF APPROPRIATIONS.—
22 There is authorized to be appropriated to carry out
23 this subsection \$10,000,000 for each of fiscal years
24 2023 through 2026.

25 (d) DEFINITIONS.—In this section:

1 (1) CLINICAL TRIAL.—The term “clinical trial”
2 means a research study in which one or more human
3 subjects are prospectively assigned to one or more
4 interventions (which may include placebo or other
5 control) to evaluate the effects of those interventions
6 on health-related biomedical or behavioral outcomes.

7 (2) SPONSOR.—The term “sponsor” has the
8 meaning given such term in section 50.3 of title 21,
9 Code of Federal Regulations (or successor regula-
10 tions).

11 **SEC. 7554. PATIENT EXPERIENCE DATA.**

12 (a) POLICY.—Section 569C of the Federal Food,
13 Drug, and Cosmetic Act (21 U.S.C. 360bbb–8c) is amend-
14 ed—

15 (1) by redesignating subsections (b) and (c) as
16 subsections (c) and (d), respectively; and

17 (2) by inserting after subsection (a) the fol-
18 lowing new subsection:

19 “(b) COLLECTION, SUBMISSION, AND USE OF
20 DATA.—

21 “(1) IN GENERAL.—The Secretary shall—

22 “(A) for any drug for which an exemption
23 is granted for investigational use under section
24 505(i) of this Act or section 351(a) of the Pub-
25 lic Health Service Act, require the sponsor of

1 the drug to collect standardized patient experi-
2 ence data as part of the clinical trials conducted
3 pursuant to such exemption;

4 “(B) require any application for the ap-
5 proval or licensing of such drug under section
6 505(b) of this Act or section 351(a) of the Pub-
7 lic Health Service Act to include—

8 “(i) the standardized patient experi-
9 ence data so collected; and

10 “(ii) such related information as the
11 Secretary may require; and

12 “(C) consider patient experience data and
13 related information that is submitted pursuant
14 to subparagraph (B) in deciding whether to ap-
15 prove or license, as applicable, the drug in-
16 volved.

17 “(2) APPLICABILITY.—Paragraph (1) applies
18 only with respect to drugs for which a request for
19 an exemption described in paragraph (1)(A) is sub-
20 mitted on or after the date of the enactment of the
21 Health Equity and Accountability Act of 2022, or an
22 application under section 505(b) of this Act or sec-
23 tion 351(a) of the Public Health Service Act is filed,
24 as applicable, on or after the day that is 2 years

1 after the date of the enactment of the Health Equity
2 and Accountability Act of 2022.”.

3 (b) REGULATIONS.—Not later than 1 year after the
4 date of the enactment of this Act, the Secretary of Health
5 and Human Services, acting through the Commissioner of
6 Food and Drugs, shall promulgate final regulations to im-
7 plement section 569C(b) of the Federal Food, Drug, and
8 Cosmetic Act, as added by this section.

9 **Subtitle M—Additional Provisions**
10 **Addressing High Impact Minor-**
11 **ity Diseases**

12 **SEC. 7601. MEDICARE COVERAGE OF MULTI-CANCER EARLY**
13 **DETECTION SCREENING TESTS.**

14 (a) COVERAGE.—Section 1861 of the Social Security
15 Act (42 U.S.C. 1395x), as amended by sections 2007,
16 4221, 4251, 6011, and 7220, is amended —

17 (1) in subsection (s)(2)—

18 (A) in subparagraph (JJ), by striking
19 “and” at the end;

20 (B) in subparagraph (KK), by striking the
21 period at the end and inserting “; and”; and

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

24 “(LL) multi-cancer early detection screen-
25 ing tests (as defined in subsection (qqq));”; and

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

3 “(qqq) MULTI-CANCER EARLY DETECTION SCREEN-
4 ING TESTS.—The term ‘multi-cancer early detection
5 screening test’ means any of the following tests, approved
6 or cleared by the Food and Drug Administration, fur-
7 nished to an individual for the purpose of early detection
8 of cancer across many cancer types (as categorized in the
9 Annual Report to the Nation on the Status of Cancer
10 issued by the National Cancer Institute):

11 “(1) A genomic sequencing blood or blood prod-
12 uct test that includes the analysis of cell-free nucleic
13 acids.

14 “(2) Such other equivalent tests (which are
15 based on urine or other sample of biological mate-
16 rial) as the Secretary determines appropriate.”.

17 (b) PAYMENT AND FREQUENCY LIMIT.—

18 (1) PAYMENT UNDER FEE SCHEDULE.—Section
19 1833(h) of the Social Security Act (42 U.S.C.
20 1395l(h)) is amended—

21 (A) in paragraph (1)(A), by inserting after
22 “(including” the following: “multi-cancer early
23 detection screening tests under section
24 1861(qqq) and including”; and

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1 (B) by adding at the end the following new
2 paragraph:

3 “(10) No payment may be made under this
4 part for a multi-cancer early detection screening test
5 (as defined in section 1861(qqq)) for an individual
6 if such a test was furnished to the individual during
7 the previous 11 months.”.

8 (2) CONFORMING AMENDMENT.—Section
9 1862(a) of the Social Security Act (42 U.S.C.
10 1395y(a)) is amended—

11 (A) in paragraph (1)—

12 (i) in subparagraph (O), by striking
13 “and” at the end;

14 (ii) in subparagraph (P), by striking
15 the semicolon at the end and inserting “,
16 and”; and

17 (iii) by adding at the end the fol-
18 lowing new subparagraph:

19 “(Q) in the case of multi-cancer early detection
20 screening tests (as defined in section 1861(qqq)),
21 which are performed more frequently than is covered
22 under section 1833(h)(10);”; and

23 (B) in paragraph (7), by striking “or (P)”
24 and inserting “(P), or (Q)”.

1 (c) RULE OF CONSTRUCTION RELATING TO OTHER
2 CANCER SCREENING TESTS.—Nothing in this section, in-
3 cluding the amendments made by this section, shall be
4 construed—

5 (1) in the case of an individual who undergoes
6 a multi-cancer early detection screening test, to af-
7 fect coverage under part B for other cancer screen-
8 ing tests covered under this section, such as screen-
9 ing tests for breast, cervical, colorectal, lung, or
10 prostate cancer; or

11 (2) in the case of an individual who undergoes
12 another cancer screening test, to affect coverage for
13 a multi-cancer early detection screening test or the
14 use of such a test as a diagnostic or confirmatory
15 test for a result of the other cancer screening test.

16 **SEC. 7602. AMPUTATION REDUCTION AND COMPASSION**
17 **ACT.**

18 (a) PERIPHERAL ARTERY DISEASE EDUCATION PRO-
19 GRAM.— Part P of title III of the Public Health Service
20 Act (42 U.S.C. 280g et seq.), as amended by section 7254,
21 is further amended by adding at the end the following new
22 section:

1 **“SEC. 399V-13. PERIPHERAL ARTERY DISEASE EDUCATION**
2 **PROGRAM.**

3 “(a) ESTABLISHMENT.—The Secretary, acting
4 through the Director of the Centers for Disease Control
5 and Prevention, in collaboration with the Administrator
6 of the Centers for Medicare & Medicaid Services and the
7 Administrator of the Health Resources and Services Ad-
8 ministration, shall establish and coordinate a peripheral
9 artery disease education program to support, develop, and
10 implement educational initiatives and outreach strategies
11 that inform health care professionals and the public about
12 the existence of peripheral artery disease and methods to
13 reduce amputations related to such disease, particularly
14 with respect to at-risk populations.

15 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
16 is authorized to be appropriated to carry out this section
17 such sums as may be necessary for each of fiscal years
18 2023 through 2027.”.

19 (b) MEDICARE COVERAGE OF PERIPHERAL ARTERY
20 DISEASE SCREENING TESTS FURNISHED TO AT-RISK
21 BENEFICIARIES WITHOUT IMPOSITION OF COST SHARING
22 REQUIREMENTS.—

23 (1) IN GENERAL.—Section 1861 of the Social
24 Security Act (42 U.S.C. 1395x), as amended be sec-
25 tions 2007, 4221, 4251, 6011, 7220, and 7601, is
26 amended—

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1 (A) in subsection (s)(2)—

2 (i) in subparagraph (KK), by striking

3 “and” at the end;

4 (ii) in subparagraph (LL), by striking

5 the period at the end and inserting “;

6 and”; and

7 (iii) by adding at the end the fol-

8 lowing new subparagraph:

9 “(MM) peripheral artery disease screening

10 tests furnished to at-risk beneficiaries (as such

11 terms are defined in subsection (rrr)).”; and

12 (B) by adding at the end the following new

13 subsection:

14 “(rrr) PERIPHERAL ARTERY DISEASE SCREENING

15 TEST; AT-RISK BENEFICIARY.—(1) The term ‘peripheral

16 artery disease screening test’ means—

17 “(A) noninvasive physiologic studies of extrem-

18 ity arteries (commonly referred to as ankle-brachial

19 index testing);

20 “(B) arterial duplex scans of lower extremity

21 arteries vascular; and

22 “(C) such other items and services as the Sec-

23 retary determines, in consultation with relevant

24 stakeholders, to be appropriate for screening for pe-

25 ripheral artery disease for at-risk beneficiaries.

1 “(2) The term ‘at-risk beneficiary’ means an indi-
2 vidual entitled to, or enrolled for, benefits under part A
3 and enrolled for benefits under part B—

4 “(A) who is 65 years of age or older;

5 “(B) who is at least 50 years of age but not
6 older than 64 years of age with risk factors for ath-
7 erosclerosis (such as diabetes mellitus, a history of
8 smoking, hyperlipidemia, and hypertension) or a
9 family history of peripheral artery disease;

10 “(C) who is younger than 50 years of age with
11 diabetes mellitus and one additional risk factor for
12 atherosclerosis; or

13 “(D) with a known atherosclerotic disease in
14 another vascular bed such as coronary, carotid, sub-
15 clavian, renal, or mesenteric artery stenosis, or ab-
16 dominal aortic aneurysm.

17 “(3) The Secretary shall, in consultation with appro-
18 priate organizations, establish standards regarding the
19 frequency for peripheral artery disease screening tests de-
20 scribed in subsection (s)(2)(II) for purposes of coverage
21 under this title.”.

22 (2) INCLUSION OF PERIPHERAL ARTERY DIS-
23 EASE SCREENING TESTS IN INITIAL PREVENTIVE
24 PHYSICAL EXAMINATION.—Section 1861(ww)(2) of

1 the Social Security Act (42 U.S.C. 1395x(w)(2)) is
2 amended—

3 (A) in subparagraph (N), by moving the
4 margins of such subparagraph 2 ems to the
5 left;

6 (B) by redesignating subparagraph (O) as
7 subparagraph (P); and

8 (C) by inserting after subparagraph (N)
9 the following new subparagraph:

10 “(O) Peripheral artery disease screening
11 tests furnished to at risk-beneficiaries (as such
12 terms are defined in subsection (rrr)).”.

13 (3) PAYMENT.—

14 (A) IN GENERAL.—Section 1833(a) of the
15 Social Security Act (42 U.S.C. 1395l(a)), as
16 amended by sections 4251(c)(3), 6011(a)(4),
17 and 7220, is amended —

18 (i) in paragraph (1)—

19 (I) in subparagraph (N), by in-
20 serting “and other than peripheral ar-
21 tery disease screening tests furnished
22 to at-risk beneficiaries (as such terms
23 are defined in section 1861(l))” after
24 “other than personalized prevention

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1 plan services (as defined in section
2 1861(hhh)(1))”;

3 (II) by striking “and” before
4 “(GG)”;

5 (III) by inserting before the
6 semicolon at the end the following: “,
7 and (HH) with respect to peripheral
8 artery disease screening tests fur-
9 nished to at-risk beneficiaries (as such
10 terms are defined in section
11 1861(rrr)), the amount paid shall be
12 100 percent of the lesser of the actual
13 charge for the services or the amount
14 determined under the payment basis
15 determined under section 1848”; and
16 (ii) in paragraph (2)—

17 (I) in subparagraph (G), by
18 striking “and” at the end;

19 (II) in subparagraph (H), by
20 striking the comma at the end and in-
21 serting “; and”;

22 (III) by inserting after subpara-
23 graph (H) the following new subpara-
24 graph:

1 “(I) with respect to peripheral artery disease
2 screening tests (as defined in paragraph (1) of sec-
3 tion 1861(rrr)) furnished by an outpatient depart-
4 ment of a hospital to at-risk beneficiaries (as defined
5 in paragraph (2) of such section), the amount deter-
6 mined under paragraph (1)(EE),”.

7 (B) NO DEDUCTIBLE.—Section 1833(b) of
8 the Social Security Act (42 U.S.C. 1395l(b)), as
9 amended by section 6075, is amended, in the
10 first sentence—

11 (i) by striking “and” before “(13)”;

12 and

13 (ii) by inserting “, and (14) such de-
14 ductible shall not apply with respect to pe-
15 ripheral artery disease screening tests fur-
16 nished to at-risk beneficiaries (as such
17 terms are defined in section 1861(rrr))”
18 before the period at the end.

19 (C) EXCLUSION FROM PROSPECTIVE PAY-
20 MENT SYSTEM FOR HOSPITAL OUTPATIENT DE-
21 PARTMENT SERVICES.—Section
22 1833(t)(1)(B)(iv) of the Social Security Act (42
23 U.S.C. 1395l(t)(1)(B)(iv)) is amended—

24 (i) by striking “, or personalized” and
25 inserting “, personalized”; and

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1 (ii) by inserting “, or peripheral ar-
2 tery disease screening tests furnished to
3 at-risk beneficiaries (as such terms are de-
4 fined in section 1861(rrr))” after “person-
5 alized prevention plan services (as defined
6 in section 1861(hhh)(1))”.

7 (D) PAYMENT UNDER PHYSICIAN FEE
8 SCHEDULE.—Section 1848(j)(3) of the Social
9 Security Act (42 U.S.C. 1395w–4(j)(3)), as
10 amended by section 4251(c)(4), is amended by
11 inserting “, (2)(MM),” after “(2)(II)”.

12 (4) EXCLUSION FROM COVERAGE AND MEDI-
13 CARE AS SECONDARY PAYER FOR TESTS PERFORMED
14 MORE FREQUENTLY THAN ALLOWED.—Section
15 1862(a)(1) of the Social Security Act (42 U.S.C.
16 1395y(a)(1)), as amended by section 7601, is
17 amended—

18 (A) in subparagraph (P), by striking
19 “and” at the end;

20 (B) in subparagraph (Q), by striking the
21 semicolon at the end and inserting “, and”; and

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

24 “(R) in the case of peripheral artery dis-
25 ease screening tests furnished to at-risk bene-

1 ficiaries (as such terms are defined in section
2 1861(rrr)), which are performed more fre-
3 quently than is covered under such section;”.

4 (5) AUTHORITY TO MODIFY OR ELIMINATE COV-
5 ERAGE OF CERTAIN PREVENTIVE SERVICES.—Sec-
6 tion 1834(n) of the Social Security Act (42 U.S.C.
7 1395m(n)) is amended—

8 (A) by redesignating subparagraphs (A)
9 and (B) of paragraph (1) as clauses (i) and (ii),
10 respectively, and moving the margins of such
11 clauses, as so redesignated, 2 ems to the right;

12 (B) by redesignating paragraphs (1) and
13 (2) as subparagraphs (A) and (B), respectively,
14 and moving the margins of such subparagraphs,
15 as so redesignated, 2 ems to the right;

16 (C) by striking “CERTAIN PREVENTIVE
17 SERVICES” and all that follows through “any
18 other provision of this title” and inserting:
19 “CERTAIN PREVENTIVE SERVICES.—

20 “(1) IN GENERAL.—Notwithstanding any other
21 provision of this title”; and

22 (D) by adding at the end the following new
23 paragraph:

24 “(2) INAPPLICABILITY.—The Secretarial au-
25 thority described in paragraph (1) shall not apply

1 with respect to preventive services described in sec-
2 tion 1861(ww)(2)(O).”.

3 (6) EFFECTIVE DATE.—The amendments made
4 by this subsection shall apply with respect to items
5 and services furnished on or after January 1, 2023.

6 (c) MEDICAID COVERAGE OF PERIPHERAL ARTERY
7 DISEASE SCREENING TESTS FURNISHED TO AT-RISK
8 BENEFICIARIES WITHOUT IMPOSITION OF COST SHARING
9 REQUIREMENTS.—

10 (1) IN GENERAL.—Section 1905 of the Social
11 Security Act (42 U.S.C. 1396d) as amended by sec-
12 tions 2007(d)(3) and 5201(a)(5)(G)(i), is amend-
13 ed—

14 (A) in subsection (a)—

15 (i) by redesignating paragraph (33) as
16 paragraph (34);

17 (ii) in paragraph (32), by striking
18 “and” after the semicolon; and

19 (iii) by inserting after paragraph (32)
20 the following new paragraph:

21 “(33) peripheral artery disease screening tests
22 furnished to at-risk beneficiaries (as such terms are
23 defined in subsection (qq)); and”; and

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

1 “(qq) PERIPHERAL ARTERY DISEASE SCREENING
2 TEST; AT-RISK BENEFICIARY.—

3 “(1) PERIPHERAL ARTERY DISEASE SCREENING
4 TEST.—The term ‘peripheral artery disease screen-
5 ing test’ means—

6 “(A) noninvasive physiologic studies of ex-
7 tremity arteries (commonly referred to as ankle-
8 brachial index testing);

9 “(B) arterial duplex scans of lower extrem-
10 ity arteries vascular; and

11 “(C) such other items and services as the
12 Secretary determines, in consultation with rel-
13 evant stakeholders, to be appropriate for
14 screening for peripheral artery disease for at-
15 risk beneficiaries.

16 “(2) AT-RISK BENEFICIARY.—The term ‘at-risk
17 beneficiary’ means an individual enrolled under a
18 State plan (or a waiver of such plan)—

19 “(A) who is 65 years of age or older;

20 “(B) who is at least 50 years of age but
21 not older than 64 years of age with risk factors
22 for atherosclerosis (such as diabetes mellitus, a
23 history of smoking, hyperlipidemia, and hyper-
24 tension) or a family history of peripheral artery
25 disease;

1 “(C) who is younger than 50 years of age
2 with diabetes mellitus and one additional risk
3 factor for atherosclerosis; or

4 “(D) with a known atherosclerotic disease
5 in another vascular bed such as coronary, ca-
6 rotid, subclavian, renal, or mesenteric artery
7 stenosis, or abdominal aortic aneurysm.

8 “(3) FREQUENCY.—The Secretary shall, in con-
9 sultation with appropriate organizations, establish
10 standards regarding the frequency for peripheral ar-
11 tery disease screening tests described in subsection
12 (a)(33) for purposes of coverage under a State plan
13 under this title.”.

14 (2) NO COST SHARING.—

15 (A) IN GENERAL.—Subsections (a)(2) and
16 (b)(2) of section 1916 of the Social Security
17 Act (42 U.S.C. 1396o), as amended by section
18 7154(b)(1), are each amended—

19 (i) in subparagraph (J), by striking
20 “or” after the comma at the end;

21 (ii) in subparagraph (K), by striking
22 “; and” and inserting “, or”; and

23 (iii) by adding at the end the fol-
24 lowing new subparagraph:

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1 “(L) peripheral artery disease screening
2 tests furnished to at-risk beneficiaries (as such
3 terms are defined in section 1905(hh)); and”.

4 (B) APPLICATION TO ALTERNATIVE COST
5 SHARING.—Section 1916A(b)(3)(B) of the So-
6 cial Security Act (42 U.S.C. 1396o-
7 1(b)(3)(B)), , as amended by section
8 7154(b)(2), is amended by adding at the end
9 the following new clause:

10 “(xv) Peripheral artery disease screen-
11 ing tests furnished to at-risk beneficiaries
12 (as such terms are defined in section
13 1905(qq)).”.

14 (3) MANDATORY COVERAGE.—Section
15 1902(a)(10)(A) of the Social Security Act (42
16 U.S.C. 1396a(a)(10)(A)), as amended by section
17 2007(d)(2), is amended by striking “and (31)” and
18 inserting “(31), and (33)”.

19 (d) REQUIREMENT FOR GROUP HEALTH PLANS AND
20 HEALTH INSURANCE ISSUERS OFFERING GROUP OR IN-
21 DIVIDUAL HEALTH INSURANCE COVERAGE TO PROVIDE
22 COVERAGE FOR PERIPHERAL ARTERY DISEASE SCREEN-
23 ING TESTS FURNISHED TO AT-RISK ENROLLEES WITH-
24 OUT IMPOSITION OF COST SHARING REQUIREMENTS.—

1 (1) IN GENERAL.—Section 2713 of the Public
2 Health Service Act (42 U.S.C. 300gg–13) is amend-
3 ed—

4 (A) by amending subsection (a), as amend-
5 ed by section 7220(a)(1)(A), to read as follows:

6 “(a) COVERAGE OF PREVENTIVE HEALTH SERV-
7 ICES.—

8 “(1) IN GENERAL.—A group health plan and a
9 health insurance issuer offering group or individual
10 health insurance coverage shall, at a minimum, pro-
11 vide coverage for and shall not impose any cost shar-
12 ing requirements for—

13 “(A) evidence-based items or services that
14 have in effect a rating of ‘A’ or ‘B’ in the cur-
15 rent recommendations of the United States Pre-
16 ventive Services Task Force;

17 “(B) immunizations that have in effect a
18 recommendation from the Advisory Committee
19 on Immunization Practices of the Centers for
20 Disease Control and Prevention with respect to
21 the individual involved;

22 “(C) with respect to infants, children, and
23 adolescents, evidence-informed preventive care
24 and screenings provided for in the comprehen-

1 sive guidelines supported by the Health Re-
2 sources and Services Administration;

3 “(D) with respect to women, such addi-
4 tional preventive care and screenings not de-
5 scribed in subparagraph (A) as provided for in
6 comprehensive guidelines supported by the
7 Health Resources and Services Administration
8 for purposes of this subparagraph;

9 “(E) any prescription drug approved by
10 the Food and Drug Administration for the pre-
11 vention of HIV (other than a drug subject to
12 preauthorization requirements consistent with
13 section 2729A), administrative fees for such
14 drugs, laboratory and other diagnostic proce-
15 dures associated with the use of such drugs,
16 and clinical follow up and monitoring, including
17 any related services recommended in current
18 United States Public Health Service clinical
19 practice guidelines, without limitation; and

20 “(F) with respect to at-risk enrollees, pe-
21 ripheral artery disease screening tests.

22 “(2) PERIPHERAL ARTERY DISEASE SCREENING
23 TEST; AT-RISK ENROLLEE.—For purposes of para-
24 graph (1)(E):

1 “(A) PERIPHERAL ARTERY DISEASE
2 SCREENING TEST.—The term ‘peripheral artery
3 disease screening test’ means—

4 “(i) noninvasive physiologic studies of
5 extremity arteries (commonly referred to
6 as ankle-brachial index testing);

7 “(ii) arterial duplex scans of lower ex-
8 tremity arteries vascular; and

9 “(iii) such other items and services as
10 the Secretary determines, in consultation
11 with relevant stakeholders, to be appro-
12 priate for screening for peripheral artery
13 disease for at-risk enrollees.

14 “(B) AT-RISK ENROLLEE.—The term ‘at-
15 risk enrollee’ means an individual enrolled in a
16 group health plan or group or individual health
17 insurance coverage—

18 “(i) who is 65 years of age or older;

19 “(ii) who is at least 50 years of age
20 but not older than 64 years of age with
21 risk factors for atherosclerosis (such as di-
22 abetes mellitus, a history of smoking,
23 hyperlipidemia, and hypertension) or a
24 family history of peripheral artery disease;

1 “(iii) who is younger than 50 years of
2 age with diabetes mellitus and one addi-
3 tional risk factor for atherosclerosis; or

4 “(iv) with a known atherosclerotic dis-
5 ease in another vascular bed such as coro-
6 nary, carotid, subclavian, renal, or mesen-
7 teric artery stenosis, or abdominal aortic
8 aneurysm.

9 “(C) FREQUENCY.—The Secretary shall,
10 in consultation with appropriate organizations,
11 establish standards regarding the frequency for
12 peripheral artery disease screening tests de-
13 scribed in paragraph (1)(E) for purposes of
14 coverage under this section.

15 “(3) CLARIFICATION REGARDING BREAST CAN-
16 CER SCREENING, MAMMOGRAPHY, AND PREVENTION
17 RECOMMENDATIONS.—For the purposes of this Act,
18 and for the purposes of any other provision of law,
19 the current recommendations of the United States
20 Preventive Service Task Force regarding breast can-
21 cer screening, mammography, and prevention shall
22 be considered the most current other than those
23 issued in or around November 2009.

24 “(4) RULE OF CONSTRUCTION.—Nothing in
25 this subsection shall be construed to prohibit a plan

1 or issuer from providing coverage for services in ad-
2 dition to those recommended by the United States
3 Preventive Services Task Force or to deny coverage
4 for services that are not recommended by such Task
5 Force.”; and

6 (B) in subsection (b)(1)—

7 (i) by striking “subsection (a)(1) or
8 (a)(2) or a guideline under subsection
9 (a)(3)” and inserting “subparagraph (A)
10 or (B) of subsection (a)(1) or a guideline
11 under subparagraph (C) of such sub-
12 section”; and

13 (ii) by striking “described in sub-
14 section (a)” and inserting “described in
15 subsection (a)(1)”.

16 (2) EFFECTIVE DATE.—The amendments made
17 by paragraph (1) shall apply with respect to plan
18 years beginning on or after January 1, 2023.

19 (e) DISALLOWANCE OF PAYMENT FOR NONTRAU-
20 MATIC AMPUTATION SERVICES FURNISHED WITHOUT
21 ANATOMICAL TESTING SERVICES.—Section 1834 of the
22 Social Security Act (42 U.S.C. 1395m), as amended by
23 section 4221(b)(2), is amended by adding at the end the
24 following new subsection:

1 “(aa) DISALLOWANCE OF PAYMENT FOR NONTRAU-
2 MATIC AMPUTATION SERVICES FURNISHED WITHOUT
3 ANATOMICAL TESTING SERVICES.—

4 “(1) IN GENERAL.—In the case of nontrau-
5 matic amputation services furnished by a supplier on
6 or after January 1, 2023, to an individual entitled
7 to, or enrolled for, benefits under part A and en-
8 rolled for benefits under this part, for which pay-
9 ment is made under this part, payment may only be
10 made under this part if—

11 “(A) such supplier furnishes anatomical
12 testing services to such individual during the 3-
13 month period preceding the date on which such
14 nontraumatic amputation services is furnished;
15 or

16 “(B) such individual has a pre-existing
17 dysfunctional or unsalvageable limb, life-threat-
18 ening sepsis, intractable infection, extensive
19 gangrene or necrotic tissue loss beyond salvage,
20 a poor functional status, severe dementia, or a
21 short life expectancy after shared decision-mak-
22 ing with a health care team and patient, family,
23 or caregiver.

24 “(2) DEFINITIONS.—In this subsection:

1 “(A) ANATOMICAL TESTING SERVICES.—

2 The term ‘anatomical testing services’ means
3 arterial duplex scanning, computed tomography
4 angiography, and magnetic resonance
5 angiography.

6 “(B) NONTRAUMATIC AMPUTATION SERV-

7 ICES.—The term ‘nontraumatic amputation
8 services’ means amputations as a result of ath-
9 erosclerotic vascular disease or a related comor-
10 bidity of such disease (including diabetes).”.

11 (f) DEVELOPMENT AND IMPLEMENTATION OF QUAL-
12 ITY MEASURES.—

13 (1) DEVELOPMENT.—The Secretary of Health
14 and Human Services (referred to in this subsection
15 as the “Secretary”) shall, in consultation with rel-
16 evant stakeholders, develop quality measures for
17 nontraumatic, lower-limb, major amputation that
18 utilize appropriate diagnostic screening (including
19 peripheral artery disease screening) in order to en-
20 courage alternative treatments (including
21 revascularization) in lieu of such an amputation.

22 (2) IMPLEMENTATION.—After appropriate test-
23 ing and validation of the measures developed under
24 paragraph (1), the Secretary shall incorporate such
25 measures in quality reporting programs for appro-

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1 piate providers of services and suppliers under the
2 Medicare program under title XVIII of the Social
3 Security Act (42 U.S.C. 1395 et seq.), including for
4 purposes of—

5 (A) the merit-based incentive payment sys-
6 tem under section 1848(q) of such Act (42
7 U.S.C. 1395w-4(q));

8 (B) incentive payments for participation in
9 eligible alternative payment models under sec-
10 tion 1833(z) of such Act (42 U.S.C. 1395l(z));

11 (C) the shared savings program under sec-
12 tion 1899 of such Act (42 U.S.C. 1395jjj);

13 (D) models under section 1115A of such
14 Act (42 U.S.C. 1315a); and

15 (E) such other payment systems or models
16 as the Secretary may specify.

17 **SEC. 7603. ELIMINATING THE COINSURANCE REQUIRE-**
18 **MENT FOR CERTAIN COLORECTAL CANCER**
19 **SCREENING TESTS FURNISHED UNDER THE**
20 **MEDICARE PROGRAM.**

21 Section 1833(dd) of the Social Security Act (42
22 U.S.C. 1395l(dd)) is amended—

23 (1) in paragraph (1), by striking “and before
24 January 1, 2030,”; and

25 (2) in paragraph (2)—

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1 (A) in subparagraph (A), by adding “and”
2 at the end;

3 (B) in subparagraph (B), by striking
4 “through 2026, 85 percent; and” and inserting
5 “and each subsequent year, 100 percent.”; and

6 (C) by striking subparagraph (C).

7 **SEC. 7604. EXPANDING THE AVAILABILITY OF MEDICAL NU-**
8 **TRITION THERAPY SERVICES UNDER THE**
9 **MEDICARE PROGRAM.**

10 (a) IN GENERAL.—Section 1861 of the Social Secu-
11 rity Act (42 U.S.C. 1395x) is amended—

12 (1) in subsection (s)(2)(V), by striking “in the
13 case of” and all that follows through “organiza-
14 tions”; and

15 (2) in subsection (vv)—

16 (A) in paragraph (1)—

17 (i) by striking “disease management”
18 and inserting “the prevention, manage-
19 ment, or treatment of a disease or condi-
20 tion specified in paragraph (4)”; and

21 (ii) by striking “by a physician” and
22 all that follows through the period at the
23 end and inserting the following: “by a—

24 “(A) physician (as defined in subsection
25 (r)(1));

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1 “(B) physician assistant;

2 “(C) nurse practitioner;

3 “(D) clinical nurse specialist (as defined in
4 subsection (aa)(5)(B)); or

5 “(E) in the case of such services furnished
6 to manage such a disease or condition that is
7 an eating disorder, a clinical psychologist (as
8 defined by the Secretary).

9 Such term shall not include any services furnished
10 to an individual for the prevention, management, or
11 treatment of a renal disease if such individual is re-
12 ceiving maintenance dialysis for which payment is
13 made under section 1881.”; and

14 (B) by adding at the end the following new
15 paragraph:

16 “(4) For purposes of paragraph (1), the diseases and
17 conditions specified in this paragraph are the following:

18 “(A) Diabetes and prediabetes.

19 “(B) A renal disease.

20 “(C) Obesity (as defined for purposes of sub-
21 section (yy)(2)(C) or as otherwise defined by the
22 Secretary).

23 “(D) Hypertension.

24 “(E) Dyslipidemia.

25 “(F) Malnutrition.

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1 “(G) Eating disorders.

2 “(H) Cancer.

3 “(I) Gastrointestinal diseases, including celiac
4 disease.

5 “(J) HIV.

6 “(K) AIDS.

7 “(L) Cardiovascular disease.

8 “(M) Any other disease or condition—

9 “(i) specified by the Secretary relating to
10 unintentional weight loss;

11 “(ii) for which the Secretary determines
12 the services described in paragraph (1) to be
13 medically necessary and appropriate for the
14 prevention, management, or treatment of such
15 disease or condition, consistent with any appli-
16 cable recommendations of the United States
17 Preventive Services Task Force; or

18 “(iii) for which the Secretary determines
19 the services described in paragraph (1) are
20 medically necessary, consistent with either pro-
21 tocols established by registered dietitians or nu-
22 trition professional organizations or with ac-
23 cepted clinical guidelines identified by the Sec-
24 retary.”.

1 (b) EXCLUSION MODIFICATION.—Section 1862(a)(1)
2 of the Social Security Act (42 U.S.C. 1395y(a)(1)), as
3 amended by sections 7601 and 7602, is amended—

4 (1) in subparagraph (Q), by striking “and” at
5 the end;

6 (2) in subparagraph (R), by striking the semi-
7 colon at the end and inserting “, and”; and

8 (3) by adding at the end the following new sub-
9 paragraph:

10 “(S) in the case of medical nutrition therapy
11 services (as defined in section 1861(vv)), which are
12 not furnished for the prevention, management, or
13 treatment of a disease or condition specified in para-
14 graph (4) of such section;”.

15 (c) EFFECTIVE DATE.—The amendments made by
16 this section shall apply with respect to items and services
17 furnished on or after January 1, 2023.

18 **SEC. 7605. ENCOURAGING THE DEVELOPMENT AND USE OF**
19 **DISARM ANTIMICROBIAL DRUGS.**

20 (a) ADDITIONAL PAYMENT FOR DISARM ANTI-
21 MICROBIAL DRUGS UNDER MEDICARE.—

22 (1) IN GENERAL.—Section 1886(d)(5) of the
23 Social Security Act (42 U.S.C. 1395ww(d)(5)) is
24 amended by adding at the end the following new
25 subparagraph:

1 “(N)(i)(I) Effective for discharges beginning on or
2 after October 1, 2023, or such sooner date as specified
3 by the Secretary, subject to subclause (II), the Secretary
4 shall, after notice and opportunity for public comment (in
5 the publications required by subsection (e)(5) for a fiscal
6 year or otherwise), provide for an additional payment
7 under a mechanism (separate from the mechanism estab-
8 lished under subparagraph (K)), with respect to such dis-
9 charges involving any DISARM antimicrobial drug, in an
10 amount equal to—

11 “(aa) the amount payable under section 1847A
12 for such drug during the calendar quarter in which
13 the discharge occurred; or

14 “(bb) if no amount for such drug is determined
15 under section 1847A, an amount to be determined
16 by the Secretary in a manner similar to the manner
17 in which payment amounts are determined under
18 section 1847A based on information submitted by
19 the manufacturer or sponsor of such drug (as re-
20 quired under clause (v)).

21 “(II) In determining the amount payable under sec-
22 tion 1847A for purposes of items (aa) and (bb) of sub-
23 clause (I), subparagraphs (A) and (B) of subsection (b)(1)
24 of such section shall be applied by substituting ‘102 per-
25 cent’ for ‘106 percent’ each place it appears and para-

1 graph (8)(B) of such section shall be applied by sub-
2 stituting ‘2 percent’ for ‘6 percent’.

3 “(ii) For purposes of this subparagraph, a DISARM
4 antimicrobial drug is—

5 “(I) a drug—

6 “(aa) that—

7 “(AA) is approved by the Food and
8 Drug Administration;

9 “(BB) is designated by the Food and
10 Drug Administration as a qualified infec-
11 tious disease product under subsection (d)
12 of section 505E of the Federal Food,
13 Drug, and Cosmetic Act; and

14 “(CC) has received an extension of its
15 exclusivity period pursuant to subsection
16 (a) of such section; and

17 “(bb) that has been designated by the Sec-
18 retary pursuant to the process established
19 under clause (iv)(I)(bb); or

20 “(II) an antibacterial or antifungal biological
21 product—

22 “(aa) that is licensed for use, or an anti-
23 bacterial or antifungal biological product for
24 which an indication is first licensed for use, by
25 the Food and Drug Administration on or after

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1 June 5, 2014, under section 351(a) of the Pub-
2 lic Health Service Act for human use to treat
3 serious or life-threatening infections, as deter-
4 mined by the Food and Drug Administration,
5 including those caused by, or likely to be caused
6 by—

7 “(AA) an antibacterial or antifungal
8 resistant pathogen, including novel or
9 emerging infectious pathogens; or

10 “(BB) a qualifying pathogen (as de-
11 fined under section 505E(f) of the Federal
12 Food, Drug, and Cosmetic Act); and

13 “(bb) has been designated by the Secretary
14 pursuant to the process established under
15 clause (iv)(I)(bb).

16 “(iii) The mechanism established pursuant to clause
17 (i) shall provide that the additional payment under clause
18 (i) shall—

19 “(I) with respect to a discharge, only be made
20 to a subsection (d) hospital that, as determined by
21 the Secretary—

22 “(aa) is participating in the National
23 Healthcare Safety Network Antimicrobial Use
24 and Resistance Module of the Centers for Dis-
25 ease Control and Prevention; and

1 “(bb) has an antimicrobial stewardship
2 program that aligns with the Core Elements of
3 Hospital Antibiotic Stewardship Programs of
4 the Centers for Disease Control and Prevention
5 or the Antimicrobial Stewardship Standard set
6 by the Joint Commission; and

7 “(II) apply to discharges occurring on or after
8 October 1 of the year in which the drug or biological
9 product is designated by the Secretary as a DIS-
10 ARM antimicrobial drug.

11 For purposes of this clause, in the case of a similar report-
12 ing program described in item (aa), a subsection (d) hos-
13 pital shall be treated as participating in such a program
14 if the entity maintaining such program identifies to the
15 Secretary such hospital as so participating.

16 “(iv)(I) The mechanism established pursuant to
17 clause (i) shall provide for a process for—

18 “(aa) a manufacturer or sponsor of a drug or
19 biological product to request the Secretary to des-
20 ignate the drug or biological product as a DISARM
21 antimicrobial drug; and

22 “(bb) the designation (and removal of such des-
23 ignation) by the Secretary of drugs and biological
24 products as DISARM antimicrobial drugs.

1 “(II) A designation of a drug or biological product
2 as a DISARM antimicrobial drug may be revoked by the
3 Secretary if the Secretary determines that—

4 “(aa) the drug or biological product no longer
5 meets the requirements for a DISARM antimicrobial
6 drug under clause (ii);

7 “(bb) the request for such designation con-
8 tained an untrue statement of material fact; or

9 “(cc) clinical or other information that was not
10 available to the Secretary at the time such designa-
11 tion was made shows that—

12 “(AA) such drug or biological product is
13 unsafe for use or not shown to be safe for use
14 for individuals who are entitled to benefits
15 under part A; or

16 “(BB) an alternative to such drug or bio-
17 logical product is an advance that substantially
18 improves the diagnosis or treatment of such in-
19 dividuals.

20 “(III) Not later than October 1, 2023, the Secretary
21 shall publish in the Federal Register a list of the DISARM
22 antimicrobial drugs designated under this subparagraph
23 pursuant to the process established under subclause
24 (I)(bb). The Secretary shall annually update such list.

1 “(v)(I) For purposes of determining additional pay-
2 ment amounts under clause (i), a manufacturer or sponsor
3 of a drug or biological product that submits a request de-
4 scribed in clause (iv)(I)(aa) shall submit to the Secretary
5 information described in section 1927(b)(3)(A)(iii).

6 “(II) The penalties for failure to provide timely infor-
7 mation under clause (i) of subparagraph (C) section
8 1927(b)(3) and for providing false information under
9 clause (ii) of such subparagraph shall apply to manufac-
10 turers and sponsors of a drug or biological product under
11 this section with respect to information under subclause
12 (I) in the same manner as such penalties apply to manu-
13 facturers under such clauses with respect to information
14 under subparagraph (A) of such section.

15 “(vi)(I) The mechanism established pursuant to
16 clause (i) shall provide that—

17 “(aa) except as provided in item (bb), no addi-
18 tional payment shall be made under this subpara-
19 graph for discharges involving a DISARM anti-
20 microbial drug if any additional payments have been
21 made for discharges involving such drug as a new
22 medical service or technology under subparagraph
23 (K);

24 “(bb) additional payments may be made under
25 this subparagraph for discharges involving a DIS-

1 ARM antimicrobial drug if any additional payments
2 have been made for discharges occurring prior to the
3 date of enactment of this subparagraph involving
4 such drug as a new medical service or technology
5 under subparagraph (K); and

6 “(cc) no additional payment shall be made
7 under subparagraph (K) for discharges involving a
8 DISARM antimicrobial drug as a new medical serv-
9 ice or technology if any additional payments for dis-
10 charges involving such drug have been made under
11 this subparagraph.”.

12 (2) CONFORMING AMENDMENT.—Section
13 1886(d)(5)(K)(ii)(III) of the Social Security Act (42
14 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by
15 striking “provide” and inserting “subject to sub-
16 paragraph (N)(vii), provide”.

17 (b) AUTHORIZATION OF APPROPRIATIONS FOR THE
18 CENTERS FOR DISEASE CONTROL AND PREVENTION.—
19 There is authorized to be appropriated to the Centers for
20 Disease Control and Prevention \$500,000,000, to remain
21 available until expended, to support establishment and im-
22 plementation of antimicrobial stewardship programs and
23 data reporting capabilities to the Antimicrobial Use and
24 Resistance option of the CDC National Healthcare Safety
25 Network, especially in critical access hospitals, rural hos-

1 pitals, and community hospitals, to support detection, sur-
2 veillance, containment, and prevention of resistant patho-
3 gens in the United States and overseas.

4 (c) STUDY AND REPORTS ON REMOVING BARRIERS
5 TO THE DEVELOPMENT OF DISARM ANTIMICROBIAL
6 DRUGS.—

7 (1) STUDY.—The Comptroller General of the
8 United States (in this subsection referred to as the
9 “Comptroller General”) shall, in consultation with
10 the Director of the National Institutes of Health,
11 the Commissioner of Food and Drugs, the Adminis-
12 trator of the Centers for Medicare & Medicaid Serv-
13 ices, and the Director of the Centers for Disease
14 Control and Prevention, conduct a study over a 5-
15 year period of the barriers that prevent the develop-
16 ment of DISARM antimicrobial drugs (as defined in
17 section 1886(d)(5)(N)(ii) of the Social Security Act,
18 as added by subsection (a)), including—

19 (A) patient outcomes in conjunction with
20 the use of DISARM drugs, including—

21 (i) duration of stay in the intensive
22 care unit;
23 (ii) recidivism within 30 days; and
24 (iii) measures of additional follow up
25 care;

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1 (B) the effectiveness of antimicrobial stew-
2 ardsnip and surveillance programs, including—

3 (i) changes in the percentage of hos-
4 pitals in the United States with an anti-
5 microbial stewardship program in place
6 that aligns with the Core Elements of Hos-
7 pital Antibiotic Stewardship Programs, as
8 outlined by the Centers for Disease Control
9 and Prevention;

10 (ii) changes in inpatient care of
11 clostridioides difficile infection; and

12 (iii) changes in inpatient rates of re-
13 sistance to key pathogens; and

14 (C) considerations relating to Medicare
15 payment reform, including—

16 (i) changes in the number of qualified
17 antimicrobial products approved;

18 (ii) changes in wholesale acquisition
19 cost of individual qualified antimicrobial
20 products over time;

21 (iii) changes in year-over-year volume
22 of individual qualified antimicrobial prod-
23 ucts sold; and

24 (iv) the overall cost of qualified anti-
25 microbial products to the Medicare pro-

1 gram as a proportion of total Medicare
2 part A spending.

3 (2) REPORT.—Not later than 5 years after the
4 date of the enactment of this section, the Comp-
5 troller General shall submit to Congress a report
6 containing the results of the study conducted under
7 paragraph (1), together with recommendations for
8 such legislation and administrative action as the
9 Comptroller General determines appropriate.

10 **SEC. 7606. TREAT AND REDUCE OBESITY ACT.**

11 (a) AUTHORITY TO EXPAND HEALTH CARE PRO-
12 VIDERS QUALIFIED TO FURNISH INTENSIVE BEHAVIORAL
13 THERAPY.—Section 1861(ddd) of the Social Security Act
14 (42 U.S.C. 1395x(ddd)) is amended by adding at the end
15 the following new paragraph:

16 “(4)(A) Subject to subparagraph (B), the Sec-
17 retary may, in addition to qualified primary care
18 physicians and other primary care practitioners,
19 cover intensive behavioral therapy for obesity fur-
20 nished by any of the following:

21 “(i) A physician (as defined in subsection
22 (r)(1)) who is not a qualified primary care phy-
23 sician.

24 “(ii) Any other appropriate health care
25 provider (including a physician assistant, nurse

1 practitioner, or clinical nurse specialist (as
2 those terms are defined in subsection (aa)(5)),
3 a clinical psychologist, a registered dietitian or
4 nutrition professional (as defined in subsection
5 (vv))).

6 “(iii) An evidence-based, community-based
7 lifestyle counseling program approved by the
8 Secretary.

9 “(B) In the case of intensive behavioral therapy
10 for obesity furnished by a provider described in
11 clause (ii) or (iii) of subparagraph (A), the Secretary
12 may only cover such therapy if such therapy is fur-
13 nished—

14 “(i) upon referral from, and in coordina-
15 tion with, a physician or primary care practi-
16 tioner operating in a primary care setting or
17 any other setting specified by the Secretary;
18 and

19 “(ii) in an office setting, a hospital out-
20 patient department, a community-based site
21 that complies with the Federal regulations con-
22 cerning the privacy of individually identifiable
23 health information promulgated under section
24 264(c) of the Health Insurance Portability and

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1 Accountability Act of 1996, or another setting
2 specified by the Secretary.

3 “(C) In order to ensure a collaborative effort,
4 the coordination described in subparagraph (B)(i)
5 shall include the health care provider or lifestyle
6 counseling program communicating to the referring
7 physician or primary care practitioner any rec-
8 ommendations or treatment plans made regarding
9 the therapy.”.

10 (b) MEDICARE PART D COVERAGE OF OBESITY
11 MEDICATION.—

12 (1) IN GENERAL.—Section 1860D–2(e)(2)(A)
13 of the Social Security Act (42 U.S.C. 1395w–
14 102(e)(2)(A)) is amended, in the first sentence—

15 (A) by striking “and other than” and in-
16 serting “other than”; and

17 (B) by inserting after “benzodiazepines,”
18 the following: “and other than subparagraph
19 (A) of such section if the drug is used for the
20 treatment of obesity (as defined in section
21 1861(yy)(2)(C)) or for weight loss management
22 for an individual who is overweight (as defined
23 in section 1861(yy)(2)(F)(i)) and has one or
24 more related comorbidities,”.

1 (2) EFFECTIVE DATE.—The amendments made
2 by paragraph (1) shall apply to plan years beginning
3 on or after the date that is 2 years after the date
4 of the enactment of this section.

5 (c) REPORT TO CONGRESS.—Not later than the date
6 that is 1 year after the date of the enactment of this sec-
7 tion, and every 2 years thereafter, the Secretary of Health
8 and Human Services shall submit a report to Congress
9 describing the steps the Secretary has taken to implement
10 the provisions of, and amendments made by, this section.
11 Such report shall also include recommendations for better
12 coordination and leveraging of programs within the De-
13 partment of Health and Human Services and other Fed-
14 eral agencies that relate in any way to supporting appro-
15 priate research and clinical care (such as any interactions
16 between physicians and other health care providers and
17 their patients) to treat, reduce, and prevent obesity in the
18 adult population.

19 **SEC. 7607. INCENTIVES, IMPROVEMENTS, AND OUTREACH**
20 **TO INCREASE DIVERSITY IN ALZHEIMER'S**
21 **DISEASE RESEARCH.**

22 (a) IMPROVING ACCESS FOR AND OUTREACH TO
23 UNDERREPRESENTED POPULATIONS.—

24 (1) EXPANDING ACCESS TO ALZHEIMER'S RE-
25 SEARCH CENTERS.—

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1 (A) IN GENERAL.—Section 445(a)(1) of
2 the Public Health Service Act (42 U.S.C. 285e–
3 2(a)(1)) is amended—

4 (i) by striking “(a)(1) The Director of
5 the Institute may” and inserting the fol-
6 lowing:

7 “(a)(1) The Director of the Institute—

8 “(A) may”;

9 (ii) by striking “disease.” and insert-
10 ing “disease; and”; and

11 (iii) by adding at the end the fol-
12 lowing:

13 “(B) beginning January 1, 2023, shall enter
14 into cooperative agreements and make grants to
15 public or private nonprofit entities under this sub-
16 section for the planning, establishment, and oper-
17 ation of new such centers that are located in areas
18 with a higher concentration of minority groups (as
19 determined under section 444(d)(3)(D)), such as en-
20 tities that are historically Black colleges and univer-
21 sities, Hispanic-serving institutions, Tribal colleges
22 and universities, or centers of excellence for other
23 minority populations.”.

24 (B) USE OF FUNDING FOR CLINICS TO OP-
25 ERATE CLINICAL TRIALS.—Section 445(b) of

1 the Public Health Service Act (42 U.S.C. 285e–
2 2(b)) is amended by adding at the end the fol-
3 lowing:

4 “(3) Federal payments made under a cooperative
5 agreement or grant under subsection (a) from funds made
6 available under section 7607(g) of the Health Equity and
7 Accountability Act of 2022 shall, with respect to Alz-
8 heimer’s disease, be used in part to establish and operate
9 diagnostic and treatment clinics designed—

10 “(A) to meet the special needs of minority and
11 rural populations and other underserved populations;
12 and

13 “(B) to operate clinical trials.”.

14 (2) OUTREACH.—

15 (A) ALZHEIMER’S DISEASE CENTERS.—

16 Section 445(b) of the Public Health Service Act
17 (42 U.S.C. 285e–2(b)), as amended by para-
18 graph (1)(B), is further amended by adding at
19 the end the following new paragraph:

20 “(4) Federal payments made under a cooperative
21 agreement or grant under subsection (a) shall be used to
22 establish engagement centers to carry out public outreach,
23 education efforts, and dissemination of information for
24 members of minority groups about clinical trial participa-

1 tion. Activities funded pursuant to the preceding sentence
2 shall include—

3 “(A) using established mechanisms to encour-
4 age members of minority groups to participate in
5 clinical trials on Alzheimer’s disease;

6 “(B) expanding education efforts to make mem-
7 bers of minority groups aware of ongoing clinical
8 trials;

9 “(C) working with trial sponsors to increase the
10 number of recruitment events for members of minor-
11 ity groups;

12 “(D) conducting outreach to national, State,
13 and local physician professional organizations, espe-
14 cially for members of such organizations who are
15 primary care physicians or physicians who specialize
16 in dementia, to increase awareness of clinical re-
17 search opportunities for members of minority
18 groups; and

19 “(E) using community-based participatory re-
20 search methodologies to engage with minority popu-
21 lations.”.

22 (B) RESOURCE CENTERS FOR MINORITY
23 AGING RESEARCH.—Section 444(c) of the Pub-
24 lic Health Service Act (42 U.S.C. 285e–1(c)) is
25 amended—

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1 (i) by striking “(c)” and inserting
2 “(c)(1)” ; and

3 (ii) by adding at the end the following
4 new paragraph:

5 “(2) The Director of the Institute, acting through the
6 Resource Centers for Minority Aging Research of the In-
7 stitute, shall carry out public outreach, education efforts,
8 and dissemination of information for members of minority
9 groups about participation in clinical research on Alz-
10 heimer’s disease carried out or supported under this sub-
11 part.”.

12 (b) INCENTIVES TO INCREASE DIVERSITY IN ALZ-
13 HEIMER’S DISEASE RESEARCH THROUGH PRINCIPAL IN-
14 VESTIGATORS AND RESEARCHERS FROM UNDERREP-
15 RESENTED POPULATIONS.—

16 (1) ALZHEIMER’S CLINICAL RESEARCH AND
17 TRAINING AWARDS.—Section 445I of the Public
18 Health Service Act (42 U.S.C. 285e–10a) is amend-
19 ed by adding at the end the following new sub-
20 section:

21 “(d) ENHANCING THE PARTICIPATION OF PRINCIPAL
22 INVESTIGATORS AND RESEARCHERS WHO ARE MEMBERS
23 OF UNDERREPRESENTED POPULATIONS.—

24 “(1) IN GENERAL.—The Director of the Insti-
25 tute shall enhance diversity in the conduct or sup-

1 port of clinical research on Alzheimer’s disease
2 under this subpart by encouraging the participation
3 of individuals from groups that are underrepresented
4 in the biomedical, clinical, behavioral, and social
5 sciences as principal investigators of such clinical re-
6 search, as researchers for such clinical research, or
7 both.

8 “(2) TRAINING FOR PRINCIPAL INVESTIGA-
9 TORS.—The Director of the Institute shall provide
10 training for principal investigators who are members
11 of a minority group with respect to skills for—

12 “(A) the design and conduct of clinical re-
13 search and clinical protocols;

14 “(B) applying for grants for clinical re-
15 search; and

16 “(C) such other areas as the Director of
17 the Institute determines to be appropriate.”.

18 (2) SENIOR RESEARCHER AWARDS.—Section
19 445B(a) of the Public Health Service Act (42
20 U.S.C. 285e–4(a)) is amended by inserting “, in-
21 cluding senior researchers who are members of a mi-
22 nority group” before the period at the end of the
23 first sentence.

24 (c) INCENTIVES TO INCREASE DIVERSITY IN ALZ-
25 HEIMER’S DISEASE RESEARCH THROUGH TRIAL SITES.—

1 Section 444(d) of the Public Health Service Act (42
2 U.S.C. 285e–1(d)) is amended—

3 (1) by striking “(d)” and inserting “(d)(1)” ;
4 and

5 (2) by adding at the end the following new
6 paragraphs:

7 “(2) In conducting or supporting clinical research on
8 Alzheimer’s disease for purposes of this subpart, in addi-
9 tion to requirements otherwise imposed under this title,
10 including under section 492B, the Director of the Institute
11 shall increase the participation of members of minority
12 groups in such clinical research through one or more of
13 the activities described in paragraph (3).

14 “(3)(A) The Director of the Institute shall provide
15 incentives for the support of clinical research on Alz-
16 heimer’s disease with clinical trial sites established in
17 areas with a higher concentration of minority groups, in-
18 cluding rural areas if practicable.

19 “(B) In determining whether to conduct or support
20 clinical research on Alzheimer’s disease, the Director of
21 the Institute shall encourage the conduct of clinical re-
22 search with clinical trial sites in areas described in sub-
23 paragraph (A) as a higher-level priority criterion among
24 the criteria established to evaluate whether to conduct or
25 support clinical research.

1 “(C) In determining the amount of funding to be pro-
2 vided for the conduct or support of such clinical research,
3 the Director of the Institute shall provide additional fund-
4 ing for the conduct of such clinical research with clinical
5 trial sites in areas described in subparagraph (A).

6 “(D) In determining whether an area is an area with
7 a higher concentration of minority groups, the Director
8 of the Institute—

9 “(i) shall consider the most recent data col-
10 lected by the Bureau of the Census; and

11 “(ii) may also consider—

12 “(I) data from the Centers for Medicare &
13 Medicaid Services on the incidence of Alz-
14 heimer’s disease in the United States by region;
15 and

16 “(II) such other data as the Director de-
17 termines appropriate.

18 “(4) In order to facilitate the participation of mem-
19 bers of minority groups in clinical research supported
20 under this subpart, in addition to activities described in
21 paragraph (3), the Director of the Institute shall—

22 “(A) ensure that such clinical research uses
23 community-based participatory research methodolo-
24 gies; and

1 “(B) encourage the use of remote health tech-
2 nologies, including telehealth, remote patient moni-
3 toring, and mobile technologies, that reduce or elimi-
4 nate barriers to participation of members of minor-
5 ity groups in such clinical research.

6 “(5)(A) Clinical research on Alzheimer’s disease con-
7 ducted or supported under this subpart shall ensure that
8 such research includes outreach activities designed to in-
9 crease the participation of members of minority groups in
10 such research.

11 “(B)(i) Each applicant for a grant under this subpart
12 for clinical research on Alzheimer’s disease shall submit
13 to the Director of the Institute in the application for such
14 grant—

15 “(I) a budget for outreach activities to members
16 of minority populations with respect to participation
17 in such clinical research; and

18 “(II) a description of the plan to conduct such
19 outreach.

20 “(ii) The Director of the Institute shall encourage ap-
21 plicants for, and recipients of, grants under this subpart
22 to conduct clinical research on Alzheimer’s disease to en-
23 gage with community-based organizations to increase par-
24 ticipation of minority populations in such research.

25 “(6) For purposes of this subpart:

1 “(A) The term ‘clinical research’ includes a
2 clinical trial.

3 “(B) The term ‘minority group’ has the mean-
4 ing given such term under section 492B(g).”.

5 (d) PARTICIPANT ELIGIBILITY CRITERIA.—Section
6 445I of the Public Health Service Act (42 U.S.C. 285e–
7 10a), as amended by subsection (b)(1), is further amended
8 by adding at the end the following new subsection:

9 “(e) PARTICIPANT ELIGIBILITY CRITERIA.—The Di-
10 rector of the Institute shall take such actions as are nec-
11 essary to ensure that clinical research on Alzheimer’s dis-
12 ease conducted or supported under this subpart is de-
13 signed with eligibility criteria that ensure the clinical trial
14 population reflects the diversity of the prospective patient
15 population. Such actions may include the following:

16 “(1) EXAMINATION OF CRITERIA.—

17 “(A) IN GENERAL.—An examination of
18 each exclusion criterion to determine if the cri-
19 terion is necessary to ensure the safety of trial
20 participants or to achieve the study objectives.

21 “(B) MODIFICATION OF CRITERIA.—In the
22 case of an exclusion criterion that is not nec-
23 essary to ensure the safety of trial participants
24 or to achieve the study objectives—

1 “(i) encouraging the modification or
2 elimination of the criterion; or

3 “(ii) encouraging tailoring the cri-
4 terion as narrowly as possible to avoid un-
5 necessary limits to the population of the
6 clinical study.

7 “(2) REQUIREMENT FOR STRONG JUSTIFICA-
8 TION FOR EXCLUSION.—A review of each exclusion
9 criterion to ensure that populations are included in
10 clinical trials, such as older adults, individuals with
11 a mild form of disease, individuals at the extremes
12 of the weight range, or children, unless there is a
13 strong clinical or scientific justification to exclude
14 them.

15 “(3) USE OF ADAPTIVE DESIGN.—Encouraging
16 the use of an adaptive clinical trial design that—

17 “(A) starts with a defined population
18 where there are concerns about safety; and

19 “(B) may expand to a broader population
20 based on initial data from the trial and external
21 data.”.

22 (e) RESOURCE CENTER FOR SUCCESSFUL STRATE-
23 GIES TO INCREASE PARTICIPATION OF UNDERREP-
24 RESENTED POPULATIONS IN ALZHEIMER’S DISEASE
25 CLINICAL RESEARCH.—Section 444 of the Public Health

1 Service Act (42 U.S.C. 285e–1) is amended by adding at
2 the end the following new subsection:

3 “(e)(1) Acting through the Office of Special Popu-
4 lations and in consultation with the Division of Extra-
5 mural Activities, the Director of the Institute shall support
6 resource information and technical assistance to grantees
7 under section 445 (relating to Alzheimer’s disease cen-
8 ters), other grantees, and prospective grantees, designed
9 to increase the participation of minority populations in
10 clinical research on Alzheimer’s disease conducted or sup-
11 ported under this subpart.

12 “(2) The resource information and technical assist-
13 ance provided under paragraph (1) shall include the main-
14 tenance of a central resource library in order to collect,
15 prepare, analyze, and disseminate information relating to
16 strategies and best practices used by recipients of grants
17 under this subpart and other researchers in the develop-
18 ment of the clinical research designed to increase the par-
19 ticipation of minority populations in such clinical re-
20 search.”.

21 (f) ANNUAL REPORTS.—Section 444 of the Public
22 Health Service Act (42 U.S.C. 285e–1), as amended by
23 subsection (e), is further amended by adding at the end
24 the following new subsection:

1 “(f)(1)(A) The Director of the Institute shall submit
2 annual reports to the Congress on the impact of the
3 amendments made to this subpart by the Health Equity
4 and Accountability Act of 2022.

5 “(B) The Secretary shall transmit a copy of each
6 such report to the Advisory Council on Alzheimer’s Re-
7 search, Care, and Services established under section 2(e)
8 of the National Alzheimer’s Project Act (Public Law 111–
9 375).

10 “(2) In each report under paragraph (1), the Director
11 of the Institute shall include information and data on the
12 following matters with respect to clinical trials on Alz-
13 heimer’s disease conducted during the preceding year:

14 “(A) The number of participants who are mem-
15 bers of a minority group in such clinical trials.

16 “(B) The number of such clinical trials for
17 which incentives under subsection (d)(3) were made
18 available, the nature of such incentives, the amount
19 of increased funding (if any) made available for re-
20 search on Alzheimer’s disease, and the training pro-
21 vided to principal investigators who are members of
22 a minority group and the amount of funding (if any)
23 for such training.

1 “(C) The number of such clinical trials for
2 which the principal investigator is a member of a mi-
3 nority group.

4 “(D) The number of such clinical trials for
5 which a significant percentage of researchers are
6 members of a minority group.

7 “(E) Modifications to patient eligibility criteria
8 in clinical trial designs under section 445I(e).

9 “(F) Outreach and education efforts conducted
10 under section 445(b)(4).

11 “(3) The Director of the Institute shall make each
12 report under paragraph (1) available to the public, includ-
13 ing through posting on the appropriate website of the De-
14 partment of Health and Human Services.”.

15 (g) AUTHORIZATION OF APPROPRIATIONS.—For each
16 of fiscal years 2023 through 2027, there is authorized to
17 be appropriated to the Secretary of Health and Human
18 Services \$60,000,000 to carry out the amendments made
19 by this section, to remain available until expended.

20 **TITLE VIII—HEALTH**
21 **INFORMATION TECHNOLOGY**

22 **SEC. 8001. DEFINITIONS.**

23 In this title:

24 (1) ACCESS.—The term “access”, with respect
25 to health information, means access described in sec-

1 tion 164.524 of title 45, Code of Federal Regula-
2 tions (or any successor regulations).

3 (2) CERTIFIED ELECTRONIC HEALTH RECORD
4 TECHNOLOGY.—The term “certified EHR tech-
5 nology”—

6 (A) has the meaning given such term in
7 section 3000 of the Public Health Service Act
8 (42 U.S.C. 300jj);

9 (B) includes the health information infra-
10 structure for interoperability, access, exchange,
11 and use of electronic health information re-
12 quired under title XXX of the Public Health
13 Service Act (42 U.S.C. 300jj et seq.); and

14 (C) is not limited to electronic health
15 records maintained by doctors.

16 (3) EHR.—The term “EHR”—

17 (A) means an electronic health record;

18 (B) includes the health information infra-
19 structure for interoperability, access, exchange,
20 and use of electronic health information re-
21 quired under title XXX of the Public Health
22 Service Act (42 U.S.C. 300jj et seq.); and

23 (C) is not limited to electronic health
24 records maintained by doctors.

1 (4) INTEROPERABILITY.—The term “interoper-
2 ability” has the meaning given such term in section
3 3000 of the Public Health Service Act (42 U.S.C.
4 300jj).

5 **Subtitle A—Reducing Health**
6 **Disparities Through Health IT**

7 **SEC. 8101. HRSA ASSISTANCE TO HEALTH CENTERS FOR**
8 **PROMOTION OF HEALTH IT.**

9 (a) IN GENERAL.—The Secretary of Health and
10 Human Services, acting through the Administrator of the
11 Health Resources and Services Administration, shall ex-
12 pand and intensify the programs and activities of the Ad-
13 ministration (directly or through grants or contracts) to
14 provide technical assistance and resources to health cen-
15 ters (as defined in section 330(a) of the Public Health
16 Service Act (42 U.S.C. 254b(a))) to adopt and meaning-
17 fully use certified EHR technology for the management
18 of chronic diseases and health conditions and reduction
19 of health disparities.

20 (b) FUNDING INITIATIVES.—The activities under
21 subsection (a) may include funding initiatives, including
22 establishing basic connectivity such as 5G internet for
23 telemedicine capabilities, grant funding to implement the
24 next generation of EHR, and funding for technology hard-
25 ware.

1 **SEC. 8102. ASSESSMENT OF IMPACT OF HEALTH IT ON RA-**
2 **CIAL AND ETHNIC MINORITY COMMUNITIES;**
3 **OUTREACH AND ADOPTION OF HEALTH IT IN**
4 **SUCH COMMUNITIES.**

5 (a) NATIONAL COORDINATOR FOR HEALTH INFOR-
6 MATION TECHNOLOGY.—

(1) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the National Coordinator for Health Information Technology (referred to in this title as the “National Coordinator”) shall—

(A) conduct an evaluation of the level of interoperability, access, use, and accessibility of electronic health records in racial and ethnic minority communities, focusing on whether patients in such communities have providers who use electronic health records, and the degree to which patients in such communities can access, exchange, and use without special effort their health information in those electronic health records;

22 (B) include in such evaluation an indica-
23 tion of whether such providers—

(i) are participating in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or

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1 a State plan under title XIX of such Act
2 (42 U.S.C. 1396 et seq.) (or a waiver of
3 such plan);

4 (ii) have received incentive payments
5 or incentive payment adjustments under
6 Medicare and Medicaid Electronic Health
7 Records Incentive Programs (as defined in
8 subsection (c)(2));

9 (iii) are MIPS eligible professionals,
10 as defined in paragraph (1)(C) of section
11 1848(q) of the Social Security Act (42
12 U.S.C. 1395w-4(q)), for purposes of the
13 Merit-Based Incentive Payment System
14 under such section; or

15 (iv) have been recruited by any of the
16 Health Information Technology Regional
17 Extension Centers established under sec-
18 tion 3012 of the Public Health Service Act
19 (42 U.S.C. 300jj-32); and

20 (C) publish the results of such evaluation
21 including the indications under subparagraph
22 (B), the race and ethnicity of such providers,
23 and the populations served by such providers.

24 (2) EVALUATION OF INTEROPERABILITY.—The
25 evaluation of the level of interoperability described in

1 paragraph (1)(A) shall consider exchange of elec-
2 tronic health information, usability of exchanged
3 electronic health information, effective application
4 and use of the exchanged electronic health informa-
5 tion, and impact on outcomes of interoperability.

6 (3) CERTIFICATION CRITERION.—Not later
7 than 1 year after the date of enactment of this Act,
8 the National Coordinator shall—

9 (A) promulgate a certification criterion and
10 module of certified EHR technology that strati-
11 fies quality measures for purposes of the Merit-
12 Based Incentive Payment System by disparity
13 characteristics, including race, ethnicity, lan-
14 guage, gender, gender identity, sexual orienta-
15 tion, socio-economic status, and disability sta-
16 tus, as such characteristics are defined for pur-
17 poses of certified EHR technology; and

18 (B) report to the Centers for Medicare &
19 Medicaid Services the quality measures strati-
20 fied by race and at least 2 other disparity char-
21 acteristics.

22 (b) NATIONAL CENTER FOR HEALTH STATISTICS.—
23 As soon as practicable after the date of enactment of this
24 Act, the Director of the National Center for Health Statis-
25 tics shall provide to Congress a more detailed analysis of

1 the data presented in National Center for Health Statis-
2 ties data brief entitled “Adoption of Certified Electronic
3 Health Record Systems and Electronic Information Shar-
4 ing in Physician Offices: United States, 2013 and 2014”
5 (NCHS Data Brief No. 236).

6 (c) CENTERS FOR MEDICARE & MEDICAID SERV-
7 ICES.—

8 (1) IN GENERAL.—As part of the process of
9 collecting information, with respect to a provider, at
10 registration and attestation for purposes of Medicare
11 and Medicaid Electronic Health Records Incentive
12 Programs (as defined in paragraph (2)) or the
13 Merit-Based Incentive Payment System under sec-
14 tion 1848(q) of the Social Security Act (42 U.S.C.
15 1395w–4(q)), the Secretary of Health and Human
16 Services shall collect the race and ethnicity of such
17 provider.

18 (2) MEDICARE AND MEDICAID ELECTRONIC
19 HEALTH RECORDS INCENTIVE PROGRAMS DE-
20 FINED.—For purposes of paragraph (1), the term
21 “Medicare and Medicaid Electronic Health Records
22 Incentive Programs” means the incentive programs
23 under the following:

24 (A) Subsection (l)(3) of section 1814(l)(3)
25 of the Social Security Act (42 U.S.C. 1395f).

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1 (B) Subsections (a)(7) and (o) of section
2 1848 of such Act (42 U.S.C. 1395w-4).

3 (C) Subsections (l) and (m) of section
4 1853 of such Act (42 U.S.C. 1395w-23).

5 (D) Subsections (b)(3)(B)(ix)(I) and (n) of
6 section 1886 of such Act (42 U.S.C. 1395ww).

7 (E) Subsections (a)(3)(F) and (t) of sec-
8 tion 1903 such Act (42 U.S.C. 1396b).

9 (d) NATIONAL COORDINATOR'S ASSESSMENT OF IM-
10 PACT OF HIT.—Section 3001(c)(6)(C) of the Public
11 Health Service Act (42 U.S.C. 300jj-11(c)(6)(C)) is
12 amended—

13 (1) in the heading by inserting “, RACIAL AND
14 ETHNIC MINORITY COMMUNITIES,” after “HEALTH
15 DISPARITIES”;

16 (2) by inserting “, in communities with a high
17 proportion of individuals from racial and ethnic mi-
18 nority groups (as defined in section 1707(g)), in-
19 cluding people with disabilities in such groups,”
20 after “communities with health disparities”;

21 (3) by striking “The National Coordinator” and
22 inserting the following:

23 “(i) IN GENERAL.—The National Co-
24 ordinator”; and

25 (4) by adding at the end the following:

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1 “(ii) CRITERIA.—In any publication
2 under clause (i), the National Coordinator
3 shall include best practices for encouraging
4 partnerships between the Federal Govern-
5 ment, States, private entities, national
6 nonprofit intermediaries, and community-
7 based organizations to expand outreach
8 and education for and the adoption of cer-
9 tified EHR technology in communities with
10 a high proportion of individuals from racial
11 and ethnic minority groups (as defined in
12 section 1707(g)), while also maintaining
13 the accessibility requirements of section
14 508 of the Rehabilitation Act of 1973 to
15 encourage patient involvement in patient
16 health care. The National Coordinator
17 shall—

18 “(I) not later than 6 months
19 after the submission of the report re-
20 quired under section 8302 of the
21 Health Equity and Accountability Act
22 of 2022, establish criteria for evalu-
23 ating the impact of health information
24 technology on communities with a
25 high proportion of individuals from

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1 racial and ethnic minority groups (as
2 so defined) taking into account the
3 findings in such report; and
4 “(II) not later than 1 year after
5 the submission of such report, publish
6 the results of an evaluation of such
7 impact.”.

8 **SEC. 8103. NONDISCRIMINATION AND HEALTH EQUITY IN**
9 **HEALTH INFORMATION TECHNOLOGY.**

10 (a) IN GENERAL.—Covered entities shall ensure that
11 electronic and information technology in their health pro-
12 grams or activities does not exclude individuals from par-
13 ticipation in, deny individuals the benefits of, or subject
14 individuals to discrimination under any health program or
15 activity on the basis of race, color, national origin, sex,
16 age, or disability.

17 (b) COVERED ENTITIES.—In this section, the term
18 “covered entity” means—

19 (1) an entity that operates a health program or
20 activity, any part of which receives Federal financial
21 assistance;

22 (2) an entity established under title I of the Pa-
23 tient Protection and Affordable Care Act (Public
24 Law 114–148) that administers a health program or
25 activity; or

1 (3) the Department of Health and Human
2 Services.

3 **SEC. 8104. LANGUAGE ACCESS IN HEALTH INFORMATION**
4 **TECHNOLOGY.**

5 The National Coordinator shall—

6 (1) not later than 18 months after the date of
7 enactment of this Act, propose a rule for providing
8 access to patients, through certified EHR tech-
9 nology, to their personal health information in a
10 computable format, including using patient portals
11 or third-party applications (as described in section
12 3009(e) of the Public Health Service Act (42 U.S.C.
13 300jj–19(e))), in the 10 most common non-English
14 languages;

15 (2) hold a public hearing to identify best prac-
16 tices for carrying out paragraph (1); and

17 (3) not later than 6 months after the public
18 hearing under paragraph (2), promulgate a final
19 regulation with respect to paragraph (1).

1 **Subtitle B—Modifications To**
2 **Achieve Parity in Existing Pro-**
3 **grams**

4 **SEC. 8201. EXTENDING FUNDING TO STRENGTHEN THE**
5 **HEALTH IT INFRASTRUCTURE IN RACIAL**
6 **AND ETHNIC MINORITY COMMUNITIES.**

7 Section 3011 of the Public Health Service Act (42
8 U.S.C. 300jj–31) is amended—

9 (1) in subsection (a), in the matter preceding
10 paragraph (1), by inserting “, including with respect
11 to communities with a high proportion of individuals
12 from racial and ethnic minority groups (as defined
13 in section 1707(g))” before the colon at the end; and
14 (2) by adding at the end the following new sub-
15 section:

16 “(e) ANNUAL REPORT ON EXPENDITURES.—The
17 National Coordinator shall report annually to Congress on
18 activities and expenditures under this section.”.

19 **SEC. 8202. EXTENDING COMPETITIVE GRANTS FOR THE DE-**
20 **VELOPMENT OF LOAN PROGRAMS TO FACILI-**
21 **TATE ADOPTION OF CERTIFIED EHR TECH-**
22 **NOLOGY BY PROVIDERS SERVING RACIAL**
23 **AND ETHNIC MINORITY GROUPS.**

24 Section 3014(e) of the Public Health Service Act (42
25 U.S.C. 300jj–34(e)) is amended, in the matter preceding

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1 paragraph (1), by inserting “, including with respect to
2 communities with a high proportion of individuals from
3 racial and ethnic minority groups (as defined in section
4 1707(g))” after “health care provider to”.

5 **SEC. 8203. AUTHORIZATION OF APPROPRIATIONS.**

6 Section 3018 of the Public Health Service Act (42
7 U.S.C. 300jj–38) is amended by striking “fiscal years
8 2009 through 2013” and inserting “fiscal years 2023
9 through 2028”.

10 **Subtitle C—Additional Research**
11 **and Studies**

12 **SEC. 8301. DATA COLLECTION AND ASSESSMENTS CON-**
13 **DUCTED IN COORDINATION WITH MINORITY-**
14 **SERVING INSTITUTIONS.**

15 Section 3001(c)(6) of the Public Health Service Act
16 (42 U.S.C. 300jj–11(c)(6)) is amended by adding at the
17 end the following new subparagraph:

18 “(F) DATA COLLECTION AND ASSESS-
19 MENTS CONDUCTED IN COORDINATION WITH
20 MINORITY-SERVING INSTITUTIONS.—

21 “(i) IN GENERAL.—In carrying out
22 subparagraph (C) with respect to commu-
23 nities with a high proportion of individuals
24 from racial and ethnic minority groups (as
25 defined in section 1707(g)), the National

1 Coordinator shall, to the greatest extent
2 possible, coordinate with an entity de-
3 scribed in clause (ii).

4 “(ii) MINORITY-SERVING INSTITU-
5 TIONS.—For purposes of clause (i), an en-
6 tity described in this clause is a historically
7 black college or university, a Hispanic-serv-
8 ing institution, a Tribal College or Univer-
9 sity, or an Asian-American-, Native Amer-
10 ican-, or Pacific Islander-serving institu-
11 tion with an accredited public health,
12 health policy, or health services research
13 program.”.

14 **SEC. 8302. STUDY OF HEALTH INFORMATION TECHNOLOGY**
15 **IN MEDICALLY UNDERSERVED COMMU-**
16 **NITIES.**

17 (a) IN GENERAL.—Not later than 2 years after the
18 date of enactment of this Act, the Secretary of Health and
19 Human Services shall—

20 (1) enter into an agreement with the National
21 Academies of Sciences, Engineering, and Medicine to
22 conduct a study on the development, implementa-
23 tion, and effectiveness of health information tech-
24 nology within medically underserved areas; and

1 (2) submit a report to Congress describing the
2 results of such study, including any recommenda-
3 tions for legislative or administrative action.

4 (b) STUDY.—The study described in subsection
5 (a)(1) shall—

6 (1) identify barriers to successful implementa-
7 tion of health information technology in medically
8 underserved areas;

9 (2) survey a cross-section of individuals in
10 medically underserved areas and report their opin-
11 ions about the various topics of study;

12 (3) examine the degree of interoperability
13 among health information technology and users of
14 health information technology in medically under-
15 served areas, including patients, providers, and com-
16 munity services, which such examination shall con-
17 sider the exchange of electronic health information,
18 usability of exchanged electronic health information,
19 effective application and use of the exchanged elec-
20 tronic health information, and impact on outcomes
21 of interoperability;

22 (4) examine the impact of health information
23 technology on providing quality care and reducing
24 the cost of care to individuals in such areas, includ-
25 ing the impact of such technology on improved

1 health outcomes for individuals, including which
2 technology worked for which population and how it
3 improved health outcomes for that population;

4 (5) examine the impact of health information
5 technology on improving health care-related deci-
6 sions by both patients and providers in such areas;

7 (6) identify specific best practices for using
8 health information technology to foster the con-
9 sistent provision of physical accessibility and reason-
10 able policy accommodations in health care to individ-
11 uals with disabilities in such areas;

12 (7) assess the feasibility and costs associated
13 with the use of health information technology in
14 such areas;

15 (8) evaluate whether the adoption and use of
16 qualified electronic health records (as defined in sec-
17 tion 3000 of the Public Health Service Act (42
18 U.S.C. 300jj)) is effective in reducing health dispari-
19 ties, including analysis of clinical quality measures
20 reported by providers who are participating in the
21 Medicare program under title XVIII of the Social
22 Security Act (42 U.S.C. 1395 et seq.) or a State
23 plan under title XIX of such Act (42 U.S.C. 1396
24 et seq.) (or a waiver of such plan), pursuant to pro-

1 grams to encourage the adoption and use of certified
2 EHR technology;

3 (9) identify providers in medically underserved
4 areas that are not electing to adopt and use elec-
5 tronic health records and determine what barriers
6 are preventing those providers from adopting and
7 using such records; and

8 (10) examine urban and rural community
9 health systems and determine the impact that health
10 information technology may have on the capacity of
11 primary health providers in those systems.

12 (c) **MEDICALLY UNDERSERVED AREA.**—In this sec-
13 tion, the term “medically underserved area” means—

14 (1) a population that has been designated as a
15 medically underserved population under section
16 330(b)(3) of the Public Health Service Act (42
17 U.S.C. 254b(b)(3));

18 (2) an area that has been designated as a
19 health professional shortage area under section 332
20 of the Public Health Service Act (42 U.S.C. 254e);

21 (3) an area or population that has been des-
22 ignated as a medically underserved community under
23 section 799B of the Public Health Service Act (42
24 U.S.C. 295p); or

25 (4) another area or population that—

1 (A) experiences significant barriers to ac-
2 cessing quality health services; and

3 (B) has a high prevalence of diseases or
4 conditions described in title VII, with such dis-
5 eases or conditions having a disproportionate
6 impact on racial and ethnic minority groups (as
7 defined in section 1707(g) of the Public Health
8 Service Act (42 U.S.C. 300u-6(g))) or a sub-
9 group of people with disabilities who have spe-
10 cific functional impairments.

11 **SEC. 8303. ASSESSMENT OF USE AND MISUSE OF DE-IDEN-**
12 **TIFIED HEALTH DATA.**

13 (a) IN GENERAL.—Not later than 18 months after
14 the date of enactment of this Act, the Secretary of Health
15 and Human Services shall—

16 (1) enter into an agreement with the Office of
17 the National Coordinator of Health Information
18 Technology to conduct a study, in consultation with
19 relevant stakeholders, on the impact of digital health
20 technology on medically underserved areas (as de-
21 fined in section 8302(c)); and

22 (2) submit a report to Congress describing the
23 results of such study, including any recommenda-
24 tions for legislative or administrative action.

1 (b) STUDY.—The study described in subsection
2 (a)(1) shall—

3 (1) examine the overall prevalence, and histor-
4 ical and existing practices and their respective preva-
5 lence, of use and misuse of de-identified protected
6 health information to discriminate against or benefit
7 medically underserved areas;

8 (2) identify best practices and tools to leverage
9 the benefits and prevent misuse of de-identified pro-
10 tected health information to discriminate against
11 medically underserved areas;

12 (3) examine the overall prevalence, and histor-
13 ical and existing practices and their respective preva-
14 lence, of use and misuse of de-identified personal
15 health information other than protected health infor-
16 mation to discriminate against or benefit medically
17 underserved areas; and

18 (4) identify best practices and tools to leverage
19 the benefits and prevent misuse of de-identified per-
20 sonal health information other than protected health
21 information to discriminate against medically under-
22 served areas.

23 (c) DEFINITION OF PROTECTED HEALTH INFORMA-
24 TION.—In this section, the term “protected health infor-
25 mation” has the meaning given such term in section

1 160.103, title 45, Code of Federal Regulations (or any
2 successor regulations).

3 **Subtitle D—Closing Gaps in**
4 **Funding To Adopt Certified EHRs**

5 **SEC. 8401. EXTENDING MEDICAID EHR INCENTIVE PAY-**
6 **MENTS TO REHABILITATION FACILITIES,**
7 **LONG-TERM CARE FACILITIES, AND HOME**
8 **HEALTH AGENCIES.**

9 (a) IN GENERAL.—Section 1903(t)(2)(B) of the So-
10 cial Security Act (42 U.S.C. 1396b(t)(2)(B)) is amend-
11 ed—

12 (1) in clause (i), by striking “, or” and insert-
13 ing a semicolon;

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

16 (3) by inserting after clause (ii) the following
17 new clauses:

18 “(iii) a rehabilitation facility (as defined in sec-
19 tion 1886(j)(1)) that furnishes acute or subacute re-
20 habilitation services;

21 “(iv) a long-term care hospital described in sec-
22 tion 1886(d)(1)(B)(iv); or

23 “(v) a home health agency (as defined in sec-
24 tion 1861(o)).”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply with respect to amounts ex-
3 pended under section 1903(a)(3)(F) of the Social Security
4 Act (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters be-
5 ginning on or after the date of the enactment of this Act.

6 **SEC. 8402. EXTENDING PHYSICIAN ASSISTANT ELIGIBILITY**
7 **FOR MEDICAID ELECTRONIC HEALTH**
8 **RECORD INCENTIVE PAYMENTS.**

9 (a) IN GENERAL.—Section 1903(t)(3)(B)(v) of the
10 Social Security Act (42 U.S.C. 1396b(t)(3)(B)(v)) is
11 amended to read as follows:

12 “(v) physician assistant.”.

13 (b) EFFECTIVE DATE.—The amendment made by
14 subsection (a) shall apply with respect to amounts ex-
15 pended under section 1903(a)(3)(F) of the Social Security
16 Act (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters be-
17 ginning on or after the date of the enactment of this Act.

18 **Subtitle E—Expanding Access to**
19 **Telehealth Services**

20 **SEC. 8501. REMOVING GEOGRAPHIC REQUIREMENTS FOR**
21 **TELEHEALTH SERVICES.**

22 Section 1834(m)(4)(C) of the Social Security Act (42
23 U.S.C. 1395m(m)(4)(C)) is amended—

1 (1) in clause (i), in the matter preceding sub-
2 clause (I), by striking “clause (iii)” and inserting
3 “clauses (iii) and (iv)”; and

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

6 “(iv) REMOVAL OF GEOGRAPHIC RE-
7 QUIREMENTS.—The geographic require-
8 ments described in clause (i) shall not
9 apply with respect to telehealth services
10 furnished on or after the first day after the
11 end of the period for which clause (iii) ap-
12 plies.”.

13 **SEC. 8502. EXPANDING ORIGINATING SITES.**

14 (a) EXPANDING THE HOME AS AN ORIGINATING
15 SITE.—Section 1834(m)(4)(C)(ii)(X) of the Social Secu-
16 rity Act (42 U.S.C. 1395m(m)(4)(C)(ii)(X)) is amended
17 to read as follows:

18 “(X)(aa) Prior to the date de-
19 scribed in item (bb), the home of an
20 individual but only for purposes of
21 section 1881(b)(3)(B) or telehealth
22 services described in paragraph (7) or
23 clause (iii).

24 “(bb) On or after the first day
25 after the end of the period for which

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1 clause (iii) applies, the home of an in-
2 dividual.”.

3 (b) ALLOWING ADDITIONAL ORIGINATING SITES.—

4 Section 1834(m)(4)(C)(ii) of the Social Security Act (42
5 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the
6 end the following new subclause:

7 “(XII) Any other site determined
8 appropriate by the Secretary at which
9 an eligible telehealth individual is lo-
10 cated at the time a telehealth service
11 is furnished via a telecommunications
12 system.”.

13 (c) PARAMETERS FOR NEW ORIGINATING SITES.—

14 Section 1834(m)(4)(C) of the Social Security Act (42
15 U.S.C. 1395m(m)(4)(C)), as amended by section 8501, is
16 amended by adding at the end the following new clause:

17 “(v) REQUIREMENTS FOR NEW
18 SITES.—

19 “(I) IN GENERAL.—The Sec-
20 retary may establish requirements for
21 the furnishing of telehealth services at
22 sites described in clause (ii)(XII) to
23 provide for beneficiary and program
24 integrity protections.

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1 “(II) CLARIFICATION.—Nothing
2 in this clause shall be construed to
3 preclude the Secretary from estab-
4 lishing requirements for other origi-
5 nating sites described in clause (ii)”.

6 (d) NO ORIGINATING SITE FACILITY FEE FOR NEW
7 SITES.—Section 1834(m)(2)(B)(ii) of the Social Security
8 Act (42 U.S.C. 1395m(m)(2)(B)(ii)) is amended—

9 (1) in the heading, by striking “IF ORIGINATING
10 SITE IS THE HOME” and inserting “FOR CERTAIN
11 SITES”; and

12 (2) by striking “paragraph (4)(C)(ii)(X)” and
13 inserting “subclause (X) or (XII) of paragraph
14 (4)(C)”.

1 **TITLE IX—ACCOUNTABILITY**
2 **AND EVALUATION**

3 **SEC. 9001. PROHIBITION ON DISCRIMINATION IN FEDERAL**
4 **ASSISTED HEALTH CARE SERVICES AND RE-**
5 **SEARCH ON THE BASIS OF SEX (INCLUDING**
6 **SEXUAL ORIENTATION, GENDER IDENTITY,**
7 **AND PREGNANCY, INCLUDING TERMINATION**
8 **OF PREGNANCY), RACE, COLOR, NATIONAL**
9 **ORIGIN, MARITAL STATUS, FAMILIAL STATUS,**
10 **OR DISABILITY STATUS.**

11 (a) IN GENERAL.—No person in the United States
12 shall, on the basis of sex (including sexual orientation,
13 gender identity, and pregnancy, including termination of
14 pregnancy), race, color, national origin, marital status, fa-
15 milial status, sexual orientation, gender identity, or dis-
16 ability status, be excluded from participation in, be denied
17 the benefits of, or be subjected to discrimination under—

18 (1) any health program or activity, including
19 any health research program or activity, receiving
20 Federal financial assistance, including credits, sub-
21 sidies, or contracts of insurance; or

22 (2) any health program or activity that is ad-
23 ministered by an executive agency.

24 (b) DEFINITION.—In this section, the term “familial
25 status” means, with respect to one or more individuals—

- 1 (1) being domiciled with any individual related
2 by blood or affinity whose close association with the
3 individual is the equivalent of a family relationship;
4 (2) being in the process of securing legal cus-
5 tody of any individual; or
6 (3) being pregnant.

7 **SEC. 9002. TREATMENT OF MEDICARE PAYMENTS UNDER**
8 **TITLE VI OF THE CIVIL RIGHTS ACT OF 1964.**

9 For the purposes of title VI of the Civil Rights Act
10 of 1964 (42 U.S.C. 2000d et seq.), a payment made under
11 part A, B, C, or D of title XVIII of the Social Security
12 Act (42 U.S.C. 1395 et seq.) to a provider of services,
13 physician, or other supplier (including a payment made
14 to a subcontractor of the provider of services, physician,
15 or other supplier) shall be deemed a grant, not a contract
16 of insurance or guaranty.

17 **SEC. 9003. ACCOUNTABILITY AND TRANSPARENCY WITHIN**
18 **THE DEPARTMENT OF HEALTH AND HUMAN**
19 **SERVICES.**

20 Title XXXIV of the Public Health Service Act, as
21 amended by titles I, II, III, and IV of this Act, is further
22 amended by inserting after subtitle D the following:

1 **“Subtitle E—Strengthening**
2 **Accountability**

3 **“SEC. 3451. ELEVATION OF THE OFFICE FOR CIVIL RIGHTS**
4 **AND HEALTH EQUITY.**

5 “(a) IN GENERAL.—

6 “(1) NAME OF OFFICE.—Beginning on the date
7 of enactment of this subtitle, the Office for Civil
8 Rights of the Department of Health and Human
9 Services shall be known as the ‘Office for Civil
10 Rights and Health Equity’ of the Department of
11 Health and Human Services. Any reference to the
12 Office for Civil Rights of the Department of Health
13 and Human Services in any law, regulation, map,
14 document, record, or other paper of the United
15 States shall be deemed to be a reference to the Of-
16 fice for Civil Rights and Health Equity.

17 “(2) HEAD OF OFFICE.—The head of the Office
18 for Civil Rights and Health Equity shall be the Di-
19 rector for Civil Rights and Health Equity, to be ap-
20 pointed by the President. Any reference to the Di-
21 rector of the Office for Civil Rights of the Depart-
22 ment of Health and Human Services in any law,
23 regulation, map, document, record, or other paper of
24 the United States shall be deemed to be a reference
25 to the Director for Civil Rights and Health Equity.

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1 “(b) PURPOSE.—The Director for Civil Rights and
2 Health Equity shall ensure that the health programs, ac-
3 tivities, policies, projects, procedures, and operations of
4 health entities that receive Federal financial assistance are
5 in compliance with title VI of the Civil Rights Act of 1964
6 (42 U.S.C. 2000d et seq.), including through the following
7 activities:

8 “(1) The development and implementation of
9 an action plan to address racial and ethnic health
10 care disparities. Such plan shall—

11 “(A) address concerns relating to the Of-
12 fice for Civil Rights and Health Equity as re-
13 leased by the United States Commission on
14 Civil Rights in the report entitled ‘Health Care
15 Challenge: Acknowledging Disparity, Con-
16 fronting Discrimination, and Ensuring Equity’
17 (September 1999), in conjunction with existing
18 and future reports of the National Academy of
19 Medicine (formerly known as the Institute of
20 Medicine) including the reports titled ‘Unequal
21 Treatment: Confronting Racial and Ethnic Dis-
22 parities in Health Care’, ‘Crossing the Quality
23 Chasm: A New Health System for the 21st
24 Century’, ‘In the Nation’s Compelling Interest:
25 Ensuring Diversity in the Health Care Work-

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1 force', 'The National Partnership for Action to
2 End Health Disparities', and 'The Health of
3 Lesbian, Gay, Bisexual, and Transgender Peo-
4 ple', and other related reports of the National
5 Academies of Sciences, Engineering, and Medi-
6 cine;

7 “(B) be issued in proposed form for public
8 review and comment; and

9 “(C) be finalized taking into consideration
10 any comments or concerns that are received by
11 the Office.

12 “(2) Investigative and enforcement actions
13 against intentional or in effect discrimination and
14 policies and practices that have a disparate impact
15 on racial or ethnic minorities and communities of
16 color pursuant to section 9007 of the Health Equity
17 and Accountability Act of 2022.

18 “(3) The review of racial, ethnic, gender iden-
19 tity, sexual orientation, sex, disability status, socio-
20 economic status, and primary language health data
21 collected by Federal health agencies to assess health
22 care disparities related to intentional discrimination
23 and policies and practices that have a disparate im-
24 pact on minorities. Such review shall include an as-

1 sessment of health disparities in communities with a
2 combination of these classes.

3 “(4) Outreach and education activities relating
4 to compliance with title VI of the Civil Rights Act
5 of 1964, including the process of filing a complaint
6 in accordance with section 9007 of the Health Eq-
7 uity and Accountability Act of 2022.

8 “(5) The provision of technical assistance for
9 health entities to facilitate compliance with title VI
10 of the Civil Rights Act of 1964.

11 “(6) Coordination and oversight of activities of
12 the civil rights compliance offices established under
13 section 3452.

14 “(7) Ensuring—

15 “(A) at a minimum, compliance with the
16 most recent version of the Office of Manage-
17 ment and Budget statistical policy directive en-
18 titled ‘Standards for Maintaining, Collecting,
19 and Presenting Federal Data on Race and Eth-
20 nicity’; and

21 “(B) consideration of available data and
22 language standards such as—

23 “(i) the standards for collecting, mon-
24 itoring, and reporting data under section
25 3101; and

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1 “(ii) the National Standards on Cul-
2 turally and Linguistically Appropriate
3 Services of the Office of Minority Health.

4 “(c) FUNDING AND STAFF.—The Secretary shall en-
5 sure the effectiveness of the Office for Civil Rights and
6 Health Equity by ensuring that the Office is provided
7 with—

8 “(1) adequate funding to enable the Office to
9 carry out its duties under this section; and

10 “(2) staff with expertise in—

11 “(A) epidemiology;

12 “(B) statistics;

13 “(C) health quality assurance;

14 “(D) minority health and health dispari-
15 ties;

16 “(E) health equity;

17 “(F) cultural and linguistic competency;

18 “(G) civil rights; and

19 “(H) social, political, mental, behavioral,
20 economic, and related determinants of health,
21 including education access and quality, health
22 care access and quality, neighborhood and built
23 environment, and social and community context.

24 “(d) ADVISORY BOARD.—

1 “(1) ESTABLISHMENT.—The Secretary, in col-
2 laboration with the Director Civil Rights and Health
3 Equity and the Deputy Assistant Secretary for Mi-
4 nority Health, shall establish an advisory board (in
5 this subsection referred to as the ‘advisory board’)
6 to report in accordance with paragraph (2).

7 “(2) REPORTS TO CONGRESS.—Not later than
8 December 31, 2023, and annually thereafter, the ad-
9 visory board shall publish and submit to the Office,
10 other Federal agencies, and the Congress a report
11 that includes—

12 “(A) the number of complaints filed in ac-
13 cordance with section 9007 of the Health Eq-
14 uity and Accountability Act of 2022 during the
15 reporting period under title VI of the Civil
16 Rights Act of 1964, broken down by category;

17 “(B) the number of such complaints inves-
18 tigated and closed by the Office;

19 “(C) the outcomes of such complaints in-
20 vestigated;

21 “(D) the staffing levels of the Office, in-
22 cluding staff credentials;

23 “(E) the number of such complaints that
24 are pending (including backlogged complaints)
25 in which civil rights inequities can be dem-

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1 onstrated and an explanation of why such com-
2 plaints remain pending; and

3 “(F) trends among filed complaints and
4 other systemic patterns or themes, including an
5 analysis from the Department of Justice about
6 litigation concerning such complaints.

7 “(3) COMPOSITION.—The members of the advi-
8 sory board shall include—

9 “(A) representatives of stakeholders; and

10 “(B) subject matter- and disciplinary-ap-
11 propriate experts.

12 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this section
14 such sums as may be necessary for each of fiscal years
15 2023 through 2027.

16 **“SEC. 3452. ESTABLISHMENT OF HEALTH PROGRAM OF-**
17 **FICES FOR CIVIL RIGHTS WITHIN AGENCIES**
18 **OF DEPARTMENT OF HEALTH AND HUMAN**
19 **SERVICES.**

20 “(a) IN GENERAL.—The Secretary shall establish
21 civil rights compliance offices in each agency within the
22 Department of Health and Human Services that admin-
23 isters health programs.

24 “(b) PURPOSE OF OFFICES.—Each office established
25 under subsection (a) shall ensure that recipients of Fed-

1 eral financial assistance under Federal health programs
2 administer programs, and determine and implement poli-
3 cies, services, and activities, in a manner that—

4 “(1) does not discriminate, either intentionally
5 or in effect, on the basis of race, color, national ori-
6 gin, language, ethnicity, sex, age, disability status,
7 sexual orientation, or gender identity; and

8 “(2) promotes the reduction and elimination of
9 disparities in health and health care based on race,
10 color, national origin, language, ethnicity, sex, age,
11 disability status, sexual orientation, or gender iden-
12 tity.

13 “(c) POWERS AND DUTIES.—The offices established
14 in subsection (a) shall, with respect to the applicable agen-
15 cy, have the following powers and duties:

16 “(1) The establishment of compliance and pro-
17 gram participation standards for recipients of Fed-
18 eral financial assistance under each program admin-
19 istered by the agency, including the establishment of
20 disparity reduction standards to encompass dispari-
21 ties in health and health care related to race, color,
22 national origin, language, ethnicity, sex, age, dis-
23 ability, sexual orientation, or gender identity.

24 “(2) The development and implementation of
25 policies, procedures, and program-specific guidelines

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1 that interpret and apply Department of Health and
2 Human Services guidance under title VI of the Civil
3 Rights Act of 1964 and section 1557 of the Patient
4 Protection and Affordable Care Act to each Federal
5 health program administered by the agency.

6 “(3) The development of a disparity-reduction
7 impact analysis methodology that shall—

8 “(A) be applied to every rule issued by the
9 agency and published as part of the formal
10 rulemaking process under sections 555, 556,
11 and 557 of title 5, United States Code; and

12 “(B) include an analysis of the intersecting
13 forms of discrimination.

14 “(4) Oversight of data collection, reporting,
15 analysis, and publication requirements for all recipi-
16 ents of Federal financial assistance under each Fed-
17 eral health program administered by the agency,
18 compliance with, at a minimum, the most recent
19 version of the Office of Management and Budget
20 statistical policy directive entitled ‘Standards for
21 Maintaining, Collecting, and Presenting Federal
22 Data on Race and Ethnicity’, and consideration of
23 available data and language standards such as—

24 “(A) the standards for collecting and re-
25 porting data under section 3101;

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1 “(B) the National Standards on Culturally
2 and Linguistically Appropriate Services of the
3 Office of Minority Health; and

4 “(C) the disaggregation of all health and
5 health care data by racial and ethnic minority
6 population group.

7 “(5) The conduct of publicly available studies
8 regarding discrimination within Federal health pro-
9 grams administered by the agency as well as dis-
10 parity reduction initiatives by recipients of Federal
11 financial assistance under Federal health programs.

12 “(6) Annual reports to the Committee on
13 Health, Education, Labor, and Pensions and the
14 Committee on Finance of the Senate and the Com-
15 mittee on Energy and Commerce and the Committee
16 on Ways and Means of the House of Representatives
17 on the progress in reducing disparities in health and
18 health care through the Federal programs adminis-
19 tered by the agency.

20 “(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS
21 IN THE DEPARTMENT OF JUSTICE.—

22 “(1) DEPARTMENT OF HEALTH AND HUMAN
23 SERVICES.—The Office for Civil Rights of the De-
24 partment of Health and Human Services shall pro-
25 vide standard-setting and compliance review inves-

1 tigation support services to each civil rights compli-
2 ance office established under subsection (a), subject
3 to paragraph (2).

4 “(2) DEPARTMENT OF JUSTICE.—The Office
5 for Civil Rights of the Department of Justice may,
6 as appropriate, institute formal proceedings when a
7 civil rights compliance office established under sub-
8 section (a) determines that a recipient of Federal fi-
9 nancial assistance is not in compliance with the dis-
10 parity reduction standards of the applicable agency.

11 “(e) DEFINITION.—In this section, the term ‘Federal
12 health programs’ mean programs—

13 “(1) under the Social Security Act (42 U.S.C.
14 301 et seq.) that pay for health care and services;
15 and

16 “(2) under this Act that—

17 “(A) provide Federal financial assistance
18 for health care, biomedical research, or health
19 services research; or

20 “(B) are designed to improve the public’s
21 health, including health service programs.”.

22 **SEC. 9004. UNITED STATES COMMISSION ON CIVIL RIGHTS.**

23 (a) COORDINATION WITHIN DEPARTMENT OF JUS-
24 TICE OF ACTIVITIES REGARDING HEALTH DISPARI-

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1 TIES.—Section 3(a) of the Civil Rights Commission Act
2 of 1983 (42 U.S.C. 1975a(a)) is amended—

3 (1) in paragraph (1), by striking “and” at the
4 end;

5 (2) in paragraph (2), by striking the period at
6 the end and inserting “; and”; and

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

8 “(3) shall, with respect to activities carried out
9 in health care and correctional facilities, toward the
10 goal of eliminating health disparities between the
11 general population and members of minority groups
12 based on race or color, promote coordination of such
13 activities of—

14 “(A) the Office of Justice Programs of the
15 Department of Justice, including the Office for
16 Civil Rights within that Office;

17 “(B) the Office for Civil Rights within the
18 Department of Health and Human Services;
19 and

20 “(C) the Office of Minority Health within
21 the Department of Health and Human Serv-
22 ices.”.

23 (b) AUTHORIZATION OF APPROPRIATIONS.—Section
24 5 of the Civil Rights Commission Act of 1983 (42 U.S.C.
25 1975c) is amended by striking the first sentence and in-

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1 setting the following: “For the purpose of carrying out
2 this Act, there are authorized to be appropriated
3 \$30,000,000 for fiscal year 2023, and such sums as may
4 be necessary for each of the fiscal years 2024 through
5 2028.”.

6 **SEC. 9005. SENSE OF CONGRESS CONCERNING FULL FUND-**
7 **ING OF ACTIVITIES TO ELIMINATE RACIAL**
8 **AND ETHNIC HEALTH DISPARITIES.**

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

10 (1) The health status of the population of the
11 United States is declining, and the United States
12 currently ranks below most industrialized nations in
13 health status measured by longevity, sickness, and
14 mortality.

15 (2) Racial and ethnic minority populations tend
16 to have the poorest health status and face substan-
17 tial cultural, social, political, and economic barriers
18 to obtaining high-quality health care.

19 (3) Racial and ethnic minority populations ex-
20 perience and suffer from the extreme and egregious
21 health disparities and inequities that are caused by
22 racism, discrimination, and implicit racial and ethnic
23 bias in and throughout the health care system.

24 (4) Communities of color with intersecting iden-
25 tities and backgrounds, including children, older

1 adults, women, people with disabilities, people with
2 limited English proficiency, immigrants, lesbian,
3 gay, bisexual, transgender, queer, and questioning
4 populations, and people with lower incomes experi-
5 ence significant personal and structural barriers to
6 obtaining affordable, high-quality health care.

7 (5) Efforts to reduce and eliminate racial and
8 ethnic health disparities and inequities, and improve
9 minority health, have been limited by inadequate re-
10 sources (such as funding, staffing, and stewardship),
11 a lack of prioritization, and a lack of accountability
12 from the Federal Government, particularly due to
13 stagnant or declining appropriations that are not in
14 line with the dire need faced by communities that
15 are impacted.

16 (b) SENSE OF CONGRESS.—It is the sense of the
17 Congress that—

18 (1) health disparities negatively impact out-
19 comes for health and human security of the Nation;

20 (2) reducing racial, ethnic, age, sexual, and
21 gender disparities in prevention and treatment are
22 unique civil and human rights challenges and, as
23 such, Federal agencies and health care entities and
24 systems receiving Federal funds should be account-

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1 able for their role in causing disparities and in-
2 equity;

3 (3) funding for the National Institute on Mi-
4 nority Health and Health Disparities, the Office of
5 Civil Rights in the Department of Health and
6 Human Services, the National Institute of Nursing
7 Research, and the Office of Minority Health should
8 be doubled by fiscal year 2023, to effectively address
9 racial and ethnic disparities elimination in health
10 and health care as a matter of health and national
11 security;

12 (4) adequate funding by fiscal year 2023, and
13 subsequent funding increases, should be provided for
14 health and human service professions training pro-
15 grams, the Racial and Ethnic Approaches to Com-
16 munity Health Initiative at the Centers for Disease
17 Control and Prevention, the Minority HIV/AIDS
18 Initiative, the Excellence Centers to Eliminate Eth-
19 nic/Racial Disparities Program at the Agency for
20 Healthcare Research and Quality, and the National
21 Health Service Corps Scholarship Program initia-
22 tives, programs, policies, projects, and activities that
23 are the backbone of the Nation's agenda to eliminate
24 racial and ethnic health disparities and inequities;

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1 (5) adequate funding for fiscal year 2023 and
2 increased funding for future years should be pro-
3 vided for the Racial and Ethnic Approaches to Com-
4 munity Health Initiative’s United States Risk Fac-
5 tor Survey to ensure adequate data collection to
6 track health disparities, and there should be appro-
7 priate avenues provided to disseminate findings to
8 the general public;

9 (6) current and newly created health disparity
10 elimination incentives, programs, agencies, and de-
11 partments under this Act (and the amendments
12 made by this Act) should receive adequate staffing
13 and funding by fiscal year 2023; and

14 (7) stewardship and accountability should be
15 provided to the Congress and the President for
16 measurable and sustainable progress toward health
17 disparity elimination under programs under this Act,
18 including increased data collection and reporting, ca-
19 pacity building for impacted communities, technical
20 assistance, training programs, and avenues to dis-
21 seminate program details and successes to the public
22 and to policymakers.

23 **SEC. 9006. GAO AND NIH REPORTS.**

24 (a) GAO REPORT ON NIH GRANT RACIAL AND ETH-
25 NIC DIVERSITY.—

1 (1) IN GENERAL.—The Comptroller General of
2 the United States shall conduct a study on the racial
3 and ethnic diversity among the following groups:

4 (A) All applicants for grants, contracts,
5 and cooperative agreements awarded by the Na-
6 tional Institutes of Health during the period be-
7 ginning on January 1, 2023, and ending De-
8 cember 31, 2032.

9 (B) All recipients of such grants, con-
10 tracts, and cooperative agreements during such
11 period.

12 (C) All members of the peer review panels
13 of such applicants and recipients, respectively.

14 (2) REPORT.—Not later than 6 months after
15 the date of enactment of this Act, the Comptroller
16 General shall complete the study under paragraph
17 (1) and submit to the Congress a report containing
18 the results of such study.

19 (b) NIH REPORT ON CERTAIN AUTHORITY OF NA-
20 TIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH
21 DISPARITIES.—Not later than 6 months after the date of
22 enactment of this Act, and biennially thereafter, the Direc-
23 tor of the National Institutes of Health, in collaboration
24 with the Director of the National Institute on Minority

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1 Health and Health Disparities, shall submit to the Con-
2 gress a report that details and evaluates—

3 (1) the steps taken during the applicable report
4 period by the Director of the National Institutes of
5 Health to plan, coordinate, review, and evaluate all
6 minority health and health disparity research that is
7 conducted or supported by the institutes and centers
8 at the National Institutes of Health; and

9 (2) the outcomes of such steps.

10 (c) GAO REPORT RELATED TO RECIPIENTS OF
11 PPACA FUNDING.—Not later than one year after the
12 date of enactment of this Act and biennially thereafter,
13 the Comptroller General of the United States shall submit
14 to the Congress a report that identifies—

15 (1) the racial and ethnic diversity of commu-
16 nity-based organizations that applied for Federal en-
17 rollment funding provided pursuant to the Patient
18 Protection and Affordable Care Act (Public Law
19 111–148) (including the amendments made by such
20 Act);

21 (2) the percentage of such organizations that
22 were awarded such funding; and

23 (3) the impact of such community-based organi-
24 zations' enrollment efforts on the insurance status of
25 their communities.

1 (d) ANNUAL REPORT ON ACTIVITIES OF NATIONAL
2 INSTITUTE ON MINORITY HEALTH AND HEALTH DIS-
3 PARITIES.—The Director of the National Institute on Mi-
4 nority Health and Health Disparities shall prepare an an-
5 nual report on the activities carried out or to be carried
6 out by such institute, and shall submit each such report
7 to the Committee on Health, Education, Labor, and Pen-
8 sions of the Senate, the Committee on Energy and Com-
9 merce of the House of Representatives, the Secretary of
10 Health and Human Services, and the Director of the Na-
11 tional Institutes of Health. With respect to the fiscal year
12 involved, the report shall—

13 (1) describe and evaluate the progress made in
14 health disparities research conducted or supported
15 by institutes and centers of the National Institutes
16 of Health;

17 (2) summarize and analyze expenditures made
18 for activities with respect to health disparities re-
19 search conducted or supported by the National Insti-
20 tutes of Health;

21 (3) include a separate statement applying the
22 requirements of paragraphs (1) and (2) specifically
23 to minority health disparities research; and

24 (4) contain such recommendations as the Direc-
25 tor of the Institute considers appropriate.

1 **SEC. 9007. INVESTIGATIVE AND ENFORCEMENT ACTIONS.**

2 (a) IN GENERAL.—In carrying out the investigative
3 and enforcement actions of section 3451(b)(2) of the Pub-
4 lic Health Service Act, as added by section 9003 of this
5 Act, the Director for Civil Rights and Health Equity (re-
6 ferred to in this section as the “Director”) shall pursue
7 such investigative and enforcement actions pursuant to
8 this section.

9 (b) ADMINISTRATIVE COMPLAINT AND CONCILIATION
10 PROCESS.—

11 (1) COMPLAINTS AND ANSWERS.—

12 (A) IN GENERAL.—An aggrieved person
13 may, not later than 1 year after an alleged vio-
14 lation of subsection (a) has occurred or con-
15 cluded, file a complaint with the Director alleg-
16 ing inequitable provision of health care by a
17 provider described in subsection (a).

18 (B) COMPLAINT.—A complaint submitted
19 pursuant to subparagraph (A) shall be in writ-
20 ing and shall contain such information and be
21 in such form as the Director requires.

22 (C) OATH OR AFFIRMATION.—The com-
23 plaint and any answer made under this sub-
24 section shall be made under oath or affirmation,
25 and may be reasonably and fairly modified at
26 any time.

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1 (2) RESPONSE TO COMPLAINTS.—

2 (A) IN GENERAL.—Upon the filing of a
3 complaint under this subsection, the following
4 procedures shall apply:

5 (i) COMPLAINANT NOTICE.—The Di-
6 rector shall serve notice upon the com-
7 plainant acknowledging receipt of such fil-
8 ing and advising the complainant of the
9 time limits and procedures provided under
10 this section.

11 (ii) RESPONDENT NOTICE.—The Di-
12 rector shall, not later than 30 days after
13 receipt of such filing—

14 (I) serve on the respondent a no-
15 tice of the complaint, together with a
16 copy of the original complaint; and

17 (II) advise the respondent of the
18 procedural rights and obligations of
19 respondents under this section.

20 (iii) ANSWER.—The respondent may
21 file, not later than 60 days after receipt of
22 the notice from the Director, an answer to
23 such complaint.

24 (iv) INVESTIGATIVE DUTIES.—The Di-
25 rector shall—

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1 (I) make an investigation of the
2 alleged inequitable provision of health
3 care; and

4 (II) complete such investigation
5 within 180 days (unless it is impracti-
6 cable to complete such investigation
7 within 180 days) after the filing of
8 the complaint.

9 (B) INVESTIGATIONS.—

10 (i) PATTERN OR PRACTICE.—In the
11 course of investigating the complaint, the
12 Director may seek records of care provided
13 to patients other than the complainant if
14 necessary to demonstrate or disprove an
15 allegation of inequitable provision of health
16 care or to determine whether there is a
17 pattern or practice of such care.

18 (ii) ACCOUNTING FOR SOCIAL DETER-
19 MINANTS OF HEALTH.—In investigating
20 the complaint and reaching a determina-
21 tion on the validity of the complaint, the
22 Director shall account for social deter-
23 minants of health and the effect of such
24 social determinants on health care out-
25 comes.

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1 (iii) INABILITY TO COMPLETE INVES-
2 TIGATION.—If the Director is unable to
3 complete (or finds it is impracticable to
4 complete) the investigation within 180
5 days after the filing of the complaint (or,
6 if the Secretary takes further action under
7 paragraph (6)(B) with respect to a com-
8 plaint, within 180 days after the com-
9 mencement of such further action), the Di-
10 rector shall notify the complainant and re-
11 spondent in writing of the reasons in-
12 volved.

13 (C) REPORT.—

14 (i) FINAL REPORT.—On completing
15 each investigation under this paragraph,
16 the Director shall prepare a final investiga-
17 tive report.

18 (ii) MODIFICATION OF REPORT.—A
19 final report under this subparagraph may
20 be modified if additional evidence is later
21 discovered.

22 (3) CONCILIATION.—

23 (A) IN GENERAL.—During the period be-
24 ginning on the date on which a complaint is
25 filed under this subsection and ending on the

1 date of final disposition of such complaint (in-
2 cluding during an investigation under para-
3 graph (2)(B)), the Director shall, to the extent
4 feasible, engage in conciliation with respect to
5 such complaint.

6 (B) CONCILIATION AGREEMENT.—A con-
7 ciliation agreement arising out of such concilia-
8 tion shall be an agreement between the re-
9 spondent and the complainant, and shall be
10 subject to approval by the Director.

11 (C) RIGHTS PROTECTED.—The Director
12 shall approve a conciliation agreement only if
13 the agreement protects the rights of the com-
14 plainant and other persons similarly situated.

15 (D) PUBLICLY AVAILABLE AGREEMENT.—

16 (i) IN GENERAL.—Subject to clause
17 (ii), the Secretary shall make available to
18 the public a copy of a conciliation agree-
19 ment entered into pursuant to this sub-
20 section unless the complainant and re-
21 spondent otherwise agree, and the Sec-
22 retary determines, that disclosure is not re-
23 quired to further the purposes of this sub-
24 section.

1 (ii) LIMITATION.—A conciliation
2 agreement that is made available to the
3 public pursuant to clause (i) may not dis-
4 close individually identifiable health infor-
5 mation.

6 (4) FAILURE TO COMPLY WITH CONCILIATION
7 AGREEMENT.—Whenever the Director has reason-
8 able cause to believe that a respondent has breached
9 a conciliation agreement, the Director shall refer the
10 matter to the Attorney General to consider filing a
11 civil action to enforce such agreement.

12 (5) WRITTEN CONSENT FOR DISCLOSURE OF
13 INFORMATION.—Nothing said or done in the course
14 of conciliation under this subsection may be made
15 public, or used as evidence in a subsequent pro-
16 ceeding under this subsection, without the written
17 consent of the parties to the conciliation.

18 (6) PROMPT JUDICIAL ACTION.—

19 (A) IN GENERAL.—If the Director deter-
20 mines at any time following the filing of a com-
21 plaint under this subsection that prompt judi-
22 cial action is necessary to carry out the pur-
23 poses of this subsection, the Director may rec-
24 ommend that the Attorney General promptly
25 commence a civil action under subsection (d).

1 (B) IMMEDIATE SUIT.—If the Director de-
2 termines at any time following the filing of a
3 complaint under this subsection that the public
4 interest would be served by allowing the com-
5 plainant to bring a civil action under subsection
6 (c) in a State or Federal court immediately, the
7 Director shall certify that the administrative
8 process has concluded and that the complainant
9 may file such a suit immediately.

10 (7) ANNUAL REPORT.—Not later than 1 year
11 after the date of enactment of this Act, and annually
12 thereafter, the Director shall make publicly available
13 a report detailing the activities of the Office for Civil
14 Rights and Health Equity under this subsection, in-
15 cluding—

16 (A) the number of complaints filed and the
17 basis on which the complaints were filed;

18 (B) the number of investigations under-
19 taken as a result of such complaints; and

20 (C) the disposition of all such investiga-
21 tions.

22 (c) ENFORCEMENT BY PRIVATE PERSONS.—

23 (1) IN GENERAL.—

24 (A) CIVIL ACTION.—

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1 (i) IN SUIT.—A complainant under
2 subsection (b) may commence a civil action
3 to obtain appropriate relief with respect to
4 an alleged violation of subsection (a), or
5 for breach of a conciliation agreement
6 under subsection (b), in an appropriate
7 district court of the United States or State
8 court—

9 (I) not sooner than the earliest
10 of—

11 (aa) the date a conciliation
12 agreement is reached under sub-
13 section (b);

14 (bb) the date of a final dis-
15 position of a complaint under
16 subsection (b); or

17 (cc) 180 days after the first
18 day of the alleged violation; and

19 (II) not later than 2 years after
20 the final day of the alleged violation.

21 (ii) STATUTE OF LIMITATIONS.—The
22 computation of such 2-year period shall
23 not include any time during which an ad-
24 ministrative proceeding (including inves-
25 tigation or conciliation) under subsection

1 (b) was pending with respect to a com-
2 plaint under such subsection.

3 (B) BARRING SUIT.—If the Director has
4 obtained a conciliation agreement under sub-
5 section (b) regarding an alleged violation of
6 subsection (a), no action may be filed under
7 this paragraph by the complainant involved
8 with respect to the alleged violation except for
9 the purpose of enforcing the terms of such an
10 agreement.

11 (2) RELIEF WHICH MAY BE GRANTED.—

12 (A) IN GENERAL.—In a civil action under
13 paragraph (1), if the court finds that a viola-
14 tion of subsection (a) or breach of a conciliation
15 agreement has occurred, the court may award
16 to the plaintiff actual and punitive damages,
17 and may grant as relief, as the court deter-
18 mines to be appropriate, any permanent or tem-
19 porary injunction, temporary restraining order,
20 or other order (including an order enjoining the
21 defendant from engaging in a practice violating
22 subsection (a) or ordering such affirmative ac-
23 tion as may be appropriate).

24 (B) FEES AND COSTS.—In a civil action
25 under paragraph (1), the court, in its discre-

1 tion, may allow the prevailing party, other than
2 the United States, a reasonable attorney's fee
3 and costs. The United States shall be liable for
4 such fees and costs to the same extent as a pri-
5 vate person.

6 (3) INTERVENTION BY ATTORNEY GENERAL.—

7 Upon timely application, the Attorney General may
8 intervene in a civil action under paragraph (1), if
9 the Attorney General certifies that the case is of
10 general public importance.

11 (d) ENFORCEMENT BY THE ATTORNEY GENERAL.—

12 (1) COMMENCEMENT OF ACTIONS.—

13 (A) PATTERN OR PRACTICE CASES.—The
14 Attorney General may commence a civil action
15 in any appropriate district court of the United
16 States if the Attorney General has reasonable
17 cause to believe that any health care provider
18 covered by subsection (a)—

19 (i) is engaged in a pattern or practice
20 that violates such subsection; or

21 (ii) is engaged in a violation of such
22 subsection that raises an issue of signifi-
23 cant public importance.

24 (B) CASES BY REFERRAL.—The Director
25 may determine, based on a pattern of com-

1 plaints, a pattern of violations, a review of data
2 reported by a health care provider covered by
3 subsection (a), or any other means, that there
4 is reasonable cause to believe a health care pro-
5 vider is engaged in a pattern or practice that
6 violates subsection (a). If the Director makes
7 such a determination, the Director shall refer
8 the related findings to the Attorney General. If
9 the Attorney General finds that such reasonable
10 cause exists, the Attorney General may com-
11 mence a civil action in any appropriate district
12 court of the United States.

13 (2) ENFORCEMENT OF SUBPOENAS.—The At-
14 torney General, on behalf of the Director, or another
15 party at whose request a subpoena is issued under
16 this subsection, may enforce such subpoena in ap-
17 propriate proceedings in the district court of the
18 United States for the district in which the person to
19 whom the subpoena was addressed resides, was
20 served, or transacts business.

21 (3) RELIEF WHICH MAY BE GRANTED IN CIVIL
22 ACTIONS.—

23 (A) IN GENERAL.—In a civil action under
24 paragraph (1), the court—

1 (i) may award such preventive relief,
2 including a permanent or temporary in-
3 junction, temporary restraining order, or
4 other order against the person responsible
5 for a violation of subsection (a) as is nec-
6 essary to assure the full enjoyment of the
7 rights granted by this subsection;

8 (ii) may award such other relief as the
9 court determines to be appropriate, includ-
10 ing monetary damages, to aggrieved per-
11 sons; and

12 (iii) may, to vindicate the public inter-
13 est, assess punitive damages against the
14 respondent—

15 (I) in an amount not exceeding
16 \$500,000, for a first violation; and

17 (II) in an amount not exceeding
18 \$1,000,000, for any subsequent viola-
19 tion.

20 (B) FEES AND COSTS.—In a civil action
21 under this subsection, the court, in its discre-
22 tion, may allow the prevailing party, other than
23 the United States, a reasonable attorney's fee
24 and costs. The United States shall be liable for

1 such fees and costs to the extent provided by
2 section 2412 of title 28, United States Code.

3 (4) INTERVENTION IN CIVIL ACTIONS.—Upon
4 timely application, any person may intervene in a
5 civil action commenced by the Attorney General
6 under paragraphs (1) and (2) if the action involves
7 an alleged violation of subsection (a) with respect to
8 which such person is an aggrieved person (including
9 a person who is a complainant under subsection (b))
10 or a conciliation agreement to which such person is
11 a party.

12 **SEC. 9008. FEDERAL HEALTH EQUITY COMMISSION.**

13 (a) ESTABLISHMENT OF COMMISSION.—

14 (1) IN GENERAL.—There is established the
15 Federal Health Equity Commission (hereinafter in
16 this section referred to as the “Commission”).

17 (2) MEMBERSHIP.—

18 (A) IN GENERAL.—The Commission shall
19 be composed of—

20 (i) 8 voting members appointed under
21 subparagraph (B); and

22 (ii) the nonvoting, ex officio members
23 listed in subparagraph (C).

24 (B) VOTING MEMBERS.—Not more than 4
25 of the members described in subparagraph

1 (A)(i) shall at any one time be of the same po-
2 litical party. Such members shall have recog-
3 nized expertise in and personal experience with
4 racial and ethnic health inequities, health care
5 needs of vulnerable and marginalized popu-
6 lations, and health equity as a vehicle for im-
7 proving health status and health outcomes.
8 Such members shall be appointed to the Com-
9 mission as follows:

10 (i) Four members of the Commission
11 shall be appointed by the President.

12 (ii) Two members of the Commission
13 shall be appointed by the President pro
14 tempore of the Senate, upon the rec-
15 ommendations of the majority leader and
16 the minority leader of the Senate. Each
17 member appointed to the Commission
18 under this clause shall be appointed from
19 a different political party.

20 (iii) Two members of the Commission
21 shall be appointed by the Speaker of the
22 House of Representatives upon the rec-
23 ommendations of the majority leader and
24 the minority leader of the House of Rep-
25 resentatives. Each member appointed to

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1 the Commission under this clause shall be
2 appointed from a different political party.

3 (C) EX OFFICIO MEMBER.—The Commis-
4 sion shall have the following nonvoting, ex offi-
5 cio members:

6 (i) The Director for Civil Rights and
7 Health Equity of the Department of
8 Health and Human Services.

9 (ii) The Deputy Assistant Secretary
10 for Minority Health of the Department of
11 Health and Human Services.

12 (iii) The Director of the National In-
13 stitute on Minority Health and Health Dis-
14 parities.

15 (iv) The Chairperson of the Advisory
16 Committee on Minority Health established
17 under section 1707(c) of the Public Health
18 Service Act (42 U.S.C. 300u–6(c)).

19 (3) TERMS.—The term of office of each mem-
20 ber appointed under paragraph (2)(B) of the Com-
21 mission shall be 6 years.

22 (4) CHAIRPERSON; VICE CHAIRPERSON.—

23 (A) CHAIRPERSON.—The President shall,
24 with the concurrence of a majority of the mem-
25 bers of the Commission appointed under para-

1 graph (2)(B), designate a Chairperson from
2 among the members of the Commission ap-
3 pointed under such paragraph.

4 (B) VICE CHAIRPERSON.—

5 (i) DESIGNATION.—The Speaker of
6 the House of Representatives shall, in con-
7 sultation with the majority leaders and the
8 minority leaders of the Senate and the
9 House of Representatives and with the
10 concurrence of a majority of the members
11 of the Commission appointed under para-
12 graph (2)(B), designate a Vice Chairperson
13 from among the members of the Commis-
14 sion appointed under such paragraph. The
15 Vice Chairperson may not be a member of
16 the same political party as the Chair-
17 person.

18 (ii) DUTY.—The Vice Chairperson
19 shall act in place of the Chairperson in the
20 absence of the Chairperson.

21 (5) REMOVAL OF MEMBERS.—The President
22 may remove a member of the Commission only for
23 neglect of duty or malfeasance in office.

24 (6) QUORUM.—A majority of members of the
25 Commission appointed under paragraph (2)(B) shall

1 constitute a quorum of the Commission, but a lesser
2 number of members may hold hearings.

3 (b) DUTIES OF THE COMMISSION.—

4 (1) IN GENERAL.—The Commission shall—

5 (A) monitor and report on the implementa-
6 tion of this Act; and

7 (B) investigate, monitor, and report on
8 progress towards health equity and the elimi-
9 nation of health disparities.

10 (2) ANNUAL REPORT.—The Commission
11 shall—

12 (A) submit to the President and Congress
13 at least one report annually on health equity
14 and health disparities; and

15 (B) include in such report—

16 (i) a description of actions taken by
17 the Department of Health and Human
18 Services and any other Federal agency re-
19 lated to health equity or health disparities;
20 and

21 (ii) recommendations on ensuring eq-
22 uitable health care and eliminating health
23 disparities.

24 (c) POWERS.—

25 (1) HEARINGS.—

1 (A) IN GENERAL.—The Commission or, at
2 the direction of the Commission, any sub-
3 committee or member of the Commission, may,
4 for the purpose of carrying out this section, as
5 the Commission or the subcommittee or mem-
6 ber considers advisable—

7 (i) hold such hearings, meet and act
8 at such times and places, take such testi-
9 mony, receive such evidence, and admin-
10 ister such oaths; and

11 (ii) require, by subpoena or otherwise,
12 the attendance and testimony of such wit-
13 nesses and the production of such books,
14 records, correspondence, memoranda, pa-
15 pers, documents, tapes, and materials.

16 (B) LIMITATION ON HEARINGS.—The
17 Commission may hold a hearing under subpara-
18 graph (A)(i) only if the hearing is approved—

19 (i) by a majority of the members of
20 the Commission appointed under sub-
21 section (a)(2)(B); or

22 (ii) by a majority of such members
23 present at a meeting when a quorum is
24 present.

1 (2) ISSUANCE AND ENFORCEMENT OF SUB-
2 POENAS.—

3 (A) ISSUANCE.—A subpoena issued under
4 paragraph (1) shall—

5 (i) bear the signature of the Chair-
6 person of the Commission; and

7 (ii) be served by any person or class
8 of persons designated by the Chairperson
9 for that purpose.

10 (B) ENFORCEMENT.—In the case of contu-
11 macy or failure to obey a subpoena issued
12 under paragraph (1), the United States district
13 court for the district in which the subpoenaed
14 person resides, is served, or may be found may
15 issue an order requiring the person to appear at
16 any designated place to testify or to produce
17 documentary or other evidence.

18 (C) NONCOMPLIANCE.—Any failure to
19 obey the order of the court may be punished by
20 the court as a contempt of court.

21 (3) WITNESS ALLOWANCES AND FEES.—

22 (A) IN GENERAL.—Section 1821 of title
23 28, United States Code, shall apply to a witness
24 requested or subpoenaed to appear at a hearing
25 of the Commission.

1 (B) EXPENSES.—The per diem and mile-
2 age allowances for a witness shall be paid from
3 funds available to pay the expenses of the Com-
4 mission.

5 (4) POSTAL SERVICES.—The Commission may
6 use the United States mails in the same manner and
7 under the same conditions as other agencies of the
8 Federal Government.

9 (5) GIFTS.—The Commission may accept, use,
10 and dispose of gifts or donations of services or prop-
11 erty.

12 (d) ADMINISTRATIVE PROVISIONS.—

13 (1) STAFF.—

14 (A) DIRECTOR.—There shall be a full-time
15 staff director for the Commission who shall—

16 (i) serve as the administrative head of
17 the Commission; and

18 (ii) be appointed by the Chairperson
19 with the concurrence of the Vice Chair-
20 person.

21 (B) OTHER PERSONNEL.—The Commis-
22 sion may—

23 (i) appoint such other personnel as it
24 considers advisable, subject to the provi-
25 sions of title 5, United States Code, gov-

erning appointments in the competitive service, and the provisions of chapter 51 and subchapter III of chapter 53 of that title relating to classification and General Schedule pay rates; and

(ii) may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals not in excess of the daily equivalent paid for positions at the maximum rate for GS-15 of the General Schedule under section 5332 of title 5, United States Code.

(2) COMPENSATION OF MEMBERS.—

(A) NON-FEDERAL EMPLOYEES.—Each member of the Commission who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which the member is engaged in the performance of the duties of the Commission.

1 (B) FEDERAL EMPLOYEES.—Each member
2 of the Commission who is an officer or em-
3 ployee of the Federal Government shall serve
4 without compensation in addition to the com-
5 pensation received for the services of the mem-
6 ber as an office or employee of the Federal
7 Government.

8 (C) TRAVEL EXPENSES.—A member of the
9 Commission shall be allowed travel expenses, in-
10 cluding per diem in lieu of subsistence, at rates
11 authorized for an employee of an agency under
12 subchapter I of chapter 57 of title 5, United
13 States Code, while away from the home or reg-
14 ular place of business of the member in the per-
15 formance of the duties of the Commission.

16 (3) COOPERATION.—The Commission may se-
17 cure directly from any Federal department or agency
18 such information as the Commission considers nec-
19 essary to carry out this Act. Upon request of the
20 Chairman of the Commission, the head of such de-
21 partment or agency shall furnish such information to
22 the Commission.

23 (e) PERMANENT COMMISSION.—Section 14 of the
24 Federal Advisory Committee Act (5 U.S.C. App.) shall not
25 apply to the Commission.

1 (f) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated for fiscal year 2023 and
3 each fiscal year thereafter such sums as may be necessary
4 to carry out the duties of the Commission.

5 **TITLE X—ADDRESSING SOCIAL**
6 **DETERMINANTS AND IM-**
7 **PROVING ENVIRONMENTAL**
8 **JUSTICE**

9 **Subtitle A—In General**

10 **SEC. 10001. DEFINITIONS.**

11 In this title:

12 (1) ADMINISTRATOR.—The term “Adminis-
13 trator” means the Administrator of the Environ-
14 mental Protection Agency.

15 (2) AGENCY.—The term “Agency” means the
16 Environmental Protection Agency.

17 (3) BUILT ENVIRONMENT.—The term “built
18 environment” means the components of the environ-
19 ment, and the location of those components in a geo-
20 graphically defined space, that are created or modi-
21 fied by individuals to form the physical and social
22 characteristics of a community or enhance quality of
23 human life, including—

24 (A) homes, schools, and places of work and
25 worship;

1 (B) parks, recreation areas, and green-
2 ways;

3 (C) transportation systems;

4 (D) business, industry, and agriculture;
5 and

6 (E) land-use plans, projects, and policies
7 that impact the physical or social characteris-
8 tics of a community, including access to services
9 and amenities.

10 (4) DETERMINANTS OF HEALTH.—The term
11 “determinants of health”—

12 (A) means the range of nonclinical factors
13 inclusive of personal, social, economic, and envi-
14 ronmental factors that directly influence health
15 status; and

16 (B) includes social determinants of health.

17 (5) ECONOMIC DETERMINANTS OF HEALTH.—

18 The term “economic determinants of health” means
19 income and social status.

20 (6) ENVIRONMENTAL DETERMINANTS OF

21 HEALTH.—The term “environmental determinants
22 of health” means the broad physical (including man-
23 made and natural), psychological, social, spiritual,
24 cultural, and aesthetic environment.

1 (7) PERSONAL DETERMINANTS OF HEALTH.—

2 The term “personal determinants of health” means
3 an individual’s behavior, biology, and genetics.

4 (8) SECRETARY.—The term “Secretary” means
5 the Secretary of Health and Human Services.

6 (9) SOCIAL DETERMINANTS OF HEALTH.—The
7 term “social determinants of health”—

8 (A) means a subset of determinants of the
9 health of individuals and environments (such as
10 communities, neighborhoods, and societies) that
11 describe an individual’s or group of people’s so-
12 cial identity, describe the social and economic
13 resources to which such individual or group has
14 access, and describe the conditions in which an
15 individual or group of people works, lives, and
16 plays; and

17 (B) are sometimes referred to as “social
18 and economic determinants of health”, “socio-
19 economic determinants of health”, “environ-
20 mental determinants of health”, “social drivers
21 of inequality”, or “personal determinants of
22 health”.

23 **SEC. 10002. FINDINGS.**

24 Congress finds as follows:

1 (1) Social determinants of health are the great-
2 est predictors of health outcomes.

3 (2) Social determinants of health, including
4 health-related behaviors, social and economic factors,
5 and physical environment factors account for 80 per-
6 cent of health outcomes, whereas clinical care ac-
7 counts for 20 percent of improved health outcomes.
8 Yet, in 2017, public health spending represented
9 only 2.5 percent of all health spending in the United
10 States.

11 (3) There are more opportunities to improve
12 health for everyone when we understand that health
13 starts, not in a medical setting, but in our families,
14 in our schools and workplaces, in our neighborhoods,
15 in the air we breathe, and in the water we drink.

16 (4)(A) Healthy People 2030 identifies health
17 and health care quality as a function of not only ac-
18 cess to health care, but also the social determinants
19 of health, categorized into the following: neighbor-
20 hoods and the built environment; social and commu-
21 nity context; education; and economic stability.

22 (B) The following examples illustrate the nexus
23 between the unequal distribution of the social deter-
24 minants of health and health inequities:

1 (i) The built environment influences resi-
2 dents' level of physical activity. Neighborhoods
3 with high levels of poverty are significantly less
4 likely to have places where children can be
5 physically active, such as parks, green spaces,
6 and bike paths and lanes. Neighborhoods and
7 communities can provide opportunities for phys-
8 ical activity and support active lifestyles
9 through accessible and safe parks and open
10 spaces and through land use policy, zoning, and
11 healthy community design.

12 (ii) Emotional and physical health and
13 well-being are directly impacted by perceived
14 levels of safety, such as unlit streets at night.
15 Community members have expressed that safety
16 is not only a barrier to accessing programs and
17 services that increase quality of life, but also a
18 barrier to accessing physical activity in their
19 community through the built environment.

20 (iii) Historical and institutional racism in
21 the United States has shaped the way in which
22 social and economic resources and exposure to
23 health promoting environments are distributed.
24 Income, education, occupation, neighborhood
25 conditions, schools, workplaces, the use of

1 health and social services, and experiences with
2 the criminal justice system are all highly pat-
3 terned by race, with people of color experiencing
4 more that is health harming. Finding ways to
5 uncouple the link between race and access to re-
6 sources and healthy environments is a principal
7 means of reducing health inequities. Addition-
8 ally, the anticipation of racism itself causes
9 higher psychological and cardiovascular stress
10 levels that are linked to poor health outcomes.
11 Remedying discriminatory practices at the indi-
12 vidual and systemic levels will likely reduce
13 health inequities caused by this unequal dis-
14 tribution of stress.

15 (iv) Poor health among Native Americans
16 has largely been driven by post-colonial oppres-
17 sion and historical trauma. The expropriation of
18 native lands and territories to the American
19 state had severe consequences on Native Amer-
20 ican health. This resulted in the deprivation of
21 traditional food sources—and nutrients—for
22 Native Americans and also the destruction of
23 traditional economies and community organiza-
24 tion. Today, Native Americans have twice the
25 rate of diabetes of non-Hispanic Whites. Rec-

1 ognition of the origins of diabetes as having a
2 social and community context, rather than just
3 individual responsibility and genetic predisposi-
4 tion, will shape better policy to provide food se-
5 curity.

6 (v) In the context of prisons, overcrowding
7 has led to the deterioration of the physical and
8 mental health of individuals after they leave
9 prison. In particular, the mass incarceration of
10 African-American males as a result of inequities
11 within and treatment in the criminal justice
12 system has contributed to an overburdening of
13 certain infectious diseases within the African-
14 American community. As a social institution,
15 incarceration amplifies existing adverse health
16 conditions by concentrating diseases and harm-
17 ful health behaviors such as tobacco use, drug
18 use, and violence.

19 (vi) Educational attainment is the strong-
20 est predictor of adult mortality. It is a basic
21 component of socioeconomic status that shapes
22 earning potential, and consequently, access to
23 resources that promote health. People with
24 more education are less likely to report that

1 they are in poor health, and are also less likely
2 to have diabetes and other chronic diseases.

3 (vii) Individuals with lower levels of edu-
4 cational attainment are much more likely to re-
5 port to be current smokers. In 2017, smoking
6 prevalence was 36.8 percent among adults with
7 a GED diploma, 23.1 percent with less than a
8 high school diploma, and 18.7 percent with a
9 high school diploma, while dropping signifi-
10 cantly to 7.1 percent among adults with an un-
11 dergraduate college degree and 4.1 percent with
12 a postgraduate college degree.

13 (viii) Income inequality differences account
14 for a large part of health inequities. For exam-
15 ple, children living in poverty experience poorer
16 housing conditions, increased exposure to in-
17 door allergens and toxins (such as pesticides,
18 lead, mercury, radon, air pollution, and carcino-
19 gens), increased food insecurity, and more psy-
20 chological stress. These experiences culminate
21 in worse adult health as compared with children
22 with higher socioeconomic status. Specifically,
23 children living in lower socioeconomic neighbor-
24 hoods have higher rates of asthma due to high-
25 er rates of psychological stress resulting from

1 higher rates of violence. Food insecurity is asso-
2 ciated with obesity, and racial and ethnic mi-
3 norities have higher rates of food insecurity.

4 (ix) Lesbian, gay, bisexual, transgender,
5 queer or questioning, intersex, and asexual or
6 allied (referred to in this section as
7 “LGBTQIA+”) individuals face health inequi-
8 ties linked to societal stigma, discrimination,
9 and denial of their civil and human rights. Dis-
10 crimination against LGBTQIA+ individuals
11 has been associated with high rates of psy-
12 chiatric disorders, substance abuse, and suicide.
13 Experiences of violence and victimization are
14 frequent for LGBTQIA+ individuals, and have
15 long-lasting effects on the individual and the
16 community. Personal, family, and social accept-
17 ance of sexual orientation and gender identity
18 affects the mental health and personal safety of
19 LGBTQIA+ individuals.

20 (x) Individuals in older and cheaper hous-
21 ing are at higher risk to be exposed to lead,
22 particularly in housing built prior to 1960. The
23 threat of lead poisoning disproportionately af-
24 fects vulnerable populations, with children living
25 in poverty (5.6 percent) and Black children

1 (5.6) experiencing the highest rates. According
2 to the Department of Housing and Urban De-
3 velopment, about 3,600,000 homes nationwide
4 that house young children have lead hazards
5 such as contaminated drinking water, peeling
6 paint, contaminated dust, or toxic soil. The
7 combined cost of medical treatment and special
8 education for lead poisoned children averages
9 about \$5,600 per child per year, and lead poi-
10 soning costs the United States an estimated
11 \$50,000,000,000 annually.

12 (xi) According to the report Healthy Peo-
13 ple 2030, people with disabilities, as a group,
14 experience health inequities in routine public
15 health arenas such as health behaviors, clinical
16 preventive services, and chronic conditions.
17 Compared with people without disabilities, peo-
18 ple with disabilities are—

19 (I) less likely to receive recommended
20 preventive health care services, such as
21 routine teeth cleanings and cancer
22 screenings;

23 (II) at a high risk for poor health out-
24 comes such as obesity, hypertension, falls-

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1 related injuries, and mood disorders such
2 as depression; and

3 (III) more likely to engage in
4 unhealthy behaviors that put their health
5 at risk, such as cigarette smoking and in-
6 adequate physical activity.

7 (5) Laws and regulations that improve opportu-
8 nities to live in safe neighborhoods with more social
9 cohesion, attain higher education, sustain stable em-
10 ployment, and bridge class differences help foster
11 the health and safety of individuals.

12 (6) The global public health community has
13 reached consensus through the Rio Political Declara-
14 tion of Social Determinants of Health adopted by
15 the World Health Organization in October 2011 that
16 “[c]ollaboration in coordinated and intersectoral pol-
17 icy actions has proven to be effective. Health in All
18 Policies, an initiative of the American Public Health
19 Association, together with intersectoral cooperation
20 and action, is one promising approach to enhance
21 accountability in other sectors of health, as well as
22 the promotion of health equity and more inclusive
23 and productive societies.”.

1 **SEC. 10003. HEALTH IMPACT ASSESSMENTS.**

2 (a) FINDINGS.—Congress makes the following find-
3 ings:

4 (1) Health impact assessment is a tool to help
5 planners, health officials, decision makers, and the
6 public make more informed decisions about the po-
7 tential health effects of proposed plans, policies, pro-
8 grams, and projects in order to maximize health
9 benefits and minimize harms.

10 (2) Health impact assessments foster commu-
11 nity leadership, ownership, and participation in deci-
12 sion-making processes.

13 (3) Health impact assessments can build com-
14 munity support and reduce opposition to a project or
15 policy, thereby facilitating economic growth by aid-
16 ing the development of consensus regarding new de-
17 velopment proposals.

18 (4) Health impact assessments facilitate col-
19 laboration across sectors.

20 (b) PURPOSES.—It is the purpose of this section to—

21 (1) provide more information about the poten-
22 tial human health effects of policy decisions and the
23 distribution of those effects;

24 (2) improve how health is considered in plan-
25 ning and decision-making processes; and

1 (3) build stronger, healthier communities
2 through the use of health impact assessments.

3 (c) HEALTH IMPACT ASSESSMENTS.—Part P of title
4 III of the Public Health Service Act (42 U.S.C. 280g et
5 seq.), as amended by section 7602(a), is further amended
6 by adding at the end the following:

7 **“SEC. 399V-14. HEALTH IMPACT ASSESSMENTS.**

8 “(a) DEFINITIONS.—In this section:

9 “(1) ADMINISTRATOR.—The term ‘Adminis-
10 trator’ means the Administrator of the Environ-
11 mental Protection Agency.

12 “(2) DIRECTOR.—The term ‘Director’ means
13 the Director of the Centers for Disease Control and
14 Prevention.

15 “(3) HEALTH IMPACT ASSESSMENT.—The term
16 ‘health impact assessment’ means a systematic proc-
17 ess that uses an array of data sources and analytic
18 methods and considers input from stakeholders to
19 determine the potential effects of a proposed policy,
20 plan, program, or project on the health of a popu-
21 lation and the distribution of those effects within the
22 population. Such term includes identifying and rec-
23 ommending appropriate actions on monitoring and
24 maximizing potential benefits and minimizing poten-
25 tial harms.

1 “(4) HEALTH INEQUITY.—The term ‘health in-
2 equity’ means a particular type of health difference
3 that is closely linked with social, economic, or envi-
4 ronmental disadvantage and that adversely affects
5 groups of people who have systematically experi-
6 enced greater obstacles to health based on their ra-
7 cial or ethnic group; religion; socioeconomic status;
8 gender; age; mental health; cognitive, sensory, or
9 physical disability; sexual orientation or gender iden-
10 tity; geographic location; citizenship status; or other
11 characteristics historically linked to discrimination
12 or exclusion.

13 “(b) ESTABLISHMENT.—The Secretary, acting
14 through the Director and in collaboration with the Admin-
15 istrator, shall—

16 “(1) in consultation with the Director of the
17 National Center for Chronic Disease Prevention and
18 Health Promotion and relevant offices within the
19 Department of Housing and Urban Development,
20 the Department of Transportation, and the Depart-
21 ment of Agriculture, establish a program at the Na-
22 tional Center for Environmental Health at the Cen-
23 ters for Disease Control and Prevention focused on
24 advancing the field of health impact assessment that
25 includes—

1 “(A) collecting and disseminating best
2 practices;

3 “(B) administering capacity building
4 grants to States, Indian Tribes, and Tribal or-
5 ganizations to support subgrantees in initiating
6 health impact assessments, in accordance with
7 subsection (d);

8 “(C) providing technical assistance;

9 “(D) developing training tools and pro-
10 viding training on conducting health impact as-
11 sessment and the implementation of built envi-
12 ronment and health indicators;

13 “(E) making information available, as ap-
14 propriate, regarding the existence of other com-
15 munity healthy living tools, checklists, and indi-
16 ces that help connect public health to other sec-
17 tors, and tools to help examine the effect of the
18 indoor built environment and building codes on
19 population health;

20 “(F) conducting research and evaluations
21 of health impact assessments; and

22 “(G) awarding competitive extramural re-
23 search grants;

1 “(2) develop guidance and guidelines to conduct
2 health impact assessments in accordance with sub-
3 section (c); and

4 “(3) establish a grant program to allow States,
5 Indian Tribes, and Tribal organizations to award
6 subgrants to eligible entities to conduct health im-
7 pact assessments.

8 “(c) GUIDANCE.—

9 “(1) IN GENERAL.—Not later than 1 year after
10 the date of enactment of the Correcting Hurtful and
11 Alienating Names in Government Expression Act,
12 the Secretary, acting through the Director, shall
13 issue final guidance for conducting health impact as-
14 sessments. In developing such guidance the Sec-
15 retary shall—

16 “(A) consult with the Director of the Na-
17 tional Center for Environmental Health, the Di-
18 rector of the National Center for Chronic Dis-
19 ease Prevention and Health Promotion, and rel-
20 evant offices within the Department of Housing
21 and Urban Development, the Department of
22 Transportation, and the Department of Agri-
23 culture; and

24 “(B) consider available international health
25 impact assessment guidance, North American

1 health impact assessment practice standards,
2 and recommendations from the National Acad-
3 emy of Science.

4 “(2) CONTENT.—The guidance under this sub-
5 section shall include—

6 “(A) background on national and inter-
7 national efforts to bridge urban planning, cli-
8 mate forecasting, and public health institutions
9 and disciplines, including a review of health im-
10 pact assessment best practices internationally;

11 “(B) evidence-based direct and indirect
12 pathways that link land-use planning, transpor-
13 tation, and housing policy and objectives to
14 human health outcomes;

15 “(C) data resources and quantitative and
16 qualitative forecasting methods to evaluate both
17 the status of health determinants and health ef-
18 fects, including identification of existing pro-
19 grams that can disseminate these resources;

20 “(D) best practices for inclusive public in-
21 volvement in conducting health impact assess-
22 ments; and

23 “(E) technical assistance for other agen-
24 cies seeking to develop their own guidelines and
25 procedures for health impact assessment.

1 “(d) GRANT PROGRAM.—

2 “(1) IN GENERAL.—The Secretary, acting
3 through the Director and in collaboration with the
4 Administrator, shall—

5 “(A) award grants to States, Indian
6 Tribes, and Tribal organizations to award sub-
7 grants to eligible entities for capacity building
8 or to prepare health impact assessments; and

9 “(B) ensure that States, Indian Tribes,
10 and Tribal organizations receiving a grant
11 under this subsection further support training
12 and technical assistance for subgrantees under
13 subparagraph (A) by funding and overseeing
14 appropriate experts on health impact assess-
15 ments from local, State, and Tribal govern-
16 ments, the Federal Government, institutions of
17 higher education, and nonprofit organizations
18 to provide such training and technical assist-
19 ance.

20 “(2) APPLICATIONS FOR SUBGRANTS.—

21 “(A) IN GENERAL.—To be eligible to re-
22 ceive a subgrant under this section, an eligible
23 entity shall—

24 “(i) be a community-based organiza-
25 tion serving individuals or populations the

1 health of which are, or will be, affected by
2 an activity or a proposed activity; and

3 “(ii) submit to the grantee an applica-
4 tion in accordance with this subsection, at
5 such time, in such manner, and containing
6 such additional information as the Sec-
7 retary (acting through the Director and in
8 collaboration with the Administrator) and
9 the grantee may require.

10 “(B) INCLUSION.—An application for a
11 subgrant under this subsection shall include—

12 “(i) a list of proposed activities that
13 require or would benefit from conducting a
14 health impact assessment within six
15 months of receiving the subgrant;

16 “(ii) supporting documentation, in-
17 cluding letters of support, from potential
18 conductors of health impact assessments
19 for the listed proposed activities;

20 “(iii) an assessment by the applicant
21 of the health of the population to be served
22 through the subgrant; and

23 “(iv) a description of potential adverse
24 or positive effects on health that the pro-
25 posed activities may create.

1 “(C) PREFERENCE.—In awarding sub-
2 grants under this subsection, States may give
3 preference to eligible entities that demonstrate
4 the potential to significantly improve population
5 health or lower health care costs as a result of
6 potential health impact assessment work.

7 “(3) USE OF FUNDS.—

8 “(A) IN GENERAL.—A State, Indian Tribe,
9 or Tribal organization receiving a grant under
10 this subsection shall use such grant to conduct
11 health impact assessment capacity building in
12 support of a subgrantee conducting a health im-
13 pact assessment for a proposed activity in ac-
14 cordance with this subsection.

15 “(B) PURPOSES.—The purposes of a
16 health impact assessment under this subsection
17 are—

18 “(i) to facilitate the involvement of
19 Tribal, State, and local public health offi-
20 cials in community planning, transpor-
21 tation, housing, and land use decisions and
22 other decisions affecting the built environ-
23 ment to identify any potential health con-
24 cern or health benefit relating to an activ-
25 ity or proposed activity;

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1 “(ii) to provide for an investigation of
2 any health-related issue of concern raised
3 in a planning process, an environmental
4 impact assessment process, or policy ap-
5 praisal relating to a proposed activity;

6 “(iii) to describe and compare alter-
7 natives (including no-action alternatives) to
8 a proposed activity to provide clarification
9 with respect to the potential health out-
10 comes associated with the proposed activity
11 and, where appropriate, to the related ben-
12 efit-cost or cost-effectiveness of the pro-
13 posed activity and alternatives;

14 “(iv) to contribute, when applicable,
15 to the findings of a planning process, pol-
16 icy appraisal, or an environmental impact
17 statement with respect to the terms and
18 conditions of implementing a proposed ac-
19 tivity or related mitigation recommenda-
20 tions, as necessary;

21 “(v) to ensure that the dispropor-
22 tionate distribution of negative impacts
23 among vulnerable populations is minimized
24 as much as possible;

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1 “(vi) to engage affected community
2 members and ensure adequate opportunity
3 for public comment on all stages of the
4 health impact assessment;

5 “(vii) where appropriate, to consult
6 with local and county health departments
7 and appropriate organizations, including
8 planning, transportation, and housing or-
9 ganizations, and provide them information
10 and tools regarding how to conduct and in-
11 tegrate health impact assessment into their
12 work; and

13 “(viii) to inspect homes, water sys-
14 tems, and other elements that pose risks to
15 lead exposure, with an emphasis on areas
16 that pose a higher risk to children.

17 “(4) ASSESSMENTS.—Health impact assess-
18 ments carried out using funds under this section
19 shall—

20 “(A) take appropriate health factors into
21 consideration as early as practicable during the
22 planning, review, or decision-making processes;

23 “(B) assess the effect on the health of in-
24 dividuals and populations of proposed policies,

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1 projects, or plans that result in modifications to
2 the built environment; and

3 “(C) assess the distribution of health ef-
4 fects across various factors, such as race, in-
5 come, ethnicity, age, disability status, gender,
6 and geography.

7 “(5) ELIGIBLE ACTIVITIES.—

8 “(A) IN GENERAL.—A State, Indian Tribe,
9 or Tribal organization receiving a grant under
10 this section shall conduct an evaluation of any
11 activity proposed to be funded through the
12 grant, including through a subgrant, to deter-
13 mine whether such activity will have a signifi-
14 cant adverse or positive effect on the health of
15 the affected population to be served, based on
16 the criteria described in subparagraph (B).

17 “(B) CRITERIA.—The criteria described in
18 this subparagraph include, as applicable to the
19 proposed activity, the following:

20 “(i) Any substantial adverse effect or
21 significant health benefit on health out-
22 comes or factors known to influence health,
23 including the following:

24 “(I) Physical activity.

25 “(II) Injury.

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1 “(III) Mental health.

2 “(IV) Accessibility to health-pro-
3 moting goods and services.

4 “(V) Respiratory health.

5 “(VI) Chronic disease.

6 “(VII) Nutrition.

7 “(VIII) Land use changes that
8 promote local, sustainable food
9 sources.

10 “(IX) Infectious disease.

11 “(X) Health inequities.

12 “(XI) Existing air quality,
13 ground or surface water quality or
14 quantity, or noise levels.

15 “(XII) Lead exposure.

16 “(XIII) Drinking water quality
17 and accessibility.

18 “(ii) Other factors that may be con-
19 sidered, including—

20 “(I) the potential for a proposed
21 activity to result in systems failure
22 that leads to a public health emer-
23 gency;

24 “(II) the probability that the pro-
25 posed activity will result in a signifi-

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1 cant increase in tourism, economic de-
2 velopment, or employment in the pop-
3 ulation to be served;

4 “(III) any other significant po-
5 tential hazard or enhancement to
6 human health, as determined by the
7 grantee; or

8 “(IV) whether the evaluation of a
9 proposed activity would duplicate an-
10 other analysis or study being under-
11 taken in conjunction with the pro-
12 posed activity.

13 “(C) FACTORS FOR CONSIDERATION.—In
14 evaluating a proposed activity under subpara-
15 graph (A), a grantee may take into consider-
16 ation any reasonable, direct, indirect, or cumu-
17 lative effect that can be clearly related to poten-
18 tial health effects and that is related to the pro-
19 posed activity, including the effect of any action
20 that is—

21 “(i) included in the long-range plan
22 relating to the proposed activity;

23 “(ii) likely to be carried out in coordi-
24 nation with the proposed activity;

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1 “(iii) dependent on the occurrence of
2 the proposed activity; or

3 “(iv) likely to have a disproportionate
4 impact on high-risk or vulnerable popu-
5 lations.

6 “(6) REQUIREMENTS.—A health impact assess-
7 ment prepared with funds awarded under this sub-
8 section shall incorporate the following, after con-
9 ducting the screening phase (identifying projects or
10 policies for which a health impact assessment would
11 be valuable and feasible) through the application
12 process:

13 “(A) SCOPING.—Identifying which health
14 effects to consider and the research methods to
15 be utilized.

16 “(B) ASSESSING RISKS AND BENEFITS.—
17 Assessing the baseline health status and factors
18 known to influence the health status in the af-
19 fected community, which may include aggre-
20 gating and synthesizing existing health assess-
21 ment evidence and data from the community.

22 “(C) DEVELOPING RECOMMENDATIONS.—
23 Suggesting changes to proposals to promote
24 positive or mitigate adverse health effects.

1 “(D) REPORTING.—Synthesizing the as-
2 sessment and recommendations and commu-
3 nicating the results to decision makers.

4 “(E) MONITORING AND EVALUATING.—
5 Tracking the decision and implementation effect
6 on health determinants and health status.

7 “(7) PLAN.—A subgrantee under this section
8 shall develop and implement a plan, to be approved
9 by the Secretary (acting through the Director and in
10 collaboration with the Administrator) and the grant-
11 ee, for meaningful and inclusive stakeholder involve-
12 ment in all phases of the health impact assessment.
13 Stakeholders may include community leaders, com-
14 munity-based organizations, youth-serving organiza-
15 tions, planners, public health experts, State and
16 local public health departments and officials, health
17 care experts or officials, housing experts or officials,
18 and transportation experts or officials.

19 “(8) SUBMISSION OF FINDINGS.—A grantee
20 under this section shall submit the findings of any
21 funded health impact assessment activities to the
22 Secretary and make these findings publicly available.

23 “(9) ASSESSMENT OF IMPACTS.—A subgrantee
24 under this section shall ensure the assessment of the
25 distribution of health impacts (related to the pro-

1 posed activity) across race, ethnicity, income, age,
2 gender, disability status, and geography.

3 “(10) CONDUCT OF ASSESSMENT.—To the
4 greatest extent feasible, a health impact assessment
5 shall be conducted under this section in a manner
6 that respects the needs and timing of the decision-
7 making process such assessment evaluates.

8 “(11) METHODOLOGY.—In preparing a health
9 impact assessment funded under this subsection, a
10 subgrantee under this section shall follow the guid-
11 ance published under subsection (c).

12 “(e) HEALTH IMPACT ASSESSMENT DATABASE.—
13 The Secretary, acting through the Director and in collabo-
14 ration with the Administrator, shall establish, maintain,
15 and make publicly available a health impact assessment
16 database, including—

17 “(1) a catalog of health impact assessments re-
18 ceived under this section;

19 “(2) an inventory of tools used by subgrantees
20 to conduct health impact assessments; and

21 “(3) guidance for subgrantees with respect to
22 the selection of appropriate tools described in para-
23 graph (2).

24 “(f) EVALUATION OF GRANTEE ACTIVITIES.—The
25 Secretary shall award competitive grants to Prevention

1 Research Centers, or nonprofit organizations or academic
2 institutions with expertise in health impact assessments
3 to—

4 “(1) assist grantees and subgrantees with the
5 provision of training and technical assistance in the
6 conducting of health impact assessments;

7 “(2) evaluate the activities carried out with
8 grants and subgrants under subsection (d); and

9 “(3) assist the Secretary in disseminating evi-
10 dence, best practices, and lessons learned from
11 grantees and subgrantees.

12 “(g) REPORT TO CONGRESS.—Not later than 1 year
13 after the date of enactment of the Correcting Hurtful and
14 Alienating Names in Government Expression Act, the Sec-
15 retary shall submit to Congress a report concerning the
16 evaluation of the programs under this section, including
17 recommendations as to how lessons learned from such pro-
18 grams can be incorporated into future guidance docu-
19 ments developed and provided by the Secretary and other
20 Federal agencies, as appropriate.

21 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this section
23 such sums as may be necessary.

1 **“SEC. 399V-15. IMPLEMENTATION OF RESEARCH FINDINGS**
2 **TO IMPROVE HEALTH OUTCOMES THROUGH**
3 **THE BUILT ENVIRONMENT.**

4 “(a) RESEARCH GRANT PROGRAM.—The Secretary,
5 in collaboration with the Administrator of the Environ-
6 mental Protection Agency (referred to in this section as
7 the ‘Administrator’), shall award grants to public agencies
8 or private nonprofit institutions to implement evidence-
9 based programming to improve human health through im-
10 provements to the built environment and subsequently
11 human health, by addressing—

- 12 “(1) levels of physical activity;
13 “(2) consumption of nutritional foods;
14 “(3) rates of crime;
15 “(4) air, water, and soil quality;
16 “(5) risk or rate of injury;
17 “(6) accessibility to health-promoting goods and
18 services;
19 “(7) chronic disease rates;
20 “(8) community design;
21 “(9) housing;
22 “(10) transportation options; and
23 “(11) other factors, as the Secretary determines
24 appropriate.

25 “(b) APPLICATIONS.—A public agency or private
26 nonprofit institution desiring a grant under this section

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1 shall submit to the Secretary an application at such time,
2 in such manner, and containing such agreements, assur-
3 ances, and information as the Secretary, in consultation
4 with the Administrator, may require.

5 “(c) RESEARCH.—The Secretary, in consultation
6 with the Administrator, shall support, through grants
7 awarded under this section, research that—

8 “(1) uses evidence-based research to improve
9 the built environment and human health;

10 “(2) examines—

11 “(A) the scope and intensity of the impacts
12 that the built environment (including the var-
13 ious characteristics of the built environment)
14 has on human health; or

15 “(B) the distribution of such impacts by—

16 “(i) location; and

17 “(ii) population subgroup;

18 “(3) is used to develop—

19 “(A) measures and indicators to address
20 health impacts and the connection of health to
21 the built environment;

22 “(B) efforts to link the measures to trans-
23 portation, land use, and health databases; and

24 “(C) efforts to enhance the collection of
25 built environment surveillance data;

1 “(4) distinguishes carefully between personal
2 attitudes and choices and external influences on be-
3 havior to determine how much the association be-
4 tween the built environment and the health of resi-
5 dents, versus the lifestyle preferences of the people
6 that choose to live in the neighborhood, reflects the
7 physical characteristics of the neighborhood; and

8 “(5)(A) identifies or develops effective interven-
9 tion strategies focusing on enhancements to the built
10 environment that promote increased use physical ac-
11 tivity, access to nutritious foods, or other health-pro-
12 moting activities by residents; and

13 “(B) in developing the intervention strategies
14 under subparagraph (A), ensures that the interven-
15 tion strategies will reach out to high-risk or vulner-
16 able populations, including low-income urban and
17 rural communities and aging populations, in addi-
18 tion to the general population.

19 “(d) SURVEYS.—The Secretary may allow recipients
20 of grants under this section to use such grant funds to
21 support the expansion of national surveys and data track-
22 ing systems to provide more detailed information about
23 the connection between the built environment and health.

1 “(e) PRIORITY.—In awarding grants under this sec-
2 tion, the Secretary and the Administrator shall give pri-
3 ority to entities with programming that incorporates—

4 “(1) interdisciplinary approaches; or

5 “(2) the expertise of the public health, physical
6 activity, urban planning, land use, and transpor-
7 tation research communities in the United States
8 and abroad.

9 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated such sums as may be
11 necessary to carry out this section. The Secretary may al-
12 locate not more than 20 percent of the amount so appro-
13 priated for a fiscal year for purposes of conducting re-
14 search under subsection (c).”.

15 **SEC. 10004. GRANT PROGRAM TO CONDUCT ENVIRON-**
16 **MENTAL HEALTH IMPROVEMENT ACTIVITIES**
17 **AND TO IMPROVE SOCIAL DETERMINANTS OF**
18 **HEALTH.**

19 (a) DEFINITIONS.—In this section:

20 (1) DIRECTOR.—The term “Director” means
21 the Director of the Centers for Disease Control and
22 Prevention, acting in collaboration with the Adminis-
23 trator and the Director of the National Institute of
24 Environmental Health Sciences.

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(2) ELIGIBLE ENTITY.—The term “eligible entity” means a State, Indian Tribe, Tribal organization, or local community that—

4 (A) bears a disproportionate burden of ex-
5 posure to environmental health hazards;

(B) bears a disproportionate burden of exposure to unhealthy living conditions, low standard housing conditions, low socioeconomic status, poor nutrition, less opportunity for educational attainment, disproportionately high unemployment rates, or lower literacy levels and access to information;

13 (C) has established a coalition—

(i) with not less than 1 community-based organization or demonstration program; and

17 (ii) with not less than 1—

18 (I) public health entity;

19 (II) health care provider organi-
20 zation;

(III) academic institution, including any minority-serving institution (including a Hispanic-serving institution, a historically Black college or

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1 university, or a Tribal College or Uni-
2 versity);

3 (IV) child-serving institution; or

4 (V) landlord or housing provider
5 working on lead remediation;

6 (D) ensures planned activities and funding
7 streams are coordinated to improve community
8 health; and

9 (E) submits an application in accordance
10 with subsection (c).

11 (b) ESTABLISHMENT.—The Director shall establish a
12 grant program under which eligible entities shall receive
13 grants to conduct environmental health improvement ac-
14 tivities and to improve social determinants of health.

15 (c) APPLICATION.—To receive a grant under this sec-
16 tion, an eligible entity shall submit an application to the
17 Director at such time, in such manner, and accompanied
18 by such information as the Director may require.

19 (d) USE OF GRANT FUNDS.—An eligible entity may
20 use a grant under this section—

21 (1) to promote environmental health;

22 (2) to address environmental health inequities
23 among all populations, including children; and

24 (3) to address racial and ethnic inequities in so-
25 cial determinants of health.

1 (e) AMOUNT OF COOPERATIVE AGREEMENT.—The
2 Director shall award grants to eligible entities at the fol-
3 lowing 3 funding levels:

4 (1) LEVEL 1 COOPERATIVE AGREEMENTS.—

5 (A) IN GENERAL.—An eligible entity
6 awarded a grant under this paragraph shall use
7 the funds to identify environmental health prob-
8 lems and solutions by—

9 (i) establishing a planning and
10 prioritizing council in accordance with sub-
11 paragraph (B); and

12 (ii) conducting an environmental
13 health assessment in accordance with sub-
14 paragraph (C).

15 (B) PLANNING AND PRIORITIZING COUN-
16 CIL.—

17 (i) IN GENERAL.—A planning and
18 prioritizing council established under sub-
19 paragraph (A)(i) (referred to in this para-
20 graph as a “PPC”) shall assist the envi-
21 ronmental health assessment process and
22 environmental health promotion activities
23 of the eligible entity.

24 (ii) MEMBERSHIP.—Membership of a
25 PPC shall consist of representatives from

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1 various organizations within public health,
2 planning, development, and environmental
3 services and shall include stakeholders
4 from vulnerable groups such as children,
5 the elderly, disabled, and minority ethnic
6 groups that are often not actively involved
7 in democratic or decision-making proc-
8 esses.

9 (iii) DUTIES.—A PPC shall—

10 (I) identify key stakeholders and
11 engage and coordinate potential part-
12 ners in the planning process;

13 (II) establish a formal advisory
14 group to plan for the establishment of
15 services;

16 (III) conduct an in-depth review
17 of the nature and extent of the need
18 for an environmental health assess-
19 ment, including a local epidemiological
20 profile, an evaluation of the service
21 provider capacity of the community,
22 and a profile of any target popu-
23 lations; and

24 (IV) define the components of
25 care and form essential programmatic

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1 linkages with related providers in the
2 community.

3 (C) ENVIRONMENTAL HEALTH ASSESS-
4 MENT.—

5 (i) IN GENERAL.—A PPC shall carry
6 out an environmental health assessment to
7 identify environmental health concerns.

8 (ii) ASSESSMENT PROCESS.—The
9 PPC shall—

10 (I) define the goals of the assess-
11 ment;

12 (II) generate the environmental
13 health issue list;

14 (III) analyze issues with a sys-
15 tems framework;

16 (IV) develop appropriate commu-
17 nity environmental health indicators;

18 (V) rank the environmental
19 health issues;

20 (VI) set priorities for action;

21 (VII) develop an action plan;

22 (VIII) implement the plan; and

23 (IX) evaluate progress and plan-
24 ning for the future.

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1 (D) EVALUATION.—Each eligible entity
2 that receives a grant under this paragraph shall
3 evaluate, report, and disseminate program find-
4 ings and outcomes.

5 (E) TECHNICAL ASSISTANCE.—The Direc-
6 tor may provide such technical and other non-
7 financial assistance to eligible entities as the
8 Director determines to be necessary.

9 (2) LEVEL 2 COOPERATIVE AGREEMENTS.—

10 (A) ELIGIBILITY.—

11 (i) IN GENERAL.—The Director shall
12 award grants under this paragraph to eli-
13 gible entities that have already—

14 (I) established broad-based col-
15 laborative partnerships; and

16 (II) completed environmental as-
17 sessments.

18 (ii) NO LEVEL 1 REQUIREMENT.—To
19 be eligible to receive a grant under this
20 paragraph, an eligible entity is not re-
21 quired to have successfully completed a
22 Level 1 Cooperative Agreement (as de-
23 scribed in paragraph (1)).

24 (B) USE OF GRANT FUNDS.—An eligible
25 entity awarded a grant under this paragraph

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1 shall use the funds to further activities to carry
2 out environmental health improvement activi-
3 ties, including—

4 (i) addressing community environ-
5 mental health priorities in accordance with
6 paragraph (1)(C)(ii), including—

7 (I) geography;

8 (II) the built environment;

9 (III) air quality;

10 (IV) water quality;

11 (V) land use;

12 (VI) solid waste;

13 (VII) housing;

14 (VIII) violence;

15 (IX) socioeconomic status;

16 (X) ethnicity, social construct,

17 and language preference;

18 (XI) educational attainment;

19 (XII) employment;

20 (XIII) food safety, accessibility,

21 and affordability;

22 (XIV) nutrition;

23 (XV) health care services; and

24 (XVI) injuries;

1 (ii) building partnerships between
2 planning, public health, and other sectors,
3 including child-serving institutions, to ad-
4 dress how the built environment impacts
5 food availability and access and physical
6 activity to promote healthy behaviors and
7 lifestyles and reduce overweight and obe-
8 sity, musculoskeletal diseases, respiratory
9 conditions, infectious diseases, dental, oral,
10 and mental health conditions, poverty, and
11 related co-morbidities;

12 (iii) establishing programs to ad-
13 dress—

14 (I) how environmental and social
15 conditions of work and living choices
16 influence physical activity and dietary
17 intake; or

18 (II) how the conditions described
19 in subclause (I) influence the concerns
20 and needs of people who have im-
21 paired mobility and use assistance de-
22 vices, including wheelchairs, lower
23 limb prostheses, and hip, knee, and
24 other joint replacements; and

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1 (iv) convening intervention and dem-
2 onstration programs that examine the role
3 of the social environment in connection
4 with the physical and chemical environ-
5 ment in—

6 (I) determining access to nutri-
7 tional food;

8 (II) improving physical activity to
9 reduce overweight, obesity, and co-
10 morbidities and increase quality of
11 life; and

12 (III) location and access to med-
13 ical facilities.

14 (3) LEVEL 3 COOPERATIVE AGREEMENTS.—

15 (A) IN GENERAL.—An eligible entity
16 awarded a grant under this paragraph shall use
17 the funds to identify and address racial and
18 ethnic inequities in social determinants of
19 health by creating demonstration programs that
20 assess the feasibility of establishing a federally
21 funded comprehensive program and describe
22 key outcomes that address racial and ethnic in-
23 equities in social determinants of health.

24 (B) PROGRAM DESIGN.—

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1 (i) EVALUATION.—No later than 1
2 year after enactment of this Act, the Di-
3 rector shall evaluate the best practices of
4 existing programs from the private, public,
5 community based, and academically sup-
6 ported initiatives focused on reducing in-
7 equities in the social determinants of
8 health for racial and ethnic populations.

9 (ii) DEMONSTRATION PROJECTS.—
10 Not later than 2 years after the date of en-
11 actment of this Act, the Director shall im-
12 plement at least 12 demonstration
13 projects, including at least one project for
14 each major racial and ethnic minority
15 group, each of which is unique to the cul-
16 tural and linguistic needs of each of the
17 following groups:

- 18 (I) Native Americans and Alaska
19 Natives.
20 (II) Asian Americans.
21 (III) African Americans/Blacks.
22 (IV) Hispanic/Latino-Americans.
23 (V) Native Hawaiians and Pacific
24 Islanders.

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1 (VI) Middle Eastern and North-
2 ern African communities.

3 (iii) REPORT TO CONGRESS.—No later
4 than 2 years after the implementation of
5 the initial demonstration projects under
6 this paragraph, the Director shall submit
7 to Congress a report that includes—

8 (I) a description of each dem-
9 onstration project and design;

10 (II) an evaluation of the cost-ef-
11 fectiveness of each project's preven-
12 tion and treatment efforts;

13 (III) an evaluation of the cultural
14 and linguistic appropriateness of each
15 project by racial and ethnic group;
16 and

17 (IV) an evaluation of the bene-
18 ficiary's health status improvement
19 under the demonstration project.

20 (iv) ANY OTHER INFORMATION
21 DEEMED APPROPRIATE BY THE DIREC-
22 TOR.—The Director shall require eligible
23 entities awarded a grant under this para-
24 graph to report any other information the
25 Director determines appropriate to be

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1 shared by or developed by such entity, in-
2 cluding the following:

3 (I) Developing models and evalu-
4 ating methods that improve the cul-
5 tural and linguistically appropriate
6 services provided through the Centers
7 for Disease Control and Prevention to
8 target individuals impacted by health
9 inequities based on their race, eth-
10 nicity, gender, or sexual orientation.

11 (II) Promoting the collaboration
12 between primary and specialty care
13 health care providers and patients, to
14 ensure patients impacted by health in-
15 equities based on race, ethnicity, gen-
16 der, or sexual orientation are receiving
17 comprehensive and organized treat-
18 ment and care.

19 (III) Educating health care pro-
20 fessionals on the causes and effects of
21 inequities in the social determinants
22 of health in relation to minority and
23 racial and ethnic communities and the
24 need for culturally and linguistically

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1 appropriate care in the prevention and
2 treatment of high-impact diseases.

3 (IV) Encouraging collaboration
4 among community- and patient-based
5 organizations which work to address
6 inequities in the social determinants
7 of health in relation to high-impact
8 diseases in minority and racial and
9 ethnic populations.

10 (f) AUTHORIZATION OF APPROPRIATIONS.—There
11 are authorized to be appropriated to carry out this sec-
12 tion—

13 (1) \$25,000,000 for fiscal year 2023; and
14 (2) such sums as may be necessary for fiscal
15 years 2024 through 2026.

16 **SEC. 10005. ADDITIONAL RESEARCH ON THE RELATION-**
17 **SHIP BETWEEN THE BUILT ENVIRONMENT**
18 **AND THE HEALTH OF COMMUNITY RESI-**
19 **DENTS.**

20 (a) DEFINITION OF ELIGIBLE INSTITUTION.—In this
21 section, the term “eligible institution” means a public or
22 private nonprofit institution that submits to the Secretary
23 and the Administrator an application for a grant under
24 the grant program authorized under subsection (b)(2) at
25 such time, in such manner, and containing such agree-

1 ments, assurances, and information as the Secretary and
2 Administrator may require.

3 (b) RESEARCH GRANT PROGRAM.—

4 (1) DEFINITION OF HEALTH.—In this section,
5 the term “health” includes—

6 (A) levels of physical activity;

7 (B) degree of mobility due to factors such
8 as musculoskeletal diseases, arthritis, and obe-
9 sity;

10 (C) consumption of nutritional foods;

11 (D) rates of crime;

12 (E) air, water, and soil quality;

13 (F) risk of injury;

14 (G) accessibility to health care services;

15 (H) levels of educational attainment; and

16 (I) other indicators as determined appro-
17 priate by the Secretary.

18 (2) GRANTS.—The Secretary, in collaboration
19 with the Administrator, shall provide grants to eligi-
20 ble institutions to conduct and coordinate research
21 on the built environment and its influence on indi-
22 vidual and population-based health.

23 (3) RESEARCH.—The Secretary shall support
24 research that—

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1 (A) investigates and defines the causal
2 links between all aspects of the built environ-
3 ment and the health of residents;

4 (B) examines—

5 (i) the extent of the impact of the
6 built environment (including the various
7 characteristics of the built environment) on
8 the health of residents;

9 (ii) the variation in the health of resi-
10 dents by—

11 (I) location (such as inner cities,
12 inner suburbs, outer suburbs, reserva-
13 tions, and rural areas); and

14 (II) population subgroup (includ-
15 ing children, young adults, the elderly,
16 the disadvantaged); or

17 (iii) the importance of the built envi-
18 ronment to the total health of residents,
19 which is the primary variable of interest
20 from a public health perspective;

21 (C) is used to develop—

22 (i) measures to address health and the
23 connection of health to the built environ-
24 ment; and

1 (ii) efforts to link the measures to
2 travel and health databases;

3 (D) distinguishes carefully between per-
4 sonal attitudes and choices and external influ-
5 ences on observed behavior to determine how
6 much an observed association between the built
7 environment and the health of residents, versus
8 the lifestyle preferences of the people that
9 choose to live in the neighborhood, reflects the
10 physical characteristics of the neighborhood;
11 and

12 (E)(i) identifies or develops effective inter-
13 vention strategies to promote better health
14 among residents with a focus on behavioral
15 interventions and enhancements of the built en-
16 vironment that promote increased use by resi-
17 dents; and

18 (ii) in developing the intervention strate-
19 gies under clause (i), ensures that the interven-
20 tion strategies will reach out to high-risk popu-
21 lations, including racial and ethnic minorities,
22 low-income urban and rural communities, and
23 children.

24 (4) PRIORITY.—In providing assistance under
25 the grant program authorized under paragraph (2),

1 the Secretary and the Administrator shall give pri-
2 ority to research that incorporates—

3 (A) minority-serving institutions as grant-
4 ees;

5 (B) interdisciplinary approaches; or

6 (C) the expertise of the public health,
7 physical activity, nutrition and health care (in-
8 cluding child health), urban planning, and
9 transportation research communities in the
10 United States and abroad.

11 **SEC. 10006. ENVIRONMENT AND PUBLIC HEALTH RESTORA-**
12 **TION.**

13 (a) FINDINGS.—Congress finds that—

14 (1) humans share an environment with a wide
15 variety of habitats and ecosystems that nurture and
16 sustain a diversity of species;

17 (2) the abundance of natural resources in the
18 environment forms the basis for the economy and
19 has greatly contributed to human development
20 throughout history;

21 (3) the accelerated pace of human development
22 over the last several hundred years has significantly
23 impacted—

24 (A) the natural environment and its re-
25 sources;

1 (B) the health and diversity of plant and
2 animal life;

3 (C) the availability of critical habitats;

4 (D) the quality of the air and water; and

5 (E) the global climate;

6 (4) the intervention of the Federal Government
7 is necessary to minimize and mitigate human impact
8 on the environment—

9 (A) for the benefit of public health;

10 (B) to maintain air quality and water qual-
11 ity;

12 (C) to sustain the diversity of plants and
13 animals;

14 (D) to combat global climate change; and

15 (E) to protect the environment;

16 (5) laws and regulations in the United States
17 have been enacted and promulgated to minimize and
18 mitigate human impact on the environment for the
19 benefit of public health, to maintain air quality and
20 water quality, to sustain wildlife, and to protect the
21 environment; and

22 (6) attempts to repeal or weaken key environ-
23 mental safeguards pose dangers to the public health,
24 air quality, water quality, wildlife, and the environ-
25 ment.

1 (b) STATEMENT OF POLICY.—It is the policy of the
2 Federal Government to work in conjunction with States,
3 territories, Tribal governments, international organiza-
4 tions, and foreign governments as a steward of the envi-
5 ronment for the benefit of public health, to maintain air
6 quality and water quality, to sustain the diversity of plant
7 and animal species, to combat global climate change, and
8 to protect the environment for future generations.

9 (c) STUDY AND REPORT ON PUBLIC HEALTH OR EN-
10 VIRONMENTAL IMPACT OF REVISED RULES, REGULA-
11 TIONS, LAWS, OR OTHER AGENCY DECISIONS.—

12 (1) STUDY.—Not later than 30 days after the
13 date of enactment of this Act, the President shall
14 seek to enter into an arrangement under which the
15 National Academy of Sciences shall conduct a study
16 to determine the effects on public health, air quality,
17 water quality, wildlife, and the environment of the
18 following regulations, laws, and other agency deci-
19 sions:

20 (A) CLEAN WATER.—

21 (i) The final rule of the Environ-
22 mental Protection Agency and the Corps of
23 Engineers entitled “Final Revisions to the
24 Clean Water Act Regulatory Definitions of
25 ‘Fill Material’ and ‘Discharge of Fill Mate-

1 rial’” and published in the Federal Reg-
2 ister on May 9, 2002 (67 Fed. Reg.
3 31129).

4 (ii) The final rule of the Environ-
5 mental Protection Agency entitled “Na-
6 tional Pollutant Discharge Elimination
7 System Permit Regulation for Con-
8 centrated Animal Feeding Operations: Re-
9 moval of Vacated Elements in Response to
10 2011 Court Decision” and published in the
11 Federal Register on July 30, 2012 (77
12 Fed. Reg. 44494).

13 (iii) The final rule entitled “With-
14 drawal of Revisions to the Water Quality
15 Planning and Management Regulation and
16 Revisions to the National Pollutant Dis-
17 charge Elimination System Program in
18 Support of Revisions to the Water Quality
19 Planning and Management Regulation”
20 and published in the Federal Register on
21 March 19, 2003 (68 Fed. Reg. 13608).

22 (iv) The final rule of the Environ-
23 mental Protection Agency entitled “Con-
24 solidated Permit Regulations: RCRA Haz-
25 ardous Waste; SDWA Underground Injec-

tion Control; CWA National Pollutant Discharge Elimination System; CWA Section 404 Dredge or Fill Programs; and CAA Prevention of Significant Deterioration” and published in the Federal Register on May 19, 1980 (45 Fed. Reg. 33290), with respect to the definition of the “waters of the United States”.

(v) The final rule of the Corps of Engineers and the Environmental Protection Agency entitled “Definition of ‘Waters of the United States’—Recodification of Pre-Existing Rules” and published in the Federal Register on October 22, 2019 (84 Fed. Reg. 56626).

(vi) The final rule of the Corps of Engineers and the Environmental Protection Agency entitled “The Navigable Waters Protection Rule: Definition of ‘Waters of the United States’” and published in the Federal Register on April 21, 2020 (85 Fed. Reg. 22250).

(B) FORESTS AND LAND MANAGEMENT.—

(i) The Healthy Forests Restoration Act of 2003 (16 U.S.C. 6501 et seq.).

1 (ii) The application of section 553(e)
2 of title 5, United States Code, such that a
3 State may petition for a special rule for
4 the National Forest System inventoried
5 roadless areas within the State.

6 (iii) The final rules entitled “National
7 Forest System Land Management Plan-
8 ning” (77 Fed. Reg. 21162) and “National
9 Forest System Land Management Plan-
10 ning” (81 Fed. Reg. 90723), published on
11 April 19, 2013, and December 15, 2016,
12 respectively.

13 (iv) The final rule entitled “Oil Shale
14 Management—General” and published on
15 January 15, 2009 (73 Fed. Reg. 69414).

16 (v) The record of decision described in
17 the notice of availability entitled “Notice of
18 Availability of Approved Land Use Plan
19 Amendments/Record of Decision for Allo-
20 cation of Oil Shale and Tar Sands Re-
21 sources on Lands Administered by the Bu-
22 reau of Land Management in Colorado,
23 Utah, and Wyoming and Final Pro-
24 grammatic Environmental Impact State-

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1 ment” and published on April 1, 2013 (78
2 Fed. Reg. 19518).

3 (C) SCIENTIFIC REVIEW.—The final rule
4 entitled “Interagency Cooperation Under the
5 Endangered Species Act” (December 16, 2008)
6 (73 Fed. Reg. 76272), as amended by the final
7 rule entitled “Endangered and Threatened
8 Wildlife and Plants; Regulations for Inter-
9 agency Cooperation” (August 27, 2019) (84
10 Fed. Reg. 44976).

11 (2) METHOD.—In conducting the study under
12 paragraph (1), the National Academy of Sciences
13 may use and compare existing scientific studies re-
14 garding the regulations, laws, and other agency deci-
15 sions described in paragraph (1).

16 (3) REPORT.—Not later than 270 days after
17 the date on which the President enters into the ar-
18 rangement under paragraph (1), the National Acad-
19 emy of Sciences shall make publicly available and
20 shall submit to Congress and to the head of each de-
21 partment and agency of the Federal Government
22 that issued, implements, or would implement a regu-
23 lation, law, or other agency decision described in
24 paragraph (1), a report that includes—

1 (A) a description of the effects of each reg-
2 ulation, law, or other agency decision described
3 in paragraph (1) on public health, air quality,
4 water quality, wildlife, and the environment,
5 compared to the impact of preexisting regula-
6 tions, laws, or other agency decisions in effect,
7 as applicable, including—

8 (i) any negative impacts to air quality
9 or water quality;

10 (ii) any negative impacts to wildlife;

11 (iii) any delays in hazardous waste
12 cleanup that are projected to be hazardous
13 to public health; and

14 (iv) any other negative impact on pub-
15 lic health or the environment; and

16 (B) any recommendations that the Na-
17 tional Academy of Sciences considers appro-
18 priate to maintain, restore, or improve in whole
19 or in part protections for public health, air
20 quality, water quality, wildlife, and the environ-
21 ment for each of the regulations, laws, and
22 other agency decisions described in paragraph
23 (1), which may include recommendations for
24 the adoption of any regulation or law in place
25 or proposed prior to January 1, 2001.

1 (d) DEPARTMENT AND AGENCY REVISION OF EXIST-
2 ING RULES, REGULATIONS, OR LAWS.—Not later than
3 180 days after the date on which the report is submitted
4 pursuant to subsection (c)(3), the head of each depart-
5 ment or agency that has issued or implemented a regula-
6 tion, law, or other agency decision described in subsection
7 (c)(1) shall submit to Congress a plan describing the steps
8 the department or agency will take, or has taken, to re-
9 store or improve protections for public health and the envi-
10 ronment in whole or in part that were in existence prior
11 to the issuance of the applicable regulation, law, or other
12 agency decision.

13 **SEC. 10007. GAO REPORT ON HEALTH EFFECTS OF DEEP-**
14 **WATER HORIZON OIL RIG EXPLOSION IN THE**
15 **GULF COAST.**

16 (a) STUDY.—The Comptroller General of the United
17 States shall conduct a study on the type and scope of
18 health care services administered through the Department
19 of Health and Human Services addressing the provision
20 of health care to racial and ethnic minorities, including
21 residents, cleanup workers, and volunteers, affected by the
22 blowout and explosion of the mobile offshore drilling unit
23 Deepwater Horizon that occurred on April 20, 2010, and
24 resulting hydrocarbon releases into the environment.

1 (b) SPECIFIC COMPONENTS.—In carrying out sub-
2 section (a), the Comptroller General of the United States
3 shall—

4 (1) assess the type, size, and scope of programs
5 administered by the Secretary that focus on the pro-
6 vision of health care to communities on the Gulf
7 Coast;

8 (2) identify the merits and disadvantages asso-
9 ciated with each of the programs;

10 (3) perform an analysis of the costs and bene-
11 fits of the programs; and

12 (4) determine whether there is any duplication
13 of programs.

14 (c) REPORT.—Not later than 180 days after the date
15 of enactment of this Act, the Comptroller General of the
16 United States shall submit to Congress a report that in-
17 cludes—

18 (1) the findings of the study conducted under
19 subsection (a); and

20 (2) recommendations for improving access to
21 health care for racial and ethnic minorities.

22 **SEC. 10008. ESTABLISH AN INTERAGENCY COUNSEL AND**
23 **GRANT PROGRAMS ON SOCIAL DETER-**
24 **MINANTS OF HEALTH.**

25 (a) FINDINGS; PURPOSES.—

1 (1) FINDINGS.—Congress finds as follows:

2 (A) There is a significant body of evidence
3 showing that economic and social conditions
4 have a powerful impact on individual and popu-
5 lation health outcomes and well-being, as well
6 as medical costs.

7 (B) State, local, and Tribal governments
8 and the service delivery partners of such gov-
9 ernments face significant challenges in coordi-
10 nating benefits and services delivered through
11 the Medicaid program under title XIX of the
12 Social Security Act (42 U.S.C. 1396 et seq.)
13 and other social services programs because of
14 the fragmented and complex nature of Federal
15 and State funding and administrative require-
16 ments.

17 (C) The Federal Government should
18 prioritize and proactively assist State and local
19 governments to strengthen the capacity of State
20 and local governments to improve health and
21 social outcomes for individuals, thereby improv-
22 ing cost-effectiveness and return on investment.

23 (2) PURPOSES.—The purposes of this section
24 are as follows:

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1 (A) To establish effective, coordinated Fed-
2 eral technical assistance to help State and local
3 governments to improve outcomes and cost-ef-
4 fectiveness of, and return on investment from,
5 health and social services programs.

6 (B) To build a pipeline of State and locally
7 designed, cross-sector interventions and strate-
8 gies that generate rigorous evidence about how
9 to improve health and social outcomes, and in-
10 crease the cost-effectiveness of, and return on
11 investment from, Federal, State, local, and
12 Tribal health and social services programs.

13 (C) To enlist State and local governments
14 and the service providers of such governments
15 as partners in identifying Federal statutory,
16 regulatory, and administrative challenges in im-
17 proving the health and social outcomes of, cost-
18 effectiveness of, and return on investment from,
19 Federal spending on individuals enrolled in
20 Medicaid.

21 (D) To develop strategies to improve
22 health and social outcomes without denying
23 services to, or restricting the eligibility of, vul-
24 nerable populations.

1 (b) SOCIAL DETERMINANTS ACCELERATOR COUN-
2 CIL.—

3 (1) ESTABLISHMENT.—The Secretary of Health
4 and Human Services (referred to in this section as
5 the “Secretary”), in coordination with the Adminis-
6 trator of the Centers for Medicare & Medicaid Serv-
7 ices (referred to in this section as the “Adminis-
8 trator”), shall establish an interagency council, to be
9 known as the Social Determinants Accelerator Inter-
10 agency Council (referred to in this section as the
11 “Council”) to achieve the purposes listed in sub-
12 section (b)(2).

13 (2) MEMBERSHIP.—

14 (A) FEDERAL COMPOSITION.—The Council
15 shall be composed of at least one designee from
16 each of the following Federal agencies:

17 (i) The Office of Management and
18 Budget.

19 (ii) The Department of Agriculture.

20 (iii) The Department of Education.

21 (iv) The Indian Health Service.

22 (v) The Department of Housing and
23 Urban Development.

24 (vi) The Department of Labor.

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1 (vii) The Department of Transpor-
2 tation.

3 (viii) Any other Federal agency the
4 Chair of the Council determines necessary.

5 (B) DESIGNATION.—

6 (i) IN GENERAL.—The head of each
7 agency specified in subparagraph (A) shall
8 designate at least one employee described
9 in clause (ii) to serve as a member of the
10 Council.

11 (ii) RESPONSIBILITIES.—An employee
12 described in this clause shall be a senior
13 employee of the agency—

14 (I) whose responsibilities relate
15 to authorities, policies, and procedures
16 with respect to the health and well-
17 being of individuals receiving medical
18 assistance under a State plan (or a
19 waiver of such plan) under title XIX
20 of the Social Security Act (42 U.S.C.
21 1396 et seq.); or

22 (II) who has authority to imple-
23 ment and evaluate transformative ini-
24 tiatives that harness data or conduct
25 rigorous evaluation to improve the im-

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1 pact and cost-effectiveness of federally
2 funded services and benefits.

3 (C) HHS REPRESENTATION.—In addition
4 to the designees under subparagraph (A), the
5 Council shall include designees from at least 3
6 agencies within the Department of Health and
7 Human Services, including the Centers for
8 Medicare & Medicaid Services, at least one of
9 whom shall meet the criteria under subpara-
10 graph (B)(ii).

11 (D) OMB ROLE.—The Director of the Of-
12 fice of Management and Budget shall facilitate
13 the timely resolution of Federal Government-
14 wide and multiagency issues to help the Council
15 achieve consensus recommendations described
16 under this section.

17 (E) NON-FEDERAL COMPOSITION.—The
18 Comptroller General of the United States may
19 designate up to 6 Council designees—

20 (i) who have relevant subject matter
21 expertise, including expertise implementing
22 and evaluating transformative initiatives
23 that harness data and conduct evaluations
24 to improve the impact and cost-effective-
25 ness of Federal Government services; and

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1 (ii) that each represent—

2 (I) State, local, and Tribal health
3 and human services agencies;

4 (II) public housing authorities or
5 State housing finance agencies;

6 (III) State and local government
7 budget offices;

8 (IV) State Medicaid agencies; or

9 (V) national consumer advocacy
10 organizations.

11 (F) CHAIR.—

12 (i) IN GENERAL.—The Secretary shall
13 select the Chair of the Council from among
14 the members of the Council.

15 (ii) INITIATING GUIDANCE.—The
16 Chair, on behalf of the Council, shall iden-
17 tify and invite individuals from diverse en-
18 tities to provide the Council with advice
19 and information pertaining to addressing
20 social determinants of health, including—

21 (I) individuals from State and
22 local government health and human
23 services agencies;

24 (II) individuals from State Med-
25 icaid agencies;

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1 (III) individuals from State and
2 local government budget offices;

3 (IV) individuals from public
4 housing authorities or State housing
5 finance agencies;

6 (V) individuals from nonprofit or-
7 ganizations, small businesses, and
8 philanthropic organizations;

9 (VI) advocates;

10 (VII) researchers; and

11 (VIII) any other individuals the
12 Chair determines to be appropriate.

13 (3) DUTIES.—The duties of the Council are—

14 (A) to make recommendations to the Sec-
15 retary and the Administrator regarding the cri-
16 teria for making awards under this section;

17 (B) to identify Federal authorities and op-
18 portunities for use by States or local govern-
19 ments to improve coordination of funding and
20 administration of Federal programs, the bene-
21 ficiaries of whom include individuals, and which
22 may be unknown or underutilized, and to make
23 information on such authorities and opportuni-
24 ties publicly available;

1 (C) to provide targeted technical assistance
2 to States developing a social determinants ac-
3 celerator plan under this section, including
4 identifying potential statutory or regulatory
5 pathways for implementation of the plan and
6 assisting in identifying potential sources of
7 funding to implement the plan;

8 (D) to report to Congress annually on the
9 subjects set forth in this section;

10 (E) to develop and disseminate evaluation
11 guidelines and standards that can be used to
12 reliably assess the impact of an intervention or
13 approach that may be implemented pursuant to
14 this section on outcomes, cost-effectiveness of,
15 and return on investment from Federal, State,
16 local, and Tribal governments, and to facilitate
17 technical assistance, where needed, to help to
18 improve State and local evaluation designs and
19 implementation;

20 (F) to seek feedback from State, local, and
21 Tribal governments, including through an an-
22 nual survey by an independent third party, on
23 how to improve the technical assistance the
24 Council provides to better equip State, local,

1 and Tribal governments to coordinate health
2 and social service programs;

3 (G) to solicit applications for grants under
4 subsection (c); and

5 (H) to coordinate with other cross-agency
6 initiatives focused on improving the health and
7 well-being of low-income and at-risk populations
8 in order to prevent unnecessary duplication be-
9 tween agency initiatives.

10 (4) SCHEDULE.—Not later than 60 days after
11 the date of enactment of this Act, the Council shall
12 convene to develop a schedule and plan for carrying
13 out the duties described in this section, including so-
14 licitation of applications for the grants under this
15 section.

16 (5) REPORT TO CONGRESS.—The Council shall
17 submit an annual report to Congress, which shall in-
18 clude—

19 (A) a list of the Council members;

20 (B) activities and expenditures of the
21 Council;

22 (C) summaries of the interventions and ap-
23 proaches that will be supported by State, local,
24 and Tribal governments that received a grant
25 under this section, including—

1 (i) the best practices and evidence-
2 based approaches such governments plan
3 to employ to achieve the purposes listed in
4 this section; and

5 (ii) a description of how the practices
6 and approaches will impact the outcomes,
7 cost-effectiveness of, and return on invest-
8 ment from, Federal, State, local, and Trib-
9 al governments with respect to such pur-
10 poses;

11 (D) the feedback received from State and
12 local governments on ways to improve the tech-
13 nical assistance of the Council, including find-
14 ings from a third-party survey and actions the
15 Council plans to take in response to such feed-
16 back; and

17 (E) the major statutory, regulatory, and
18 administrative challenges identified by State,
19 local, and Tribal governments that received a
20 grant under subsection (c), and the actions that
21 Federal agencies are taking to address such
22 challenges.

23 (6) FACA APPLICABILITY.—The Federal Advi-
24 sory Committee Act (5 U.S.C. App.) shall not apply
25 to the Council.

1 (7) COUNCIL PROCEDURES.—The Secretary, in
2 consultation with the Comptroller General of the
3 United States and the Director of the Office of Man-
4 agement and Budget, shall establish procedures for
5 the Council to—

6 (A) ensure that adequate resources are
7 available to effectively execute the responsibil-
8 ities of the Council;

9 (B) effectively coordinate with other rel-
10 evant advisory bodies and working groups to
11 avoid unnecessary duplication;

12 (C) create transparency to the public and
13 Congress with regard to Council membership,
14 costs, and activities, including through use of
15 modern technology and social media to dissemi-
16 nate information; and

17 (D) avoid conflicts of interest that would
18 jeopardize the ability of the Council to make de-
19 cisions and provide recommendations.

20 (c) SOCIAL DETERMINANTS ACCELERATOR GRANTS
21 TO STATES OR LOCAL GOVERNMENTS.—

22 (1) GRANTS TO STATES, LOCAL GOVERNMENTS,
23 AND TRIBES.—Not later than 180 days after the
24 date of enactment of this Act, the Administrator, in
25 consultation with the Secretary and the Council,

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1 shall award on a competitive basis not more than 25
2 grants to eligible applicants described in this sub-
3 section, for the development of social determinants
4 accelerator plans, as described in this subsection.

5 (2) ELIGIBLE APPLICANT.—An eligible appli-
6 cant described in this subsection is a State, local, or
7 Tribal health or human services agency that—

8 (A) demonstrates the support of relevant
9 parties across relevant State, local, or Tribal ju-
10 risdictions; and

11 (B) in the case of an applicant that is a
12 local government agency, provides to the Sec-
13 retary a letter of support from the lead State
14 health or human services agency for the State
15 in which the local government is located.

16 (3) AMOUNT OF GRANT.—The Administrator,
17 in coordination with the Council, shall determine the
18 total amount that the Administrator will make avail-
19 able to each grantee under this subsection.

20 (4) APPLICATION.—An eligible applicant seek-
21 ing a grant under this subsection shall include in the
22 application the following information:

23 (A) The target population (or populations)
24 that would benefit from implementation of the

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1 social determinants accelerator plan proposed to
2 be developed by the applicant.

3 (B) A description of the objective or objec-
4 tives and outcome goals of such proposed plan,
5 which shall include at least one health outcome
6 and at least one other important social out-
7 come.

8 (C) The sources and scope of inefficiencies
9 that, if addressed by the plan, could result in
10 improved cost-effectiveness of or return on in-
11 vestment from Federal, State, local, and Tribal
12 governments.

13 (D) A description of potential interventions
14 that could be designed or enabled using such
15 proposed plan.

16 (E) The State, local, and Tribal govern-
17 ments, academic institutions, nonprofit organi-
18 zations, community-based organizations, and
19 other public and private sector partners that
20 would participate in the development of the pro-
21 posed plan and subsequent implementation of
22 programs or initiatives included in such pro-
23 posed plan.

24 (F) Such other information as the Admin-
25 istrator, in consultation with the Secretary and

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1 the Council, determines necessary to achieve the
2 purposes of this section.

3 (5) USE OF FUNDS.—A recipient of a grant
4 under this subsection may use funds received
5 through the grant for the following purposes:

6 (A) To convene and coordinate with rel-
7 evant government entities and other stake-
8 holders across sectors to assist in the develop-
9 ment of a social determinant accelerator plan.

10 (B) To identify populations of individuals
11 receiving medical assistance under a State plan
12 (or a waiver of such plan) under title XIX of
13 the Social Security Act (42 U.S.C. 1396 et
14 seq.) who may benefit from the proposed ap-
15 proaches to improving the health and well-being
16 of such individuals through the implementation
17 of the proposed social determinants accelerator
18 plan.

19 (C) To engage qualified research experts to
20 advise on relevant research and to design a pro-
21 posed evaluation plan, in accordance with the
22 standards and guidelines issued by the Admin-
23 istrator.

1 (D) To collaborate with the Council to sup-
2 port the development of social determinants ac-
3 celerator plans.

4 (E) To prepare and submit a final social
5 determinants accelerator plan to the Council.

6 (6) CONTENTS OF PLANS.—A social deter-
7 minant accelerator plan developed under this sub-
8 section shall include the following:

9 (A) A description of the target population
10 (or populations) that would benefit from imple-
11 mentation of the social determinants accelerator
12 plan, including an analysis describing the pro-
13 jected impact on the well-being of individuals
14 described in paragraph (5)(B).

15 (B) A description of the interventions or
16 approaches designed under the social deter-
17 minants accelerator plan and the evidence for
18 selecting such interventions or approaches.

19 (C) The objectives and outcome goals of
20 such interventions or approaches, including at
21 least one health outcome and at least one other
22 important social outcome.

23 (D) A plan for accessing and linking rel-
24 evant data to enable coordinated benefits and
25 services for the jurisdictions described in this

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1 section and an evaluation of the proposed inter-
2 ventions and approaches.

3 (E) A description of the State, local, and
4 Tribal governments, academic institutions, non-
5 profit organizations, or any other public or pri-
6 vate sector organizations that would participate
7 in implementing the proposed interventions or
8 approaches, and the role each would play to
9 contribute to the success of the proposed inter-
10 ventions or approaches.

11 (F) The identification of the funding
12 sources that would be used to finance the pro-
13 posed interventions or approaches.

14 (G) A description of any financial incen-
15 tives that may be provided, including outcome-
16 focused contracting approaches to encourage
17 service providers and other partners to improve
18 outcomes of, cost-effectiveness of, and return on
19 investment from, Federal, State, local, or Tribal
20 government spending.

21 (H) The identification of the applicable
22 Federal, State, local, or Tribal statutory and
23 regulatory authorities, including waiver authori-
24 ties, to be leveraged to implement the proposed
25 interventions or approaches.

1 (I) A description of potential consider-
2 ations that would enhance the impact,
3 scalability, or sustainability of the proposed
4 interventions or approaches and the actions the
5 grant awardee would take to address such con-
6 siderations.

7 (J) A proposed evaluation plan, to be car-
8 ried out by an independent evaluator, to meas-
9 ure the impact of the proposed interventions or
10 approaches on the outcomes of, cost-effective-
11 ness of, and return on investment from, Fed-
12 eral, State, local, and Tribal governments.

13 (K) Precautions for ensuring that vulner-
14 able populations will not be denied access to
15 Medicaid or other essential services as a result
16 of implementing the proposed plan.

17 (d) FUNDING.—

18 (1) IN GENERAL.—Out of any money in the
19 Treasury not otherwise appropriated, there is appro-
20 priated to carry out this section \$25,000,000 to re-
21 main available for obligation until the date that is
22 5 years after the date of enactment of this section.

23 (2) RESERVATION OF FUNDS.—

24 (A) IN GENERAL.—Of the funds made
25 available under paragraph (1), the Secretary

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1 shall reserve not less than 20 percent to award
2 grants to eligible applicants for the development
3 of social determinants accelerator plans under
4 this section intended to serve rural populations.

5 (B) EXCEPTION.—In the case of a fiscal
6 year for which the Secretary determines that
7 there are not sufficient eligible applicants to
8 award up to 25 grants under subsection (d)
9 that are intended to serve rural populations and
10 the Secretary cannot satisfy the 20-percent re-
11 quirement, the Secretary may reserve an
12 amount that is less than 20 percent of amounts
13 made available under paragraph (1) to award
14 grants for such purpose.

15 (3) RULE OF CONSTRUCTION.—Nothing in this
16 section shall prevent Federal agencies represented
17 on the Council from contributing additional funding
18 from other sources to support activities to improve
19 the effectiveness of the Council.

20 **SEC. 10009. CORRECTING HURTFUL AND ALIENATING**
21 **NAMES IN GOVERNMENT EXPRESSION**
22 **(CHANGE).**

23 (a) SHORT TITLE.—This section may be cited as the
24 “Correcting Hurtful and Alienating Names in Government
25 Expression Act” or the “CHANGE Act”.

1 (b) DEFINITIONS.—In this section:

2 (1) EMPLOYEE.—The term “employee” has the
3 meaning given the term in section 2105 of title 5,
4 United States Code.

5 (2) EXECUTIVE AGENCY.—The term “Executive
6 agency” has the meaning given the term in section
7 105 of title 5, United States Code.

8 (3) OFFICER.—The term “officer” has the
9 meaning given the term in section 2104 of title 5,
10 United States Code.

11 (4) PROHIBITED TERM.—The term “prohibited
12 term” means—

13 (A) the term “alien”, when used to refer to
14 an individual who is not a citizen or national of
15 the United States; and

16 (B) the term “illegal alien”, when used to
17 refer to an individual who—

18 (i) is unlawfully present in the United
19 States; or

20 (ii) lacks a lawful immigration status
21 in the United States.

22 (c) MODERNIZATION OF LANGUAGE REFERRING TO
23 INDIVIDUALS WHO ARE NOT CITIZENS OR NATIONALS OF
24 THE UNITED STATES.—

1 (1) IN GENERAL.—Except as provided in para-
2 graph (2), on and after the date of enactment of this
3 Act, an Executive agency may not use a prohibited
4 term in any proposed or final rule, regulation, inter-
5 pretation, publication, other document, display, or
6 sign issued by the Executive agency.

7 (2) EXCEPTION.—An Executive agency may use
8 a prohibited term under paragraph (1) if the Execu-
9 tive agency uses the prohibited term while quoting
10 or reproducing text written by a source that is not
11 an officer or employee of the Executive agency.

12 (d) UNIFORM DEFINITION.—

13 (1) IN GENERAL.—Chapter 1 of title 1, United
14 States Code, is amended by adding at the end the
15 following:

16 **“§ 9. Definition of ‘foreign national’**

17 “In determining the meaning of any Act of Congress
18 or any ruling, regulation, or interpretation of an adminis-
19 trative bureau or agency of the United States, the term
20 ‘foreign national’ means any individual that is not an indi-
21 vidual who—

22 “(1) is a citizen of the United States; or

23 “(2) though not a citizen of the United States,
24 owes permanent allegiance to the United States.”.

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1 (2) TECHNICAL AMENDMENT.—The table of
2 sections for chapter 1 of title 1, United States Code,
3 is amended by adding at the end the following:

“9. Definition of ‘foreign national’.”.

4 (e) REFERENCES.—Any reference in any Federal
5 statute, rule, regulation, Executive order, publication, or
6 other document of the United States—

7 (1) to the term “alien”, when used to refer to
8 an individual who is not a citizen or national of the
9 United States, is deemed to refer to the term “for-
10 eign national”; and

11 (2) to the term “illegal alien” is deemed to
12 refer to the term “undocumented foreign national”,
13 when used to refer to an individual who—

14 (A) is unlawfully present in the United
15 States; or

16 (B) lacks a lawful immigration status in
17 the United States.

18 **SEC. 10010. ANDREW KEARSE ACCOUNTABILITY FOR DE-**
19 **NIAL OF MEDICAL CARE.**

20 (a) IN GENERAL.—Chapter 13 of title 18, United
21 States Code, is amended by adding at the end the fol-
22 lowing:

23 **“§ 250. Medical attention for individuals in Federal**
24 **custody displaying medical distress**

25 “(a) DEFINITIONS.—In this section—

1 “(1) the term ‘appropriate Inspector General’,
2 with respect to a covered official, means—

3 “(A) the Inspector General of the Federal
4 agency that employs the covered official; or

5 “(B) in the case of a covered official em-
6 ployed by a Federal agency that does not have
7 an Inspector General, the Inspector General of
8 the Department of Justice;

9 “(2) the term ‘covered official’ means—

10 “(A) a Federal law enforcement officer (as
11 defined in section 115);

12 “(B) an officer or employee of the Bureau
13 of Prisons; or

14 “(C) an officer or employee of the United
15 States Marshals Service; and

16 “(3) the term ‘medical distress’ includes breath-
17 ing difficulties.

18 “(b) REQUIREMENT.—

19 “(1) OFFENSE.—It shall be unlawful for a cov-
20 ered official to negligently fail to obtain or provide
21 immediate medical attention to an individual in Fed-
22 eral custody who displays medical distress in the
23 presence of the covered official if the individual suf-
24 fers unnecessary pain, injury, or death as a result of
25 that failure.

1 “(2) PENALTY.—A covered official who violates
2 paragraph (1) shall be fined under this title, impris-
3 oned for not more than 1 year, or both.

4 “(3) STATE CIVIL ENFORCEMENT.—Whenever
5 an attorney general of a State has reasonable cause
6 to believe that a resident of the State has been ag-
7 grieved by a violation of paragraph (1) by a covered
8 official, the attorney general, or another official,
9 agency, or entity designated by the State, may bring
10 a civil action in any appropriate district court of the
11 United States to obtain appropriate equitable and
12 declaratory relief.

13 “(c) INSPECTOR GENERAL INVESTIGATION.—

14 “(1) IN GENERAL.—The appropriate Inspector
15 General shall investigate any instance in which—

16 “(A) a covered official fails to obtain or
17 provide immediate medical attention to an indi-
18 vidual in Federal custody who displays medical
19 distress in the presence of the covered official;
20 and

21 “(B) the individual suffers unnecessary
22 pain, injury, or death as a result of the failure
23 to obtain or provide immediate medical atten-
24 tion.

1 “(2) REFERRAL FOR PROSECUTION.—If an ap-
2 propriate Inspector General, in conducting an inves-
3 tigation under paragraph (1), concludes that the
4 covered official acted negligently in failing to obtain
5 or provide immediate medical attention to the indi-
6 vidual in Federal custody, the appropriate Inspector
7 General shall refer the case to the Attorney General
8 for prosecution under this section.

9 “(3) CONFIDENTIAL COMPLAINT PROCESS.—
10 The Inspector General of a Federal agency that em-
11 ploys covered officials shall establish a process under
12 which an individual may confidentially submit a
13 complaint to the Inspector General regarding an in-
14 cident described in paragraph (1) involving a covered
15 official employed by the Federal agency (or, in the
16 case of the Inspector General of the Department of
17 Justice, involving a covered official employed by a
18 Federal agency that does not have an Inspector Gen-
19 eral).

20 “(d) TRAINING.—The head of an agency that em-
21 ploys covered officials shall provide training to each such
22 covered official on obtaining or providing medical assist-
23 ance to individuals in medical distress.”.

24 (b) TECHNICAL AND CONFORMING AMENDMENT.—
25 The table of sections for chapter 13 of title 18, United

1 States Code, is amended by adding at the end the fol-
2 lowing:

“250. Medical attention for individuals in Federal custody displaying medical
distress.”.

3 **SEC. 10011. INVESTING IN COMMUNITY HEALING.**

4 (a) FINDINGS.—Congress finds as follows:

5 (1) According to the Bureau of Justice Statis-
6 tics, African Americans are more likely to have face-
7 to-face contact with law enforcement and are 2.5
8 times more likely to experience a threat or use of
9 nonfatal force by police.

10 (2) Research shows that young men who have
11 experienced these law enforcement practices display
12 higher levels of stress, anxiety, and trauma associ-
13 ated with the interaction.

14 (3) Witnessing or experiencing invasive encoun-
15 ters with law enforcement can also be an everyday
16 stressor for racial and ethnic minorities, leading to
17 physiological and psychological strain.

18 (4) Racial and ethnic minorities face inequities
19 in accessing mental health services.

20 (5) Addressing the stigma in some communities
21 of color associated with receiving mental health serv-
22 ices and informing individuals about available treat-
23 ment can encourage better utilization of these serv-
24 ices.

1 (b) SENSE OF CONGRESS.—It is the sense of Con-
2 gress that it is imperative that a comprehensive public
3 health approach to addressing trauma and mental health
4 care be focused on care delivery that is culturally sensitive
5 and competent.

6 (c) RESEARCH ON ADVERSE HEALTH EFFECTS AS-
7 SOCIATED WITH INTERACTIONS WITH LAW ENFORCE-
8 MENT.—

9 (1) IN GENERAL.—The Secretary, acting
10 through the Director of the Office of Minority
11 Health of the Centers for Disease Control and Pre-
12 vention (established pursuant to section 1707A of
13 the Public Health Service Act (42 U.S.C. 300u-
14 6a)), shall conduct research on the adverse health
15 effects associated with interactions with law enforce-
16 ment.

17 (2) EFFECTS AMONG RACIAL AND ETHNIC MI-
18 NORITIES.—The research under paragraph (1) shall
19 include research on—

20 (A) the health consequences, both indi-
21 vidual and community-wide, of trauma related
22 to violence committed by law enforcement
23 among racial and ethnic minorities; and

1 (B) the disproportionate burden of mor-
2 bidity and mortality associated with such trau-
3 ma.

4 (3) REPORT.—Not later than 1 year after the
5 date of enactment of this Act, the Secretary shall—

6 (A) complete the research under this sub-
7 section; and

8 (B) submit to Congress a report on the
9 findings, conclusions, and recommendations re-
10 sulting from such research.

11 (d) GRANTS FOR INCREASING RACIAL AND ETHNIC
12 MINORITY ACCESS TO HIGH-QUALITY TRAUMA SUPPORT
13 SERVICES AND MENTAL HEALTH CARE.—

14 (1) IN GENERAL.—The Secretary, acting
15 through the Assistant Secretary for Mental Health
16 and Substance Use, shall award grants to eligible
17 entities to establish or expand programs for the pur-
18 pose of increasing racial and ethnic minority access
19 to high-quality trauma support services and mental
20 health care.

21 (2) ELIGIBLE ENTITIES.—To seek a grant
22 under this subsection, an entity shall be a commu-
23 nity-based program or organization that—

24 (A) provides culturally competent pro-
25 grams and resources that are aligned with evi-

1 dence-based practices for trauma-informed care;
2 and

3 (B) has demonstrated expertise in serving
4 communities of color or can partner with a pro-
5 gram that has such demonstrated expertise.

6 (3) USE OF FUNDS.—As a condition on receipt
7 of a grant under this subsection, a grantee shall
8 agree to use the grant to increase racial and ethnic
9 minority access to high-quality trauma support serv-
10 ices and mental health care, such as by—

11 (A) establishing and maintaining commu-
12 nity-based programs providing evidence-based
13 services in trauma-informed care and culturally
14 specific services and other resources;

15 (B) developing innovative culturally spe-
16 cific strategies and projects to enhance access
17 to trauma-informed care and resources for ra-
18 cial and ethnic minorities who face obstacles to
19 using more traditional services and resources
20 (such as obstacles in geographic access to pro-
21 viders, insurance coverage, and access to audio
22 and video technologies);

23 (C) working with State and local govern-
24 ments and social service agencies to develop and

1 enhance effective strategies to provide culturally
2 specific services to racial and ethnic minorities;

3 (D) increasing communities' capacity to
4 provide culturally specific resources and support
5 for communities of color;

6 (E) working in cooperation with the com-
7 munity to develop education and prevention
8 strategies highlighting culturally specific issues
9 and resources regarding racial and ethnic mi-
10 norities;

11 (F) providing culturally specific programs
12 for racial and ethnic minorities exposed to law
13 enforcement violence; and

14 (G) examining the dynamics of culture and
15 its impact on victimization and healing.

16 (4) PRIORITY.—In awarding grants under this
17 subsection, the Secretary shall give priority to eligi-
18 ble entities proposing to serve communities that have
19 faced high rates of community trauma, including
20 from exposure to law enforcement violence, intergen-
21 erational poverty, civil unrest, discrimination, or op-
22 pression.

23 (5) GRANT PERIOD.—The period of a grant
24 under this subsection shall be 4 years.

1 (6) EVALUATION.—Not later than 6 months
2 after the end of the period of all grants under this
3 subsection, the Secretary shall—

4 (A) conduct an evaluation of the programs
5 funded by a grant under this subsection;

6 (B) include in such evaluation an assess-
7 ment of the outcomes of each such program;
8 and

9 (C) submit a report on the results of such
10 evaluation to Congress.

11 (7) AUTHORIZATION OF APPROPRIATIONS.—To
12 carry out this subsection, there is authorized to be
13 appropriated \$20,000,000 for each of fiscal years
14 2023 through 2027.

15 (e) BEHAVIORAL AND MENTAL HEALTH OUTREACH
16 EDUCATION STRATEGY.—

17 (1) IN GENERAL.—The Secretary, in coordina-
18 tion with advocacy and behavioral and mental health
19 organizations serving racial and ethnic minority
20 groups, shall develop and implement an outreach
21 and education strategy to promote behavioral and
22 mental health, and reduce stigma associated with
23 mental health conditions, among racial and ethnic
24 minorities.

1 (2) DESIGN.—The strategy under this sub-
2 section shall be designed to—

3 (A) meet the diverse cultural and language
4 needs of racial and ethnic minority groups;

5 (B) provide information on evidence-based,
6 culturally and linguistically appropriate and
7 adapted interventions and treatments;

8 (C) increase awareness of symptoms of
9 mental illness among racial and ethnic minority
10 groups; and

11 (D) ensure full participation of, and en-
12 gage, both consumers and community members
13 in the development and implementation of ma-
14 terials.

15 (3) REPORT.—Not later than 1 year after the
16 date of enactment of this Act, the Secretary shall
17 submit to Congress, and make publicly available, a
18 report detailing the outreach and education strategy
19 that is developed and implemented under this sub-
20 section and the results of such implementation.

21 **SEC. 10012. ENVIRONMENTAL JUSTICE MAPPING AND DATA**
22 **COLLECTION.**

23 (a) FINDINGS.—Congress finds that—

24 (1) environmental hazards causing adverse
25 health outcomes have disproportionately affected en-

1 vironmental justice communities as a result of sys-
2 temic injustices relating to factors that include race
3 and income;

4 (2) environmental justice communities have in-
5 creased vulnerability to the adverse effects of climate
6 change and need significant investment to face cur-
7 rent and future environmental hazards;

8 (3) the Federal Government has lacked a cohe-
9 sive and consistent strategy to carry out the respon-
10 sibilities of Federal agencies described in Executive
11 Order 12898 (42 U.S.C. 4321 note; relating to Fed-
12 eral actions to address environmental justice in mi-
13 nority populations and low-income populations);

14 (4) it is necessary that the Federal Government
15 meaningfully engage environmental justice commu-
16 nities in the process of developing a robust strategy
17 to address environmental justice, including high lev-
18 els of review, input, and consent;

19 (5) there is a lack of nationwide high-quality
20 data relating to environmental justice concerns, such
21 as socioeconomic factors, air pollution, water pollu-
22 tion, soil pollution, and public health, and a failure
23 to update the existing data with adequate frequency;

24 (6) there is no nationally consistent method to
25 identify environmental justice communities based on

1 the cumulative effects of socioeconomic factors, pol-
2 lution burden, and public health;

3 (7) a method described in paragraph (6) is
4 needed to correct for racist and unjust practices
5 leading to historical and current environmental in-
6 justices through the targeted investment in environ-
7 mental justice communities of at least 40 percent of
8 the funds provided for a clean energy transition and
9 other related investments, including transportation
10 infrastructure, housing infrastructure, and water
11 quality infrastructure;

12 (8) funds targeted for environmental justice
13 communities should include set-asides for technical
14 assistance and capacity building for environmental
15 justice communities to access the funds;

16 (9) particular oversight and care are necessary
17 when investing in environmental justice communities
18 to ensure that existing issues are not exacerbated
19 and new issues are not created, particularly issues
20 relating to pollution burden and the displacement of
21 residents;

22 (10) several States, academic institutions, and
23 nonprofit organizations have engaged in cumulative
24 impact environmental justice mapping efforts that
25 can serve as references for a Federal mapping effort;

1 (11) many environmental justice communities,
2 such as communities in “Cancer Alley” in the State
3 of Louisiana, have been clearly affected by extreme
4 environmental hazards such that the communities—

5 (A) are identifiable before the establish-
6 ment of the tool under paragraph (2) of sub-
7 section (d) and the completion of the data gap
8 audit under paragraph (4) of that subsection;
9 and

10 (B) should be eligible for programs tar-
11 geted toward environmental justice communities
12 that have faced extreme environmental hazards
13 before the establishment of that tool and the
14 completion of that audit;

15 (12) in addition to investment in environmental
16 justice communities, pollution reduction is essential
17 to achieving equitable access to a healthy and clean
18 environment and an equitable energy system; and

19 (13) specific policy and permitting decisions
20 and investments may rely on different combinations
21 of data sets and indicators relating to environmental
22 justice, and race alone may be considered a criterion
23 when assessing the susceptibility of a community to
24 environmental injustice.

25 (b) DEFINITIONS.—In this section:

1 (1) ADVISORY COUNCIL.—The term “advisory
2 council” means the advisory council established
3 under subsection (c)(4)(B)(i).

4 (2) COMMITTEE.—The term “Committee”
5 means the Environmental Justice Mapping Com-
6 mittee established by subsection (c)(1).

7 (3) ENVIRONMENTAL JUSTICE.—The term “en-
8 vironmental justice” means the fair treatment and
9 meaningful involvement of all people regardless of
10 race, color, culture, national origin, or income, with
11 respect to the development, implementation, and en-
12 forcement of environmental laws, regulations, and
13 policies to ensure that each person enjoys—

14 (A) the same degree of protection from en-
15 vironmental and health hazards; and

16 (B) equal access to any Federal agency ac-
17 tion relating to the development, implementa-
18 tion, and enforcement of environmental laws,
19 regulations, and policies for the purpose of hav-
20 ing a healthy environment in which to live,
21 learn, work, and recreate.

22 (4) ENVIRONMENTAL JUSTICE COMMUNITY.—
23 The term “environmental justice community” means
24 a community with significant representation of com-
25 munities of color, low-income communities, or Tribal

1 and indigenous communities, that experiences, or is
2 at risk of experiencing, higher or more adverse
3 human health or environmental effects, as compared
4 to other communities.

5 (5) GROUND-TRUTHING.—The term “ground-
6 truthing” means a community fact-finding process
7 by which residents of a community supplement tech-
8 nical information with local knowledge for the pur-
9 pose of better informing policy and project decisions.

10 (6) RELEVANT STAKEHOLDER.—The term “rel-
11 evant stakeholder” means—

12 (A) a representative of a regional, State,
13 Tribal, or local government agency;

14 (B) a representative of a nongovernmental
15 organization with experience in areas that may
16 include Tribal relations, environmental con-
17 servation, city and regional planning, and public
18 health;

19 (C) a representative of a labor union;

20 (D) a representative or member of—

21 (i) an environmental justice commu-
22 nity; or

23 (ii) a community-based organization
24 for an environmental justice community;

1 (E) an individual with expertise in cumu-
2 lative impacts, geospatial data, and environ-
3 mental justice, particularly such an individual
4 from an academic or research institution; and

5 (F) an advocate with experience in envi-
6 ronmental justice who represents an environ-
7 mental justice community.

8 (c) ESTABLISHMENT OF COMMITTEE.—

9 (1) IN GENERAL.—There is established a com-
10 mittee, to be known as the “Environmental Justice
11 Mapping Committee”.

12 (2) MEMBERSHIP.—

13 (A) IN GENERAL.—The Committee shall be
14 composed of not fewer than 1 representative of
15 each of the following:

16 (i) Of the Environmental Protection
17 Agency—

18 (I) the Office of Air and Radi-
19 ation;

20 (II) the Office of Chemical Safety
21 and Pollution Prevention;

22 (III) the Office of International
23 and Tribal Affairs;

24 (IV) the Office of Land and
25 Emergency Management;

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1 (V) the Office of Water;

2 (VI) the Office of Environmental
3 Justice;

4 (VII) the Office of Research and
5 Development; and

6 (VIII) the Office of Public En-
7 gagement and Environmental Edu-
8 cation.

9 (ii) The Council on Environmental
10 Quality.

11 (iii) Of the Department of Com-
12 merce—

13 (I) the Office of Oceanic and At-
14 mospheric Research, including not
15 fewer than 1 representative of the Cli-
16 mate Program Office;

17 (II) the Economics and Statistics
18 Administration, including not fewer
19 than 1 representative of the Bureau
20 of Economic Analysis; and

21 (III) the National Institute of
22 Standards and Technology.

23 (iv) Of the Department of Health and
24 Human Services—

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1 (I) the Centers for Disease Con-
2 trol and Prevention, not including the
3 Agency for Toxic Substances and Dis-
4 ease Registry;

5 (II) the Agency for Toxic Sub-
6 stances and Disease Registry;

7 (III) the Administration for Chil-
8 dren and Families;

9 (IV) of the National Institutes of
10 Health—

11 (aa) the National Institute
12 of Environmental Health
13 Sciences;

14 (bb) the National Institute
15 of Mental Health; and

16 (cc) the National Institute
17 on Minority Health and Health
18 Disparities; and

19 (V) the Office for Civil Rights.

20 (v) Of the Department of the Inte-
21 rior—

22 (I) the Bureau of Indian Affairs;

23 (II) the Office of Civil Rights;

24 and

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1 (III) the United States Geologi-
2 cal Survey.

3 (vi) The Forest Service.

4 (vii) The Department of Housing and
5 Urban Development.

6 (viii) The Department of Energy.

7 (ix) The Department of Transpor-
8 tation.

9 (x) The Department of Justice.

10 (xi) The Federal Energy Regulatory
11 Commission.

12 (xii) The Department of the Treasury.

13 (xiii) Such other Federal departments,
14 agencies, and offices as the Administrator
15 determines to be appropriate, particularly
16 offices relating to public engagement.

17 (B) SELECTION OF REPRESENTATIVES.—

18 The head of a department or agency described
19 in subparagraph (A) shall, in appointing to the
20 Committee a representative of the department
21 or agency, select a representative—

22 (i) of a component of the department
23 or agency that is among the components
24 that are the most relevant to the respon-
25 sibilities of the Committee; or

1 (ii) who has expertise in areas rel-
2 evant to those responsibilities, such as de-
3 mographic indicators relating to socio-
4 economic hardship, environmental justice,
5 public engagement, public health, exposure
6 to pollution, future climate and extreme
7 weather mapping, affordable energy, sus-
8 tainable transportation, and access to
9 water, food, and green space.

10 (C) CO-CHAIRS.—

11 (i) IN GENERAL.—The members of
12 the Committee shall select 3 members to
13 serve as co-chairs of the Committee—

14 (I) 1 of whom shall be a rep-
15 resentative of the Environmental Pro-
16 tection Agency;

17 (II) 1 of whom shall be a rep-
18 resentative of the Council on Environ-
19 mental Quality; and

20 (III) 1 of whom shall have sub-
21 stantial experience in public engage-
22 ment.

23 (ii) TERMS.—Each co-chair shall
24 serve for a term of not more than 3 years.

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1 (iii) RESPONSIBILITIES OF CO-
2 CHAIRS.—The co-chairs of the Committee
3 shall—

4 (I) determine the agenda of the
5 Committee, in consultation with other
6 members of the Committee;

7 (II) direct the work of the Com-
8 mittee, including the oversight of a
9 meaningful public engagement proc-
10 ess; and

11 (III) convene meetings of the
12 Committee not less frequently than
13 once each fiscal quarter.

14 (3) ADMINISTRATIVE SUPPORT.—

15 (A) IN GENERAL.—The Administrator
16 shall provide technical and administrative sup-
17 port to the Committee.

18 (B) FUNDING.—The Administrator may
19 carry out subparagraph (A) using, in addition
20 to any amounts made available under sub-
21 section (f), amounts authorized to be appro-
22 priated to the Administrator before the date of
23 enactment of this Act and available for obliga-
24 tion as of that date of enactment.

25 (4) CONSULTATION.—

1 (A) IN GENERAL.—In carrying out the du-
2 ties of the Committee, the Committee shall con-
3 sult with relevant stakeholders.

4 (B) ADVISORY COUNCIL.—

5 (i) IN GENERAL.—The Committee
6 shall establish an advisory council com-
7 posed of a balanced proportion of relevant
8 stakeholders, at least $\frac{1}{2}$ of whom shall
9 represent environmental justice commu-
10 nities.

11 (ii) CHAIR.—The advisory council
12 shall be chaired by an environmental jus-
13 tice advocate or other relevant stakeholder
14 with substantial experience in environ-
15 mental justice.

16 (iii) REQUIREMENTS.—Consultation
17 described in subparagraph (A) shall in-
18 clude—

19 (I) early and regular engagement
20 with the advisory council, including in
21 carrying out public engagement under
22 subparagraph (C); and

23 (II) consideration of the rec-
24 ommendations of the advisory council.

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1 (iv) RECOMMENDATIONS NOT USED.—

2 If the Committee does not use a rec-
3 ommendation of the advisory council, not
4 later than 60 days after the date on which
5 the Committee receives notice of the rec-
6 ommendation, the Committee shall—

7 (I) make available to the public
8 on an internet website of the Environ-
9 mental Protection Agency a written
10 report describing the rationale of the
11 Committee for not using the rec-
12 ommendation; and

13 (II) submit the report described
14 in subclause (I) to the Committee on
15 Environment and Public Works of the
16 Senate and the Committee on Energy
17 and Commerce of the House of Rep-
18 resentatives.

19 (v) OUTREACH.—The advisory council
20 may carry out public outreach activities
21 using amounts made available under sub-
22 section (f) to supplement public engage-
23 ment carried out by the Committee under
24 subparagraph (C).

25 (C) PUBLIC ENGAGEMENT.—

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1 (i) IN GENERAL.—The Committee
2 shall, throughout the process of carrying
3 out the duties of the Committee described
4 in subsection (d)—

5 (I) meaningfully engage with rel-
6 evant stakeholders, particularly—

7 (aa) members and represent-
8 atives of environmental justice
9 communities;

10 (bb) environmental justice
11 advocates; and

12 (cc) individuals with exper-
13 tise in cumulative impacts and
14 geospatial data; and

15 (II) ensure that the input of the
16 stakeholders described in subclause (I)
17 is central to the activities of the Com-
18 mittee.

19 (ii) PLAN.—

20 (I) IN GENERAL.—In carrying
21 out clause (i), the Committee shall de-
22 velop a plan, in consultation with the
23 advisory council, for comprehensive
24 public engagement with, and incorpo-
25 ration of feedback from, environ-

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1 mental justice advocates and members
2 of environmental justice communities.

3 (II) STRATEGIES TO OVERCOME
4 BARRIERS TO PUBLIC ENGAGE-
5 MENT.—The plan developed under
6 subclause (I) shall include strategies
7 to overcome barriers to public engage-
8 ment, including—

- 9 (aa) language barriers;
10 (bb) transportation barriers;
11 (cc) economic barriers; and
12 (dd) lack of internet access.

13 (III) CONSIDERATION.—In devel-
14 oping the plan under subclause (I),
15 the Committee shall consider the di-
16 verse and varied experiences of envi-
17 ronmental justice communities relat-
18 ing to the scope and types of environ-
19 mental hazards and socioeconomic in-
20 justices.

21 (iii) CONSULTATION AND SOLICITA-
22 TION OF PUBLIC COMMENT.—

23 (I) IN GENERAL.—In carrying
24 out clause (i), not less frequently than
25 once each fiscal quarter, the Com-

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1 mittee shall consult with the advisory
2 council and solicit meaningful public
3 comment, particularly from relevant
4 stakeholders, on the activities of the
5 Committee.

6 (II) REQUIREMENTS.—The Com-
7 mittee shall carry out subclause (I)
8 through means including—

9 (aa) public notice of a meet-
10 ing of the Committee occurring
11 during the applicable fiscal quar-
12 ter, which shall include—

13 (AA) notice in publica-
14 tions relevant to environ-
15 mental justice communities;

16 (BB) notification to en-
17 vironmental justice commu-
18 nities through direct means,
19 such as community centers
20 and schools; and

21 (CC) direct outreach to
22 known environmental justice
23 groups;

24 (bb) public broadcast of that
25 meeting, including soliciting and

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1 receiving comments by virtual
2 means; and

3 (cc) public availability of a
4 transcript of that meeting
5 through publication on an acces-
6 sible website.

7 (III) LANGUAGES.—The Com-
8 mittee shall provide each notice, noti-
9 fication, direct outreach, broadcast,
10 and transcript described in subclause
11 (II) in each language commonly used
12 in the applicable environmental justice
13 community, including through oral in-
14 terpretation, if applicable.

15 (iv) FUNDING.—Of amounts made
16 available under subsection (f), the Admin-
17 istrator shall make available to the Com-
18 mittee such sums as are necessary for par-
19 ticipation by relevant stakeholders in pub-
20 lic engagement under this paragraph, as
21 determined by the Administrator, in con-
22 sultation with the advisory council.

23 (d) DUTIES OF COMMITTEE.—

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

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1 (A) establish a tool described in paragraph
2 (2) to identify environmental justice commu-
3 nities, including the identification of—

4 (i) criteria to be used in the tool; and
5 (ii) a methodology to determine the
6 cumulative impacts of those criteria;

7 (B) assess and address data gaps in ac-
8 cordance with paragraph (4); and

9 (C) collect data for the environmental jus-
10 tice data repository established under sub-
11 section (e).

12 (2) ESTABLISHMENT OF TOOL.—

13 (A) IN GENERAL.—The Committee, in con-
14 sultation with relevant stakeholders and the ad-
15 visory council, shall establish an interactive,
16 transparent, integrated, and Federal Govern-
17 ment-wide tool for assessing and mapping envi-
18 ronmental justice communities based on the cu-
19 mulative impacts of all indicators selected by
20 the Committee to be integrated into the tool.

21 (B) REQUIREMENTS.—In establishing the
22 tool under subparagraph (A), the Committee
23 shall—

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- 1 (i) integrate into the tool multiple
2 data layers of indicators that fall into cat-
3 egories including—
- 4 (I) demographics, particularly re-
5 lating to socioeconomic hardship and
6 social stressors, such as—
- 7 (aa) race and ethnicity;
8 (bb) low income;
9 (cc) high unemployment;
10 (dd) low levels of home own-
11 ership;
12 (ee) high rent burden;
13 (ff) high transportation bur-
14 den;
15 (gg) low levels of educational
16 attainment;
17 (hh) linguistic isolation;
18 (ii) energy insecurity or high
19 utility rate burden;
20 (jj) food insecurity;
21 (kk) health insurance status
22 and access to health care; and
23 (ll) membership in an Indian
24 Tribe;

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1 (II) public health, particularly
2 data that are indicative of sensitive
3 populations, such as—

4 (aa) rates of asthma;

5 (bb) rates of cardiovascular
6 disease;

7 (cc) childhood leukemia or
8 other cancers that correlate with
9 environmental hazards;

10 (dd) low birth weight;

11 (ee) maternal mortality;

12 (ff) rates of lead poisoning;

13 and

14 (gg) rates of diabetes;

15 (III) pollution burdens, such as
16 pollution burdens created by—

17 (aa) toxic chemicals;

18 (bb) air pollutants;

19 (cc) water pollutants;

20 (dd) soil contaminants; and

21 (ee) perfluoroalkyl and
22 polyfluoroalkyl substances; and

23 (IV) environmental effects, such
24 as effects created by proximity to—

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1 (aa) risk management plan
2 sites;

3 (bb) hazardous waste facili-
4 ties;

5 (cc) sites on the National
6 Priorities List developed by the
7 President in accordance with sec-
8 tion 105(a)(8)(B) of the Com-
9 prehensive Environmental Re-
10 sponse, Compensation, and Li-
11 ability Act of 1980 (42 U.S.C.
12 9605(a)(8)(B)); and

13 (dd) fossil fuel infrastruc-
14 ture;

15 (ii) investigate how further indicators
16 of vulnerability to the impacts of climate
17 change (including proximity and exposure
18 to sea level rise, wildfire smoke, flooding,
19 drought, rising average temperatures, ex-
20 treme storms, and extreme heat, and fi-
21 nancial burdens from flood and fire insur-
22 ance) should be incorporated into the tool
23 as an additional set of layers;

24 (iii) identify and consider the effects
25 of other indicators relating to environ-

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1 mental justice for integration into the tool
2 as layers, including—

3 (I) safe, sufficient, and affordable
4 drinking water, sanitation, and
5 stormwater services;

6 (II) access to and the quality
7 of—

8 (aa) green space and tree
9 canopy cover;

10 (bb) healthy food;

11 (cc) affordable energy and
12 water;

13 (dd) transportation;

14 (ee) reliable communication
15 systems, such as broadband
16 internet;

17 (ff) child care;

18 (gg) high-quality public
19 schools, early childhood edu-
20 cation, and child care; and

21 (hh) health care facilities;

22 (III) length of commute;

23 (IV) indoor air quality in multi-
24 unit dwellings;

25 (V) mental health;

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1 (VI) labor market categories,
2 particularly relating to essential work-
3 ers; and

4 (VII) each type of utility expense;

5 (iv) consider the implementation of
6 specific regional indicators, with the poten-
7 tial—

8 (I) to create regionally and lo-
9 cally downscaled maps in addition to a
10 national map;

11 (II) to provide incentives for
12 States to collect data and conduct ad-
13 ditional analyses to capture conditions
14 specific to their localities;

15 (III) to provide resources for and
16 engage in ground-truthing to identify
17 and verify important data with com-
18 munity members; and

19 (IV) to develop companion re-
20 sources for, and provide technical sup-
21 port to, regional, State, local, or Trib-
22 al governments to create their own
23 maps and environmental justice scores
24 with relevant regional, State, local,
25 and Tribal data;

1 (v) identify a methodology to account
2 for the cumulative impacts of all indicators
3 selected by the Committee under clause (i),
4 in addition to other indicators as the Com-
5 mittee determines to be necessary, to pro-
6 vide relative environmental justice scores
7 for regions that are—

8 (I) as small as practicable to
9 identify communities; and

10 (II) not larger than a census
11 tract;

12 (vi) ensure that the tool is capable of
13 providing maps of environmental justice
14 communities based on environmental jus-
15 tice scores described in clause (v);

16 (vii) ensure that users of the tool are
17 able to map available layers together or
18 independently as desired;

19 (viii) implement a method for users of
20 the tool to generate a map and environ-
21 mental justice score based on a subset of
22 indicators, particularly for the purpose of
23 using the tool in addressing various policy
24 needs, permitting processes, and invest-
25 ment goals;

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1 (ix) make the tool customizable to ad-
2 dress specific policy needs, permitting
3 processes, and investment goals;

4 (x) account for conditions that are not
5 captured by the quantitative data used to
6 develop the 1 or more maps and environ-
7 mental justice scores comprising the tool,
8 by—

9 (I) developing and executing a
10 plan to perform outreach to relevant
11 communities; and

12 (II) establishing a mechanism by
13 which communities can self-identify as
14 environmental justice communities to
15 be included in the tool, which may in-
16 clude citing qualitative data on condi-
17 tions for which quantitative data are
18 lacking, such as cultural loss in Tribal
19 communities;

20 (xi) consider that the tool—

21 (I) will be used across the Fed-
22 eral Government in screening Federal
23 policies, permitting processes, and in-
24 vestments for environmental and cli-
25 mate justice impacts; and

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1 (II) may be used to assess com-
2 munities for pollution reduction pro-
3 grams; and

4 (xii) carry out such other activities as
5 the Committee determines to be appro-
6 priate.

7 (3) TRANSPARENCY AND UPDATES.—

8 (A) IN GENERAL.—

9 (i) NOTICE AND COMMENT.—The
10 Committee shall establish the tool de-
11 scribed in paragraph (2) after providing
12 notice and an opportunity for public com-
13 ment.

14 (ii) HEARINGS.—In carrying out
15 clause (i), the Committee shall hold hear-
16 ings, which shall be time- and language-ap-
17 propriate, in communities affected by envi-
18 ronmental justice issues in geographically
19 disparate States and Tribal areas.

20 (B) UPDATES.—

21 (i) ANNUAL UPDATES.—The Com-
22 mittee shall update the tool described in
23 paragraph (2) not less frequently than an-
24 nually to account for data sets that are up-
25 dated annually.

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1 (ii) OTHER UPDATES.—Not less fre-
2 quently than once every 3 years, the Com-
3 mittee shall—

4 (I) update the indicators, meth-
5 odology, or both for the tool described
6 in paragraph (2); and

7 (II) reevaluate data submitted by
8 Federal departments and agencies
9 that is used for the tool.

10 (iii) REPORTS.—After the initial es-
11 tablishment of the tool described in para-
12 graph (2) and each update under clause (i)
13 or (ii), the Committee shall publish a re-
14 port describing—

15 (I) the process for identifying in-
16 dicators relating to environmental jus-
17 tice in the development of the tool;

18 (II) the methodology described in
19 paragraph (2)(B)(v); and

20 (III) the use of public input and
21 community engagement in that proc-
22 ess.

23 (C) TRAINING TUTORIALS AND SES-
24 SIONS.—

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1 (i) IN GENERAL.—The Committee
2 shall—

3 (I) develop virtual training tuto-
4 rials and sessions for environmental
5 justice communities for the use of the
6 tool described in paragraph (2); and

7 (II) where practicable, provide in-
8 person training sessions for environ-
9 mental justice communities for the
10 use of that tool.

11 (ii) LANGUAGES.—The tutorials and
12 sessions under clause (i) shall be made
13 available in each language commonly used
14 in the applicable environmental justice
15 community.

16 (D) PUBLIC AVAILABILITY.—

17 (i) IN GENERAL.—The Committee
18 shall make available to the public on an
19 internet website of the Environmental Pro-
20 tection Agency—

21 (I) the tool described in para-
22 graph (2);

23 (II) each update under clauses (i)
24 and (ii) of subparagraph (B);

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1 (III) each report under subpara-
2 graph (B)(iii); and

3 (IV) the training tutorials and
4 sessions developed under subpara-
5 graph (C)(i)(I).

6 (ii) ACCESSIBILITY.—The Committee
7 shall make the tool, updates, and reports
8 described in clause (i) accessible to the
9 public by publication in relevant languages
10 and with accessibility functions, as appro-
11 priate.

12 (iii) REQUIREMENT.—In carrying out
13 clause (i)(I), the Committee shall take
14 measures to prevent the tool from being
15 misused to discriminate against environ-
16 mental justice communities, such as by
17 providing safeguards against the use of
18 downscaled data that may enable the iden-
19 tification of individuals.

20 (4) DATA GAP AUDIT.—

21 (A) IN GENERAL.—In establishing the tool
22 described in paragraph (2), the Committee shall
23 direct relevant Federal departments and agen-
24 cies to conduct an audit of data collected by the
25 department or agency to identify any data that

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1 are relevant to environmental justice concerns,
2 including data relating to—

- 3 (i) public health metrics;
- 4 (ii) toxic chemicals;
- 5 (iii) socioeconomic demographics;
- 6 (iv) air quality;
- 7 (v) water quality; and
- 8 (vi) killings of individuals by law en-
9 forcement officers.

10 (B) REQUIREMENTS.—An audit described
11 in subparagraph (A) shall—

- 12 (i) examine the granularity and acces-
13 sibility of the data;
- 14 (ii) address the need for improved air
15 quality monitoring; and
- 16 (iii) include recommendations to other
17 Federal departments and agencies on
18 means to improve the quality, granularity,
19 and transparency of, and public involve-
20 ment in, data collection and dissemination.

21 (C) IMPROVEMENTS.—The Committee
22 shall direct a Federal department or agency, in
23 conducting an audit under subparagraph (A), to
24 address gaps in existing data collection that will
25 assist the Committee in establishing and oper-

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1 ating the tool described in paragraph (2), in-
2 cluding by providing to the department or agen-
3 cy—

4 (i) benchmarks to meet in addressing
5 the gaps;

6 (ii) instructions for consistency in
7 data formatting that will allow for inclu-
8 sion of data in the environmental justice
9 data repository described in subsection (e);
10 and

11 (iii) best practices for collecting data
12 in collaboration with local organizations
13 and partners, such as engaging in ground-
14 truthing.

15 (D) REPORTS.—Not later than 180 days
16 after a Federal department or agency has con-
17 ducted an audit under subparagraph (A), the
18 Committee shall—

19 (i) make available to the public on an
20 internet website of the Environmental Pro-
21 tection Agency a report describing the
22 findings and conclusions of the audit, in-
23 cluding the progress made by the Federal
24 department or agency in addressing envi-
25 ronmental justice data gaps; and

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1 (ii) submit the report described in
2 clause (i) to—

3 (I) the Committee on Environ-
4 ment and Public Works of the Senate;

5 (II) the Committee on Health,
6 Education, Labor, and Pensions of
7 the Senate;

8 (III) the Committee on Energy
9 and Commerce of the House of Rep-
10 resentatives; and

11 (IV) the Committee on Education
12 and Labor of the House of Represent-
13 atives.

14 (e) ENVIRONMENTAL JUSTICE DATA REPOSITORY.—

15 (1) IN GENERAL.—The Administrator shall es-
16 tablish an environmental justice data repository to
17 maintain—

18 (A) the data collected by the Committee
19 through the establishment of the tool described
20 in subsection (d)(2) and the audits conducted
21 under subsection (d)(4)(A); and

22 (B) any subnational data collected under
23 paragraph (3)(B).

24 (2) UPDATES.—The Administrator shall update
25 the data in the data repository described in para-

1 graph (1) as frequently as practicable, including
2 every year if practicable, but not less frequently than
3 once every 3 years.

4 (3) AVAILABILITY; INCLUSION OF SUBNATIONAL
5 DATA.—The Administrator—

6 (A) shall make the data repository de-
7 scribed in paragraph (1) available to regional,
8 State, local, and Tribal governments; and

9 (B) may collaborate with the governments
10 described in subparagraph (A) to include within
11 that data repository subnational data in exist-
12 ence before the establishment of the tool de-
13 scribed in subsection (d)(2) and the completion
14 of the audits under subsection (d)(4)(A).

15 (4) REQUIREMENT.—The Administrator shall
16 take measures to prevent the data in the data repos-
17 itory described in paragraph (1) from being misused
18 to discriminate against environmental justice com-
19 munities, such as by providing safeguards against
20 the use of downscaled data that may enable the
21 identification of individuals.

22 (f) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to the Administrator to
24 carry out this section, including any necessary administra-
25 tive costs of the Committee—

1 (1) \$20,000,000 for each of fiscal years 2023
2 and 2024; and

3 (2) \$18,000,000 for each of fiscal years 2025
4 through 2027.

5 (g) EFFECT.—Nothing in any provision of this sec-
6 tion relating to the tool described in subsection (d)(2) pro-
7 hibits a State from developing a map relating to environ-
8 mental justice or pollution burden that relies on different
9 data, or analyzes data differently, than that tool.

10 **SEC. 10013. ANTI-RACISM IN PUBLIC HEALTH.**

11 (a) FINDINGS.—Congress finds as follows:

12 (1) For centuries, structural racism, defined by
13 the National Museum of African American History
14 and Culture as an “overarching system of racial bias
15 across institutions and society”, in the United States
16 has negatively affected communities of color, espe-
17 cially Black, Latinx, Asian American, Pacific Is-
18 lander, and American Indian and Alaska Native peo-
19 ple, to expand and reinforce White supremacy.

20 (2) Structural racism determines the conditions
21 in which people are born, grow, work, live, and age
22 and determine people’s access to quality housing,
23 education, food, transportation, and political power,
24 and other social determinants of health.

1 (3) Structural racism serves as a major barrier
2 to achieving health equity and eliminating racial and
3 ethnic inequities in health outcomes that exist at
4 alarming rates and are determined by a wider set of
5 forces and systems.

6 (4) Due to structural racism in the United
7 States, people of color are more likely to suffer from
8 chronic health conditions (such as heart disease, dia-
9 betes, asthma, hepatitis, and hypertension) and in-
10 fectious diseases (such as HIV/AIDS, and COVID-
11 19) compared to their White counterparts.

12 (5) Due to structural racism in maternal health
13 care in the United States, Black and American In-
14 dian and Alaska Native infants are more than twice
15 as likely to die than White infants, Black women are
16 3 to 4 times more likely to die from pregnancy-re-
17 lated causes than White women, and American In-
18 dian and Alaska Native women are 5 times more
19 likely to die from pregnancy-related causes than
20 White women. This trend persists even when adjust-
21 ing for income and education.

22 (6) Due to structural racism in the United
23 States, Non-Hispanic Black women have the highest
24 rates for 22 of 25 severe morbidity indicators used
25 by the Center for Disease Control and Prevention.

1 (7) Due to structural racism in the United
2 States, people of color comprise a disproportionate
3 percentage of persons with disabilities in the United
4 States.

5 (8) Due to structural racism in the United
6 States, Black men are up to 3½ times as likely to
7 be killed by police as White men, and 1 in every
8 1,000 Black men will die as a result of police vio-
9 lence. Policing has adverse effects on mental health
10 in Black communities.

11 (9) Due to the confluence of structural racism
12 and factors such as gender, class, and sexual ori-
13 entation or gender identity, commonly referred to as
14 intersectionality, Black and Latinx transgender
15 women are more likely to die due to violence and
16 homicide than their White counterparts.

17 (10) Due to structural racism, inequitable ac-
18 cess to quality health care and longterm services and
19 supports also disproportionately burdens commu-
20 nities of color; people of color and immigrants are
21 less likely to be insured and are more likely to live
22 in medically underserved areas.

23 (11) Due to structural racism, older adults of
24 color are also more likely to be admitted to nursing
25 homes and assisted living facilities and to reside in

1 those of poor quality, and when older adults of color
2 do receive home and community based services, Med-
3 icaid spends less money on their services and they
4 are more likely to be hospitalized than older White
5 adults.

6 (12) In addition, the Federal Government's fail-
7 ure to honor the unique political status of American
8 Indian and Alaska Native people, to respect the in-
9 herent sovereignty of Tribal Nations, and to uphold
10 its trust and treaty obligations to Tribal Nations
11 and American Indian and Alaska Native people, is
12 an ongoing and unjust manifestation of centuries of
13 oppression, with the consequence of adverse health
14 outcomes for Native peoples.

15 (13) The COVID-19 pandemic has exposed the
16 devastating impact of structural racism on the
17 United States ability to ensure equitable health out-
18 comes for people of color, and made these commu-
19 nities more likely to suffer from severe outcomes due
20 to the coronavirus infection.

21 (14) Racial and ethnic inequity in public health
22 is a result of systematic, personally mediated, and
23 internalized racism and racist public and private
24 policies and practices, and dismantling structural
25 racism is integral to addressing public health.

1 (b) PUBLIC HEALTH RESEARCH AND INVESTMENT
2 IN DISMANTLING STRUCTURAL RACISM.—Part B of title
3 III of the Public Health Service Act (42 U.S.C. 243 et
4 seq.) is amended by adding at the end the following:

5 **“SEC. 320C. NATIONAL CENTER ON ANTIRACISM AND**
6 **HEALTH.**

7 “(a) IN GENERAL.—

8 “(1) NATIONAL CENTER.—There is established
9 within the Centers for Disease Control and Preven-
10 tion a center to be known as the ‘National Center
11 on Antiracism and Health’ (referred to in this sec-
12 tion as the ‘Center’). The Director of the Centers for
13 Disease Control and Prevention shall appoint a di-
14 rector to head the Center who has experience living
15 in and working with racial and ethnic minority com-
16 munities. The Center shall promote public health
17 by—

18 “(A) declaring racism a public health crisis
19 and naming racism as an historical and present
20 threat to the physical and mental health and
21 well-being of the United States and world;

22 “(B) aiming to develop new knowledge in
23 the science and practice of antiracism, including
24 by identifying the mechanisms by which racism

1 operates in the provision of health care and in
2 systems that impact health and well-being;

3 “(C) transferring that knowledge into
4 practice, including by developing interventions
5 that dismantle the mechanisms of racism and
6 replace such mechanisms with equitable struc-
7 tures, policies, practices, norms, and values so
8 that a healthy society can be realized; and

9 “(D) contributing to a national and global
10 conversation regarding the impacts of racism on
11 the health and well-being of the United States
12 and world.

13 “(2) GENERAL DUTIES.—The Secretary, acting
14 through the Center, shall undertake activities to
15 carry out the mission of the Center as described in
16 paragraph (1), such as the following:

17 “(A) Conduct research into, collect, ana-
18 lyze and make publicly available data on, and
19 provide leadership and coordination for the
20 science and practice of antiracism, the public
21 health impacts of structural racism, and the ef-
22 fectiveness of intervention strategies to address
23 these impacts. Topics of research and data col-
24 lection under this subparagraph may include
25 identifying and understanding—

1 “(i) policies and practices that have a
2 disparate impact on the health and well-
3 being of communities of color;

4 “(ii) the public health impacts of im-
5 plicit racial bias, White supremacy, weath-
6 ering, xenophobia, discrimination, and
7 prejudice;

8 “(iii) the social determinants of health
9 resulting from structural racism, including
10 poverty, housing, employment, political
11 participation, and environmental factors;
12 and

13 “(iv) the intersection of racism and
14 other systems of oppression, including as
15 related to age, sexual orientation, gender
16 identity, and disability status.

17 “(B) Award noncompetitive grants and co-
18 operative agreements to eligible public and non-
19 profit private entities, including State, local,
20 territorial, and Tribal health agencies and orga-
21 nizations, for the research and collection, anal-
22 ysis, and reporting of data on the topics de-
23 scribed in subparagraph (A).

24 “(C) Establish, through grants or coopera-
25 tive agreements, at least 3 regional centers of

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1 excellence, located in racial and ethnic minority
2 communities, in antiracism for the purpose of
3 developing new knowledge in the science and
4 practice of antiracism in health by researching,
5 understanding, and identifying the mechanisms
6 by which racism operates in the health space,
7 racial and ethnic inequities in health care ac-
8 cess and outcomes, the history of successful
9 antiracist movements in health, and other
10 antiracist public health work.

11 “(D) Establish a clearinghouse within the
12 Centers for Disease Control and Prevention for
13 the collection and storage of data generated
14 under the programs implemented under this
15 section for which there is not an otherwise ex-
16 isting surveillance system at the Centers for
17 Disease Control and Prevention. Such data
18 shall—

19 “(i) be comprehensive and
20 disaggregated, to the extent practicable, by
21 including racial, ethnic, primary language,
22 sex, gender identity, sexual orientation,
23 age, socioeconomic status, and disability
24 disparities;

25 “(ii) be made publicly available;

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1 “(iii) protect the privacy of individuals
2 whose information is included in such data;
3 and

4 “(iv) comply with privacy protections
5 under the regulations promulgated under
6 section 264(c) of the Health Insurance
7 Portability and Accountability Act of 1996.

8 “(E) Provide information and education to
9 the public on the public health impacts of struc-
10 tural racism and on antiracist public health
11 interventions.

12 “(F) Consult with other Centers and Na-
13 tional Institutes within the Centers for Disease
14 Control and Prevention, including the Office of
15 Minority Health and Health Equity and the
16 Center for State, Tribal, Local, and Territorial
17 Support, to ensure that scientific and pro-
18 grammatic activities initiated by the agency
19 consider structural racism in their designs,
20 conceptualizations, and executions, which shall
21 include—

22 “(i) putting measures of racism in
23 population-based surveys;

24 “(ii) establishing a Federal Advisory
25 Committee on racism and health for the

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1 Centers for Disease Control and Preven-
2 tion;

3 “(iii) developing training programs,
4 curricula, and seminars for the purposes of
5 training public health professionals and re-
6 searchers around issues of race, racism,
7 and antiracism;

8 “(iv) providing standards and best
9 practices for programming and grant re-
10 cipient compliance with Federal data col-
11 lection standards, including section 3101
12 of the Public Health Service Act; and

13 “(v) establishing leadership and stake-
14 holder councils with experts and leaders in
15 racism and public health disparities.

16 “(G) Coordinate with the Indian Health
17 Service and with the Centers for Disease Con-
18 trol and Prevention’s Tribal Advisory Com-
19 mittee to ensure meaningful Tribal consulta-
20 tion, the gathering of information from Tribal
21 authorities, and respect for Tribal data sov-
22 ereignty.

23 “(H) Engage in government to government
24 consultation with Indian Tribes and Tribal or-
25 ganizations.

1 “(I) At least every 2 years, produce and
2 publicly post on the Centers for Disease Control
3 and Prevention’s website a report on antiracist
4 activities completed by the Center, which may
5 include newly identified antiracist public health
6 practices.

7 “(b) DEFINITIONS.—In this section:

8 “(1) ANTIRACISM.—The term ‘antiracism’ is a
9 collection of antiracist policies that lead to racial eq-
10 uity, and are substantiated by antiracist ideas.

11 “(2) ANTIRACIST.—The term ‘antiracist’ is any
12 measure that produces or sustains racial equity be-
13 tween racial groups.

14 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
15 is authorized to be appropriated such sums as may be nec-
16 essary to carry out this section.”.

17 (c) PUBLIC HEALTH RESEARCH AND INVESTMENT
18 IN POLICE VIOLENCE.—

19 (1) IN GENERAL.—The Secretary shall establish
20 within the National Center for Injury Prevention
21 and Control of the Centers for Disease Control and
22 Prevention (referred to in this subsection as the
23 “Center”) a law enforcement violence prevention
24 program.

1 (2) GENERAL DUTIES.—In implementing the
2 program under paragraph (1), the Center shall con-
3 duct research into, and provide leadership and co-
4 ordination for—

5 (A) the understanding and promotion of
6 knowledge about the public health impacts of
7 uses of force by law enforcement, including po-
8 lice brutality and violence;

9 (B) developing public health interventions
10 and perspectives for eliminating deaths, injury,
11 trauma, and negative mental health effects
12 from police presence and interactions, including
13 police brutality and violence; and

14 (C) ensuring comprehensive data collection,
15 analysis, and reporting regarding police violence
16 and misconduct, in consultation with the De-
17 partment of Justice and independent research-
18 ers.

19 (3) FUNCTIONS.—Under the program under
20 paragraph (1), the Center shall—

21 (A) summarize and enhance the knowledge
22 of the distribution, status, and characteristics
23 of law enforcement-related death, trauma, and
24 injury;

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1 (B) conduct research and prepare, with the
2 assistance of State public health departments—

3 (i) statistics on law enforcement-re-
4 lated death, injury, and brutality;

5 (ii) studies of the factors, including
6 legal, socioeconomic, discrimination, and
7 other factors that correlate with or influ-
8 ence police brutality;

9 (iii) public information about uses of
10 force by law enforcement, including police
11 brutality and violence, for the practical use
12 of the public health community, including
13 publications that synthesize information
14 relevant to the national goal of under-
15 standing police violence and methods for
16 its control;

17 (iv) information to identify socio-
18 economic groups, communities, and geo-
19 graphic areas in need of study, and a stra-
20 tegic plan for research necessary to com-
21 prehend the extent and nature of police
22 uses of force by law enforcement, including
23 police brutality and violence, and deter-
24 mine what options exist to reduce or eradi-
25 cate death and injury that result; and

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1 (v) best practices in police violence
2 prevention in other countries;

3 (C) award grants, contracts, and coopera-
4 tive agreements to provide for the conduct of
5 epidemiologic research on uses of force by law
6 enforcement, including police brutality and vio-
7 lence, by Federal, State, local, and private
8 agencies, institutions, organizations, and indi-
9 viduals;

10 (D) award grants, contracts, and coopera-
11 tive agreements to community groups, inde-
12 pendent research organizations, academic insti-
13 tutions, and other entities to support, execute,
14 or conduct research on interventions to reduce
15 or eliminate uses of force by law enforcement,
16 including police brutality and violence;

17 (E) coordinate with the Department of
18 Justice, and other Federal, State, and local
19 agencies on the standardization of data collec-
20 tion, storage, and retrieval necessary to collect,
21 evaluate, analyze, and disseminate information
22 about the extent and nature of uses of force by
23 law enforcement, including police brutality and
24 violence, as well as options for the eradication
25 of such practices;

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1 (F) submit an annual report to Congress
2 on research findings with recommendations to
3 improve data collection and standardization and
4 to disrupt processes in policing that preserve
5 and reinforce racism and racial disparities in
6 public health;

7 (G) conduct primary research and explore
8 uses of force by law enforcement, including po-
9 lice brutality and violence, and options for its
10 control; and

11 (H) study alternatives to law enforcement
12 response as a method of reducing police vio-
13 lence.

14 (4) AUTHORIZATION OF APPROPRIATIONS.—

15 There is authorized to be appropriated, such sums
16 as may be necessary to carry out this subsection.

17 **SEC. 10014. LGBTQ ESSENTIAL DATA.**

18 (a) IMPROVING DATA COLLECTION ON THE SEXUAL
19 ORIENTATION AND GENDER IDENTITY OF DECEASED IN-
20 DIVIDUALS THROUGH THE NATIONAL VIOLENT DEATH
21 REPORTING SYSTEM.—

22 (1) COLLECTION OF SEXUAL ORIENTATION AND
23 GENDER IDENTITY DATA.—

24 (A) IN GENERAL.—Not later than 120
25 days after the date of enactment of this Act,

1 the Director of the Centers for Disease Control
2 and Prevention shall take measures to improve
3 the incidence of the collection of information on
4 the sexual orientation and gender identity of de-
5 ceased individuals through the National Violent
6 Death Reporting System or any successor pro-
7 grams.

8 (B) CONFIDENTIALITY.—Any information
9 collected relating to the sexual orientation or
10 gender identity of a decedent shall be main-
11 tained in accordance with the confidentiality
12 and privacy standards and policies for the pro-
13 tection of individuals applicable to all other
14 data collected for purposes of the National Vio-
15 lent Death Reporting System.

16 (2) DEFINITIONS.—In this subsection:

17 (A) GENDER IDENTITY.—The term “gen-
18 der identity” means an individual’s sense of
19 being male, female, transgender, or another
20 gender, as distinct from the individual’s sex as-
21 signed at birth.

22 (B) SEXUAL ORIENTATION.—The term
23 “sexual orientation” means how a person iden-
24 tifies in terms of their emotional, romantic, or
25 sexual attractions, and includes identification as

1 straight, heterosexual, gay, lesbian, or bisexual,
2 among other terms.

3 (3) AUTHORIZATION.—There is authorized to
4 be appropriated \$25,000,000 for fiscal year 2023 to
5 carry out this subsection.

6 (b) SENSE OF CONGRESS.—It is the sense of Con-
7 gress that—

8 (1) the Centers for Disease Control and Preven-
9 tion has made significant efforts to encourage States
10 and other jurisdictions to collect data on sexual ori-
11 entation and gender identity through the National
12 Violent Death Reporting System; and

13 (2) jurisdictions that participate in the collec-
14 tion of such data through the National Violent
15 Death Reporting System should be commended for
16 their participation.

17 **SEC. 10015. SOCIAL DETERMINANTS ACCELERATOR.**

18 (a) FINDINGS; PURPOSES.—

19 (1) FINDINGS.—Congress finds as follows:

20 (A) There is a significant body of evidence
21 showing that economic and social conditions
22 have a powerful impact on individual and popu-
23 lation health outcomes and well-being, as well
24 as medical costs.

1 (B) State, local, and Tribal governments
2 and the service delivery partners of such gov-
3 ernments face significant challenges in coordi-
4 nating benefits and services delivered through
5 the Medicaid program and other social services
6 programs because of the fragmented and com-
7 plex nature of Federal and State funding and
8 administrative requirements.

9 (C) The Federal Government should
10 prioritize and proactively assist State and local
11 governments to strengthen the capacity of State
12 and local governments to improve health and
13 social outcomes for individuals, thereby improv-
14 ing cost-effectiveness and return on investment.

15 (2) PURPOSES.—The purposes of this section
16 are as follows:

17 (A) To establish effective, coordinated Fed-
18 eral technical assistance to help State and local
19 governments to improve outcomes and cost-ef-
20 fectiveness of, and return on investment from,
21 health and social services programs.

22 (B) To build a pipeline of State and locally
23 designed, cross-sector interventions and strate-
24 gies that generate rigorous evidence about how
25 to improve health and social outcomes, and in-

1 crease the cost-effectiveness of, and return on
2 investment from, Federal, State, local, and
3 Tribal health and social services programs.

4 (C) To enlist State and local governments
5 and the service providers of such governments
6 as partners in identifying Federal statutory,
7 regulatory, and administrative challenges in im-
8 proving the health and social outcomes of, cost-
9 effectiveness of, and return on investment from,
10 Federal spending on individuals enrolled in
11 Medicaid.

12 (D) To develop strategies to improve
13 health and social outcomes without denying
14 services to, or restricting the eligibility of, vul-
15 nerable populations.

16 (b) SOCIAL DETERMINANTS ACCELERATOR COUN-
17 CIL.—

18 (1) ESTABLISHMENT.—The Secretary of Health
19 and Human Services (referred to in this section as
20 the “Secretary”), in coordination with the Adminis-
21 trator of the Centers for Medicare & Medicaid Serv-
22 ices (referred to in this section as the “Adminis-
23 trator”), shall establish an interagency council, to be
24 known as the Social Determinants Accelerator Inter-
25 agency Council (referred to in this section as the

1 “Council”) to achieve the purposes listed in sub-
2 section (a)(2).

3 (2) MEMBERSHIP.—

4 (A) FEDERAL COMPOSITION.—The Council
5 shall be composed of at least one designee from
6 each of the following Federal agencies:

7 (i) The Office of Management and
8 Budget.

9 (ii) The Department of Agriculture.

10 (iii) The Department of Education.

11 (iv) The Indian Health Service.

12 (v) The Department of Housing and
13 Urban Development.

14 (vi) The Department of Labor.

15 (vii) The Department of Transpor-
16 tation.

17 (viii) Any other Federal agency the
18 Chair of the Council determines necessary.

19 (B) DESIGNATION.—

20 (i) IN GENERAL.—The head of each
21 agency specified in subparagraph (A) shall
22 designate at least one employee described
23 in clause (ii) to serve as a member of the
24 Council.

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1 (ii) RESPONSIBILITIES.—An employee
2 described in this subparagraph shall be a
3 senior employee of the agency—

4 (I) whose responsibilities relate
5 to authorities, policies, and procedures
6 with respect to the health and well-
7 being of individuals receiving medical
8 assistance under a State plan (or a
9 waiver of such plan) under title XIX
10 of the Social Security Act (42 U.S.C.
11 1396 et seq.); or

12 (II) who has authority to imple-
13 ment and evaluate transformative ini-
14 tiatives that harness data or conducts
15 rigorous evaluation to improve the im-
16 pact and cost-effectiveness of federally
17 funded services and benefits.

18 (C) HHS REPRESENTATION.—In addition
19 to the designees under subparagraph (A), the
20 Council shall include designees from at least
21 three agencies within the Department of Health
22 and Human Services, including the Centers for
23 Medicare & Medicaid Services, at least one of
24 whom shall meet the criteria under subpara-
25 graph (B)(ii).

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1 (D) OMB ROLE.—The Director of the Of-
2 fice of Management and Budget shall facilitate
3 the timely resolution of Governmentwide and
4 multiagency issues to help the Council achieve
5 consensus recommendations described under
6 paragraph (3)(A).

7 (E) NON-FEDERAL COMPOSITION.—The
8 Comptroller General of the United States may
9 designate up to 6 Council designees—

10 (i) who have relevant subject matter
11 expertise, including expertise implementing
12 and evaluating transformative initiatives
13 that harness data and conduct evaluations
14 to improve the impact and cost-effective-
15 ness of Federal Government services; and

16 (ii) that each represent—

17 (I) State, local, and Tribal health
18 and human services agencies;

19 (II) public housing authorities or
20 State housing finance agencies;

21 (III) State and local government
22 budget offices;

23 (IV) State Medicaid agencies; or

24 (V) national consumer advocacy
25 organizations.

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1 (F) CHAIR.—

2 (i) IN GENERAL.—The Secretary shall
3 select the Chair of the Council from among
4 the members of the Council.

5 (ii) INITIATING GUIDANCE.—The
6 Chair, on behalf of the Council, shall iden-
7 tify and invite individuals from diverse en-
8 tities to provide the Council with advice
9 and information pertaining to addressing
10 social determinants of health, including—

11 (I) individuals from State and
12 local government health and human
13 services agencies;

14 (II) individuals from State Med-
15 icaid agencies;

16 (III) individuals from State and
17 local government budget offices;

18 (IV) individuals from public
19 housing authorities or State housing
20 finance agencies;

21 (V) individuals from nonprofit or-
22 ganizations, small businesses, and
23 philanthropic organizations;

24 (VI) advocates;

25 (VII) researchers; and

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1 (VIII) any other individuals the
2 Chair determines to be appropriate.

3 (3) DUTIES.—The duties of the Council are—

4 (A) to make recommendations to the Sec-
5 retary and the Administrator regarding the cri-
6 teria for making awards under subsection (c);

7 (B) to identify Federal authorities and op-
8 portunities for use by States or local govern-
9 ments to improve coordination of funding and
10 administration of Federal programs, the bene-
11 ficiaries of whom include individuals described
12 in subsection (a), and which may be unknown
13 or underutilized and to make information on
14 such authorities and opportunities publicly
15 available;

16 (C) to provide targeted technical assistance
17 to States developing a social determinants ac-
18 celerator plan under subsection (c), including
19 identifying potential statutory or regulatory
20 pathways for implementation of the plan and
21 assisting in identifying potential sources of
22 funding to implement the plan;

23 (D) to report to Congress annually on the
24 subjects set forth in paragraph (4);

1 (E) to develop and disseminate evaluation
2 guidelines and standards that can be used to
3 reliably assess the impact of an intervention or
4 approach that may be implemented pursuant to
5 this section on outcomes, cost-effectiveness of,
6 and return on investment from Federal, State,
7 local, and Tribal governments, and to facilitate
8 technical assistance, where needed, to help to
9 improve State and local evaluation designs and
10 implementation;

11 (F) to seek feedback from State, local, and
12 Tribal governments, including through an an-
13 nual survey by an independent third party, on
14 how to improve the technical assistance the
15 Council provides to better equip State, local,
16 and Tribal governments to coordinate health
17 and social service programs;

18 (G) to solicit applications for grants under
19 subsection (c); and

20 (H) to coordinate with other cross-agency
21 initiatives focused on improving the health and
22 well-being of low-income and at-risk populations
23 in order to prevent unnecessary duplication be-
24 tween agency initiatives.

1 (4) SCHEDULE.—Not later than 60 days after
2 the date of enactment of this Act, the Council shall
3 convene to develop a schedule and plan for carrying
4 out the duties described in paragraph (3), including
5 solicitation of applications for the grants under sub-
6 section (c).

7 (5) REPORT TO CONGRESS.—The Council shall
8 submit an annual report to Congress, which shall in-
9 clude—

10 (A) a list of the Council members;

11 (B) activities and expenditures of the
12 Council;

13 (C) summaries of the interventions and ap-
14 proaches that will be supported by State, local,
15 and Tribal governments that received a grant
16 under subsection (c), including—

17 (i) the best practices and evidence-
18 based approaches such governments plan
19 to employ to achieve the purposes listed in
20 subsection (a)(2); and

21 (ii) a description of how the practices
22 and approaches will impact the outcomes,
23 cost-effectiveness of, and return on invest-
24 ment from, Federal, State, local, and Trib-

1 al governments with respect to such pur-
2 poses;

3 (D) the feedback received from State and
4 local governments on ways to improve the tech-
5 nical assistance of the Council, including find-
6 ings from a third-party survey and actions the
7 Council plans to take in response to such feed-
8 back; and

9 (E) the major statutory, regulatory, and
10 administrative challenges identified by State,
11 local, and Tribal governments that received a
12 grant under subsection (c), and the actions that
13 Federal agencies are taking to address such
14 challenges.

15 (6) FACA APPLICABILITY.—The Federal Advi-
16 sory Committee Act (5 U.S.C. App.) shall not apply
17 to the Council.

18 (7) COUNCIL PROCEDURES.—The Secretary, in
19 consultation with the Comptroller General of the
20 United States and the Director of the Office of Man-
21 agement and Budget, shall establish procedures for
22 the Council to—

23 (A) ensure that adequate resources are
24 available to effectively execute the responsibil-
25 ities of the Council;

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1 (B) effectively coordinate with other rel-
2 evant advisory bodies and working groups to
3 avoid unnecessary duplication;

4 (C) create transparency to the public and
5 Congress with regard to Council membership,
6 costs, and activities, including through use of
7 modern technology and social media to dissemi-
8 nate information; and

9 (D) avoid conflicts of interest that would
10 jeopardize the ability of the Council to make de-
11 cisions and provide recommendations.

12 (c) SOCIAL DETERMINANTS ACCELERATOR GRANTS
13 TO STATES OR LOCAL GOVERNMENTS.—

14 (1) GRANTS TO STATES, LOCAL GOVERNMENTS,
15 AND TRIBES.—Not later than 180 days after the
16 date of enactment of this Act, the Administrator, in
17 consultation with the Secretary and the Council,
18 shall award on a competitive basis not more than 25
19 grants to eligible applicants described in paragraph
20 (2), for the development of social determinants ac-
21 celerator plans, as described in paragraph (6).

22 (2) ELIGIBLE APPLICANT.—An eligible appli-
23 cant described in this subsection is a State, local, or
24 Tribal health or human services agency that—

1 (A) demonstrates the support of relevant
2 parties across relevant State, local, or Tribal ju-
3 risdictions; and

4 (B) in the case of an applicant that is a
5 local government agency, provides to the Sec-
6 retary a letter of support from the lead State
7 health or human services agency for the State
8 in which the local government is located.

9 (3) AMOUNT OF GRANT.—The Administrator,
10 in coordination with the Council, shall determine the
11 total amount that the Administrator will make avail-
12 able to each grantee under this subsection.

13 (4) APPLICATION.—An eligible applicant seek-
14 ing a grant under this subsection shall include in the
15 application the following information:

16 (A) The target population (or populations)
17 that would benefit from implementation of the
18 social determinants accelerator plan proposed to
19 be developed by the applicant.

20 (B) A description of the objective or objec-
21 tives and outcome goals of such proposed plan,
22 which shall include at least one health outcome
23 and at least one other important social out-
24 come.

1 (C) The sources and scope of inefficiencies
2 that, if addressed by the plan, could result in
3 improved cost-effectiveness of or return on in-
4 vestment from Federal, State, local, and Tribal
5 governments.

6 (D) A description of potential interventions
7 that could be designed or enabled using such
8 proposed plan.

9 (E) The State, local, Tribal, academic,
10 nonprofit, community-based organizations, and
11 other private sector partners that would partici-
12 pate in the development of the proposed plan
13 and subsequent implementation of programs or
14 initiatives included in such proposed plan.

15 (F) Such other information as the Admin-
16 istrator, in consultation with the Secretary and
17 the Council, determines necessary to achieve the
18 purposes of this section.

19 (5) USE OF FUNDS.—A recipient of a grant
20 under this subsection may use funds received
21 through the grant for the following purposes:

22 (A) To convene and coordinate with rel-
23 evant government entities and other stake-
24 holders across sectors to assist in the develop-
25 ment of a social determinant accelerator plan.

1 (B) To identify populations of individuals
2 receiving medical assistance under a State plan
3 (or a waiver of such plan) under title XIX of
4 the Social Security Act (42 U.S.C. 1396 et
5 seq.) who may benefit from the proposed ap-
6 proaches to improving the health and well-being
7 of such individuals through the implementation
8 of the proposed social determinants accelerator
9 plan.

10 (C) To engage qualified research experts to
11 advise on relevant research and to design a pro-
12 posed evaluation plan, in accordance with the
13 standards and guidelines issued by the Admin-
14 istrator.

15 (D) To collaborate with the Council to sup-
16 port the development of social determinants ac-
17 celerator plans.

18 (E) To prepare and submit a final social
19 determinants accelerator plan to the Council.

20 (6) CONTENTS OF PLANS.—A social deter-
21 minant accelerator plan developed under this sub-
22 section shall include the following:

23 (A) A description of the target population
24 (or populations) that would benefit from imple-
25 mentation of the social determinants accelerator

1 plan, including an analysis describing the pro-
2 jected impact on the well-being of individuals
3 described in paragraph (5)(B).

4 (B) A description of the interventions or
5 approaches designed under the social deter-
6 minants accelerator plan and the evidence for
7 selecting such interventions or approaches.

8 (C) The objectives and outcome goals of
9 such interventions or approaches, including at
10 least one health outcome and at least one other
11 important social outcome.

12 (D) A plan for accessing and linking rel-
13 evant data to enable coordinated benefits and
14 services for the jurisdictions described in para-
15 graph (2)(A) and an evaluation of the proposed
16 interventions and approaches.

17 (E) A description of the State, local, Trib-
18 al, academic, nonprofit, or community-based or-
19 ganizations, or any other private sector organi-
20 zations that would participate in implementing
21 the proposed interventions or approaches, and
22 the role each would play to contribute to the
23 success of the proposed interventions or ap-
24 proaches.

1 (F) The identification of the funding
2 sources that would be used to finance the pro-
3 posed interventions or approaches.

4 (G) A description of any financial incen-
5 tives that may be provided, including outcome-
6 focused contracting approaches to encourage
7 service providers and other partners to improve
8 outcomes of, cost-effectiveness of, and return on
9 investment from, Federal, State, local, or Tribal
10 government spending.

11 (H) The identification of the applicable
12 Federal, State, local, or Tribal statutory and
13 regulatory authorities, including waiver authori-
14 ties, to be leveraged to implement the proposed
15 interventions or approaches.

16 (I) A description of potential consider-
17 ations that would enhance the impact,
18 scalability, or sustainability of the proposed
19 interventions or approaches and the actions the
20 grant awardee would take to address such con-
21 siderations.

22 (J) A proposed evaluation plan, to be car-
23 ried out by an independent evaluator, to meas-
24 ure the impact of the proposed interventions or
25 approaches on the outcomes of, cost-effective-

1 ness of, and return on investment from, Fed-
2 eral, State, local, and Tribal governments.

3 (K) Precautions for ensuring that vulner-
4 able populations will not be denied access to
5 Medicaid or other essential services as a result
6 of implementing the proposed plan.

7 (d) FUNDING.—

8 (1) IN GENERAL.—Out of any money in the
9 Treasury not otherwise appropriated, there is appro-
10 priated to carry out this section \$25,000,000, of
11 which up to \$5,000,000 may be used to carry out
12 this section, to remain available for obligation until
13 the date that is 5 years after the date of enactment
14 of this Act.

15 (2) RESERVATION OF FUNDS.—

16 (A) IN GENERAL.—Of the funds made
17 available under paragraph (1), the Secretary
18 shall reserve not less than 20 percent to award
19 grants to eligible applicants for the development
20 of social determinants accelerator plans under
21 subsection (c) intended to serve rural popu-
22 lations.

23 (B) EXCEPTION.—In the case of a fiscal
24 year for which the Secretary determines that
25 there are not sufficient eligible applicants to

1 award up to 25 grants under subsection (c)
2 that are intended to serve rural populations and
3 the Secretary cannot satisfy the 20-percent re-
4 quirement, the Secretary may reserve an
5 amount that is less than 20 percent of amounts
6 made available under paragraph (1) to award
7 grants for such purpose.

8 (3) RULE OF CONSTRUCTION.—Nothing in this
9 section shall prevent Federal agencies represented
10 on the Council from contributing additional funding
11 from other sources to support activities to improve
12 the effectiveness of the Council.

13 **SEC. 10016. IMPROVING SOCIAL DETERMINANTS OF**
14 **HEALTH.**

15 (a) FINDINGS.—Congress finds as follows:

16 (1) Healthy People 2030 defines social deter-
17 minants of health as conditions in the environments
18 where people are born, live, learn, work, play, wor-
19 ship, and age that affect a wide range of health,
20 functioning, and quality-of-life outcomes and risks.

21 (2) One of the overarching goals of Healthy
22 People 2030 is to “create social, physical, and eco-
23 nomic environments that promote attaining the full
24 potential for health and well-being for all”.

1 (3) Healthy People 2030 developed a “place-
2 based” organizing framework, reflecting five key
3 areas of social determinants of health namely—

- 4 (A) economic stability;
5 (B) education access and quality;
6 (C) social and community context;
7 (D) health care access and quality; and
8 (E) neighborhood and built environment.

9 (4) It is estimated that medical care accounts
10 for only 10 to 20 percent of the modifiable contribu-
11 tors to healthy outcomes for a population.

12 (5) The Centers for Medicare & Medicaid Serv-
13 ices has indicated the importance of the social deter-
14 minants in its work stating that, “As we seek to fos-
15 ter innovation, rethink rural health, find solutions to
16 the opioid epidemic, and continue to put patients
17 first, we need to take into account social deter-
18 minants of health and recognize their importance.”.

19 (6) The Department of Health and Human
20 Services’ Public Health 3.0 initiative recognizes the
21 role of public health in working across sectors on so-
22 cial determinants of health, as well as the role of
23 public health as chief health strategist in commu-
24 nities.

1 (7) Through its Health Impact in 5 Years ini-
2 tiative, the Centers for Disease Control and Preven-
3 tion has highlighted nonclinical, community-wide ap-
4 proaches that show positive health impacts, results
5 within 5 years, and cost-effectiveness or cost-savings
6 over the lifetime of the population or earlier.

7 (8) Health departments and the Centers for
8 Disease Control and Prevention are not funded for
9 such cross-cutting work.

10 (b) SOCIAL DETERMINANTS OF HEALTH PRO-
11 GRAM.—

12 (1) PROGRAM.—To the extent and in the
13 amounts made available in advance in appropriations
14 Acts, the Director of the Centers for Disease Control
15 and Prevention (in this section referred to as the
16 “Director”) shall carry out a program, to be known
17 as the Social Determinants of Health Program (in
18 this section referred to as the “Program”), to
19 achieve the following goals:

20 (A) Improve health outcomes and reduce
21 health inequities by coordinating social deter-
22 minants of health activities across the Centers
23 for Disease Control and Prevention.

24 (B) Improve the capacity of public health
25 agencies and community organizations to ad-

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1 dress social determinants of health in commu-
2 nities.

3 (2) ACTIVITIES.—To achieve the goals listed in
4 paragraph (1), the Director shall carry out activities
5 including the following:

6 (A) Coordinating across the Centers for
7 Disease Control and Prevention to ensure that
8 relevant programs consider and incorporate so-
9 cial determinants of health in grant awards and
10 other activities.

11 (B) Awarding grants under subsection (c)
12 to State, local, territorial, and Tribal health
13 agencies and organizations, and to other eligible
14 entities, to address social determinants of
15 health in target communities.

16 (C) Awarding grants under subsection (d)
17 to nonprofit organizations and public or other
18 nonprofit institutions of higher education—

19 (i) to conduct research on best prac-
20 tices to improve social determinants of
21 health;

22 (ii) to provide technical assistance,
23 training, and evaluation assistance to
24 grantees under subsection (c); and

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1 (iii) to disseminate best practices to
2 grantees under subsection (c).

3 (D) Coordinating, supporting, and aligning
4 activities of the Centers for Disease Control and
5 Prevention related to social determinants of
6 health with activities of other Federal agencies
7 related to social determinants of health, includ-
8 ing such activities of agencies in the Depart-
9 ment of Health and Human Services such as
10 the Centers for Medicare & Medicaid Services.

11 (E) Collecting and analyzing data related
12 to the social determinants of health.

13 (c) GRANTS TO ADDRESS SOCIAL DETERMINANTS OF
14 HEALTH.—

15 (1) IN GENERAL.—The Director, as part of the
16 Program, shall award grants to eligible entities to
17 address social determinants of health in their com-
18 munities.

19 (2) ELIGIBILITY.—To be eligible to apply for a
20 grant under this subsection, an entity shall be—

21 (A) a State, local, territorial, or Tribal
22 health agency or organization;

23 (B) a qualified nongovernmental entity, as
24 defined by the Director; or

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1 (C) a consortium of entities that includes
2 a State, local, territorial, or Tribal health agen-
3 cy or organization.

4 (3) USE OF FUNDS.—

5 (A) IN GENERAL.—A grant under this sub-
6 section shall be used to address social deter-
7 minants of health in a target community by de-
8 signing and implementing innovative, evidence-
9 based, cross-sector strategies.

10 (B) TARGET COMMUNITY.—For purposes
11 of this subsection, a target community shall be
12 a State, county, city, or other municipality.

13 (4) PRIORITY.—In awarding grants under this
14 subsection, the Director shall prioritize applicants
15 proposing to serve target communities with signifi-
16 cant unmet health and social needs, as defined by
17 the Director.

18 (5) APPLICATION.—To seek a grant under this
19 subsection, an eligible entity shall—

20 (A) submit an application at such time, in
21 such manner, and containing such information
22 as the Director may require;

23 (B) propose a set of activities to address
24 social determinants of health through evidence-

1 based, cross-sector strategies, which activities
2 may include—

3 (i) collecting quantifiable data from
4 health care, social services, and other enti-
5 ties regarding the most significant gaps in
6 health-promoting social, economic, and en-
7 vironmental needs;

8 (ii) identifying evidence-based ap-
9 proaches to meeting the nonmedical, social
10 needs of populations identified by data col-
11 lection described in clause (i), such as un-
12 stable housing or food insecurity;

13 (iii) developing scalable methods to
14 meet patients' social needs identified in
15 clinical settings or other sites;

16 (iv) convening entities such as local
17 and State governmental and nongovern-
18 mental organizations, health systems,
19 payors, and community-based organiza-
20 tions to review, plan, and implement com-
21 munity-wide interventions and strategies to
22 advance health-promoting social conditions;

23 (v) monitoring and evaluating the im-
24 pact of activities funded through the grant
25 on the health and well-being of the resi-

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1 dents of the target community and on the
2 cost of health care; and

3 (vi) such other activities as may be
4 specified by the Director;

5 (C) demonstrate how the eligible entity will
6 collaborate with—

7 (i) health systems;

8 (ii) payors, including, as appropriate,
9 medicaid managed care organizations (as
10 defined in section 1903(m)(1)(A) of the
11 Social Security Act (42 U.S.C.
12 1396b(m)(1)(A))), Medicare Advantage
13 plans under part C of title XVIII of such
14 Act (42 U.S.C. 1395w–21 et seq.), and
15 health insurance issuers and group health
16 plans (as such terms are defined in section
17 2791 of the Public Health Service Act (42
18 U.S.C. 300gg–91));

19 (iii) other relevant stakeholders and
20 initiatives in areas of need, such as the Ac-
21 countable Health Communities Model of
22 the Centers for Medicare & Medicaid Serv-
23 ices, health homes under the Medicaid pro-
24 gram under title XIX of the Social Secu-
25 rity Act (42 U.S.C. 1396 et seq.), commu-

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1 nity-based organizations, and human serv-
2 ices organizations;

3 (iv) other non-health care sector orga-
4 nizations, including organizations focusing
5 on transportation, housing, or food access;
6 and

7 (v) local employers; and

8 (D) identify key health inequities in the
9 target community and demonstrate how the
10 proposed efforts of the eligible entity would ad-
11 dress such inequities.

12 (6) MONITORING AND EVALUATION.—As a con-
13 dition of receipt of a grant under this subsection, a
14 grantee shall agree to submit an annual report to
15 the Director describing the activities carried out
16 through the grant and the outcomes of such activi-
17 ties.

18 (7) INDEPENDENT NATIONAL EVALUATION.—

19 (A) IN GENERAL.—Not later than 5 years
20 after the first grants are awarded under this
21 subsection, the Director shall provide for the
22 commencement of an independent national eval-
23 uation of the program under this subsection.

24 (B) REPORT TO CONGRESS.—Not later
25 than 60 days after receiving the results of such

1 independent national evaluation, the Director
2 shall report such results to Congress.

3 (d) RESEARCH AND TRAINING.—The Director, as
4 part of the Program—

5 (1) shall award grants to nonprofit organiza-
6 tions and public or other nonprofit institutions of
7 higher education—

8 (A) to conduct research on best practices
9 to improve social determinants of health;

10 (B) to provide technical assistance, train-
11 ing, and evaluation assistance to grantees under
12 subsection (c); and

13 (C) to disseminate best practices to grant-
14 ees under subsection (c); and

15 (2) may require a grantee under paragraph (1)
16 to provide technical assistance and capacity building
17 to entities that are eligible entities under subsection
18 (c) but not receiving funds through such section.

19 (e) FUNDING.—

20 (1) IN GENERAL.—There is authorized to be
21 appropriated to carry out this section, \$50,000,000
22 for each of fiscal years 2023 through 2028.

23 (2) ALLOCATION.—Of the amount made avail-
24 able to carry out this section for a fiscal year, not

1 less than 75 percent shall be used for grants under
2 subsections (c) and (d).

3 **Subtitle B—Gun Violence**

4 **SEC. 10101. REAFFIRMING RESEARCH AUTHORITY OF THE**
5 **CENTERS FOR DISEASE CONTROL AND PRE-**
6 **VENTION.**

7 (a) IN GENERAL.—Section 391 of the Public Health
8 Service Act (42 U.S.C. 280b) is amended—

9 (1) in subsection (a)(1), by striking “research
10 relating to the causes, mechanisms, prevention, diag-
11 nosis, treatment of injuries, and rehabilitation from
12 injuries;” and inserting the following: “research, in-
13 cluding data collection, relating to—

14 “(A) the causes, mechanisms, prevention,
15 diagnosis, and treatment of injuries, including
16 with respect to gun violence; and

17 “(B) rehabilitation from such injuries;”;
18 and

19 (2) by adding at the end the following new sub-
20 section:

21 “(c) NO ADVOCACY OR PROMOTION OF GUN CON-
22 TROL.—Nothing in this section shall be construed to—

23 “(1) authorize the Secretary to give assistance,
24 make grants, or enter into cooperative agreements or

1 contracts for the purpose of advocating or promoting
2 gun control; or

3 “(2) permit a recipient of any assistance, grant,
4 cooperative agreement, or contract under this section
5 to use such assistance, grant, agreement, or contract
6 for the purpose of advocating or promoting gun con-
7 trol.”.

8 **SEC. 10102. NATIONAL VIOLENT DEATH REPORTING SYS-**
9 **TEM.**

10 The Secretary of Health and Human Services, acting
11 through the Director of the Centers for Disease Control
12 and Prevention, shall improve the National Violent Death
13 Reporting System (as authorized by sections 301(a) and
14 391(a) of the Public Service Health Act (42 U.S.C.
15 241(a), 280b(a)), particularly through the inclusion of ad-
16 ditional States and activities to increase the quality, type,
17 and timeliness of reported data. Participation in the Sys-
18 tem by the States shall be voluntary.

19 **SEC. 10103. REPORT ON EFFECTS OF GUN VIOLENCE ON**
20 **PUBLIC HEALTH.**

21 Not later than one year after the date of enactment
22 of this Act, and annually thereafter, the Surgeon General
23 shall submit to Congress a report on the effects on public
24 health, including mental health, of gun violence in the

1 United States during the preceding year, and the status
2 of actions taken to address such effects.

3 **SEC. 10104. REPORT ON EFFECTS OF GUN VIOLENCE ON**
4 **MENTAL HEALTH IN MINORITY COMMU-**
5 **NITIES.**

6 Not later than one year after the date of enactment
7 of this Act, the Deputy Assistant Secretary for Minority
8 Health in the Office of the Secretary of Health and
9 Human Services shall submit to Congress a report on the
10 effects of gun violence on public health, including mental
11 health, in minority communities in the United States, and
12 the status of actions taken to address such effects.